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LOSS, SEPARATION, TERMINATION:

A PORTFOLIO ON ENDINGS

VOLUME I

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A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Psychology.

City University, London
Department of Psychology
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PART ONE

OVERVIEW

LOSS IN PERSONAL LIFE,
ENDINGS IN PROFESSIONAL PRACTICE

Endings are an inseparable part of our lives. We experience the loss of a loved one, the dissolution of relationships and other separations in our everyday lives. As professionals, Counselling Psychologists deal with repeated endings with clients as well as with colleagues, supervisors and training peers in everyday practice and training experiences. This portfolio focuses on the experience of endings from these two perspectives: as people in personal life and as professionals in clinical practice. As it will be concluded, the two may overlap at times and the professional may deal with personal grief in a therapeutic context.

In the first part of the portfolio the dissolution of heterosexual non-marital romantic relationships will be explored through a critical review of recent literature. The focus of this paper is on gender differences and attachment styles and how they influence the person's reactions to the ending of romantic relationships. Gender is critically explored as a factor differentiating people's behaviour, especially in the context of personal relationships. Even though there is strong evidence that women are more aware of and more often discuss relationship issues (e.g., Lin & Raghubi, 2005), the results regarding gender differences in reaction to relationship breakups are ambiguous and sometimes contradictive (e.g. Hill, Rubin & Peplau, 1976, Baxter, 1986, Chung et al., 2002). This suggests that gender is not a reliable variable to differentiate people's reactions to relationship breakups. Research on individual differences in the response to relationship dissolutions has focused on adult attachment styles and concluded that early attachment styles and separation experiences influence the person's response to relationship breakups (e.g. Feeney & Noller, 1992). Further research is suggested that will include gender meanings and attachment styles in various cultural contexts.

The second part of the portfolio focuses on the ending of a different relationship, the therapeutic relationship. It is deemed to be an unequal relationship where the therapist is the expert and the patient is the one who seeks help, but also it is an encounter of

two real people who meet for a specific goal (e.g., Jacobs, 2004). Therapists' experience of the phase of termination of therapeutic relationships is the focus of the present empirical research project. Therapists' attachment styles have been suggested to be important aspects of the therapeutic relationship and their experience of loss is significant at the time of termination (e.g., Pistole, 1999, Brugnoli, 1990). Ten psychoanalytic and psychodynamic therapists shared in an intimate way their experience of ending the relationship with their patients and identified the important factors that differentiated these experiences. With the use of grounded theory methodology and analysis of data (Strauss & Corbin, 1998, Charmaz, 2006, Rennie, Philips and Quartaro, 1988) six central categories emerged. Their definitions and relationships contributed to the development of a model of the therapists' journey through the termination of therapy with patients. Issues such as the therapist as a person, the process of termination and the post-termination phase as well as the therapists' self-care are further discussed in this paper.

Therapists are real people who experience ending of relationships in their everyday practice. These endings stir up personal feelings in them which influence the way they will deal with termination with their patients. Moreover, different patients stir up different feelings and the significance of the therapeutic relationship has been emphasised in this study. Reflecting on the influence of attachment styles in the dissolution of romantic relationships (e.g. Feeney & Noller, 1992) one wonders what it is the therapists' personalities and history that account for the degree of intensity in their separations from their patients and make the termination "proper" or "despondent". The therapists' attachment style and the way it influences the development of the therapeutic relationship has been explored in the literature (Pistole, 1999) as well as the therapists' experience of loss at the time of dissolution of therapeutic relationships (Brugnoli, 1990). Differentiation in therapists' experience of termination could thus be attributed partly to their individual differences with regard to attachment, as well as the way they have dealt with separations in their personal lives. Hence the therapist's involvement as a person in the termination stage of therapy resembles the dissolution of romantic relationships in terms of influence of attachment and experience of loss. Attachment style and its reflection on the therapists' reactions to termination need further systematic exploration for one to draw consistent conclusions.

The third part of the portfolio entails a clinical case study of my practice as a trainee Counselling Psychologist in an NHS psychotherapy department. As in any NHS setting, it was a time-limited therapy process, but being in a psychotherapy context it was long term, lasting for one year. This was my first experience of long term therapy with a client, especially in a psychodynamic framework. The challenges of the work are outlined and the issue of termination is extensively discussed. The ending with this client coincided with the writing up of the results for the empirical research part of this portfolio. Reflecting on these results helped me understand more my experience of ending with this client. I felt a deep feeling of sadness as well as anxiety about the outcome of therapy. I reassured the client she could contact me after the ending and I informed her of the date I would be leaving the setting myself. I felt like I wanted to reward her for her effort and thank her for offering me a great learning experience, both on a personal and professional level. I was longing for some feedback from her about our relationship, but I knew that in the context of psychodynamic practice this would not be appropriate.

I therefore searched for resources I could turn to in order to work through my feelings. I felt my emotions were normalised as I reflected on the results of my research and thus felt ready to be open about them. I first talked to my supervisor and discussed in an honest way my countertransference feelings as well as the deep sadness I even feel now when I think about this client. This is a final termination since there is little chance I will ever have the chance to find out what has happened to her and that makes my feelings of nostalgia more intense. I am not sure though whether I would be able to talk or write about these feelings had I not conducted this piece of research and immersed myself in the experience of qualified therapists.

Talking and writing about endings for this portfolio has been at times painful for me. Writing about breakups stirred up personal memories which I would otherwise prefer to keep hidden. Being in interviews with therapists who discussed in an emotional way traumatic experiences of loss and death was demanding of me sometimes. Coding, analysis and writing have been processes that demanded time and my full attention to difficult feelings regarding endings which at times was hard to endure.

Moreover, reflecting on my experience of termination with my first long term client, for whom I really cared, still brings tears in my eyes.

The ending of the writing-up also marks the ending of a three-year journey I went through during my training. At present time I am going through a series of personal, professional, expected and unexpected endings. I value my personal therapy (which will terminate soon) and the support from my peers and friends, but I also agree with my participants when they talk about it being a lonely place; while sharing is important there are feelings that I will just have to contain within myself.

As painful as it may have been, I feel content for the development of this portfolio and my managing to articulate issues that are most often omitted as unbearable. I hope to offer to the reader similar relief to what I felt when I was able to feel more comfortable with my emotions at the end of this journey.

PART TWO

CRITICAL LITERATURE REVIEW

Reactions to Heterosexual Non-Marital Relationship Dissolution:

Gender Differences and Attachment Styles

Abstract

This paper aims to explore gender differences in reactions to romantic relationship dissolutions. Within the body of research on relationship breakups, attachment theory is frequently mentioned. Empirical data on adult attachment styles and how they relate to gender differences and reactions to separations will also be explored.

The issue of gender is prevalent in psychological literature. Such classification regarding reactions to relationship breakups is ambiguous and research should turn to individuals and relationships when exploring breakups.

Introduction

Dating begins from a young age and non-marital romantic relationships are more common nowadays than any other time in history; the understanding of the individual's post-dissolution emotions and recovery is considered important (Brehm, 1987, Sbarra & Ferrer, 2006). The breakup of a close relationship can be one of life's most distressing experiences for the individual, resulting in feelings such as anxiety, depression and loneliness (Davis, Shaver & Vernon, 2003). Apart from the negative emotions a loss can provoke, relationship dissolutions may have benefits for the person, especially in terms of future partner selection (Hill, Rubin & Peplau, 1976) and personal growth (Tashiro & Frazier, 2003). In the present review, the question of whether men and women react differently to separations will be explored critically

through the literature as well as the impact of the person's attachment styles on their responses to breakups.

This review does not claim to be a systematic review of the literature but represents a selective but representative overview of the relevant literature.

Gender

"Sex" usually refers to the biological differences between male and female whereas "gender" has cultural and social connotations (Oakley, 1972, Dozier, 2005). Over the last thirty years the meanings of sex and gender have been extensively critiqued and advanced by theorists; more recently "gender is defined as the socially constructed correlate of sex" (Dozier, 2005, p.298). Gender roles develop throughout the person's life (Oakley, 1972); parents react differently as soon as they realise their child is a boy or a girl (Burck & Daniel, 1995). In everyday life, we tend to meet gender differences in a rather automatic and "polarised" way (Burck & Daniel, 1995, p.13); without much conscious consideration as soon as we see someone they are immediately identified as male or female (Fee, 2006). These differences are attributed today on socialisation and "learned responses to environmental cues" (Hook, Gerstein, Detterich & Gridlney, 2003, p.471). Feminist theory has challenged the traditional societal views of gender and argues the moving away from those stereotypes (Burck & Daniel, 1995, p.14). Gender differences tend to narrow with time (Cross & Madson, 1997) and research turns towards equality rather than validating differences (Maccoby, 1990, Connell, 2002).

Relationships Dissolution

People are keen to be close to others and this need is probably one of the most intense (Birtchnell, 1996). This would explain the euphoria people feel when they are in love; they share experiences, engage in childlike behaviours, tend to idealise the other, abandon their privacy and expose themselves (Birtchnell, 1996). Intimacy entails challenges though and partners struggle between "independence and dependence,

autonomy and sharing, inner and outer boundaries and so on" (Sørensen & Duffell, 2007, p.24) which may provoke conflicts, which ask for resolution or may even cause the dissolution of the relationship (Dym & Glenn, 1993). Relationship breakups influence the person's sense of self and subsequent mate selection (Lewandowski & Sahner, 2005), may have consequences on young adults' mental health (Overbeek, Vollebergh, Engels & Meeus, 2003, p.675) or influence subsequent marriage stability (O'Connor, Pickering, Dunn, Golding, et al., 1999). Amongst the major variables that have been studied in relation to the nature of the post-dissolution distress are: i) characteristics of the relationship while it was intact, ii) conditions under which the relationship ended and iii) individual difference variables (Sprecher et al., 1998). For the purposes of the present paper, the focus is on individual differences, and especially gender differences and attachment styles as they are associated with reactions to romantic relationship breakups.

Link to Counselling Psychology

Gender may implicitly or explicitly influence the development of the therapeutic relationship and progress of therapy. Therapists are encouraged to challenge their own preconceptions about gender and recognise the impact on the development of relationships (Burck & Daniel, 1995, Gillion, 2007, Walker, Ladany & Pate-Carolan, 2007). In the therapy room the therapist is an individual, male or female, working with men, women, girls and boys. Gender is either overtly or latently involved in the therapy process and "gender sensitivity in the work can prove liberating" (Burck & Daniel, 1995, p.19). Gender-related factors as well as a person's reactions to separations may influence the development of the therapeutic relationship (Blazina & Watkins, 2000). Therapists should remain mindful and, where appropriate, be open to exploring these issues as they appear in the therapy room.

Counselling Psychologists come across issues of relationships and separations in their everyday practice. Couples face conflicts, which derive from a range of sources; from the change of gender roles to the partners' own upbringing and background (Dym & Glenn, 1993). Couples turn to their therapists for advice and help to resolve these conflicts (Dym & Glenn, 1993). Many relationships do not last for long and partners

find it easier to separate and move on from them (Dym & Glenn, 1993). At that distressing time, people seek help to deal with their feelings of guilt, sadness and loss and the more they manage to work through these emotions the more free they might feel to move on after the separation (Cullington, 2008). "Few experiences in life are capable of producing more emotional distress, anguish and suffering than is the dissolution of an important relationship" (Simpson, 1987, p.683). Separation and relationship dissolutions activate a person's coping strategies and they find themselves in new circumstances in which they need to adjust (Sprecher et al., 1998). Recovery from feelings of sadness and anger and how people adjust after relationship dissolutions are deemed important for the person's "restored psychological balance" (Sbarra, 2006, p.310). The understanding of the reactions a person has and the changes they make when facing a separation helps Counselling Psychologists be more effective with clients coping with loss.

The current review aims to shed some light on these issues and offer clarifications that could help improve clinical conceptualisations and practice.

Gender Differences in Relationships

Men and women are generally believed to communicate in different ways; men tend to "approach the world as a hierarchical social order" following the value of independence whereas women are believed to "approach the world as a network of connections" and adhere to negotiations in order to achieve closeness (Clulow, 2007, p.5). These differences and how they are manifested in relationships will be explored in this section.

Independence and interdependence

A considerable amount of research has focused on gender differences in relation to the development of romantic relationships. The focus is on socially developed gender roles and how they influence a person's self constructs and interaction patterns in close relationships (Maccoby, 1990). Developmentally, it has been suggested that girls tend to be co-operative, strive to maintain close friendships and interpersonal intimacy whereas boys are more competitive and dominant (Maccoby, 1990).

Research on gender differences associated with cognition, motivation, emotion and social behaviour in adults has turned to self-construal theory (Cross & Madson, 1997). According to this, women tend to appear interdependent; they are inclined to pay close attention to others, consider their partner's perception in their interactions and adjust their own behaviour accordingly, their self-esteem is enhanced by the sense of belonging and tend to place more importance on the quality of their intimate relationships (Cross & Madson, 1997). Men are characterised by independent self-construal structures and their membership in groups promotes their sense of uniqueness and individuality, and strive for autonomy (Cross & Madson, 1997).

Gabriel and Gardner (1999) attempted to expand the self-construal theory and explored the concepts of independence and interdependence as they relate to gender differences; they investigated how relational (close relationship) and collective (group memberships) aspects could be added to these conceptualisations. They found that women describe themselves in relational terms, report more emotional experiences linked to relationships, and appear motivated to behave in ways that maintain close relationships. Men tend to describe themselves in collective terms, report emotional experiences linked to groups, appear attuned to information related to the group memberships and tend to behave in ways that support their groups. The authors attributed these to differences to theories that suggest that women are more relational and men strive for social status (Gabriel & Gardner, 1999).

Dependency in relationships has also been explored in relation to gender differences (Alonso- Arbiol, Shaver & Yarnoz, 2002, Huprich, Stepp, Graham & Johnson (2004) Women were found slightly more dependent than men (Alonso-Arbiol et al., 2002) and men's experience of dependency tends to be linked to awareness of being distant and separate from others ("I need you but I don't trust you") while women's experience of dependency entails excessive focus on their need for other people's attention ("I need you so pay attention to me") (Huprich et al., 2004, p.808). Attachment styles have also been linked to dependency, suggesting that individuals with high abandonment anxiety and high desire for closeness and intimacy manifest higher levels of dependency (Alonso-Arbiol et al., 2002).

Realism, intimacy and expressiveness in relationships

Men often expect that they will have happier relationships while women appear more realistic in their expectations (Lin & Raghubir, 2005). It has been found that women tend to be more objective as they are more inclined than men to discuss their relationships in their social network and this contributes to perceiving them more realistically (Lin & Raghubir, 2005). Women also tend to express more openly affection and love than men in their relationships (Lin & Raghubir, 2005). However men and women appear similar in the way they value intimacy in relationships (Hook, Gerstein, Detterich & Gridlney, 2003) even though it has been suggested that women tend to seek closeness whereas men strive for autonomy (Hojjat, 2000).

Acitelli (1992) studied the level of relationship awareness between men and women; relationship awareness is defined in this study as "thinking about interaction patterns, comparisons, or contrasts between oneself and one's partner in a relationship" (Acitelli, 1992, p.102). Couples were interviewed in this study and it was found that women tend to talk more about their relationships. When men expressed more relationship awareness, their partners reported being more content in their relationships. As it is unusual for men to talk about their relationships, when this occurs it has a significant impact on the happiness of the couple (Acitelli, 1992). This statement is also supported by Blazina and Watkins (2000) when they explored the relation between attitudes towards gender roles and reactions to relationship problems. Their findings suggested that men with less "gender-bound" thinking about women appear less emotionally restrictive and with less relationship problems (Blazina & Watkins, 2000, p.130). These men were more acceptable to characteristics such as emotional expressiveness and intimacy and the authors highlighted the impact of Western culture in which men experience a "psychic dilemma" between needing others and being self-sufficient (Blazina & Watkins, 2000, p.130).

Hojjat (2000) explored individuals' self and partner's perceptions of "conflict management behaviours" (p.598). The findings indicated that women are more likely than men to feel assertive when they attempt to resolve conflicts whereas men tended to engage in more passive and positive strategies when they tried to resolve conflicts. Women tend to be more "conflict-engaging, whereas men are more conflict-avoiding" (Hojjat, 2000, p.611).

Burns (2002) explored qualitatively men's and women's (not couples) narratives of romantic relationships experiences. Her findings indicate that women tend to perceive men as "inexpressive" of their emotions and described themselves as emotionally intense and expressive (Burns, 2002, p.167). Men presented themselves as less romantic and more rational. The author highlighted the fact that men tend to focus more on their intimate relationships and regarded them as important for their "personal growth" and the findings do not represent absolute truths of women as "emotional" and men as "repressed" (Burns, 2002, p.168).

Agency and communion

Research has been conducted on gender differences regarding the expression of agency (endeavour for mastery) and communion (endeavour for intimacy) as personality traits and interpersonal behaviours (Suh, Moskowitz, Fournier & Zuroff, 2004). Women tend to adhere to communion and men to agency as personality traits; no significant gender differences were found, however, between agency and communion as behaviours within personal relationships (Suh et al., 2004). Women appear more "quarrelsome" and demanding than men in their relationships and they are more likely to place criticism in their relationships (Suh et al., 2004, p.56). This finding supports Hojjat's (2000) conclusion that women tend to engage more in conflict behaviours than men.

Bartz and Lydon (2004) investigated the concepts of agency and communion in relation to attachment styles. Men with secure attachment style were more inclined to express communal behaviours (warmth, kindness and cooperation) whereas men with avoidant attachment styles expressed lack of caring for others and described themselves as less understanding and less warm (Batz & Lydon, 2004). Women who felt that their relationship was under threat were more likely to express agency traits, which was associated with contextual circumstances, as opposed to attachment patterns. The authors concluded that in the face of rejection and abandonment people's agency traits "are activated and increased for individuals to protect themselves" regardless of the person's gender (Batz & Lydon, 2004, pp.1398-1399).

Reactions to betrayal

Researchers studied the areas of infidelity and betrayal (Shackelford, Buss & Bennett, 2002). Shackelford (et al., 2002) studied gender differences in reactions to emotional and sexual infidelity. Men in this study found it more difficult to forgive their partner's sexual infidelity compared to emotional infidelity and they were more likely to separate as a reaction. On the contrary, women found it harder to forgive their partners' emotional infidelity and were also more likely to separate in these cases. Sabini and Green (2004) investigated gender differences in reactions to emotional and sexual infidelity in student and non-student samples. Both genders reported the same feelings of hurt following betrayal in their romantic relationships. Both genders "reported greater anger over sexual infidelity than emotional infidelity" in the student sample whilst in the non-student sample men reported significantly greater anger as a consequence of sexual infidelity (Sabini & Green, 2004, p.1379).

Haden and Hojjat (2006) explored young people's aggressive responses to betrayal in relationships. In terms of aggressive behaviour, women were found to be as likely as men to express aggressive behaviour; with regards to emotional reactions to infidelity, men expressed frustration, anger and hostility whilst women were more inclined to experience depression. Men were also found to be more willing to end the relationship in the case of sexual infidelity (Haden & Hojjat, 2006).

Conclusions

A summary of the above studies, including details on sample, methodology and limitations, is presented in Table 1, Appendix 1.

A variety of research designs is observed when exploring gender differences in various aspects of intimate relationships. Most of the studies used quantitative self-report measures (e.g. Gabriel & Gardner, 1999, Blazina & Watkins, 2000), whilst others used diaries and imagined scenarios (e.g. Suh et al., 2004, Shackelford et al., 2002, Sabini & Green, 2004). Only one study was purely qualitative (Burns, 2002). In the field of relationships, inventories and forced-choice research designs produce limitations in the responses and therefore omit from the findings the richness of

people's attitudes in their partnerships. More in-depth qualitative data can generate a better understanding of the complex interactions that take place within a relationship and would offer a clearer picture of the gender differences that may be observed in them. Whilst most of the studies reported correlations results, there was one that made causal statements (Batz & Lydon, 2004) and offered an explanation of the relationship between attachment styles and behaviours of agency and communion. Longitudinal studies exploring couples' lives and cycles could provide more data on how relationships and partners' behaviours progress in time.

Most research designs recruited undergraduate students sample (average age of 19-21) (e.g. Huprich et al., 2004, Lin & Raghubir, 2005). Recruiting students restricts the application of the results to the particular population and more studies with non-student samples are essential for generalisations. As Sabini and Green (2004) suggest, age may differentiate people's reactions in relationships significantly. Several research designs studied couples (Acitelli, 1992, Hojjat, 2000) instead of individuals which permitted observations of the interactions in the encounters. In the field or romantic relationships, such data is valuable in order to generate more reliable findings regarding partners' behaviour patterns in dyads and how they influence each other. Specific cultural group was the target of most studies (most in the United States) and it is suggested that more cross-cultural research designs would generate valid predictions regarding the impact of social stereotypes and gender differences on behaviours and attitudes in intimate relationships.

Gender differences appear salient in various aspects of romantic relationships. Women tend to regard their intimate relationships as important, strive to maintain their relationships and express their thoughts and emotions more openly than men (Accitelli, 1992, Cross & Madson, 1997, Gabriel & Gardner, 1999, Huprich et al., 2004). Men, on the other hand, value their independence and autonomy and appear more hesitant addressing relationship problems (Hojjat, 2000, Lin & Raghubir, 2005). Even though men are stereotypically regarded as restricted in their expressions, research suggests that they value their intimate relationships (Burns, 2002). It is supported in research that when men challenge these stereotypical beliefs and express themselves openly, their relationships are more likely to be satisfactory (Accitelli, 1992, Blazina & Watkins, 2000). However, several studies did not find any significant

differences, especially regarding the esteem of intimacy (Hook et al., 2003) and the expression of aggression when faced with infidelity (Haden & Hojjat, 2006).

The subject of differences in reactions to relationship dissolutions will be explored in the next chapter.

Reactions to Relationship Dissolution

Gender Differences

It is generally believed that men are at greater risk to deal with separations in a non-constructive way (Cullington, 2008, Parkes, 2006) as they are considered non-expressive of their emotions (Accitelli, 1992) and tend to withdraw rather than deal with their issues of loss (Cullington, 2008). In the face of loss, though, both parties deal with grief, guilt, loss and sadness (Cullington, 2008). 'Love and grieving are the two sides of the same coin: we cannot have the one without risking the other" (Parkes, 2006, p.1).

It is difficult to discuss intimate relationship dissolution without considering the impact of gender (Baxter, 1986). Research has focused on two major areas: precipitating factors and emotional reactions.

Precipitating factors

The specific factor of the desire to have impact or power on others ("Hope of Power") and its relation to relationship satisfaction has been studied (Stewart & Rubin, 1974, p. 306). In this longitudinal study the results illustrated that "Hope of Power" in men was significantly related to dissatisfaction in the relationship and difficulties were met in "establishing a harmonious relationship" with women (Stewart & Rubin, 1974, p.308). For women these correlations were not statistically significant. A successive longitudinal study (Hill, Rubin & Peplau, 1976) explored a greater number of factors contributing to relationship dissolution and concluded that external factors (such as distance) and timing play a crucial role for relationships stability. Women were found to be more receptive to the problems in the relationship, tended to be more likely to

"compare their relationships to alternatives" and initiate the breakup (Hill et al., 1976, p.161). Rejected men were found to feel depressed, lonely, less free and less guilty whereas rejected women felt grief and despair.

Baxter's (1986) study is frequently mentioned in the literature on relationship dissolutions. In this study, eight factors were identified as more influential on relationship stability: autonomy, similarity display (similar attitudes, beliefs and values), supportiveness, openness, loyalty, shared time, equity and romance, and these were considered to "guide the expectations and behaviours of romantic relationship parties" (Baxter, 1986, pp.298-299). Women made longer lists of factors than men and they reported more often autonomy, openness and equity as motives for breakup initiation. Men were significantly more likely to report romance as a stability factor. As Hill (et al., 1976) concluded, Baxter (1986) observed that women appeared to be more pragmatic whereas men presented as more sentimental. Simpson (1987) explored in a longitudinal study the factors that contributed to continuation of relationship and the levels of distress in the cases of relationship dissolution. The findings illustrated that relationship satisfaction, closeness, long duration, sex and low availability of suitable partners contributed to relationship stability. Distress following a relationship breakup was significantly predicted by the same variables. No significant gender differences were reported in this study.

Research by Downey (et al., 1998) focused on a person's expectations for rejection and how they were associated to breakups in romantic relationships. The results indicated that women's rejection sensitivity led to their partner's "rejecting responses", anger and considerations of the ending of the relationship (p.553). The authors did not reach the same conclusions for men. Reflecting on these gender differences, the self-construal theory is considered (Cross & Madson, 1997), especially the fact that women regard their relationships as important and strive to maintain them. Arriaga (2001) explored the level of satisfaction within relationships and how it related to breakups in two longitudinal studies. The results indicated that when fluctuations of satisfaction are prominent it is more likely the relationship will end. The author assumed that these fluctuations of satisfaction can be evoked by "inconsistencies in interactions that stem from the partner's behaviour as well as from one's own behaviour" and supported the self-construal theory view that when partners

engage in “interdependence” behaviours with less self-interest they are more likely to be involved in lasting relationships (Arriaga, 2001, p.762).

Another factor explored in the field of relationship dissolutions is the motive to acquire relationship-threatening information and it was found that when partners scored high on this scale, they were more likely to separate, which was more often when the partners were less close to each other (Ickes, Dugosh, Simpson & Wilson, 2003). Self-disclosure, however, has been positively related to relationship quality and commitment and predicted the continuation of the relationship (Sprecher & Hendrick, 2004). In particular, “the more that women perceived their partner had disclosed, the less likely the relationship was to break up” (Sprecher & Hendrick, 2004, p.872). This supports previous findings that suggest that when men are more talkative about their thoughts and emotions they are more likely to be involved in satisfactory relationships (Blazina & Watkins, 2000).

Physical distance and how it is related to relationships stability has been explored in the literature. Focusing on long-distance relationships, physical separation and how they relate to gender differences Helgeson (1994) concluded that women tended to be more distressed than men whilst in the long-distance relationship. Men suffered more than women from a breakup initiated by the partner as they were less prepared; women had the opportunity to think about the dissolution therefore adjust better to it (Helgeson, 1994). The latter is consistent with previous findings according to which women demonstrated more awareness of their relationships than men (Acitelli, 1992). In a survey of long-distance relationships Cameron and Ross (2007) explored the reasons for relationships dissolution and their relation to negative affect (pessimism, low self-esteem and negative emotions). The findings supported the view that men’s negative affect was significantly related to relationship dissolution (Cameron & Ross, 2007).

Emotional reactions to relationship dissolution

The way men and women are expected to regulate negative emotions has been correlated with adjusting after the dissolution of a romantic relationship (Mearns, 1991). Those with high expectancies for regulating negative moods become less

depressed following a breakup and more able to adopt constructive coping skills; no significant gender differences were reported (Mearns, 1991). Choo, Levine and Hatfied (1996) explored how women react differently to men when their relationships end. Men in this study reported less joy or relief immediately after the breakup than women, and women were found to be more prepared when dealing with separation. The results support previous findings (Hill et al, 1976, Baxter, 1984, Helgeson, 1994) according to which men experience breakups they do not initiate as a shock.

Sprecher (et al., 1998) explored post-dissolution distress and its relation to attachment styles and gender. Distress was significantly greater when the relationship was characterised by high commitment, satisfaction and long duration and when one was "left" for another person (Sprecher et al., 1998, pp.803-804). In terms of individual differences, higher scores on anxiety attachment style were significantly related with post-dissolution distress. In terms of gender differences, women were more likely to be upset immediately after the breakup and more inclined to attribute the breakup to their partners (Sprecher et al., 1998). The relation between gender, love styles and post-dissolution stress has been explored by Chung (et al., 2002) and it was found that women were significantly more socially dysfunctional and depressed than men following relationship dissolution. The findings were contradictive to previous research that demonstrated women coping with breakups more constructively than men (Hill et. al., 1976, Helgeson, 1994).

Sbarra and Ferrer (2006) attempted to develop a model of the sequence of emotional reactions following relationship dissolution and concluded that the dynamic of love-anger-sadness is pertinent after the breakup (Sbarra & Ferrer, 2006).

Conclusions

A summary of the above studies, including details on sample, methodology and limitations, is presented in Table 2, Appendix 1.

Quantitative measures, interviews and diaries were mainly used in the above studies. Several studies explored specific factors contributing to a breakup (Stewart & Rubin,

1974, Downey et al., 1998, Sprecher & Hendrick, 2004). Isolating factors cannot in themselves predict stability in the relationship due to the complex nature of the phenomenon and how it evolves in time. Longitudinal studies provided data about evolvement of relationships in time (Simpson, 1987, Hill et al., 1976, Arriaga, 2001) as well as emotional reactions immediately after the breakup and in later stages (Sprecher et al., 1998, Sbarra & Ferrer, 2006). More qualitative studies are deemed essential as they would offer additional in-depth findings. Studies explored the participants' retrospective accounts of reactions to breakup which entail the risk of distortions due to memory faults or time (Sprecher et al., 1998, Chung et al., 2002); the use of diaries allowed the researchers to assess a person's reactions and emotions as they occurred (Sbarra & Ferrer, 2006).

Researchers have mainly recruited students. As Tashiro and Frazier (2003) argued, university students are considered appropriate for exploring the consequences of romantic relationship breakups since they are often not married and are likely to be in the phase of developing relational skills. However, recruiting university participants restricts the application of the results to different populations. Studies with diverse samples are deemed essential to draw conclusions on the impact of age and reactions to breakups in later stages in life. It should also be considered in the interpretation of the results that women tend to be more talkative than men about their emotions (Accitelli, 1992) and this may influence the outcome of studies on gender differences; men may appear less distressed due to their lack of expression rather than actual experience. Moreover, the above studies were conducted several years ago and more recent data would offer a clearer picture of men's and women's reactions to separation in today's society.

As results indicate, the main factors that contribute to relationship stability are quality, duration, satisfaction, autonomy, openness and contextual factors such as distance and timing (Hill et al., 1976, Baxter, 1986, Simpson, 1987, Sprecher & Hendrick, 2004). Desire for power in men (Stewart & Rubin, 1974) and rejection sensitivity in women (Downey et al., 1998) seem to influence the progress of relationship; these findings comply with the self-construal theory, according to which men strive for social status and value their independence whilst women value their intimate relationships and appear sensitive to loss (Cross & Madson, 1997). Regarding gender differences, the

findings appear ambiguous and sometimes contradictive. Women were found to be more distressed than men following a separation (Sprecher et al., 1998, Chung et al., 2002) but appeared more prepared to adjust to it (Hill et al., 1976, Baxter, 1986, Helgeson, 1994, Choo et al., 1996). The results contradict the stereotypes of romantic and sentimental women and women were found to be more pragmatic in their relationships (Helgeson, 1994, Choo et al., 1996); these findings support Burns' (2002) conclusion that thinking of women as sentimental and men as rational is a false classification.

What is suggested by authors (Choo et al, 1996, Chung et al, 2002) is that attachment styles may provide valid explanations for the differences observed concerning distress levels following relationship dissolution. The next chapter will focus on reactions to separations based on the attachment theory.

Reactions to Relationship Dissolution

Attachment Styles

Attachment styles between parents and babies have been extensively explored (Bowlby, 1969) but research has also focused on how attachment patterns influence later childhood and adulthood relationships (Parkes, 2006). Hazan and Shaver (1987) first suggested that early attachment styles are similar in adulthood as they are in infancy and can predict adults' experiences within romantic relationships. It has also been suggested that attachment styles from previous relationships and former partners are carried forward to subsequent relationships (Brumbaugh & Fraley, 2006). The experiences of attachment and nurturance are prominent in every adult romantic relationship and play a significant part to their maintenance (Parkes, 2006). Research presented in this chapter aims to conceptualise individual differences based on attachment theory.

Models of adult attachment

Attachment behaviour is expressed when a person is "strongly disposed to seek proximity to and contact with a specific figure and to do so in certain situations" (Bowlby, 1969, p.371). Every person is different in the way they respond to situations of loss and separations (Bowlby, 1973). It is believed that there are differences in "susceptibility to fear" between men and women and culture plays a crucial role in enhancing or diminishing these differences (Bowlby, 1973, p.247). Anxious attachment or separation anxiety adheres to the person's "natural desire for a close relationship with an attachment figure, and recognises that he is apprehensive lest the relationship be ended" (Bowlby, 1973, p.247). The extent of emotional attachment in a relationship relates to the degree of emotional distress experienced upon its dissolution (Bowlby, 1980). In the course of human development people engage in strong affectional bonds or attachments, initially as a child (with the mother) and later as an adult; in the face of a loss the person may experience anxiety, sorrow or anger (Bowlby, 1980).

Simpson (1990) developed a three-facet-model of adult attachment: secure (satisfaction, intimacy, trust, commitment), avoidant (less committed and intimate) and anxious/ambivalent (passion, preoccupation and low satisfaction). Simpson (1990) concluded that avoidant men tend to experience less post-dissolution distress and related this to the attachment style per se rather than the quality of the relationship. Bartholomew and Horowitz (1991) developed a four-style-model of adult attachment: secure attachment characterised by the person feeling comfortable with intimacy and autonomy (positive self/low dependence – positive other/low avoidance), preoccupied attachment characterised by preoccupation with relationships (negative self/high dependence-positive other/low avoidance), fearful attachment characterised by fear of intimacy and social avoidance (negative self/high dependence-negative other/high avoidance) and dismissing attachment characterised by dismissing intimacy and counter-dependence (positive self/low dependence-negative other/high avoidance). The authors explored individual differences based on their model and found that women reported significantly more often preoccupied attachment styles than men whilst men reported more often dismissing attachment styles (Bartholomew & Horowitz, 1991). These findings support Gabriel and

Gardner's (1999) development of self-construal theory where women adhere to interdependent patterns of relating whilst men strive for independence and autonomy.

Cassidy (2000) reviewed theoretical and empirical data of developmental perspectives of attachment and their relation to individual differences as they appear in romantic relationships and concluded that "within a romantic relationship, an individual may be influenced by early attachment to behave in ways that elicit, for instance, rejection or withdrawal from the current partner" (p.126). The individual's adult attachment circumstances they find themselves in are a result of both early-developed attachment styles and of the way they have been treated by their partners (Cassidy, 2000). In their longitudinal study, Simpson (et al., 2007) explored the attachment patterns from infancy to adulthood and assessed various stages of participants' lives (infancy, early childhood, elementary school age, adolescence and early twenties). Their results confirmed that "both the experience and expression of emotions in adult romantic relationships were meaningfully linked to attachment-relevant experiences earlier" in the person's development (Simpson, Collins, Tran & Haydon, 2007, p.363). Early secure attachment predicted competence with peers in elementary school years, formation of close relationship during adolescent years and expression of emotions in romantic relationships during adulthood (Simpson et al., 2007). On the other hand, individuals with insecure early attachments expressed "less positive and more negative emotions in their relationships" (Simpson et al, 2007, p.364).

Attachment styles and relationship dissolution

Feeney and Noller (1992) explored how attachment styles relate to affective responses to romantic relationship breakups. Avoidant participants reported relief and low levels of emotional distress whereas anxious participants were more surprised in the face of a breakup, which reflects their lack of monitoring their relationships, and became involved in new dating relationships more often (Feeney & Noller, 1992, p.73). Furthermore, women with avoidant attachment style were more inclined to be involved in unstable relationships. Combining gender differences and attachment styles in their research design Kirkpatrick and Davis (1994) explored how they influence relationship stability. The findings of this longitudinal study indicated that relationships in which men were characterised by avoidant attachment style (avoided

intimacy and remained emotionally distanced) appeared to be less stable. In relationships within which women had anxious-ambivalent attachment styles, less satisfaction or viability was recorded by both partners. Gender-roles theories support these findings that men appear relatively independent and women express more "possessiveness and demands for intimacy" (Kirkpatrick & Davis, 1994, p.509).

Fraley and Shaver (1998) designed a naturalistic study of attachment style and separation reactions aiming to observe couples' behaviours at an airport at the time of physical separations. Their results indicated that, in behavioural terms, adults that separated demonstrated Bowlby's (1980) principle of proximity; they tried to remain close to their partners when the availability of the partner was under threat, regardless of the realistic dimensions of the separation. Other factors influenced these behaviours, such as the duration of the relationship (the longer the relationship, the less the proximity behaviours) and the partner's availability. Results also indicated that women with avoidant attachment style tended to "pull away" from their partners (Fraley & Shaver, 1998, p.1208). On the other hand, women with secure attachment experienced less separation anxiety and freely expressed caregiving behaviours. Women with preoccupied attachment style were inclined to experience high degrees of anxiety and women with dismissing attachment style avoided contact with their partners. The data for men was not significant. The authors concluded that attachment behaviour serves similar functions in adulthood as they do in childhood (Fraley & Shaver, 1998).

Davis, Shaver and Vernon (2003) explored the concepts of attachment security and insecurity and how they interact with reactions to romantic relationship dissolution in an internet survey. Greater emotional involvement, non-initiation of breakup and anxious attachment styles were associated with greater distress at the time of separation. With regards to gender differences, the results indicated that women were more likely to express anger and hostility at the time of dissolution. As far as coping strategies are concerned, avoidant individuals demonstrated less use of friends and family whilst anxious ones engaged more in avoidance behaviours and reported a loss of identity following the dissolution (Davis et al., 2003). The results of this study contradict previous research that demonstrated that adults engaged in proximity behaviours at the time of separation (Fraley & Shaver, 2000) A clear link between

attachment style and reactions to breakup was confirmed in this study, suggesting that attachment style can serve as a predictor and determining factor of relationship dissolution reactions (Davis et al, 2003).

Conclusions

A summary of the above studies, including details on sample, methodology and limitations, is presented in Table 3, Appendix 1.

The above studies used multi-assessment methods to explored multiple variables. The results offer a range of multiple correlations, sometimes making it hard to conceptualise and narrow down to a consistent conclusion. Most of the studies entailed longitudinal methodologies, resuming contact with participants at a later stage after initial measures were completed (e.g. Simpson, 1990, Simpson et al., 2007). This method allowed observations and conclusions to be made on people's reactions to separations and factors that have influenced them, looking at attachment patterns that appear persistent in the course of time. However, considering attachment patterns in relationships, other contextual factors (significant events, quality of relationship, distance, timing etc) should also be taken into account since they may differentiate significantly people's relating behaviour.

It is evident that attachment theory can offer a consistent framework to make predictions of people's reactions to relationship dissolutions. Women appear more preoccupied in their relationships whilst men tend to engage in dismissing attitudes (Bartholomew & Horowitz, 1991). This is consistent with previous findings on independence and interdependence patterns amongst men and women (Cross & Madson, 1997). Agency and communion traits have also been associated with attachment styles (Bartz & Lydon, 2004), which supports Davis' (et al., 2003) conclusion that people tend to avoid intimacy when separating and contradicts Fraley and Shaver's (1998) findings regarding people's behaviours of proximity in the face of a separation. In summary, adult attachment theory seems promising in the

exploration of people's reactions to loss and separation; however, more data is needed in order to clarify the contradictory results and offer confident and reliable conclusions.

General Discussion

Gender alone is not an adequate factor to predict and conceptualise people's reaction to relationship dissolutions. Idiosyncratic, contextual and developmental factors influence the individual's responses to loss. Research supports the magnitude of the impact separation has on people's mental or physical health (e.g. Chung et al., 2002). Conceptualising and understanding the impact of breakups offers a consistent framework in which Counselling Psychologists can improve their practice. Understanding how a person reacts to separations helps therapists predict specific reactions and help clients deal better with the ending of therapy.

Separation and loss offer people a chance to review. Women may be more likely to critically evaluate how to improve future relationships following dissolution (Cross & Madson, 1997). Men also regard their intimate relationships as important and appear motivated to maintain them (Burns, 2002). In the face of societal changes, where women become independent and improve their educational and work status (Thompson, 2003, Aronso, 2008), couples struggle finding a balance between autonomy and dependence (Sørensen & Duffell, 2007). Attachment styles influence significantly people's reactions to relationship dissolution (Davis et al., 2003). However, even though attachment styles remain similar over the course of life (Cassidy, 2000) empirical research supports the view that patterns are likely to change in subsequent relationships (Downey et al., 1998).

Future research should focus on cross-cultural studies and how societal changes influence the individual's perceptions of relationships and breakups. More data on factors contributing to relationship dissolutions is needed, especially through longitudinal studies. More qualitative data would also offer in-depth findings on how

people experience the ending of their intimate relationships. Research on coping strategies following a separation is also essential.

Men and women seem to be more similar than different. Exploring and studying attachment styles in combination with gender differences, the findings look more promising.

PART THREE

EMPIRICAL RESEARCH

TERMINATION OF PSYCHOTHERAPY:

THE JOURNEY OF TEN PSYCHODYNAMIC AND PSYCHOANALYTIC THERAPISTS THROUGH TERMINATION OF THERAPY WITH PATIENTS

ABSTRACT

The purpose of this study is to examine the process of termination of therapy based on therapists' narratives of experiences of endings with patients. The significance of therapists' involvement as a person and working through their emotions in therapy process has been highlighted in the literature (e.g., Messinger, 1990, Meissner, 1996). The therapeutic relationship has been conceptualised as transferential, instrumental and real (including genuine and human features of the two persons involved in it) (e.g., Greenson, 1967, Clarkson, 2003). Literature on termination originates mainly from clinical and theoretical accounts as well as practitioners' personal reflections; little is recorded as systematic empirical research studies on termination and especially on therapists' experience of it (e.g., Novick, 1997, Murdin, 2000, Schlesinger, 2005). Ten psychoanalytic and psychodynamic therapists were interviewed for this study and the techniques for the analysis of the data drew on descriptions of grounded theory as they appear in Strauss and Corbin (1998), Charmaz (2006) and Rennie, Philips and Quartaro (1988). Six central categories derived from the analysis: therapist as a person, therapist's intellectual awareness of termination, development of therapeutic relationship, working through termination, termination through death and aftermath (post-termination phase). Their subcategories and their relationships will be extensively explored. Termination as a process, parallel processes in therapy, and therapists' dealing with emotions will be further discussed. This study also aims to contribute to the effort for collaboration of the disciplines of Counselling Psychology and Psychotherapy.

LITERATURE REVIEW

Introduction

The therapeutic relationship is different from everyday relationships; there is an expectation that it will have a definite ending. "Ending is what therapy is all about" (Schlesinger, 2005, p.23). The word "termination" is not used in every day language to indicate relationship dissolution; it is used to describe the phase of ending of a therapeutic relationship (Schlesinger, 2005). The term "termination" was initially introduced in the translation of Freud's paper "Analysis Terminable and Interminable" (Freud, 1937). Both parties in therapy have the awareness that the relationship will inevitably end (Schlesinger, 2005). However, in reality what ends is the regular contact between therapist[1] and patient[2] (Murdin, 2000). The implications of endings of therapy for the therapist, beyond the concrete meaning of termination, will be explored in this literature review.

This study aims to explore the therapist's experience of termination with patients. In this first section, the literature review has been conducted based on cotemporary empirical and theoretical reports on the therapeutic relationship and termination of therapy. In particular, the focus is on the therapist's being-as-a-person in the therapeutic relationship, the impact of her[3] personality, personal history, personal therapy and the use of self-disclosure. The therapeutic relationship will be explored based on contemporary theoretical reports and research. Finally, the termination process of therapy will be discussed, focusing on the therapist's experience of it.

The themes for the literature review emerged from the results of this study. The categories derived from the qualitative analysis defined the topics that are explored in

[1] The term "therapist" will be used to include analysts, psychoanalytic and psychodynamic psychotherapists, counselling psychologists and counsellors. This is implemented to ensure the homogeneity of the writing.
[2] The term "patient" will be used instead of the term "client" to represent closely the words used by the participants during interviews.
[3] The feminine pronouns will be used in all cases for the therapist and the patient regardless of the actual gender. This does not apply to the "Results" chapter.

this review. The therapist as a person, the development of the therapeutic relationship and the termination stage of the therapy process coincide with the three major areas that are indicated in the data: therapist's personal history, development of therapeutic relationship and time of termination. The focus will be on psychodynamic and psychoanalytic theory, since the participants of this study originate from this background. However, the contemporary theories and research in the field have been developed from a diverse psychotherapy theory background, which is represented in this review.

Therapist as a Person

Psychoanalytic theory and practice today moves away from the one-person model and the therapy process is perceived more as an intersubjective experience, adhering to a two-person model (Ginot, 1997). Even in the traditional analytical model, which has been promoting an anonymous therapist who takes an objective position, it is widely acknowledged today that the therapist is inevitably a "full participant" in therapy and "necessarily and uniquely influences the process" (Davis, 2002, p. 437). Theorists have concluded that the model of abstistence and anonymity, keeping the therapist in a neutral position, is not possible; the therapist has her own dynamics and conflicts that are evoked during the sessions with her patients (Mitchell, 1997). Based on contemporary psychoanalytic practice, the therapist regards her subjective reactions as inescapable, natural and helpful, whilst she embraces the intersubjective nature of the therapeutic encounter (Natterson, 1991, Davis, 2002). The intersubjective space in the therapy is defined as "the real aspects of the analyst's personality as they emerge in the relationship with the patient" (Meissner, 1996, p. 62).

Countertransference

Countertransference is the "transference reaction" of the therapist to a patient, "a parallel to transference, a counterpart of transference" (Greenson, 1967, p. 348). Freud did not explore the issue of countertransference to a great extent; he acknowledged it as the therapist's "unconscious response running 'counter' to the patient's transference (…) it is a reaction which, when it has not been sufficiently processed and integrated by the analyst, opposes the unfolding of the transference"

(Quinodoz, 2004, p.71). Winnicott (1949) offered a lengthy account of the issue of countertransference and argued for the therapist that "however much he loves his patients, he cannot avoid hating them and fearing them" (p. 69). Countertransference is perceived as the feelings evoked in the therapist by the patient by more contemporary theorists (Jacobs, 2004). It was first considered a barrier to effective therapy whilst later it has been regarded as a valuable element of the therapeutic relationship that helps the therapist gain a better understanding of the patient (Jacobs, 2004). The therapist's feelings during the therapy process is one of the tools she uses (Hinshelwood, 1999).

Therapist's personal history and feelings in the therapeutic encounter

The therapist enters the therapeutic relationship carrying her own personal history, experiences and memories (Silverman, 2006). She makes her idiosyncratic associations during therapy sessions and her affective reactions can deepen the analytic work with the patients (Silverman, 2006). A therapist with past traumatic experiences is a common phenomenon in the psychotherapy field; assumptions have been made about whether or not this is what leads people to become therapists (Silverman, 2006). The therapist develops "sensibility, empathy, responsiveness, and powerful antennae" which "indicate that as a child he probably used to fulfil other people's needs and to repress his own" (Miller, 1987, p. 22). The therapist often tends to keep her personal history out of the consulting room (Silverman, 2006). When incidents during therapy stir up personal feelings, she may feel vulnerable or even ashamed (Silverman, 2006). The therapist's idiosyncratic personality traits and style is embedded in the therapy process (Meissner, 1996). As Meissner (1996) argues, it is not a matter of "therapist's involvement or non-involvement but more about the kind of the therapist's involvement" (p.62). In the therapeutic encounter there are "inevitable dimensions introduced by interaction between two individuals who bring to the process distinctive orientations, backgrounds, attitudes and commitments" (Meissner, 1996, p. 82).

In the context of family therapy, it is often suggested that the therapist should resolve the unfinished family-of-origin issues in order to be therapeutically effective with patients; she, like her patients, carries negative impacts from her past (Lum, 2002). In

the field of Person-Centred therapy, Rogers (1951) discussed the therapist's core conditions in order to facilitate change in therapy: congruence, unconditional positive regard and empathy. During the therapy process, the therapist has a profound experience of relating to the patients in the relationship and there is a genuine sense of acceptance and receptiveness when she sees them as real people instead of "work" (Cooper, 2005). In psychodynamic therapy it is recognised how the therapist is "not a saint, and they need to get in touch with their own feelings, whether nice or nasty, some of which may be triggered by what a client evokes in them" (Jacobs, 2004, p.103). Mistakes during therapy can be attributed to the therapist's reactions "as though the patients were a significant person" of their early history (Greenson, 1967, p. 348).

The therapist experiences a range of negative feelings during therapy sessions with patients. She may experience anxiety with difficult patients who challenge her competencies; she may feel physically threatened or have the sense of a heightened physical tension (Menninger, 1990). It has been highlighted how the therapist needs to remain attuned to these feelings (Menninger, 1990). It is not uncommon for therapists to have these emotions towards their patients (Silverman, 2006). The therapist's personal issues can also cause impasses in the therapeutic alliance; such as her difficulties in dealing with negative feelings, her family-of-origin history as well as concurrent life stressors (Williams, Heaton, Thomson & Rhodes, 1996). She also experiences personal feelings in the course of her professional practice, namely emotional exhaustion, fatigue, problems in personal relationships and isolation as well as anxiety and depression (Mahoney, 1997, Linley & Joseph, 2007). In order to deal with these feelings, she tends to engage in hobbies and pleasurable activities as well as use supervision, peer groups and personal therapy (Mahoney, 1997).

As Kahn (1991) suggests, the therapist, like the patients, perceives the patients through her own attitudes, principles and values and she does not need to be defensive against these feelings but enhance her awareness and understanding of them. The therapist's personal characteristics and personal history affect the development of a positive therapeutic relationship (Dunkle & Friedlander, 1996).

Self-disclosure

The use of self disclosure is commonly mentioned as an important aspect of the therapist's use of self in therapy. The question of how much the patients should know still remains unanswered (Vamos, 1993). The therapist struggles with the use of self-disclosure; the inhibition of self-disclosure can sometimes serve as a protection or avoidance of the reality on behalf of the therapist, especially when she experiences emotionally disturbing life events, such as the loss of a loved one (Vamos, 1993). The therapist tends to "hide behind their professional role" and she remains quiet sometimes in order to meet her own needs (Silverman, 2006, p.530). When she self-discloses, she may feel vulnerable but it is argued that sometimes this is necessary in order to "join with the patients" (Silverman, 2006, p. 541).

Among theorists and practitioners there is a clear consensus on the fact that patients know about their therapists even from the way a therapist dresses or decorates her office (Meissner, 1996, Davis, 2002). Self-disclosure can be used in therapy as a way to teach the patient; the therapist uses herself in order to be in touch, aware and monitor her emotions during the process (Lum, 2002). Should the therapist neglect this aspect in therapy, discomfort, avoidance, denial and resistance could develop (Lum, 2002). Self-disclosure may assist the patient deal with her resistances and defences using this "authentic kind of empathic understanding" (Ginot, 1997, p. 370).

Personal Therapy

Personal therapy is considered to be an essential part of therapists' training; it helps the trainee therapist "be more aware of when they are responding to themselves rather than to the patients" (Loewenthal, 2001). Personal therapists are chosen on the basis of their professional experience, interpersonal qualities and competences (Norcross, Strausser & Faltus, 1988). The choice of a personal therapist is of primary importance since this relationships is also a "mentoring relationship" and provides therapists with a unique educational experience (Bridges, 1993, p.44). The therapist tends to imitate or identify with her personal therapist; she internalises and it becomes a "part of the development of their professional life" (Wiseman & Shefler, 2001, p.138).

The therapist has various motives when seeking personal therapy; apart from training requirements, she might seek a therapist due to marital conflicts, depression and anxiety (Norcross, Strausser & Missar, 1988). However, the therapist will regularly seek personal therapy not for symptom relief but in order to improve her relationships and gain confidence as practitioners (Buckley, Karasu & Charles, 1981). The development of a good therapeutic relationship with the personal therapist is important for therapy to be effective and the therapist pays close attention to the feelings of liking and being liked by her personal therapist (Buckley et al., 1981).

The therapist seeks "meaningful interpersonal exchanges and learning experiences" in her personal therapy (Norcross et al., 1988). Personal therapy aims to help her enhance her awareness and life satisfaction as a professional as well as be more effective in her therapeutic work (Norcross, 2005). It is a vital professional and interpersonal experience and often therapists seek therapy more than once in their careers (Norcross, 2005). Freud (1937) suggested that therapists should return to therapy periodically at intervals of almost five years. Personal therapy helps the therapist realise what it feels like for the patients to be in therapy (Norcross, 2005) and it provides her with the opportunity to observe clinical methods and therapeutic models (Norcross et al., 1988).

Personal therapy helps the therapist reach deeper levels of understanding in the therapy process, especially regarding issues of transference and countertransference (Wiseman & Shefler, 2001). She learns how to use techniques and boundaries in the therapeutic relationship with her patients as well as to separate her feelings from her patients' feelings, making better judgements during therapy (Macram, Stiles & Smith, 1999). Personal therapists become role models and offer the space for the therapist's positive identifications (Macram et al., 1999).

The therapist's person has been differentiated between her "personal self" and "professional self" (Wiseman & Shefler, 2001, p.137). She adheres to her professional self in the use of supervision and she unfolds her personal self in personal therapy, even though in the latter the two may be inseparable (Wiseman & Shefler, 2001). Within the therapeutic relationship the therapist serves as an "instrument" for the patient and "spends all day as the object of transference" (Schlesinger, 2005, pp.193-

199). She may then experience symptoms of burn-out and loss of pleasure in her work, especially when she misses satisfactions in personal life and finds herself unsatisfied within her work (Schlesinger, 2005, p.196). It is of primary importance then for her to have personal therapy and a trusted support network to deal with the difficulties of the work (Schlesinger, 2005, p.198).

Conclusion

With the use of case studies and theoretical papers (Davis, 2002, Lum, 2002, Schlesinger, 2005, Silverman, 2006) authors strive to illustrate the significance of the impact of the therapists' personality traits in the therapeutic encounters. Phenomenological and other qualitative studies (Williams et al., 1996, Wiseman & Sheffer, 2001, Cooper, 2005) have attempted to explore in depth how therapists relate in therapy and the experience of personal therapy. However, more research is needed in broader samples examining the perspectives of both the therapist and the patient. Moreover, researchers are usually therapists as well (e.g. Williams et al., 1996) and the issue of bias reduction is crucial. Quantitative studies tend to include more representative samples and objective measures to assess therapists' anxiety, self-care behaviours and personal growth through personal therapy (Menninger, 1990, Mahoney, 1997, Linley & Joseph, 2007); the authors emphasise the limitations of self-report inventories and the use of limited questionnaires with pre-determined variables and suggest that larger samples and data collected from in-depth interviews offer richer information on therapists' experiences in therapeutic encounters (Norcross et al., 1988, Macram et al., 1999).

Therapeutic Relationship

The various aspects and dimensions of the therapeutic relationship will be explored in this section. In particular, the three major facets of transference, working alliance and real relationship will be presented as they appear in literature.

Transference relationship

In psychodynamic theory, transference is considered primary aspect of the therapeutic relationship (Jacobs, 2004). It is defined as the "repetition" by the patient of "former, often child-like, patterns relating to significant people, such as parents, but now seen

in relation" to the therapist (Jacobs, 2004, p.17). The patient's transference reactions are "always inappropriate" and "unsuitable in its current context" (Greenson, 1967, p.152). In Clarkson's (2003) model of the five facets of the therapeutic relationship, she refers to the transferential/ countertransferential relationship as the "experience of distortion of the working alliance by wishes and fears and experiences from the past transferred onto the therapeutic partnership" (p.11). The analysis of the transference relationship is an important task in therapeutic practice and the therapist provides the patients with insight through interpretations (Greenson, 1967).

The therapeutic relationship is deemed to be the most important element for the therapy process to be effective (Jacobs, 2004). It is differentiated from the working alliance, but both are considered equally significant for the prevention of unilateral terminations and for a successful therapy outcome (Tryon & Kane, 1995, Crits-Christoph, Gibbons & Hearon, 2006, Horvath & Luborsky, 1993). The contemporary theories and research will be explored regarding the dimensions of the therapeutic relationship as well as the therapist's involvement in it.

Working alliance

An important dimension of the therapeutic relationship is the working alliance; it is defined as the "patient's capacity to work purposefully in the treatment situation" (Greenson, 1967, p.192). The working alliance represents the relationship that is developed between two adults who meet in order to carry out specific tasks, work through specific issues and carry out a specific type of job (Jacobs, 2004). Bordin (1979) attempted to conceptualise the working alliance based on three distinct components: therapist's and patient's agreement on goals, agreement on the way to achieve goals and the strong emotional bond that characterises the alliance (mutual trust, positive attachment, acceptance and confidence). Clarkson (2003) defines the working alliance as "the part of client-psychotherapist relationship that enables the client and therapist to work together even when either or both of them do not want to" (p.10). There is an increased emphasis in the literature on the collaborative task and the relational aspect of the working alliance.

Even though the working alliance refers mainly to reality, transference issues may influence its course (Jacobs, 2004) and the therapist's and the patient's personal histories are expected to influence its positive development (Horvath & Luborsky, 1993). The therapist's countertransference feelings may influence the formation of the working alliance and careful monitoring of these reactions is considered essential in the therapeutic encounter (Gelso & Carter, 1994). Negative countertransference feelings have been found to be negatively related to the quality of the working alliance (Ligièro & Gelso, 2002). The therapist and the patient work in a collaborative fashion and the patient has the motive of attaining help by an expert (Greenson, 1967).

Real relationship

The term "real relationship" refers to the aspect of the therapeutic relationship that is not characterised by the distortions of the transference and refers to "genuine, authentic and true" aspects of the two participants in the relationship; it refers to the "realistic and genuine relationship" between the therapist and the patient (Greenson, 1967, p. 217). The relationship that exists between the therapist and the patient is also a real relationship of "two people coming together; one in the role of the helper, the other seeking help" (Jacobs, 2004, p.124). In Clarkson's (2003) five-relationship model, she defined the "person-to-person relationship" as "the dialogic relationship or core relationship; it concerns the authentic humanness shared by client and therapist" (p.15). In the context of this real relationship, the therapist's subjectivity is prominent; her feelings are not only conceptualised as countertransferential resulting from unresolved conflicts but as real emotional reactions towards the patient (Clarkson, 2003). The real relationship refers to the aspect of the therapeutic relationship that is characterised by non-transferential elements (Gelso & Carter, 1994). The therapist's attitude is guided by her personality and her perceptions of the patients and the relationship are realistic (Gelso & Carter, 1994).

Research has focused on the interpersonal encounter between therapist and patient and in particular the therapist's involvement in it (Pistole, 1999, Dunkle & Friedlander, 1996, Dumont & Fitzpatrick, 2001, Black, Hardy, Turpin & Parry, 2005). The therapist's attachment style has been explored and the way it influences the

therapy process (Pistole, 1999). The therapeutic relationship is a "non-reciprocal" attachment relationship in which the therapist experiences a "caregiving bond" and provides proximity and security so that the patient feels safe and guided (Pistole, 1999, p.439). A "real attachment bond" is developed between the two, in which the therapist provides care and protects the relationship through the use of boundaries (Pistole, 1999, p.440-441). Therapists with less hostility, more social support and greater comfort with closeness are more likely to develop strong working alliances with patients (Dunkle & Friedlander, 1996). Therapists with features of secure attachment develop more positive therapeutic alliances whereas therapists' insecure attachment patterns predict poorer alliances (Black, Hardy, Turpin & Parry, 2005). Dumont and Fitzpatrick (2001) explored the therapist's experiences of past relationships and how they relate to the arousal of personal feelings during therapy with patients. The authors hypothesised that the therapist, like patients, has her transferential reactions during therapy where feelings, "attitudes and behaviours are displaced onto one patient or another" (Dumont & Fitzpatrick, 2001, p.14). They reviewed the parallel processes and the functions of transference and countertransference and concluded that, in conjunction with the traditional definitions of transference and countertransference, the therapist's transference (therapist's "perceptions that derive largely from their own expectations, stereotypes and latent interpersonal schemas") and the patient's countertransference (patient's "reactions to the therapist's transferential perceptions") should be equally considered (Dumont & Fitzpatrick, 2001, p.14).

Conclusion

The therapeutic relationship is conceived as an "instrumental relationship" since both participants engage in the encounter with specific goals in mind (Schlesinger, 2005, p.10). The therapist enters the relationship influencing the patient with her own social and idiosyncratic preconceptions, biased by her social and personal history (Dumont & Fitzpatrick, 2001). Researchers used scales, inventories and questionnaires to investigate the working alliance, attachment styles as well as therapists' and patients' characteristics as they influence the therapeutic relationship (Tryon & Kane, 1995, Dunkle & Friedlander, 1996, Ligièro & Gelso, 2002). Scale-item measures, however,

are not deemed sufficient to encompass the complexity of the phenomenon of the therapeutic encounter and authors suggest that qualitative research and observations of therapist-patient dyads would offer richer results (Tryon & Kane, 1995, Black et al., 2005). All relationships consist of a "mixture of transference and reality" and it is important to differentiate these states (Greenson, 1967, p.219). The three aspects of the therapeutic relationship interact with each other; the transference relationship affects the development of the working alliance and the more positive the real relationship, the stronger the alliance is (Gelso & Carter, 1994). The various facets of the therapeutic relationship frequently overlap and rarely follow a specific sequence (Clarkson, 2003).

Fit between therapist and patient

Therapy is commonly perceived as a two-person process and the "analytic match" has gained great significance; it is acknowledged that the two persons' personalities and conflicts (therapist and patient) will affect the development of the relationship (Frayn, 2008, p.48). Bordin (1979) spoke about the three components of the therapeutic alliance and how they represent the "matching" between the therapist and the patient that needs to be achieved in order for therapy to be effective (p.258). It has been suggested that when the therapist has extroverted characteristics and feels comfortable expressing her feelings, the patient rates the therapeutic relationship as more positive (Nelson & Stake, 1994). For therapists and patients to obtain an ultimate match, therapists need to understand better the impact they have on their patients (Nelson & Stake, 1994). The multiple facets of the therapeutic relationship as well as the acknowledgment of therapist's personal involvement in its development support the view that not all therapists can work with all patients (Meissner, 1996). In order to evaluate the "mismatch" between therapist and patient, therapists monitor their feelings during therapy process and when they experience negative emotional reactions (dislike, irritation, impatience, lack of sympathy) it is suggested that the patient should be referred to another therapist (Meissner, 1996, p.82).

Termination

After the exploration of the therapist-as-a-person in therapy and the facets of the therapeutic relationship, this section will deal with the stage of termination of therapy. As an instrumental relationship, the therapeutic relationship is limited and finite (Murdin, 2000). Termination has been considered to be a specific phase of therapy but not just as a momentary phase, since it journeys on (Schlesinger, 2005). Neither Freud nor his followers paid much attention to termination as a distinct process of therapy (Novick, 1997). Termination can be better conceptualised as a process; it takes place over time and therapy is considered to be a life long process, continuing on after the ending (Schlesinger, 2005). At the time of termination, what really stops is the regular contact and meetings between therapist and patient (Schlesinger, 2005, Firestein, 2001). The process of termination does not stop on the date of the last session due to the emotional aftermath (Firestein, 2001, Murdin, 2000, Fordham, 1978). When therapy ends, the emotions of anxiety and the conflicts do not disappear but become part of the patient's living since therapy remains in her mind (Strean & Freeman, 1988, p.217) and the relationship remains alive (Schafer, 2002).

Termination ideally occurs when the patient has reached her goals, feels better and has achieved a sense of mastery (Schlesinger, 2005). Schlesinger (2005) compares the termination of therapy with the educational model, arguing that it is a learning experience which influences and lasts for life (p.4). He also argues that many endings are entailed during the therapy process, when tasks have been accomplished and change occurs (Schlesinger, 2005, p.56). Both therapist and patient need "time to come to terms with the absence of the other" (Schlesinger, 2005, p.220). Even though termination has been acknowledged as an important process of therapy, the field hasn't been adequately researched (Pearson, 1998, Maholick & Turner, 1979, Roe, Dekel, Harel, Fennig & Fennig, 2006, Quintana & Holahan, 1992, Boyer & Hoffman, 1993, Weddington & Cavenar, 1979, Willock, 2007) and the existing literature focuses more on theoretical connotations rather than empirical evidence (Brady, Guy, Poelstra & Brown, 1996, Kramer, 1986).

Conceptualising Termination

Novick (1997) addresses the difficulties in conceptualising termination and defines it as a "blind spot in the training that prohibits scientific and clinical growth" (p.147). Termination is not a homogeneous phenomenon; it varies significantly depending on the success of therapy, diagnosis, therapist's therapeutic commitment, length of therapy, patient's attachment styles, therapist's personality traits, significant events and other human variables (O'Donohue & Cucciare, 2008, p.xvi). The "style of ending corresponds to the relationship" (Schlesinger, 2005, p.20). Pedder (1988) suggests that the term "termination" implies "negative and finite connotations" (p.454); it does not convey the positive aspects of this stage and it should be used to define forced or premature endings (Pedder, 1988).

There is a common consensus in the literature that termination should be initiated by the patient (Murdin, 2000) and that it is mutual when both parties agree on an ending date (Graybar & Leonard, 2008). Bender & Messner (2003) make a distinction between two types of termination: mature termination (therapy goals have been achieved) and premature termination (ending that needs to occur for other reasons, e.g. geographical moves or graduation) (p. 291). Frayn (2008) classifies termination in the following categories: premature, delayed, rapid but appropriate, and planned and appropriate (p.156). Quintana (1993) defined two types of termination: termination-as-loss (as it entails potential for crisis but also the opportunity for intrapsychic development) and termination-as-transformation (as it entails a transition period in which the relationship between therapist and patients is characterised by therapeutic internalisations). The latter is achieved mainly in successful cases where the therapist is de-idealised and "de-mystified" (Quintana, 1993, p.431). The two types of termination (termination-as-loss and termination-as-transformation) are not mutually exclusive but complementary and mutually informative (Graybar & Leonard, 2008, p.63). For the purposes of this study, Quintana's (1993) conceptualisation of termination will be adopted in the exploration of the literature.

Termination as Loss

Endings provoke a range of emotions for both parties and "there is a relationship to be mourned in the end" (Brugnoli, 1990, p.188). Mourning is deemed to be an

inseparable part of the termination process (Schlesinger, 2005). Loss of the therapeutic relationship is experienced by both therapist and patient (Murdin, 2000). For patients, the ending of therapy provides the opportunity to work through experienced endings and the accompanied feelings of sadness, anger, disappointment and gratitude; loss of the therapeutic relationship is like "every bereavement and loss in other contexts" (Murdin, 2000, p.139). It evokes previous losses and separation anxiety for patients (Firestein, 2001, p.205) induced by the loss of the attachment figure (therapist) (Pistole, 1999, p.443).

It has been suggested that the feelings of loss do not only relate to the real person of the therapist or the patient. Novick (1997) argues that the feelings of loss are associated with the fantasies that both participants in the relationship have, derived from their development and serve a range of functions and desires (p.153). Termination does not only entail the separation from the therapist but also "from whom the therapist unconsciously represents" (Frank, 1999, p.123). It is generally accepted that the ending of therapy is a loss for both "members of the dyad" (Firestein, 2001, p.215). It is a sad and painful time for both therapist and patient within which their separation history, defences and difficulties are embedded (Graybar & Leonard, 2008, p.60).

Termination as Transformation

Termination is the stage of patient's separation from relatedness to the therapist and the relationship, from instrumental, "takes a life of its own" (Schlesinger, 2005, p.22). At the end of the therapy, the resolution of the transference occurs; the therapist is perceived as another real person and not merely as projection of parts of the patient's self (Murdin, 2000, pp.35-44, Fordham, 1978). Firestein (2001) concluded that the therapeutic relationship improves at the termination stage because both participants are under the pressure of the ending date and work through the negative transference or feelings (p.208). The therapist should allow adequate time for transference reactions to be worked through when therapy has been effective and the relationship positive (Buckley et al., 1981). The therapeutic relationship is then "less distorted" in the ending (Pistole, 1999).

There is a process of change and growth that occurs during the termination phase and the therapist self-discloses in order to achieve "balance and equality in the therapeutic relationship" (Graybar & Leonard, 2008, p.61); a "de-mystification" of therapy takes place (Graybar & Leonard, 2008, p.62). The patient begins relating to the therapist in a more equal way rather than idealising or depreciating her (Kramer, 1986). Therefore, one of the goals of therapy should be for the patient to perceive the therapist in a realistic manner at the time of the ending (Strean & Freeman, 1988).

Techniques of Termination

Freud (1937) suggested that analysis should end when the patient no longer suffers from symptoms, anxieties or inhibitions and when a sufficient amount of repressed material has been made conscious. The time of termination is determined when the patient experiences relief from symptoms and forms of her suffering (Murdin, 2000). It is generally believed that the patients should initiate termination (Kramer, 1986, Ticho, 1971). There are various reasons for which a patient might initiate termination but the way in which a patient leaves is important in order to formulate the ending (Novick, 1997). However, the therapist is encouraged to remain realistic in her expectations and aim for symptoms relief rather than "character modifications" (Firestein, 2001, p.220).

There is no agreed technique of how therapists should terminate with their patients. It is suggested that it is significantly related to the therapy process and the therapeutic relationship (Schlesinger, 2005). Kramer (1986) interviewed twenty private-practice practitioners who conducted open-ended therapy and explored the techniques they used when terminating with patients. The findings indicated that there is a "lack of planning" of termination; therapists "engaged in complex and vague interactions around the process of termination rather than having a specific approach" (Kramer, 1986, p. 528).

Termination of therapy can be perceived as an analogy of the way we deal with endings in general (Maholick & Turner, 1979). The time of termination is a time of review of therapy and patients should be helped to "remember and forget" whilst the therapist makes "references to what happened initially" in the treatment (Murdin,

2000, p.136). Reviewing is deemed to be an important technique (Kramer, 1986). Therapists explore how the patients have developed coping skills and the ability to love and cooperate more effectively (Maholick & Turner, 1979) as well as how the "resilient ego" has been developed so that the patient can deal with a range of difficulties in the future (Firestein, 2001, p.219). The therapist should help the patient deal with the endings, her "inner private feelings, fantasies and dreams" (Maholick & Turner, 1979, p.590).

Marx and Gelso (1987) explored the therapists' "termination behaviours" as the patients experienced it (p.4). They concluded that there were three general themes: looking back (review), looking ahead (setting ending date, discussing future,exploring potential continuation of therapy) and saying goodbye (patients expressing appreciation, patient and therapist sharing feelings on endings) (Marx & Gelso, 1987, p.7). Quintana and Holahan (1992) used the same "termination behaviours" to measure the therapists' experience of the ending (p.301). They concluded that in the cases of unsuccessful endings there was less discussion on termination, less reviewing, less activity bringing closure and less discussion on patients' feelings (Quintana and Holahan, 1992, pp.303-304).

Therapists are encouraged to be natural in their responses at the termination stage (Murdin, 2000, p.142). Therapy should end with "thoughtfulness and care" (Graybar & Leonard, 2008, p.53).

Abrupt Termination

Satisfactory endings are not as common in the therapist's clinical practice and frequently she has a different agenda and aims than those of the patient (Schlesinger, 2005). It is suggested that therapy should continue until the goals have been achieved but there are occasions when the therapist initiates termination either because she cannot continue the work with specific patients or due to external circumstances (Schlesinger, 2005). The therapist's negative feelings towards the patient (such as hostility, mistrust, denial and anxiety) are frequently associated with premature terminations (Frayn, 2008, Kramer, 1986). There are also occasions when the patient takes a "unilateral decision" to terminate therapy and the therapist does not have a

chance to work through it (Murdin, 2000, p.61). Sometimes therapists find it hard judging when it is the right time for the patient to end treatment and they disagree with the patients regarding the time of termination (Schlesinger, 2005, Kramer 1986).

At termination of therapy, as in all separations, there is a "constant dialogue between closeness and separation, attunement and challenge, attachment and loss" (Holmes, 1997, p.170). Ending is part of therapy since the beginning (Schlesinger, 2005). As Holmes (1997) argues, ending is "casting its shadow on therapy from the start and, when it comes, is a culmination of all the countless little endings that have prefigured it" (p.170). "Termination begins when the patient starts therapy" (Strean & Freeman, 1988, p.211).

Therapist's Experience of Termination

The therapists experience repeated endings in their every-day practice, which can be rewarding or non-rewarding experiences (Schlesinger, 2005). Therapists repeatedly find themselves in the position where they need to let the patients go and deal with the finite nature of the therapeutic relationship (Murdin, 2000). The therapist gains her personal satisfactions through the development of these relationships (Murdin, 2000). At termination, she sometimes has to "give up a relationship she has enjoyed" (Murdin, 2000, p.171). The therapist feels she has learned a lot with specific patients and experiences grief for ending with "interesting or successful cases" (Firestein, 2001, p.215).

The process of ending can evoke real feelings of loss for the therapist (Murdin, 2000). The therapist needs to change at the termination (Schlesinger, 2005) and make "intellectual and emotional adjustments" when the patient leaves (Murdin, 2000, p.11). More is demanded for the therapists than just apply a list of techniques since they need to work through their personal "resistances and repressions" (Murdin, 2000, p.33). "The therapist is not immune from her past" (Murdin, 2000, p.37). She may experience ambiguity at the time of termination since she needs to deal with the sadness or relief as well as keep the boundaries and the realism her professional role demands (Holmes, 1997). Holmes (1997) attempted to relate the therapist's experience of termination with her attachment style: when the therapist over-

empathises and the patient is ambivalent, the ending may take place later than when it should; when the therapist over-emphasises the structure and the patient is avoidant then the ending occurs sooner than it should (p.169).

Boyer and Hoffman (1993) conducted a quantitative study on the therapist's experience of loss at the time of termination. Their findings indicated that the therapist's loss history and the perceived patient's sensitivity to endings were predictive of the therapist's affective reactions to termination, specifically anxiety and depression (Boyer & Hoffman, 1993). Significant life events or life stressors in the therapist's life may influence the termination phase and the more the therapist invests on the therapeutic relationship, also in terms of time, the more painful the termination will be; it feels like "losing a friend" (Brady et al., 1996, p.69). Due to her countertransference, the therapist may struggle judging when is the correct time for termination; this occurs either because she avoids the painful but essential mourning reaction or holds on to the patient and lengthens the therapy process as part of her difficulty to allow the patient grow up and become independent (Ticho, 1971).

The ending provokes a range of feelings for therapists, such as anxiety and anger (Murdin, 2000). She may feel anxiety for the outcome of therapy, concern for the patients and how they will deal with crises in the future and desire to work more on specific issues, which also causes doubts for the time of termination (Firestein, 2001, p.214, Wittenberg, 1999). Brugnoli (1990) conducted a phenomenological study to explore the therapist's feelings when terminating with patients. The results illustrated three main themes of attachment, loss and resolution and eight content themes: ideal terminations, abrupt terminations, displacement of feelings, therapy and termination patterns, termination with children, personal history and coping with loss (Brugnoli, 1990). It was concluded that abrupt terminations are more painful for therapists but in general they mourn for the loss of the relationship and a range of feelings are evoked (Brugnoli, 1990, pp.187-191). Martin and Schurtman (1985) explored the sources for the therapist's anxiety at the time of termination. Their findings suggested that it derives from a range of factors such as the therapist's personal history, the loss of the professional role, as a response to the patient's anxiety at termination, therapist's over-concern with successful outcome or when she experiences the loss of an intimate relationship (Martin & Schurtman, 1985).

The therapist may become more tentative at termination due to her own early experiences when termination stirs up previous losses in her (Strean & Freeman, 1988). The termination stage evokes her anxieties and conflicts that she has met in her past (Novick, 1997). In terms of the therapist's history, her personal therapy seems to be playing an important role since the therapist's techniques echo their own experience of termination of personal therapy (Firestein, 2001). The therapist can identify with the patient and memories from the termination of her personal therapy are stirred up (Strean & Freeman, 1988).

In the unsuccessful cases the therapist needs to "tolerate failure" and manage her feelings (Murdin, 2000, p.19). When termination is abrupt the therapist is left with "unanswered questions" (Willock, 2007, p.306). The ending of the therapeutic relationship leaves the therapist with the "poignant aftertaste of what was and is not any more" (Willock, 2007, p.308). When the therapist does not agree with the patient for the date of ending, the issues of the therapist's financial and emotional dependency are involved as well as other countertransferential elements (Kramer, 1986). When the therapist initiates termination (forced termination) and "leaves patients she cares about" (Penn, 1990, p.381) feelings such as anxiety, sadness and anger may evoke in her, which can be enhanced when her history entails painful losses and separations (Penn, 1990).

The therapist's narcissism at the time of termination has also been addressed in the literature. Murdin (2000) differentiates among two main sources of the therapist's narcissism: the therapist needs the patient's gratitude and finds it hard to let her go or she "exaggerates her independence" from the patients and becomes "oblivious" when the patients make efforts to connect (p.57). In the latter case, when the patient initiates discussion on termination, the therapist encourages it as she perceives it as part of successful therapy (Murdin, 2000). The therapist sometimes does not pay much attention on the patients' positive reactions to termination because of her need to feel she has been important for the patients and assumes that the ending will be difficult for them (O'Donohue & Cucciare, 2008, p.xvi). She may keep a fantasy where she is irreplaceable and necessary for the patients and their well-being (Graybar & Leonard, 2008, p.226).

The therapist needs to search into her subjectivity and motivations when she negotiates ending with patients (Murdin, 2000). She should work through her experiences of losses and separations and gain a deeper awareness of her emotions (Graybar & Leonard, 2008). It is significant for the therapist to be in touch with her needs and motivations and become more aware of the problems that may arise because of her countertransference (Kramer, 1986, Schafer, 2002). She may achieve this level of awareness through personal therapy and supervision (Kramer, 1986).

Conclusion

The therapist's feelings at the time of termination have not been adequately explored despite the significance of the therapist's awareness of her difficulties when terminating with patients (Strean & Freeman, 1988). Authors of theoretical, clinical and autobiographical papers attempt to explore the issues of techniques and types of termination (Ticho, 1971, Novick, 1997, Schafer, 2002, Graybar & Leonard, 2008). The majority of empirical research is quantitative where specific variables, termination behaviour inventories and scales measuring affect are used to investigate how therapists end treatment and how patients feel and react to their techniques (Quintana & Holahan, 1992, Boyer & Hoffman, 1993, Roe et al., 2006). However, termination is a complex phenomenon which cannot be limited to a specific range of factors under investigation. Researchers, for example, focus on descriptive analysis (Quintana & Holahan, 1992), short-term therapy (Marx & Gelso, 1987, Holmes, 1997) and self-report measures (Boyer & Hoffman, 1993), leaving aside issues such as personal history, personality traits and other issues that influence the ending stage of therapy. Firestein (2001) conducted an extended qualitative study, interviewing both patients and therapists in order to draw conclusions on what helps at the termination stage. Only one phenomenological study explored therapists' feelings at termination in an open way that allowed therapists to discuss their experiences (Brugnoli, 1990). The therapists experience a "paradox" in the therapeutic relationship between been "connected and objective at the same time" (Brugnoli, 1990, p.188). Limited literature refers to the therapist's feelings and reactions when patients leave (Novick, 1997). For therapy to be effective and termination

constructive, the therapist should not deny or ignore her emotional reactions to it (Novick, 1997). Even the mention of termination can provoke “deep anxieties” in her (Wittenberg, 1999, p.340). The present empirical study aims to add to the efforts to fill this gap in the literature and conceptualise the experience of termination of ten qualified psychoanalytic and psychodynamic therapists. The aim is to provide a consistent model of termination which is applicable to clinical practice.

METHODOLOGY

Introduction

The process of termination is explored in this research project using the paradigm and techniques of qualitative research. Qualitative researchers advocate that the reality is constructed from people's perspectives and interactions and aim to understand and represent them in studies (Cutcliffe, 1999). The understanding of the phenomenon under study is based on the participants' perspectives as much as possible (Elliot, Fischer & Rennie, 1999). In this study the narratives of therapists' experiences of termination with patients are analysed in order to develop a theory grounded on the data and convey a more elaborate understanding of this stage of therapy.

Definition of the Research Question

Researchers, as people, have various "selves" and in order to "undertake a piece of research with passion and sustainability", the area of research needs to be of special interest and of great concern to one of these "selves" (Mills, Bonner & Francis, 2006, p.10). As a trainee Counselling Psychologist, having experienced emotionally intense, forced, premature and planned terminations, I[4] became interested in exploring the phenomenon of termination in a more systematic way. Reflecting on this experience, the literature was reviewed and the gaps in knowledge were identified; authors have stated that the phenomenon has been neglected in psychotherapy research (Wittenberg, 1999). In the next stage, I organised a brainstorming meeting with a number of colleagues, where the initial research thoughts were explored in order to narrow them down and define the research question; the aim was to ensure consistency of the research project (Annells, 2006, Strauss & Corbin, 1998). The research question has been modified as the project progressed, influenced by the participants' responses, the research process itself, and my reflections (Strauss & Corbin, 1998).

[4] First person will be used in the writing of this study for the researcher's reflexivity parts.

Method

Grounded theory methodology has been used in this study to conceptualise the process of termination of psychotherapy from the therapists' perspective. In particular, the paradigm of social constructivist approach of grounded theory has been followed (Charmaz, 2006) and the techniques for the analysis of the data drew on descriptions of grounded theory as they appear in Strauss and Corbin (1998), Charmaz (2006) and Rennie, Philips and Quartaro (1988).

Philosophical Assumption

Research Paradigm

Paradigm is defined as "the context of an investigator's study, (which) guides philosophical assumptions, selection of tools, participants and methods" (Ponterotto, 2005, p.128).

The constructivist philosophical position has been adopted in this study. Constructivism places the reality creation process within the person; each individual has a particular mental structure to make sense of the world (Hansen, 2004). Ponterotto (2005) highlights the aim of constructivism to bring to the surface the meanings of people's narratives of their experiences; reality is constructed by the participants and there are multiple realities (relativist approach) rather than a single true one. Reality is influenced by the context, the participant's experience and perceptions, the social environment and the interaction between researcher and participants (Ponterotto, 2005). Constructivism advocates that reality is represented as social constructions of the participants (Mills et al., 2006). The constructivist researcher aims to identify the various ways of constructing reality that are available, explore the conditions of their use and trace the implications for human experience and practice (Willig, 2001).

Epistemology

Epistemology is defined as "the study of knowledge, the acquisition of knowledge and the relationship between knower (research participant) and would-be-knower (the researcher)" (Ponterotto, 2005, p.127).

Grounded theory is the methodology used to define the meaning of the symbols (e.g. language) people use to communicate the way they construct their realities (Fassinger, 2005). Grounded theory methodology was initially developed by Glaser and Strauss (1967) in response to their concern that theorisation in sociology was too removed from primary data (Rennie, 1992). They outlined practical guidelines and a set of systematic techniques of analysis of data in order to produce an inductive theory about the phenomenon under exploration (Glaser, 2004). They introduced a qualitative research methodology characterised by objectivity, generality and replication of research, aiming to discover causal explanations and make predictions (Charmaz, 2006). According to traditional grounded theory, the researcher engages in interviews in an objective manner (Mills et al., 2006). These ideas reflected a postpositivistic epistemological perspective, assuming that there is a straightforward relationship between the world and the perception and understanding of it (Mills et. al., 2006); it is possible to describe what is there and produce objective knowledge (Willig, 2001). Since then, grounded theory has been evolved to fit other epistemological positions (Mills et al., 2006) and moved away from positivism (Charmaz, 2006). Strauss and Corbin (1998) offered advanced grounded theory methodology guidelines and suggested a flexible and self-reflective way of interacting with the data.

For this research project, the constructivist approach of applying grounded theory was adopted. Constructivist grounded theory aims to provide a theoretically sensitive analysis of the participants' experiences while still retaining a clear connection to the data from which it was derived (Mills et al., 2006). This research project is based on the position that "any theoretical rendering offers an interpretative portrayal of the studied world, not the exact picture of it" (Charmaz, 2006, p.10); they are all constructions of the reality (Charmaz, 2006). The relationship between researcher and participant, within which data is constructed, must not be neglected and has been explored in the form of reflexivity and relational context in order to enhance the rigor

of the method (Hall & Callery, 2001). The epistemology this research project follows encourages a collaborative rather than a hierarchical relationship between the researcher and participants (Mills et. al., 2006). Constructivist grounded theory "brings the social scientist into analysis as an interpreter of the scene, not as the ultimate authority defining it" (Bryant & Charmaz, 2007, p.52).

Research Design

Use of Grounded Theory

Grounded theory has been perceived as a "methodological spiral that begins with Glaser and Strauss' (1967) original text and continues today" (Mills et al, 2006, p.1 [1]). As research process evolved, so did the researcher's understanding of the epistemology and use of grounded theory. On commencement, the guidelines from Strauss and Corbin (1998) were followed in a rather rigid way; on reflection, this might have been a way of compensating for the researcher's lack of experience in qualitative research. As the study progressed, she engaged in the constructivist epistemological position and application of the methodology as it was presented in Charmaz (2006), especially regarding conceptualising the relationship between interviewer and participants as collaborative, accepting for the analysis of data that "no researcher is neutral" (Charmaz, 2006, pp.46) and using memos as a way to generate new ideas and writing in a "natural voice" (Charmaz, 2006, p.88). Techniques of grounded theory as it was presented in Rennie, Philips and Quartaro (1988), using the hermeneutics (interpretative) approach, were also followed in this study *(see "Data Analysis" chapter)*.

Rennie (et al., 1988, 1992, 2000) suggested a view of grounded theory as a hermeneutic approach; as a theory of the interpretation of a text. Hermeneutics is a theoretical approach that informs the qualitative researcher in order to "explore the conditions under which a human act took place that makes it possible to interpret meanings" (Patton, 1990, p.84). People are interpreters of their experience and the researcher engages in the interpretation of an already interpreted text, with the goal of conceptualising the meaning of the participants' experience (Rennie, 2000).

Therapists in this study offered their interpretations of their experience of endings in a deep and intimate way, which adheres to Rennie's (2000) description of data. The researcher then represents the understanding of the meaning in the form of categories and relations among them (Rennie, 2000). Fassinger (2005) states that that the epistemology behind grounded theory depends on the way grounded theory is conceptualised for a specific project. For this research project, it has been evaluated that the constructivist/interpretative approach, as it is presented in Charmaz (2006) and Rennie (et al., 1988), offers the epistemology to describe in a reliable way the process of termination as it is experienced by therapists; it provides the tools to conceptualise the subjectivity involved in the data (Rennie, 1992). The aim is to define the diversity of the meanings depending on each individual's experience and how they make sense of it. Grounded theory aims for the generation of theory derived from working with categories (Rennie et al., 1988). This will involve "the progressive identification and integration of categories of meaning from data" (Willig, 2001, p.33).

Method appropriateness

Termination of psychotherapy has not been previously systematically investigated using consistent empirical data. With the use of grounded theory the aim is to generate theory through inductive examination of the data (Rennie et al., 1988). Grounded theory is considered an appropriate methodology for psychology and psychotherapy research (Rennie et al., 1988) and has been used, among other projects, for the exploration of therapy process from client's point of view (Watson & Rennie, 1994), exploration on clients' deference (Rennie, 1994), exploration of clients' perception of change (Jinks, 1999) and investigation of therapist's reflections on individual family therapy sessions (Rober, Elliot, Buysse, Loots & De Corte, 2007).

Grounded theory methodology was chosen for this study because it provides descriptive methods and guidelines for analysis of the data that generate a "systematic map of concepts and categories" (Willig, 2001, p.46) which offer the framework to understand better the experiences of the participants (Willig, 2001). The method is suitable because the material is approached without strong prior theory (Pidgeon, 1996). It is not in this study's goal to discover a "guaranteed truth" or an objective

relationship between the world and the perception of it (Pidgeon, 1996, p.82). Rather, following the constructionist model, the aim is to understand better the phenomenon of therapists' experience towards termination through a constant "interplay between data and the researcher's developing conceptualisations" (Pidgeon, 1996, p.82). The experience of termination of psychotherapy is a complex process, influenced by diverse factors. It is the researcher's goal to define these factors and represent its complexity through the conceptualisation of codes and categories and, eventually, the generation of a theory grounded on the data. Grounded theory provides guidelines that help the researcher remain close to the data, avoiding the influence of preconceptions when analysing the data.

Ethics

The City University ethics form has been authorised (see Appendix 2). The participants signed a consent form (see Appendix 3) prior to the recording of the interviews where they expressed their understanding of the research project and their right to withdraw their participation in the case of emotional disturbance. A list of counselling agencies has been given to participants after the end of the interview (see Appendix 4) in case they needed therapy input after the end of the interview. Moreover, because of the emotional connotations of the phenomenon explored, a debriefing meeting was offered to all the participants, where their reflections and thoughts could be discussed. The participants tended to use part of the second interviews for this purpose. The participants' transcripts and personal information are kept in a safe confidential place, not accessible by persons other than the researcher. The transcripts and the data will be confidentially stored for six years, available for review requests, after which they will be destroyed.

Research Process and Design

Grounded theory offers systematic, yet flexible, guidelines for analysing data in order to construct theory (Charmaz, 2006). The goal is to produce innovative theory grounded on the generated data and represent the meaning participants give to their experiences. Theory is generated inductively through data collection, coding, conceptualising and theorising with the use of constant comparisons method *(see*

following chapters) (Fassinger, 2005). Inductive method is characterised by the "formulation of general laws from particular instances" (Rennie et al., 1988). The aim is to generate a meaningful reconstruction of the participants' stories of their experience of termination (Mills et al., 2006). No initial hypothesis is formed since the researcher entered the study with no forced preconceived ideas and the final categories of the analysis emerged from the data (Charmaz, 2003). It has been important to listen to participants' stories and analyse the transcripts as openly as possible whilst reflecting on the researcher's underlying assumptions (Mills et al., 2006).

Analytical Process

The process is briefly outlined in the following steps (Pidgeon & Henwood, 1996):

1. Data collection: Data has been collected through face-to-face interviews. The interviews have been transcribed and analysed by the researcher.
2. Initial Analysis: the transcripts were analysed using phrase-by-phrase open coding. The codes (codes are "definitions of the data as the researcher studies it" (Charmaz, 2006, p.187)) that derived were categorised under clusters that formed the descriptive categories through axial coding analysis *(see "Data Analysis" chapter)*.
3. Core Analysis: through constant comparisons and collection of more data from a set of second interviews with the participants the relational statements between categories and between data and categories were conceptualised. New, abstract categories emerged that subsumed the meaning and relationships of the descriptive categories *(see "Data Analysis" chapter)*.
4. Outcomes: the abstract categories and propertied were analysed in memos where their relationships have been revealed and presented in a narrative, which composed the developing theory grounded in the data.

The analysis process has been documented fully; initial codes, axial codes, categories, memos and diagrams have been appropriately recorded to represent the development of the analysis process. Furthermore, in grounded theory the steps may seem discrete

but the researcher often had to move between steps as the analysis progressed (Pidgeon & Henwood, 1996).

The interviews were not transcribed and analysed using open coding immediately after each interview as suggested by the authors of grounded theory (Strauss & Corbin, 1998). This was due to time restrictions and practical difficulties when recruiting participants *(see Participants chapter)*. However, the researcher reflected on the interviews each time before the next one took place in order to inform the facilitation of the subsequent ones and made meaningful changes to the interview questions and context. The researcher managed to have an encompassing understanding of the meaning of the interviews before viewing the actual transcripts. This is supported by Rennie (2000) when he states that the interviews are used as a mode of inquiry and the researcher has a sense of the narrative given by the participant even before transcribing. This understanding, along with the participants' feedback after each interview, guided the development of subsequent interviews. The act of transcribing took place after the completion of interviews by the researcher, which deepened the understanding of the text (Rennie, 2000). In order to compensate, the researcher conducted second interviews with the participants, where she had the opportunity to articulate further elaborative and clarifying questions.

Constant Comparisons

One of the basic principles of grounded theory is the constant comparisons method: compare data to data (codes) to find similarities and differences and compare categories with the conceptualisation of incidents coded earlier in the analysis (Willig, 2001). The purpose of a constant comparisons method is to help the researcher stay close to the transcript and the data and discourage subjective understanding by "importing a priori rationally derived understandings" (Rennie, 2000, p.485).

Constant comparisons of the categories are necessary in order to ensure that similarities and differences among emerging categories and subcategories are identified (Willig, 2001). The researcher seeked for similarities, differences and frequencies that concepts appear in the data (Pidgeon & Henwood, 1996). Constant comparisons increase the credibility of the analysis (Rennie et al., 1988).

Constant comparisons method is of great significance, along with the researcher's engagement in the data; it enabled the researcher to interact with the data comparing preconceived ideas that arise during the analysis with the categories that emerged (Charmaz, 2006). Comparisons have been made between data, data and codes and data and categories (Charmaz, 2006). They helped the researcher advance her conceptual understanding and define the properties of the categories (Charmaz, 2006). The researcher went back to initial data throughout the analysis process in order to define new properties for categories and reprocessed earlier stages of analysis in terms of patterns that emerged (Rennie et al., 1988). Meaningful links were thus conducted in the form of relational statements (Charmaz, 2006). As Strauss and Corbin (1998) argue, constant comparisons have been utilised as a validation tool for the researcher's interpretations.

Theoretical sensitivity

Theoretical sensitivity is defined as the researcher's level of insight into the research area and represents how she remained attuned with the nuances and complexity of the participants' words and meanings in order to reconstruct the generated data (Strauss & Corbin, 1998). One of the important elements in grounded theory methodology is to study the data and record the participants' implicit meanings and taken-for-granted concerns, always asking participants to elaborate more on them (Charmaz, 2003). The researcher transcribed and analysed the interviews herself in order to enhance her understanding, conceptualise the participants' meanings and language, feelings and views and increase her theoretical sensitivity (Charmaz, 2003). The researcher used techniques such as "flip/flop" (considering the opposite to the code meaning), diagrams and axial coding (Strauss & Corbin, 1998) in order to strengthen her understanding of the data. These techniques were used as tools in a flexible way (Strauss & Corbin, 1998). The researcher worked with the reciprocity aspect of the interviews with the participants when categorising codes and the emerging categories were based on both the participants' and the researcher's experience (Mills et al., 2006). Fassinger (2005) argues that, in order to enhance theoretical sensitivity, the researcher needs to be a member of the group of the participants. As a therapist, the researcher was empathically listening to the narratives of the participants and could

comprehend their experiences in a meaningful way. However, there are risks of bias and imposing assumptions that have been monitored throughout the research process *(see "Researcher-as-instrument" chapter)*.

Memo writing

Memos are defined as theoretical notes about the data and conceptual connections between categories (Glaser, 2004). In memos, ideas about data, categories and relationships between them have been systematically recorded (Charmaz, 2006). Memos are used to generate meaning of the data in an abstract way through raising the description to a theoretical level (Rennie et al., 1988). Mills (et al., 2006) suggested that there is a necessity to write memos in such a way that they "remain transparently grounded in the lives of those who co-constructed the data", meaning the participant and the researcher (p.11). Memo writing has been considered a reflexivity process, providing the researcher with the opportunity to remember, question, analyse and conceptualise the meaning of the data as well as reflect on starting points and influences over the course of research (Mills et al., 2006). The researcher engaged in memo-writing throughout the process of research. From the onset of the stages of coding, memos were created for each interview separately, recording codes that appeared frequently and could be conceptualised as main categories. The researcher used memo-writing to express initial relational statements and links between categories.

After building the categories Charmaz (2003) suggests that the grounded theorist should break the categories in their components and record it in memos; this stage is helpful for clarification during coding when defining the abstract categories (*see Categories section)*. This method was followed by the researcher when descriptive categories were integrated to define the abstract ones. The researcher remained spontaneous in this process and engaged into "freewriting" in order to "liberate (her) thoughts and feelings" (Charmaz, 2006, p.88). The initial memos preserved a "natural voice" (Charmaz, 2006, p.84). In the subsequent stages of analysis, the categories were defined, their emergent relationships were traced and a progressive integration of descriptive and abstract level categories was conducted (Rennie et al., 1988, Willig, 2001). Records of this process have been outlined in the form of memos (Willig, 2001).

Memos have been used in this study in order to obtain insight, think beyond simple incidents, capture relationships among categories and possible criteria for further selection of data, preserve ideas for future use, trace development of theory, and record thoughts about similarities of categories (Rennie et al., 1988, p.144). Memos also had a significant role when finalising the categories in the process of writing up (Rennie et al., 1988). Memos included the researcher's hunches, interpretations, queries and notes from the beginning of the analysis, becoming part of the data.

Theoretical Sampling

Theoretical sampling is the method used in later stages of the analysis in order to seek more data comparative to the final categories and the emerging theory (Glaser, 2004). Theoretical sampling has been used in this research project with two clear goals. The first one has been to clarify data. All participants agreed and viewed the transcripts of their interviews along with the initial codes. Their feedback was discussed during a scheduled second interview where the researcher had the opportunity to ask clarifying questions. The second goal has been to collect new data on the basis of emerging theory (Rennie et al., 1988). Rennie (et al., 1988) called this stage "theory based data collection" (p.142). The researcher collected more data in order to ensure that the categories describe accurately the participants' experiences and represent a precise fit between data and emerging theory (Charmaz, 2003). Clarification was significant in order to deepen the understanding of the meaning of the experiences of the participants, and the researcher engaged in the stance of the "naïve inquirer" (Morrow, 2005, p.254). This was particularly important given that the researcher is a part of the community of therapists herself and is already familiar with the phenomenon of termination. By clarifications, she enhanced the credibility of the concepts and categories that emerged and ensured they represent accurately the meaning participants gave to their experience. The goal has been to develop concepts to understand therapists' experience and not to generalise the findings (Pidgeon, 1996).

The researcher also looked for "negative cases"; instances that did not fit the emerged categories (Willig, 2001, p.35) (See Appendix 15). This method allowed further

elaborate on the emerging theory by adapting it to the full complexity of the data. When contradictions emerged in the data, the researcher explored whether they were inconsistencies or whether they represented an extreme variation of the phenomenon (Strauss & Corbin, 1998). Theoretical sampling provided more data for this exploration.

Saturation

The researcher would stop gathering data when the categories would be saturated; this means that new data no longer "spark new insights" and no new categories can be identified (Charmaz, 2003, p.107). This must be the goal rather than taken for granted as modifications of the categories are always possible (Willig, 2001). For the present research project, given the time restrictions, second interviews were arranged and conducted with all the participants and after those the researcher ceased collecting new data. A further analysis of the data was conducted, by writing definitions and creating links between categories (Pidgeon & Henwood, 1996).

Researcher-as-instrument

In qualitative research "it is impossible to set aside one's own perspective totally" when representing the understanding of the participants' experiences (Elliot et al., 1999, p.216). The constructivist position argues that the researcher's values and experiences cannot be separated from the research process (Ponterotto, 2005). For this reason, it is essential for the researcher to acknowledge and describe her values, without omitting them from the study (Ponterotto, 2005). This position is enhanced by the collaborative and "interdependent" interaction between researcher and participants (Ponterotto, 2005, p.131).

My aspiration in the beginning of this research project was to explore and identify the therapists' subjective experience of termination of psychotherapy with patients. I aimed to give "voice" to therapists' personal accounts and focus on their internal experience. The focus of the research slightly changed as I reflected on interviews; the participants focused on their spherical experience of termination, discussing emotions as well as other factors influencing their experience. Further data were incorporated in

the interview questions and finally broadened the attention of this study. Termination of psychotherapy has been conceptualised as a complex and diverse process taking place towards the end of therapy and including many factors that influence the therapist's experience of it. These will be presented in detail in the "Results" chapter.

Previous knowledge

My personal and professional experience has helped me acquire some previous knowledge of the phenomenon of termination in psychotherapy (Cutcliffe, 1999). I have studied literature on termination before the commencement of the research project in order to conceptualise and clarify the phenomenon under study (Cutcliffe, 1999). An initial literature review was also conducted for the research proposal, as required by the Doctorate in Counselling Psychology programme. Using the pre-conceived knowledge, I became more able to interact with and compare the data (Cutcliffe, 1999). This knowledge enhanced, rather than constrained, the theory development process (Strauss & Corbin, 1998). Furthermore, because of the characteristics of the sample, it has been important I had previous knowledge in the field for understanding the terminology of psychodynamic theory and practice participants were expected to use in the interviews.

Recognising bias

In order to minimise my intrusion in the data, it has been important to recognise my subjectivity. I needed to remain open and willing to listen and represent accurately the participants' stories (Strauss & Corbin, 1998). The research question of this project is one of my main concerns in my professional practice as a trainee Counselling Psychologist, and therefore careful attention has been given on my own biases and presumptions so that they do not intervene with the analysis and understanding of the data. It has been important to recognise where I stand in relation to the phenomenon analysed and identify my personal and emotional linkages through "personal interrogation" (Mills et al., 2006, p.10). The factors that interfere with the data collection and interpretation are my emotional involvement with the research subject, my presuppositions from the literature and aspects of my interactions with the participants (Morrow, 2005).

From my personal and professional experience, terminations and separations have been emotionally challenging experiences. I reflected on these difficulties I have encountered through supervision and personal therapy. This has helped me become more aware of my own biases towards the issue of termination of psychotherapy and I have been more able to analyse the data staying close to the participants' perspectives. Given that I developed a preliminary literature review for course requirements, careful attention was also given to the beliefs I formed on the phenomenon of termination prior to the commencement of the project; I avoided imposing predisposing ideas on the data keeping the interview questions open, especially during the initial encounters with the participants.

Strauss and Corbin (1998) and Rennie (et al., 1988) suggest the use of journal or diary for the researcher to record personal thoughts, beliefs, assumptions and emotions as well as the way these might influence the analysis of the data. I kept a personal record of my self-reflections, focusing on biases, thoughts and emotions, as they appeared during the interviews and analysis of data (Morrow, 2005). It has been important to make my presuppositions and biases overt to myself and others (Morrow, 2005). Biases and subjective assumptions were recorded as they occurred and I returned regularly to initial records.

When coding the transcripts, I paid careful attention to prohibit my motives, fears or unresolved personal and professional issues from being imposed on the data (Willig, 2001). My personal reflections and emotions regarding interviews were recorded after their completion. Memos were also created for each interview during transcribing and coding, used also as reflective processes (Mills et al., 2006). As a trainee Counselling Psychologist, I am part of the group of therapists experiencing terminations of therapy with patients in my practice. Fassinger (2005) suggests that this is a desirable way to establish rapport and trust between interviewer and participants and he tried to ensure "demographic match" between interviewers and participants in his research project (p.159). Therapists in this study were seen as the experts in the field. I identified with aspects of their narratives, which was recorded in detail in my reflective diary.

Furthermore, I consulted my research supervisor and peers[5] in the course of the analysis to receive feedback, listen to suggested alternative explanations and reflect on the analysis of the data (Morrow, 2005).

Reflections

I felt at various times emotionally and experientially close to the participants' stories. I have explored the phenomenon of termination in clinical supervision groups as well as in personal therapy. When I entered the research project, I expected to facilitate a similar discussion with the participants and accumulate personal reflections on the process. One of my presumptions was that all therapists would disclose subjectivity and emotions openly. However, early in the research, I modified the interview questions, as well as the research subject, in order to accommodate the diversity as it was presented in the participants' narratives. The interview questions were modified to include incidents from previous interviews that were not considered initially and the research question was broadened from "therapists' feelings on termination" to "therapists' journey on termination"; the latter was considered more general and inclusive of the variety of the phenomenon.

I experienced interviews with some participants as particularly more emotionally charged than others. Other participants gave more rational and articulate stories of their experiences of the termination of therapy. I contained my own feelings and represented this diversity in the analysis of the data, giving justice to the words of the participants. I gave equal significance to codes I expected to find (based on my initial presumptions) as well as codes that were unforeseen. As the research process progressed, I challenged my preconceived ideas about the findings and stayed very close to the data, by coding phrase-by-phrase in the initial stages of data analysis, going frequently back to the transcripts and listening regularly to the recorded interviews when forming the categories. I reflected on "what belonged to me" and "what belonged to the data" when I made interpretations of the relationships between categories. Consequently, I remained grounded on the data, identifying my own emotions and experiences separately from the analysis as it evolved.

[5] A specialised Grounded Theory group was formed amongst DPsych students who implemented grounded theory in their projects.

Participants

Sampling

The sampling for the present research study was purposeful (Cutcliffe, 1999). The sample was criterion-based and therapists with specific theoretical orientation and qualifications were recruited (Patton, 1990). Such narrow and homogeneous sample was selected to ensure quality and that the participants shared a common experience of the process under exploration for them to be able to comment on it (Cutcliffe, 1999). Consequently, qualified therapists of psychoanalytic and psychodynamic orientation were recruited. The specific theoretical therapeutic orientation was selected for the following reasons:

1. The sampling should not be broadened to unmanageable size of participants so it remained focused.
2. Psychodynamic theory and practice enables practitioners to explore phenomena on a deep reflective level, which would enrich the data. Psychodynamic theory focuses on the "therapeutic relationship as a vehicle for change" (Bellows, 2007, p.209) therefore it was expected that therapists would reflect on termination of the relationship as a significant part of their practice.
3. It also derived from the researcher's own experience of psychodynamic practice and supervision, where issues of countertransference and therapeutic relationship are explored extensively.

Difficulties in Recruiting Participants

Information sheets (Appendix, 5), flyers (Appendix, 6) and introductory e-mails (Appendix, 7) were sent to several organisations in the UK, mainly bodies were psychoanalytic and psychodynamic therapists are registered with. The responses were mainly negative and administration staff would not distribute the information to the practitioners of the organisations. The recruitment was finally conducted through:

1. the distribution of flyers via post mail attached to the Society of Group Analysis magazine,

2. an ad published in Therapy Today, the British Association of Counselling and Psychotherapy magazine and
3. via networking and using the researcher's contacts in the field.

The difficulties in recruiting were explored reflectively by the researcher. She discussed these difficulties with senior practitioners and reasons were considered, such as therapists' fear for misinterpretations of the interviews and their busy schedules. Therapists may also speculate that research raises questions and doubts about their practice and thus have little interest in it (Schachter & Luborsky, 1998). In order to deal with the above the researcher agreed with all participants to view the transcripts and codes in order to receive feedback and corrections and scheduled the interviews at convenient time and place for the therapists. The sample criteria were also broadened to include more choices in recruitment; initially only psychoanalytic therapists were intended to be interviewed but in a later stage psychodynamic therapists were included in the sample.

Participants' Demographics

Eleven practitioners responded and were interviewed for this research project. One participant withdrew due to confidentiality concerns. The ten participants agreed to view the transcripts and attend second interviews. Seven participants were females and three males, all qualified psychodynamic and psychoanalytic therapists. The demographics details are outlined in Table 1.

Table 1. Demographics

Participant	**Age**	**Gender**	**Years of post-qualification professional practice**	**Theoretical orientation**
P1	54	Female	14 ½ years	Jungian – psychoanalytic (independent orientation)
P2	50	Male	22 years	Psychodynamic – group analytic
P3	62	Female	10 years	Psychodynamic
P4	44	Female	17 years	Psychoanalytic

				(Kleinian, object relations)
P5[6]		Female		Jungian
P6	60	Male	25 years	Jungian
P7	64	Female	30 years	Group analytic – Jungian – Relational
P8	52	Female	28 years	Psychodynamic – psychoanalytic
P9	62	Female	6 years	Jungian
P10	55	Male	16 years	Psychoanalytic (object relations, Kleinian)

Researcher's Role and Relationship with Participants

All therapists who participated gave positive feedback about their experience of interviewing; they enjoyed it and appreciated the fact that they had the opportunity to talk about an important issue they did not have many opportunities to talk about before. Based on the constructivist epistemology, the interaction between the researcher and the participant is central for the "deeper meaning (to) be uncovered" (Ponterotto, 2005, p.129). The researcher and the participants co-constructed the findings through their interaction and dialogue (Ponterotto, 2005). The researcher engaged in a relationship of reciprocity with the participants and their contributions to the interpretation of the data helped her gain a better understanding of the meaning of their experiences of termination (Mills et al., 2006).

Sources of Data

Interview philosophy

Constructivist grounded theory encourages the interactive relationship between researcher and participants (Mills et al., 2006). The researcher adopted mutuality with the participants, as opposed to engaging into a role of an objective observer. A "partnership" was encouraged with the participants (Mills et al., 2006, p.8). Therapists were the experts of their experience of termination and the researcher listened empathically and with an explorative mind to their narratives. The researcher and participants "have given and taken from each other" (Mills et al., 2006, p.9). This research project has clearly been a "participant driven" project: the time and place of interviews were scheduled according to participants' convenience, flexible and

[6] P5 did not complete the demographics sheet for unknown reasons.

unstructured approach to questioning was implemented so that participants assumed more power over the direction of the conversation, the researcher shared her understanding of key issues with the therapists of this study, assumed an open stance toward the participants, shared personal details and answered questions openly (Mills et al., 2006, p.10). An open interchange between participants and researcher was implemented (Mills et al, 2006).

Interview context

Due to time restrictions, nine out of the ten interviews were conducted within two months. Because of the difficulties in recruiting, the researcher responded imminently to therapists that expressed interest and arranged interviews in their convenience. Moreover, the summer break was near and most therapists would be unavailable for one month. Initial semi-structured interviews were conducted (Pidgeon & Henwood, 1996). The interviews lasted from one hour to one hour and a half. All participants agreed for a second, more structured, interview; this way, codes, incidents or meanings that might have not been considered initially, where later included in the subsequent second interviews.

For purposes of safety the researcher informed a trusted person of the place and time of interviews and contacted that person at the end of every interview.

Interview questions

Strauss and Corbin (1998) suggest that the literature can be a source for stimulation, and this is how it was dealt with when forming interview questions. Initial, prompt questions were formulated for the first interviews. As the interviews proceeded, the researcher reviewed the ones already conducted before moving on to the next one and the questions were modified accordingly.

Questions were developed in an open, flexible way, aiming to explore the participants' subjective experiences in depth (Strauss & Corbin, 1998). The researcher ensured that she gave the participants "independent voice" (Strauss & Corbin, 1998, p.35) and represented the individual meaning they gave to their experience of termination (Strauss & Corbin, 1998). The questions have also been "narrow enough to elicit and elaborate the participant's specific experience" (Charmaz, 2006, p.29).

Open-ended interview questions were initially defined in order to identify the phenomenon under study without making too many assumptions about it (Willig, 2001). A few open-ended questions to facilitate conversation were preferable rather than a large number of questions; asking fewer questions enabled the participants to elicit their stories and deepen their meanings (Morrow, 2005). The fit between the initial research interests and the emerging data has constantly been evaluated. Interviews were dealt with as "directed conversations" by the researcher rather than as in a controlled form and experimental procedure, acknowledging the importance of establishing a rapport with the participants (Pidgeon & Henwood, 1996, p.89). Questions (careful for not loading them with preliminary assumptions) were formed to promote an open ended conversational style (Pidgeon & Henwood, 1996).

Examples of questions are presented in Appendix 8. Two transcripts from two different stages of the interview process are presented in Appendices 9 and 10. The participant's comments are largely omitted for reasons of confidentiality given the sensitive material they include on patients and other details.

Theoretical Sampling

A set of second interviews was arranged with all participants aiming to seek further data in order to add to the understanding of the categories that had emerged as well as gain further clarification on participants' transcripts (Cutcliffe, 1999). Two of the participants were not available for second face-to-face interviews therefore contact via e-mail and post was preferable for these cases.

Reflections on Interview Process

The relationship with the participants was a collaborative one (Mills et al., 2006). I engaged in active listening and built rapports with them, as it is also a part of the development of professional relationships in my everyday practice (Morrow, 2005). Participants asked questions regarding my interest in the research subject, professional experience and personal development. I replied to these questions in an honest and direct way. At the same time, I was cautious that biases and presumptions were not imposed. During the interviews some therapists expressed their concern about whether or not their narratives addressed the research question and whether they

would be "helpful" for the analysis of the data. I reassured and encouraged the participants to further explore their subjective experience of termination freely. This helped the therapists unfold openly their stories. It has been important to establish a comfortable relationship between researcher and participants (Rennie, 1992). I was more active during some interviews than others, following the participants' pace and specific styles of conversations developed in each interview; I was more active asking explorative questions when participants found it difficult to express their thoughts (Rennie, 1992).

As a trainee Counselling Psychologist, I found the interviews stimulating and important learning experiences. The material was rich and motivating. The process itself was interesting and intriguing. I engaged deeply and empathically in the therapist's material and interviews. Each interview was different and each therapist brought themselves into the process. It is acknowledged that no matter how much I wished not to influence the course of interviews, the fact remains that they have been co-constructed by the researcher and the participants (Rennie, 1992); both parties contributed to the style and content of the interviews.

The second interviews were also an opportunity for participants to reflect on the transcript of their interviews and offer their clarifications. I received positive feedback and appreciation for the project from all therapists. All of them were interested to learn more about the results and asked to read the final paper. I feel as if real relationships have been developed with them, with their own beginnings and endings. I found myself reassuring the participants for contact after the end of the second interview and also discussions were made on presentations and conferences that researcher and participants could meet again.

Data Analysis

The analysis has been based on constructivist grounded theory philosophy and the emphasis is on participants' actions and narratives (Charmaz, 2003). The researcher's aim has been to describe the verbal, non-verbal, explicit and implicit elements of the participants' contribution in the interviews (Charmaz, 2003). See Appendices 14 and

17 for a demonstration of coding of data along with relevant memos and construction of categories.

Open, axial and selective coding

Making analytic sense of the data means to identify what is happening in the data and frame codes by keeping them short and active (Charmaz, 2006). Through analysis of the data the researcher tried to convey how the participants understand their experience of termination. The researcher acted upon the data rather than read them passively; she interacted with the data (Charmaz, 2003, Willig, 2001). By remaining open to the transcripts the researcher remained involved and learned from the data, which led to discoveries of the relational statements (Charmaz, 2006). Coding led to "defining" the data (Charmaz, 2006, p.186) by breaking the data into their components (phrases or lines), defining the actions (codes) and looking for assumptions and implicit meanings (Charmaz, 2006, p.50). Grounded theory allowed "flexible" coding, moving back to initial stages and reviewing codes and their significance (Charmaz, 2006, p.71).

The codes created define what emerges in the data and were used to integrate low level descriptive categories through the process of axial coding. Codes and concepts that emerged frequently in the analysis were subsumed into broader meaningful units. Briefly, the following stages were followed (Charmaz, 2003, Willig, 2001):

1. naming each line and phrase of data (open coding)
2. organise large amounts of data and reassemble them (axial coding)
3. focus and select the most significant or frequent codes in order to sort, synthesise and organise large amounts of data (selective coding)

Line-by-line and phrase-by-phrase open coding was implemented for all transcripts (Charmaz, 2006). A reduction of the meaning of given segments in the transcribed text was conducted, which led to the definition of actions in each segment (Rennie, 2000, Charmaz 2006). Phrase-by-phrase analysis ensured that the analysis has been truly grounded on the data and higher-level categories and relational statements, developed in later stages, actually emerged from the transcripts (Willig, 2001). The researcher engaged in "oversampling" by coding the entire transcripts of the first

interviews in order to ensure that important information has not been missed (Fassinger, 2005, p.163). This method also gave the researcher more data based on which she would verify the emergent theory (Fassinger, 2005).

Axial coding aims to reassemble the codes derived from the initial stages of coding. Categories were treated as "an axis around which the analyst delineates relationships and specifies the dimensions" of these categories (Charmaz, 2006, p.186). The researcher organised large amounts of data and identified initial categories, their properties and dimensions (Strauss & Corbin, 1998, Charmaz, 2006). Categories and subcategories were developed and initial relationships among them were identified (Charmaz, 2006). Memos were developed throughout open and axial coding processes in order to keep a record of these primary links (Charmaz, 2006). During the process of open and axial coding, diagrams were also used to "provide a visual representation of categories and their relationships" (Charmaz, 2006, p.117). The use of diagrams allowed the researcher to understand complex links and relationships and also to integrate considerable amount of codes and categories. Examples of diagrams and tables used in the analysis are presented in Appendix 11.

Through selective coding, the concepts close in meaning were defined and analysed in memos (Charmaz, 2006). The researcher went through the initial transcripts and coding and, with the use of constant comparisons, she identified patterns and recorded the most frequent appearing codes. In the process of selective coding, the most significant relationships began to emerge with the prospect of subsuming them to more abstract categories (Rennie et al., 1988).

Due to time restrictions, the three methods of coding (open, axial, selective) were implemented simultaneously, parallel to the process of constant comparisons (Fassinger, 2005). This also helped the researcher remain close to the data, and keep in mind the relationships between codes and categories, which later in the analysis derived naturally and were recorded in memos. The researcher found her theoretical sensitivity enhanced by simultaneously coding at various levels.

Categories

The aim of the analysis has been to build categories grounded on the data and subsequently an inductive theory (Charmaz, 2003). Categories are defined as "the grouping together of instances [events, processes, occurrences] that share central features or characteristics with one another" (Willig, 2001, p.33). Categories are distinguished in the following classifications (Willig, 2001):

1. Descriptive labels or concepts (low level of abstraction)
2. Analytic categories (higher level of abstraction, they interpret rather than simply label)

The categories emerged from the data freely, especially in the early phases of the research, combining the researcher's interpretative skills and understanding as well as her theoretical sensitivity (Pidgeon & Henwood, 1996).

Descriptive categories

A reduction of the codes was recorded separately, incorporating the codes in categories (Rennie et al., 1988). The initial categories were descriptive and closely reflected the transcripts and participants' words (Rennie et al., 1988). All the codes emerging from data were categorised and the names of the categories captured certain aspects of interactions (Rennie et al., 1998). The codes were sorted into groups according to their "shared meaning" and the meaning of each group was represented under a category (Rennie, 2000, p.485). The categorisation was progressive as the analysis process evolved and new categories were added even in final stages. Initial relational statements and hypotheses were recorded regarding the relations between categories, using memos and diagrams (Strauss & Corbin, 1998, Rennie, 2000, Charmaz, 2006). Diagrams were helpful as they provide a "distance from the details and a focus on logical linkages between incidents" (Strauss & Corbin, 1998, p.153).

Codes have been assigned to as many categories as possible. Rennie (et al., 1988) named this stage "open categorising" (p.43). The goal has been to evaluate and clarify the categories and the relationship between them, where the most frequent and significant codes were identified and grouped together (Rennie et al., 1988).

Thirty four descriptive categories emerged from the process of open, axial and selective coding (Appendix 12). The categories were related to their subcategories and meaningful links were made (Strauss & Corbin, 1998). The researcher had explorative questions in mind when conceptualising the categories and their relationships: such as why, how come, where, when, how and with what results (Strauss & Corbin, 1998).

Analytic categories

The analysis of the data did not merely aim for the description of the main incidents, but engaged in more interpretative levels (Rennie, 2007). Higher ordered and more abstract categories were created to subsume the descriptive initial categories (Rennie, 2000). Categories have been incorporated into more abstract ones, using selective coding and choosing concepts that appeared more frequently in the data. Some categories appeared to be central because they "have links with many other categories as a result of the multiple categorisation of items" (Rennie et al., 1988, p.144). These categories "serve as interpretive frames and offer an abstract understanding of relationships" (Charmaz, 2006, p.139). The analytic categories that were outlined in memos and diagrams are presented in Appendix 13. The goal was to formulate a core category which would be most significantly related to other categories and their properties. This category was abstract but not vague and aimed to capture the meaning common to other categories and their relations (Rennie et al., 1988). Difficulties were encountered when trying to define the core category because of the complexity and the amount of data. However, it became clear later in the analysis that the category of *"development of therapeutic relationship"* seemed to be central in the participants' narratives of their experience of termination *(see "Results" chapter)*.

Developing grounded theory

The conceptual material expressed in memos represents the basis for the grounded theory developed (Rennie et al., 1988). The research memos were integrated and new memos were created in response to new insights, links and understandings (Rennie et al., 1988). Additional memos and diagrams were also created for the conceptualisation of the core category and its properties (Rennie et al., 1988). Based on the constructivist epistemology, the theory developed from the data analysis "depends on the researcher's view" (Charmaz, 2006, p.130). The derived theory aims

not only to theorise the participants' view of their experience but also represent an interpretation of it (Charmaz, 2006). As a constructivist study, the focus is on "how – and sometimes why – participants construct meanings and actions in specific situations" (Charmaz, 2006, p.130).

The concepts included in the final results were the most relevant to the research question and indicated the "range of variability" of the phenomenon of termination (Strauss & Corbin, 1998, p.158). The core category provided the basis for the explanatory narrative of grounded theory that was developed (Strauss & Corbin, 1998). A memo was then created to outline the "story" by using the categories, the incidents and their relationships; this has been defined as "storyline memo" (Strauss & Corbin, 1998, p.150) and it is presented in this paper in the form of theory *(see "Conceptualising Grounded Theory" in "Results" section)*.

Writing up

The results are presented in writing using detailed interview quotations and examples. Extensive quotations are deemed a main feature of constructivist grounded theory (Fassinger, 2005). The actual words of the participants would provide the reader with essential evidence to be able to inspect that the researcher's interpretations are grounded on the narratives of the participants (Morrow, 2005). An extended literature review was conducted to verify how this study fits with it (Willig, 2001).

Standards of Trustworthiness

Criteria for validity and trustworthiness in qualitative research are "closely tied to the paradigmatic underpinnings of the particular discipline in which a particular investigation is conducted" (Morrow, 2005, p.251). In constructivist grounded theory, it is important to acknowledge that the nature of the data collected and the analytic strategies are influenced by the researcher's subjectivity (Morrow, 2005). The researcher made an effort to limit and manage her subjectivity but also embraced it as a co-constructor of the meaning and interpretation of the data (Morrow, 2005).

For purposes of accuracy and validity, the analysed transcripts with the initial analysis codes were sent to the participants. This was not merely a check for the accuracy of the transcript but also an opportunity for the researcher to learn from the participant how well her interpretations and codes reflect the meaning they give to their experience of termination (Morrow, 2005). This procedure has been followed by other grounded theory researchers in the field of Counselling Psychology (Swatton & O'Callaghan, 2002, Fassinger, 2005). The participants do not have access to the full range of the data or the researcher's thinking and the validation took place on the level of open coding as well as features of the final analysis (Hall & Callery, 2001). Therefore, the researcher paid careful attention to the construction of relational statements, hypothesis and, eventually, theory, placing emphasis on interpretative and subjective influences (Strauss & Corbin, 1998).

The analysis remained transparent and the notes that drove the researcher to the hypotheses and generation of theory have been audited and discussed with the research supervisor as well as within the group of grounded theory researchers. This way "fairness" was ensured; the results represent the participants' voices and meaning of experience avoiding "lopsided interpretations" influenced by the researcher's biases (Morrow, 2005, p.255). The results were presented at the Doctorate of Counselling Psychology presentations day at City University, where the researcher received feedback. The results were also presented at the Joint Conference of the Divisions of Counselling Psychology of the Psychological Society of Ireland and the British Psychological Society.

In the writing up, detailed presentation of examples for each central category and for the core category are presented (Rennie et al,. 1988). Moreover, the researcher discussed with the participants an outline of the results in the second interviews and received feedback. The goal has been to generate categories and theory that are "internally verified" through constant comparisons, reflexivity and theoretical memoing (Rennie, 2000, p.488). The theory and the categories generated are aimed to be viewed as testable hypotheses (Rennie & Fergus, 2006, Charmaz, 2006).

Reflections

Reflections on research process

As an initially quantitative researcher during previous academic activities, grounded theory seemed appealing to me in terms of the positivist epistemology it originated from (Fassinger, 2005). However, as I engaged in more reading and process, a more constructivist approach was adopted as it fit the research question and process (Charmaz, 2006). The interviews became interactions between two practitioners, with use of self-disclosure and cooperative relationships were developed (Rennie, 2007). Turning the focus on the inter-subjective component of the research process, I acknowledged the social construction of the data and addressed the influence of the researcher-participant interaction as well as the power and trust relationships developed (Hall & Callery, 2001). I took extensive notes of reflexivity after the completion of each interview and asked for participants' feedback on the process.

The experience varied for each participant; some interviews were emotionally charged whereas others were rational and more articulate. I received feedback about how active and directive I was during the interviews, which guided my attitude for the subsequent ones. Every interview has been a learning process and contributed to the development of meaningful links. Moreover, as a trainee therapist interacting with experienced practitioners in the field, I felt I learned much about practice and myself as a practitioner. My personal reflections about the interviews have been recorded separately and reviewed frequently, ensuring they were not imposed on the analysis.

I found that trust was an important issue for the interviews, given that therapists disclosed personal information as well as information on their clinical practice. In order to develop trust and demonstrate caring, I used empathy, affirmation and self-disclosure during interviews (Hall & Callery, 2001). I engaged in the relationship with the therapists as unaware and unknowing participant in the dyad and the therapists were viewed as the experts. Therefore, there was a more "shared relational power' with them (Hall & Callery, 2001, p.268).

Reflections on data analysis

As research progressed to more abstract levels of analysis the "interpretation increasingly comes into play" (Rennie, 2000, p.487). I struggled with the creative aspect of naming abstract categories in a way that the titles would be inclusive of the meanings and emotional connotations that appear strongly in the transcripts. I encountered difficulties and invested much time on considering the best titles for the categories. I endeavoured to show clearly the emotional intensity of the data and the representation of it in the final results. My concern has been that the depth and emotional charge of the interviews would fail to be represented in the results. My fear was that the results would give a list of dry categories, which would not give justice to the data. Rennie and Fergus (2006) offer guidelines for the generation of abstract categories by using self-reflection and placing the self into participants' position, using empathy (p.491). Rennie (2000) also suggests that metaphors are good categories because they "succinctly articulate complex meanings" (p.487). Reflecting on this issue with colleagues, researchers and supervisor, it was suggested that "in vivo"[7] codes could be used as titles of categories, given that they would "crystallise" the meaning that appears in the data.

Given the fact that English is not my native language, I found difficult using metaphors. Moreover, due to my personal experiences that matched the therapists' narratives, I was cautious using self-reflections and avoided the risk of imposing my presumptions. It was then concluded that using "in vivo" codes would ensure that the analysis remained close and grounded on the data and also that the categories would contain the meaning of the therapists' narratives, as they derived directly from the transcripts. I decided to use "in vivo" codes as titles of some categories to demonstrate the relational statements using "the exact words of one respondent" (Strauss & Corbin, 1998, p.145) and ensure the deep material of the data is portrayed in the results.

[7] Codes that consist of the participants' actual words, as they are seen in the data (Charmaz, 2006)

Implications for Counselling Psychology

Fassinger (2005) argues that grounded theory (GT) is frequently sited as the methodology used in Counselling Psychology research. He mentions the reasons why GT is promising for Counselling Psychology research (Fassinger, 2005, p.165):

1. GT has an inductive nature to assimilate knowledge
2. GT's main goal is the construction of theory out of lived experiences and integrates theory and practice, which meets the notion of the scientist-practitioner model of Counselling Psychology
3. GT has evolved since the traditional positivist epistemology and offers paradigmatic flexibility and allows researchers to adapt to more areas of research focus
4. GT offers methodological flexibility (as used for this research project)
5. GT offers clear and structured methodological and analytical procedures
6. GT offers the researcher the tools to generate "experience-near" theory regarding areas of research
7. GT is applicable to a wide range of issues relevant to Counselling psychology.

The development of a conceptualised theory on the termination of psychotherapy would offer an insight into therapists' experience of the process that aims to contribute to the efforts of filling the gap in the empirical research literature. The conceptualisation of therapists' reflections would enhance the understanding of this phase of therapy and inform clinical practice.

Moreover, a new effort has recently been initiated by Psychologists to bring the disciplines of Counselling Psychology and Psychotherapy closer in meaning and practice (Rizq, 2008). It is considered that it is possible to reach a "potential for agreement, accord and affiliation" between the two disciplines (Rizq, 2008, p.16). Many psychologists have been involved in psychotherapeutic training and practice over the last years (Register of Psychologists Specialising in Psychotherapy, British Psychological Society, 2001). The Special Register aims to create the philosophy of a

scientific community including both psychologists and psychotherapists (Rizq, 2008). A recent issue of Counselling Psychology Review (February, 2008) was dedicated bringing the disciplines of psychotherapy and psychology together and it is suggested that knowledge and techniques from psychotherapy discipline can inform psychologists' practice and emphasise the similarities between the two paradigms as (Strawbridge & Joseph, 2008). This research project aims to add to these efforts and promote the unity between the two disciplines.

It is anticipated that the outcome of this study will contribute to the acknowledgement of the significance of therapy termination and the integration of it in Counselling Psychology training not only in terms of techniques but also in terms of exploring the therapists' experience of it. It is also hoped that the outcome will offer a basis to enrich Psychotherapy and Counselling Psychology practice.

"Life has inbuilt terminations…From the moment you are born the biological clock is ticking. There will be a death but throughout life there are going to be lots of terminations. They are givens in human existence really."

(P2, 343-346)

RESULTS

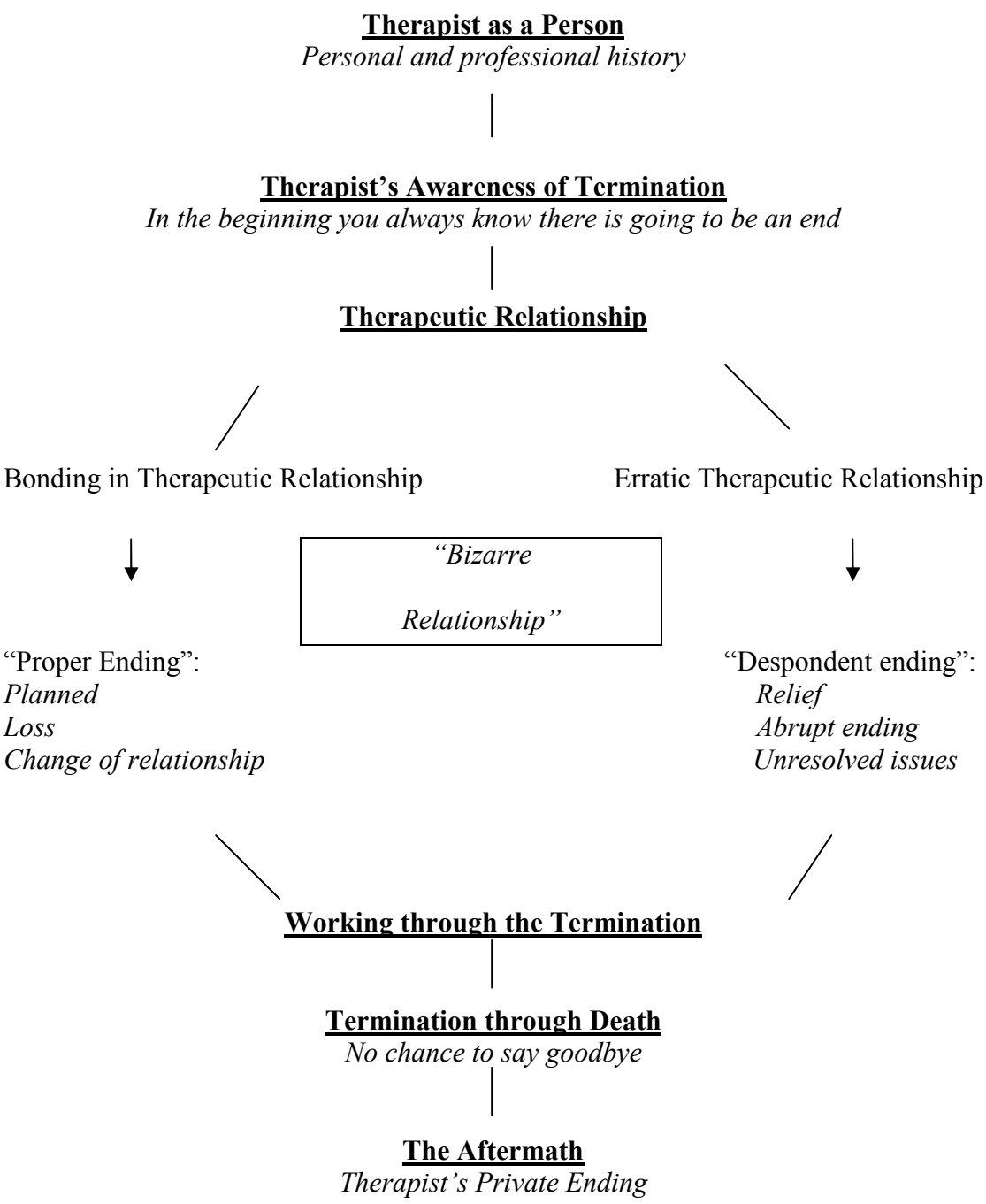
The *development of the therapeutic relationship*, and especially the concept of *bizarre relationship*, appeared frequently in the data and differentiated significantly the participants' experience of termination. Therefore *therapeutic relationship* has been treated as the core category. Six central categories emerged from the final analysis. These categories and their relationships are presented in Figure 1, where the final model of the *"Therapists' Journey through the Ending of the Therapeutic Relationship with Patients"* is outlined. The central categories and subcategories are presented in Appendix 14.

Termination and Ending: use of words

In the initial stages of the research the word "termination" was salient. It represented the particular stage of therapy and was used as a technical term to conceptualise the concrete meaning of the process. It helped participants place the narratives of their experiences into a particular framework and stirred up their memories of the stage of therapy upon which this study focuses. However, participants used the words "termination" and "ending" interchangeably, without differentiating between them. Two participants made reference to the use of the word termination:

> "Termination is a horrid word as well; and closure, it isn't closure as we have talked. It isn't closure, it doesn't close down just like that" (P3, 274-276)

Figure 1: Model of Therapist's Journey through the Ending of the Therapeutic Relationship with Patients



> "I was thinking as you said this that the word termination, in a way I suppose, there is a kind of association with, I mean, I found myself making an association with loss" (P4, 1-3)

The word "termination" acquired a meaning of finality for the participants and they made the connection with loss and separation. However, as the results indicated, termination of therapy is rarely final. Therefore, the word "ending" was more frequently used by participants, and the word "termination" appeared to be avoided. "Ending" seemed to have an implicit meaning of taking action, of a process that evolves in time and does not have the connotation of finality as much as the word "termination". For the purposes of this study, "termination" will be used to define the particular stage of the therapy process and "ending" will be used when discussing the therapists' experience of it, whilst in general the terms are mainly used interchangeably.

Therapists' journey through the ending of the therapeutic relationship

Termination is a process that evolves through time and contains its own stages, each with its own characteristics. It has a beginning and an ending. For therapists, however, the journey begins even before first seeing the patient and continues after the patient leaves. All these stages will be explored through the categories as they emerged from the data.

Termination of therapy is a complex phenomenon. "There is not an it *(termination)*" (P7, 4)[8]. Therapists' experience of termination varies significantly across patients, settings, duration of therapy, stage of professional practice, stage of life, etc. For example, in the initial stages of the research, the focus within the interviews questions was on long term therapy and its termination. However, as the interviews evolved, it

[8] In order to ensure confidentiality and anonymity, the participants will be represented in codes (P1 to P10) and when quoting parts of transcripts the code of the participant and the line numbers of the quote will be indicated.

became apparent that short term therapy endings can be intense as well. Therefore, the focus of the research has been broadened in order to accommodate the expressed variety of meanings of the phenomenon. Participants were invited to explore termination as they understood it through their personal experience and professional practice.

Conceptualising Grounded Theory

Grounded theory is presented in this study as a story that has been developed through the "inductive analysis of the data" (Charmaz, 2006, p.187). The aim is to represent the therapists' journey through the final stages of therapy with their patients as a narrative, focusing on the core category of the *therapeutic relationship*.

As derived from the data, the narrative that describes the participants' experiences of termination could be outlined as follows:

The therapist enters the termination stage as a real person; she is experiencing a real loss and separation. Termination is a journey that continues even after the actual ending of therapy: ending is not closure. The therapist feels lonely in this experience. She continues to have her own private ending and mourn the loss of the therapeutic relationship. Terminations are full of material for the therapist that she is not able to work through with the patient. The therapist cannot share the feelings stirred up in this stage because of the professional boundaries; the feelings "wander inside" (P1, 313) her. The therapist thus "exposes herself to a set of semi-resolved separations" (P4, 320). The therapeutic relationship as the therapist experiences it changes at termination. From the level of the symbolic – transference – relationship where the therapist is a symbol (e.g., of parental strength or comfort), at the termination stage the relationship becomes real; the therapist meets with the patient as two grown-ups meet after they have concluded a piece of work together. The therapist consciously discloses something about themselves to release the patient from the transference. Feelings are stirred up since someone she knows very well, someone she has shared time with in an intimate way, leaves. The loss at termination is also real; the loss of a

relationship with someone the therapist knows very well. The stronger the relationship is, the more intense the feelings are. The therapist becomes the parent that lets the child (patient) go, saying goodbye to their child when the child becomes independent and ready to go.

Central Categories

The central categories will be explored in a chronological order as they coincide with the phases of the therapy process. When exploring the therapist's experience of termination the therapy process, the development of the therapeutic relationship and the termination phase are inseparable processes; one cannot be looked into without considering the others.

Therapist as a person -

"It's about the therapist, not about the theory" (P5, 412)

The journey begins before the actual beginning of therapy. The therapist is a person who has developed personally and professionally over the years. Her *personal history* is an important factor influencing her experience of termination with patients. Moreover, she associates her experience of termination with the ending of her *personal therapy*.

Personal History

Personal history of loss

The therapist, as indicated in the data, brings to any therapeutic relationship her personal history and life experiences. Those interviewed in this study distinguished their own history of losses as a particularly important element of their past that influences their experiences of termination. P6 summarises the influence of the history of loss, talking about the impact it has had on him:

> "*(personal history is)*[9] crucial…I think it will depend on how much I have allowed myself to experience various losses in my own life. Some of which are very complicated and ambivalent. It depends on how much I can do that to the extent…if I can help the patient to live through losses that are going on between us. Which can be very intense" (P6, 90-93)

Dealing with previous losses

Based on her personal experience of dealing with losses, the therapist may struggle with the endings, becoming a "worrier" (P9, 150) or "nostalgic" (P8, 62). Some, on the other hand, may be more accepting, becoming familiar with the notion that "things do not last forever" (P7, 225). P9, P8 and P7 talk about their personal experiences and how it has influenced their work with patients:

> "I am a worrier, so this is managed. I hope they *(patients)* don't know that I am going to worry. (…) I suppose, nobody likes endings…we all…nobody likes endings. I suppose I had to do a lot of work on myself" (P9, 151-152, 154-155)

> "So there is an element of nostalgia *(in ending with patients)*. But I am nostalgic generally so I don't know, is it mine?" (P8, 61-62)

> "I feel that I grew up rather familiar with the idea that things don't last forever. Yeah…in a sort of existential sense…I don't feel uncomfortable with that as an idea" (P7, 225-227)

Termination with patients and parallels with personal losses

The termination of therapy with patients may trigger the therapist's previous losses, such as losses in her personal life. These personal issues as they affect her reactions to termination may be acknowledged as being "more about me than about him *(the patient)*" (P3, 42). When terminating with patients, the therapist may find herself in "direct parallels" (P3, 79) with incidents of personal losses and separations. P3 speaks

[9] Italics are added in participants' quotes by author to offer explication.

explicitly about her ending with a specific patient that reminded her of a personal loss she had experienced with a close relative:

> "And only then did I realise he *(patient)* had tears in his eyes. And I still don't know whether I should have hugged him or not. And that was more about me than about him, I think, at that point. (…) And I was so angry with him *(close relative)*; he had put me in this position, so angry. And that must have showed in my face. And actually, you know, I wanted to hug, I couldn't let him go, it was really hard. And I could see it was hard for him. And I can see now that tears were pricking his eyes. A direct parallel there" (P3, 41-43, 76-79)

Reactions to endings as they reflect the therapist's personality

Due to their own traumatic separation experiences, some of those interviewed are more tentative when terminating with patients. Owing to their personal history, some therapists mentioned their difficulties in relinquishing the therapeutic relationship and accepting the ending, whilst others seemed to find it easier to put aside the relationship and move on from it. P8, P2 and P6 talk about their personalities and how they have been developed to affect their work.

> "I know how my history, my personal history, influences on my termination. Because I had problems with separation in my childhood so I know that I am more, perhaps, more cautious about termination than other people, I think; because I know, my childhood trauma has just showed me how painful it might be. So perhaps I am more careful in that than other people" (P8, 127-132)

> "I think I don't end easily. I think I do hold on a long time. That's my personality. I don't like farewells and endings and I hold on to people but I suppose I let them fade over a long time, a period of time. Yes, so endings are not easy for me. I would prefer not to think about this" (P3, 225-228).

> "I am quite good at cutting off; once I finish work, I finish work" (P6, 186-187)

The choice of the therapeutic model fits the therapist's personality

Regarding the therapist's professional experience, those interviewed had many years of practice not just as psychotherapists but they have also worked in diverse areas of mental health as well as other fields. Therapeutic training plays a crucial role in the way they would experience the termination. Those interviewed have worked during their careers with many patients in diverse settings and they unfolded experiences from all stages of their careers. The level of training at each stage has influenced the way they have dealt with endings; in particular the theoretical model they trained in and personal therapy seem to be two important elements. Therapists acknowledge how the choice of theoretical model blends in their personalities. P4 (individual analytic training) and P7 (group analytic training) discuss how personality traits influenced their choice of training.

> "I am sure it's no accident that I chose the psychoanalytic model in the Kleinian, sort of Bion, branch of the psychoanalytic model. Because that, in a way, fits my personality characteristics" (P4, 196-198)

> "I think that group analysts have a different relationship with their patients. I believe it is because the people who become group analysts are generally less introverted than most psychoanalysts, I think" (P7, 184-187)

Personal Therapy

Therapists associated the word termination with the termination of their personal therapy.

Therapist currently in personal therapy

Personal therapy is deemed essential for psychodynamic and psychoanalytic therapeutic work. Three of the participants were in therapy at the time of the interview

and most of the participants had more than one previous experience of personal therapy (in various contexts and stages of life and practice). P6 talks about the significance of personal therapy, P9 discusses her experience of personal therapy which is still ongoing for her, as well as previous experience of an ending she had with a different therapist.

> "One *(meaning therapists)* has to look in oneself, see what complexes have been activated and unresolved in yourself really" (P6, 13-14)

> "And from the first one *(personal therapy)* I learned how important it is to get it right and I can't visualise leaving my therapist. I can't visualise what it will be like. But I think it will be a very, I remember the first lady, the first therapist I saw, was saying, "you could leave me being very angry". And maybe the fact I was so inarticulate in that session, was because of my anger but I wasn't emotionally articulate to deal with that. Er…the relationship with my current therapist is very different. I can't visualise stopping completely" (P9, 433-439)

Termination of personal therapy as a model

The termination of personal therapy is an example for therapists of how termination with patients should be conducted; it indicates how therapists could end and gives them experiences of positive or negative endings. P5, P4 and P9 explicate their experiences and how they have influenced the work with their patients.

> "So my feelings about therapy have been dominated by my experience as a patient. You can only do what you've had (...) But your experience of your own therapy is what matters" (P5, 273-274, 279)

> "And mostly shake hands at the end of term as well and that's very directly back to my own experience that my analyst would shake hands with me at the end of each term and that felt like a really important contact for me" (P4, 250-252)

> "Because I can't use anything from the first one *(personal therapy)* except how to end badly (laughs). Yes you would, I am sure if you did…you would use it because it's an invaluable experience of how it's handled" (P9, 440-442)

Judging how patients would feel from their own feelings at termination of personal therapy

The therapist has experienced her personal feelings when ending her personal therapy. Judging from her personal experience, she believes that patients would feel in similar ways at the end of their therapy, though of course this would depend on the experience of the therapeutic relationship. P1 summarises this point when she talks about her experience.

> "Of course it is completely coloured by our own experience of termination. Having terminated my own therapy. Which is of course why one has to be in therapy because it helps so much to know, to have been …to have been through all of that yourself. So of course when my patients are ending, then of course I am, the experience is not necessarily mine, but of course I draw on my own experience to imagine and feel what it is like from their point of view" (P1, 13-18)

After termination of personal therapy

The therapeutic relationship between the therapist and her personal therapist may change after the termination; they may become colleagues. They may meet again in various places other than the therapy setting. Thus, the relationship with the personal therapist does not have a definite ending. Moreover, therapists feel that therapy is an important ongoing part of their own life and the work continues after termination. P1, P5 and P4 discuss the significance of their therapy and the relationship with their personal therapists.

> "It was important to me to have a good experience of ending, and I have been in contact with her *(personal therapist)* since, the person

stayed alive to finish, I keep contact, we are also kind of colleagues" (P1, 127-129)

"I think, if you think of therapy…as being part of your life, which I do (…)) (P5, 272)

"I have to think about my own termination of treatments that I have been a patient in. And in some ways there is a…the work that continues but when the therapist is alive in your mind, I think the dynamic of that is different. It might actually be there but not accessible in the same way. I am sure that's real actually" (P4, 104-108)

Death of personal therapist – loss

For a person unfortunate enough to experience the death of her own therapist, there is clearly a profound sense of loss: therapists are no exception. It can be an emotionally intense experience since she does not have the opportunity for any contact with her personal therapist after the termination. In this case, she is unable to experience the change of the relationship. P10 reveals his experience of the death of his personal therapist:

"I had the most extreme loss, you know, you can have in that situation. Because my analyst having had one day off sick in ten years suddenly disappeared and died. With no warning, you know, one minute I saw him for the usual Wednesday session and I was expecting to see him on Monday; I never saw him again (…)Having had, you know, a very sort of traumatic loss, sort of out of the blue really" (P10, 426-429, 438)

Summary

The therapist is a real person in the therapeutic relationships with patients. Her own personal history and experiences of loss have a great influence on the way she will

react to endings with patients. As there are a variety of experiences and personalities, there are a variety of therapists' reactions at termination. Her personal therapy plays a crucial role since it represents a model as to how to terminate with patients. She may imitate her personal therapist's techniques, self-disclosure and, in general, how the ending was handled in her personal therapy experience. She may be judging how patients will feel at the termination of therapy based on her own experience. An experience of a good or bad ending of personal therapy informs her practice. It is also significant that therapists tend to have a different relationship with their therapist after termination and may experience a loss when this does not occur.

Therapist's Awareness of Termination –

"At the beginning you always know there is going to be an end" (P1, 6)

Therapists anticipate the ending of the therapeutic relationships on every occasion.

Termination is inevitable

The therapist is conscious of the ending from the beginning of therapy with patients. The therapist and the patient work towards the ending from the onset of the development of the relationship. P1 and P7 talk about their experience of awareness of the ending from the beginning of therapy.

> "It is inevitable. At the beginning you always know there is going to be an end. And it always stirs up huge feelings. On both sides I think" (P1, 6-8)

> "Well I guess it is whenever you start to see somebody you know that it is going to end" (P7, 183-184)

Anticipation of last session - feelings

The therapist anticipates the last session and that she will have feelings during it. P7 not only talks about the intellectual awareness of termination but also the expectation that she will have feelings about it.

> "I mean the thing that comes to mind most, immediately, when you ask me about my experience of termination with patients, what I immediately think of, is the anticipation of the last session. And the anticipation that I am going to get tearful when I feel moved" (P7, 366-369)

Patients initiating termination

In long term therapy, the practitioner may hold the belief that the patient should initiate termination, preferably when she feels resilient and the therapist would not introduce discussion on termination. However, some of those interviewed instigate termination when they feel that their patient needs to finish therapy. Other therapists hesitate to initiate the ending even when they feel it is the right time for the patient. P6 and P8 talk about the fact that the patient should initiate termination:

> "The sort of basic principle is that the patients should have control of the ending" (P6, 201)

> "In psychoanalysis, obviously, the right to terminate belongs to the client" (P8, 68-69)

P1 talks about the difficulty to instigate discussion on termination:

> "And I don't have the heart to say, I don't think I want to say "I think we can end". I kind of wait for her *(patient)* to say "I think it will be alright" (P1, 361-363)

P4 talks about her lack of hesitation to initiate the ending when she feels that it would be beneficial for the patient to stop therapy and she discusses the therapist's ability to judge when it is the right time to end.

> "Other things we know from the research is that therapists are pretty bad judges of when termination is appropriate. That actually, they often feel that more work can be done, as if that's a reason not to stop at this time. But I, in some ways, I am one of the few that believes it can be quite helpful to stop so that the person can actually then use some time on their own to continue that work or to develop it in a more autonomous way" (P4, 168-172)

Awareness of duration of therapy

Therapists interviewed in this study talked about their experiences of working in various settings such as health services and private practice. In time-limited therapy, the therapist is consciously aware of the number of sessions she has with the patient. Some therapists would remind the patient regularly the agreed duration of therapy, as P5 described:

> "I mean, I am doing 16-week therapy, which is a lot of endings because you know, you end from the beginning; you count down, you are very consciously aware and you are saying "it's session 10, it's session 15" (P5, 86-89)

Summary

Therapists have a variety of experiences in both time-limited and open-ended therapy. They are aware of the ending from the beginning of therapy. Termination is an indivisible part of therapy and therapists anticipate the patient's last session. This is one of the characteristics that differentiate the therapeutic relationship from social situations, as will be explored in the next category.

Therapist's Experience of the Therapeutic Relationship –

"Bizarre Relationship" (P1, 94)

The therapeutic relationship is the concept that appeared most frequently in the analysis of the data.

Bizarre relationship

The therapeutic relationship is an odd and unusual relationship, which cannot be compared to personal or social relationships; it is a special kind of connection between two people. The content of therapy sessions is usually intense and the patients share with the therapist information about themselves and their lives in an intimate way. The therapist is intensely involved in the relationship, she invests time and energy, and she feels she knows the patient very well. She forms a close and intimate relationship with her patients; the patients become part of the therapist's life. Even though this intense relationship is developed, the therapist knows from the beginning that it will end. It is different to social relationships because there is not the possibility of meeting again.

P2 talks about the special kind of relationship:

> "I suppose a little bit that the…in a way…this entity of therapy…that it is a very special, a very specific type of relationship" (P2, 340-341)

P1 explains why the therapeutic relationship is a bizarre one:

> "I think about these people from all my working life and I wonder what's happened to them. It is as if as a whole, I suppose it happens when you meet people and you lose contact with but it is not the same socially because on the whole you find your friends, even if you haven't met them for years, and you meet them again and you have this kind of good conversation. But with patients, probably, you never will. So it is as if there are all these people in your mind, but that's why our work is so satisfying really. But it is bizarre, it is the only kind

of relationship where you can have this intense connection and then you know it is going to come to an end" (P1, 334-241)

"So it seems an entirely natural human desire actually and it seems, it is a very bizarre kind of relationship that you share all this with somebody in this very intimate way and possibly the therapist knows you more than anyone else with these very intimate details of your life and you are never going to see them again" (P1, 93-96)

"(…) it seems such a weird thing really to be so intensely involved with someone and then, bang, it is alive and yet, unlike anyone else in your life you can't continue contact with them or you can't have that kind of different contact with them" (P1, 428-431)

Equal relationship

The therapeutic relationship involves two people developing a strong connection. The development of the encounter is equally affected by the therapist's personality and what she brings to the relationship as a real person, and her personal characteristics can intervene in the therapy process. She is also affected by the relationship with the patients. P6 and P2 describe the equal therapeutic relationship:

"There are two people in the relationship. One *(therapist)* has to look in oneself, see what complexes have been activated and…unresolved in yourself really" (P6, 12-14)

"I think it is a much more equal sort of relationship where you are not putting such a distance between your client and yourself" (P7, 220-222)

Self-disclosure – therapist's boundaries

The therapist works within boundaries for her own protection as well as for the protection of her patients. Even when the therapist has feelings in the therapeutic relationship (e.g., anxiety, personal admiration for the patient, etc.), she would not

self-disclose and keeps them, and the "impact patients have" (P1, 411) on her, unspoken and unvoiced. However, irrespective of whether the therapist discloses personal information about herself or not, patients know something about her life anyway, particularly if the therapist works privately from home. Therapists believe that elements from their personal life are revealed to the patients anyway if the relationship is strong enough.

P9 describes the importance of personal therapy in order to prohibit herself from disclosing personal information and be able to focus on the patients' issues:

> "I suppose I had to do a lot of work on myself. And I guess that…to be very boundaried so that, whatever they *(patients)* are stirring up for me is in another box that I deal with so that I can stay focused on their ending" (P9, 155-157)

P5 and P6 talked about their experience of patients who know about them without their self-disclosing:

> "Because a good patient knows exactly what's going on anyway. The reason I am not particularly uptight about telling when people ask me questions is that I think they walk into my house and I don't hide anything in it. Unless you are working in the Tavistock in a rented room…they know my daughter is in, they know everything about me" (P5, 367-371)

> "If you have been working with people for whatever it is, there is actually a very strong unconscious connection and they know all sorts of things about you unconsciously" (P6, 259-261)

Summary

The development of the therapeutic relationship has a significant impact on therapists' experience of the termination. The therapist's narratives of the experience of the relationship were classified under two categories: *bonding in therapeutic relationship*

and *erratic relationship*. The categories are not mutually exclusive. Both categories will be explored in conjunction with the experience of termination in each situation, as they have been defined by the therapists in this study.

Bonding in Therapeutic Relationship

The conceptualisation of this category proved somewhat difficult and "in vivo" codes did not seem to capture the meaning. Initially it was defined as "deep" relationship. When the initial results were presented at City University DPsych Presentations, it was noted that the concept of "deep relationship" does not convey accurately the meaning of this category. Difficult relationships can be deep as well whereas this particularly category aims to define deep, intense relationships, regardless of the outcome or how difficult the therapist found the process. Therefore, a term from the literature was chosen because it provided a "unifying concept that fits the data" (Strauss & Corbin, 1998, p.155). The term "bonding" originates from Bordin's (1979) conceptualisation of the therapeutic alliance and it represents the "nature of the human relationship between therapist and patient" (Bordin, 1979, p.254). Bordin (1979) specifically discussed the "deeper bonds of trust and attachment" (p.254) that are essential for the alliance to develop, especially for long term treatments where the material of the sessions is deep. This definition seems to capture accurately how therapists described the therapeutic relationship with specific patients when they differentiated their experience of termination.

Therapist's intense engagement

Within specific therapeutic relationships the therapist may be intensely involved, work hard with patients and feel especially connected with them. She feels that she has become part of the patient's life. In these occasions, the patient develops trust and attachment as the therapy evolves. In this type of bonding relationship, the patient feels committed and emotionally engaged in the process. The work is moving and the material reaches deep and regressed areas. P4, P6 and P7 describe their experience with specific patients that have stayed in their mind after the ending of their therapy:

"I think that people who stay in mind are probably people who I feel that the work has been difficult, that I have been pulled in transferentially, that actually we have worked hard using that (P4, 120-122)

"And when you are being through these deeply regressed places with people, there is a very, very strong connection with them" (P6, 162-164)

"A dependency *(patient's dependency)* as linked to regression…When one *(therapist)* has been in a very sort of deep place with somebody perhaps (…) It wouldn't only be that. It would also be when the dialogue, when the exchange has been a very rich exchange. You know, when there has really been a lot, when there is a sort of a sense that there has been a good feed or lots of exchange" (P7, 110-111, 113-115)

Therapist's personal admiration

On these occasions, the therapist feels personal admiration towards the patient; she admires, regards, respects and enjoys being with the patient. She admires the patient's choice to be in therapy and values the resilience that develops in her which may inform whether or not she will be able to form this type of bonding relationship. P8, P2, P3 and P4 describe these experiences with specific patients:

"I always feel kind of respect that people dared to come to the therapist and to talk about their problems and they tried and they worked hard really" (P8, 55-57)

"I was very fond of him *(patient)* and he had been very stable" (P2, 43-44)

"And I enjoyed him *(patient)*, I liked him, I enjoyed him" (P3, 51)

> "I can't work at that level of intimacy and not have things to respect and like about a person. But sometimes there are things that are very difficult and that you don't like. But there are some patients that actually, who simply you feel more warmth towards, liking, whatever it might be" (P4, 115-119)

Therapist as a symbol in the relationship

The transferential aspect of the therapeutic relationship is influenced by the perception of the therapist as a symbol in it. Some therapists spoke about their maternal transference towards the patient as well as other "symbols" they become for the patients within the therapy process. For example, the therapist becomes the parent and helps patients grow up and become "fuller people" (P9, 82). P5 illustrates this when she talks about one of her patients' achievements:

> "Not only did he get himself a promotion, he took a Master's in *(patient's area of interest)* and got the best marks. He e-mailed me when I was in *(therapist's place of holidays)*, I was there for a month, thanking me that he felt he couldn't have done it without my support. So, yeah, I did feel like his mummy of course: "yeah mum, thank you very much (…) The guy had grown up with me" (P5, 346-349)

P7 also talks about feeling maternal in the relationship:

> "I think that I probably feel, probably a bit of maternal, my transference is, as opposed to my countertransference, my transference is a bit maternal" (P7, 106-108)

P9 also indicates her role as a parent in the therapeutic relationship:

> "But I suppose very often we are in a sort of maternal or paternal to the patients. And I suppose, because of our trainings, and that we are in this work for whatever our reason is, they use us in a way a child might use a parent" (P9, 203-205)

This is also revealed when therapists talk about their patients having babies and send them pictures of them:

> "I have had quite a few patients who had babies actually, both in the health service and privately. I love seeing the babies! I do feel like a grandmother and I think it is a really nice, healthy feeling (…) So obviously we are going to have grandchildren" (P5, 174-176, 181-182)

> "But it's very nice when you do get letters out of the blue, from somebody who just had a baby, it's usually when they contact you, which must say something about the maternal transference. I have a drawer full of baby photographs" (P7, 362-365)

One of the therapists also spoke about becoming a symbol of "comfort and strength" (P3, 117) for her patient. She also spoke about a real relationship that developed between herself and one of her patients, where transferentially she became the patient's mother:

> "But over the two years we developed a real, trusting, deep relationship. Where I did become, seeing it in developmental terms, I did become the mother (…) I did become the mother that he was angry with and that he thought against; sometimes he was the toddler pushing away" (P3, 9-13)

Being through a lot together – therapist and patient

Therapists talked about the therapy process with their patients using frequently the word "together". This way they strove to demonstrate the magnitude of their involvement and investment in the process, linking their experiences with that of their patients. Due to the depth of the work, the therapist and patient engage in a moving and emotionally intense encounter; they have "been through a lot together" (P7, 111), as the following two participants indicated:

"They *(patients)* are very much there and because they've been through or we've been through together some very primitive experiences if you like" (P1, 173-175)

"(…) I think about, if I feel like we, the client and I, if we have been through a lot together" (P7, 9-10)

Long term therapy

The bonding in the therapeutic relationship is mainly developed in long term treatments. Some therapists spoke about the significance of the long-term duration of therapy as well as the weekly frequency of the sessions; the relationship becomes more intimate when the therapist meets the patient more than once weekly over a number of years. P5, P1 and P9 described their experience of meeting with patients on a long term basis:

"I mean, seeing people twice a week you get very involved in their story so when you see people three times a week you really are there. And it becomes less anecdotal and more, because I feel then more involved in their lives, they don't just tell me what happened but there is more of an involvement with the whole process" (P5, 335-339)

"You get to see someone very frequently. You think how many numbers of hours you spend in intense conversation with someone about themselves and their lives and all the things that it stirs up in you" (P1, 71-73)

"(…) they have become part of your week and life, your work life, but you certainly become part of their whole life, their outer life as well. So that, the longer it goes on the more intense it must be" (P9, 241-243)

At termination – "proper ending" (P1, 389)

The therapists talked about their experience of ending as it relates to the development of bonding in the therapeutic relationship.

Planned ending

Many times the termination of bonding relationships is a planned one. When the termination is planned, then there is enough time for both therapist and patient to work through the termination. A good ending comes when there is the element of mutuality in it; as there are two persons in the relationship, engaged in an intense encounter, then the best way to end the relationship is when both are involved in the termination process. P1 and P7 describe their experiences of planned endings:

> "A proper ending is an ending that you have talked about and thought about and planned and had some time and…during which, there is a kind of real feeling of reviewing and saying goodbye I think. This sort of going through…over what has happened. And it is a planned ending obviously, so that it gives an opportunity to work through some kind of whatever the whole range of feelings are anticipated" (P1, 389-393)

> "So what does that say about termination? I guess it seems important that there is a kind of an experience of mutuality about it" (P7, 102-104)

> "The good ending, the really good ending is one where it's definitely about two people" (P7, 287-288)

In this case the therapist feels that the patient is ready to terminate and there has been significant change in them; therapy has been effective and the therapist feels she has been helpful. P1 clarifies the expectation of the time of ending when a patient begins to make significant therapeutic changes:

> "(…) my experience of it *(termination)* is that I'd be sitting with a patient for whatever length of time it is and I would gradually be getting the feeling of "I think this person is going to start talking about ending soon" because things are beginning to feel like they are consistently better I suppose, or the person is feeling more in charge of their life and feeling they can make choices and things are going more how they wanted. Whether it's because they have a relationship that's working or the things that they were struggling with when they first came, and now feeling more able to deal with it and they are more…One of the words that stayed strongly in my mind (…) was in the notion of buoyancy, about when a patient is beginning to feel there is a much greater strength of buoyancy when things go wrong they can handle them and they can carry on as they were without disappearing into a black hole. So there is a sense in which you become more resilient I think. And it's that kind of feeling that I am beginning to think "I am sure this person is going to start talking about ending soon"" (P1, 50-64)

Therapists also experience a good ending when they are inclined to continue therapy with the patient, as P10 and P8 explain:

> "And I suppose, for me, that shows that the termination worked exactly as it should have done, because he *(patient)* wanted, he asked, to go back and see him *(therapist)*, I mean, you know, I knew that was a possibility, but the point was that *(the patient)*[10] asked, you know, he said: "oh, I think I might like to go back and see *(the therapist)*" and…you know, so that, for me, that's quite an important marker, if you like, for things having gone well enough" (P10, 63-68)

> "I think that the best termination for me is when I have this balance that I can continue with this client and I can terminate. That is the ideal balance for me" (P8, 167-169)

[10] Names have been omitted in this quote for reasons of confidentiality.

Therapist's experience of loss

Therapists associated the word "termination" with the experience of loss when ending with patients. P4 and P6 talked about their experience of loss at termination:

> "I was thinking as you said this that the word termination, in a way I suppose, there is a kind of association with, I mean I found myself making an association with loss. I think there is a key aspect to that for both the patient and the therapist" (P4, 1-4)

> "On the whole it *(termination)* is a time of sadness, it is a time of loss, it is a time of looking back" (P6, 1)

Therapists experience a separation at the ending of the therapeutic relationship, which stirs up feelings of sadness about the patient leaving as well as pleasure when the patient has made significant changes; therapist's feelings are mixed at the end of an effective treatment when bonding has been developed. The therapist is tearful in the last session and with "a lump in the throat" (P7, 108). P1 and P3 also speak about their feelings at the time of ending:

> "It can be lots of strong feelings about sadness and loss and feeling that you miss that person and all the feelings that come with major separation" (P1, 76-78)

> "It is a loss. It is a real loss. And I enjoyed him *(patient)*, I liked him, I enjoyed him (…) But there was sadness as in, at him…he left me, he left me in a personal way. Which was right…which was right and healthy for him but sad for me." (P3, 50-56)

Some therapists would cry in front of their patients whilst others would wait for the patient to leave before they allow themselves to be overtly sad. P7 and P4 discuss their different experiences:

"And the anticipation that I am going to get tearful when I feel moved. And of course I don't really mind that; there is no reason why they shouldn't see that I feel strongly about their leaving" (P7, 368-370)

"(…) it is painful but it is a painful process that you have the opportunity to work towards. And it is a different relationship; the boundaries and the containment of the relationship are very much for the patient but they also work for the therapist as well. I have never cried in front of a patient but I have cried after the patient has closed the door" (P4, 322-325)

Therapist's personal concerns for patients

The sense of loss and sadness at the termination stage is associated with the worry therapists feel for patients due to the maternal or parental transference they experience in the relationship. Some therapists compared the experience of ending with patients with the experience of a parent when their child reaches a specific age and leaves home. Several participants discussed this experience:

"So, I suppose, in a way, it's a bit like a parent seeing his 21 year old leaving home really, in a sense." (P6, 5-7)

"You know, I felt ordinarily sad that we were finishing working together because I liked him, he was an interesting patient, nice boy… I had all the usual, sort of, parental-type concerns, about whether he would manage to go and get a job now that he had finished his college." (P10, 46-49)

"I kind of went through sending a child to school, sending a child to secondary school. I was sending him *(patient)* off to university. That's what I was doing and I knew that, and it felt like that (…) I think the kind of sadness that a mother does feel when a child becomes independent. It is a loss. It is a real loss" (P3, 25-28, 50)

Anxiety and worry are also stirred up in some therapists when they initiate termination, especially because of external reasons, such as leaving a setting. P2 described his experience when he left a job he had been in for many years:

> "But, there were some I think where I felt more personal concerns about how they will be and what they will be able to take from the therapy (…) There were certainly one or two where I think it was probably the nature of what they had invested into their therapy over a long period of time." (P2, 142-143, 144-145)

Change in the nature of the therapeutic relationship

When therapy has been effective, there is a change in the relationship that occurs at termination; it becomes real. The therapist deliberately and consciously discloses something about herself and becomes a real person in the relationship. The therapist aims to reduce the effect of the transference and enhance the reality dimension of the relationship. She intends to appear as a real person rather than the transference object or the symbol. She is genuine and, even though she would not disclose any other personal feelings, she would say to some patients "I will miss you". P6, P5 and P7 summarise in their interviews their experience of change in the therapeutic relationship.

> "I should say "I really enjoyed this, working with you" I say "I will miss you". If I think I will miss them, if I know I will miss them, I will say that (…) So transparency increases towards the ending but again it's not a principle. It varies from person to person. Some people don't want to know what I feel or think" (P6, 251-255)

> "When we are finishing, we are meeting as grown ups, if we are doing a proper ending, we meet as two people who have done some work together. And I will disclose something about my own daughter or my own therapy, or whatever something, I will give them consciously something. Because I am no longer this mysterious (…) My intention

is to give them back the transference. I am a person, I have a car, I have a dog" (P5, 185-189, 193-194)

"But I think I probably, quite consciously and deliberately (…) towards the end, I say the occasional thing about myself. Because I think that it's, for me, it's part of the good ending; that somebody is not only released from therapy but released from the kind of transference where I know and they don't, where I am the expert and they are not; you know, that kind of thing" (P7, 304-308)

Summary

The therapist forms with some patients a special bond in the therapeutic relationship. She feels that she works harder in these relationships and is intensely engaged. She respects the patients and admires them as persons; she is fond of these patients. She experiences her own transference as maternal or parental and offers herself as a symbol of comfort or strength for the patients. At the ending of this relationship, she experiences a real loss and mourns the separation. Her feelings are mixed as she feels sadness as well as joy for the patient's improvement when therapy has been effective. She also experiences anxiety for some patients. There is a change in the relationship since at termination the therapist ceases being the symbol and becomes a real person in the relationship. P7 summarises the above when she talks about the nature of the relationship and the ending: "And there is this sort of interesting contradiction between really loving them and letting them go" (P7, 217-218).

Erratic Therapeutic Relationship

This category has been developed in order to demonstrate the difficulties therapists deal with in the therapeutic relationship with some patients. The term "erratic" was used by Firestein (2001) in order to define the "markedly fluctuated" therapeutic alliance (Firestein, 2001, p.208). It is acknowledged that bonding can be developed in erratic relationships as well. However, it has been differentiated for the purposes of

this study in order to conceptualise the differences in the therapist's experience of termination when treatment is constantly difficult or lacks consistency or regularity.

Patients' negative transference

Therapists talked about developing an erratic relationship with patients that express negative transference. When patients demonstrate negative transference, they become critical, hateful, mistrustful or attacking towards the therapist. In these cases, the therapist becomes the "bad parent" (P6, 60). Under these circumstances, the therapist sometimes feels that she is not helpful for the patient. Participants discussed different cases demonstrating this category; the experiences of three participants are outlined in the following quotes:

> "I suppose what was not said was so intense (…) so hateful in a way and so critical and she did her best to make me feel like a lot of rubbish" (P1, 233-235)

> "(…) people with a very, a kind of very aggrieved dynamic to their difficulties and there is something about having to constantly live with that sense of grievance, living with the sense that nothing is ever good enough" (P4, 26-29)

> "And obviously I was extremely upset about this woman *(patient)* getting abusive with me, because there was nothing I could do about it. The problem is…there was one situation where I couldn't therapy her, I couldn't interpret her, and I couldn't do anything with it. So, she had me. And I don't like feeling useless" (P5, 99-102)

Therapist's inability to connect to the patient

Therapists find it hard to connect with patients in erratic therapeutic relationships. The therapist experiences difficulties when patients are not committed to the process and sometimes do not even fulfil the financial arrangements made in the initial therapy contract. P1, P6 and P3 describe their experiences in these relationships with difficult patients:

"(…) it was so hard to know what to say to make a connection with her *(patient)*. Because she got better, but initially she would not respond, she would make me feel everything I said was complete rubbish. Occasionally she would give me a little sign that I got through to her and helped me carry on. She was obviously very unwell, she told me she had seen a couple of people as a teenager and she said they were complete rubbish so it was very hard to find any kind of way to connect with her" (P1, 239-244)

"But with certain specific sorts of people, I don't like to generalise, with specific people, there are times where it is almost impossible to stay in contact, in close contact" (P6, 74-76)

"And she began to miss, to ring up and say she couldn't come to the session. She began to miss paying and my supervision group came to say that this was an attack on me. I couldn't see it, I couldn't see that there was a negative transference going on and that she was attacking me. I couldn't see it in those terms, I couldn't deal with it in those terms. And she would pay all her arrears and then it would start again, the missing and the forgetting to pay or "I haven't brought my cheque book" (P3, 205-211)

Challenging therapeutic relationships

The term "challenging" is used here to describe the type of predicaments the therapist experiences in erratic therapeutic relationships. A challenging relationship is one with many fluctuations. In that relationship, the therapist finds it difficult to engage the patient and therapy focuses on the apparent, manifest material without reaching the deep places that characterise the bonding therapeutic relationships. P3 talks about this type of relationship with the patient who missed sessions and left arrears:

"I suppose, now thinking about it, that was a very shallow relationship between us" (P3, 217-218)

P4 and P2 explain how there is a strong relationship even with difficult patients and their quotes indicate how bonding therapeutic relationship and erratic relationship are not mutually exclusive:

> "I think there is a relationship anyway, even when the work is very difficult, kind of not getting on very well" (P4, 51-52)

> "You know, it was a different kind of relationship. Mainly because, she was so mistrustful" (P2, 262-263)

P7 has also felt with some patients that the relationship has been superficial and she describes her experience in it:

> "(…) sometimes I think that somebody might do very well to just come and talk to the chair. It doesn't really matter whether I am sitting in the chair or not" (P7, 286-287)

Ineffective therapy

In these erratic therapeutic relationships, the therapist often feels that the work has not been successful and frequently the thought occurs that more work could be done. In these situations, the therapist feels that she has not helped these patients enough and that maybe she was not the right therapist for them. P5 and P7 spoke about their experiences of disappointment and frustration in some therapeutic relationships:

> "And actually there was absolutely nothing I could do for her anyway (…) It was frustrating. So I couldn't do anything with it, I probably had failed her and I was frustrated" (P5, 57, 77-78)

> "And during that time, when she was less well, maybe there was a sense that something broke down, I wasn't always quite sure. Anyway, finally, finally, finally she became even more unwell, but at the same time, and our relationship felt as if it had broken down" (P7, 45-48)

Short term therapy

Therapists also talked about the duration of therapy and how it affects the therapeutic relationship. Most of the therapists found that it was more difficult to be effective and develop bonding in the relationship in short-term treatments. Moreover, the frequency of the sessions is usually once weekly in these cases. P5 summarises this in her interview:

> "And I also think that there is very little you can do about the relationship when you see them once a week" (P5, 339-340)

> "Because I am analytically trained, I couldn't imagine how it would work for someone in 16 weeks. And I used to feel I was damaging them, let alone helping them (…) And I think it is very, very hard to understand how anyone can get 16 weeks of anything useful" (P5, 244-248)

At termination – "despondent termination" (P2, 31)

The termination of erratic therapeutic relationships stirs up diverse and intense feelings for the therapists.

Premature termination

A despondent ending is frequently a premature one. This means that the therapist feels that it is not the right time for the patient to end treatment. With some patients, the therapist feels that they should remain in therapy for longer and tries to negotiate an ending with them. P6 summarises his experience and P1 describes her feelings when she deals with a premature ending:

> "There are a handful of people that have left before I thought they should go" (P6, 49-50)

> "So, any difficulties or when things go wrong is partly because the patient has got something different they are trying to get out of it and the therapist has got their own theory of what is going on. So as a therapist I suppose there is often the feeling that more work could be done and how long has it been and what point do you feel this is absolutely as good or good enough. I suppose that is always the question in my mind and not knowing whether this is the right time for someone to end and how to deal with it if I feel very strongly this is not the right time and try to negotiate the whole question of ending" (P1, 40-48)

Therapist feeling unhelpful

At the termination stage of erratic relationships, the therapist often feels that she could not help these patients and she feels defeated. She is dubious about the time of termination and sometimes she begins doubting her own competence. She may feel that she has not been the right therapist for the patient and occasionally she would initiate termination and/or refer the difficult patient to another therapist. P6 discusses in the next quote his personal feelings when he had to terminate with a patient because there was no improvement despite his efforts:

> "Feelings of inadequacy, helplessness, hopelessness and, I have mentioned, dislike and hate" (P6, 69-70)

P5 talks about her own feelings of inadequacy when she continues her discussion about the patient she felt was abusive with her:

> "(…) I couldn't do anything with it. So she had me. And I don't like feeling useless" (P5, 102)

P5 also talks about her experience of leaving a setting because she felt she could not help the patients there any more:

> "So I suddenly realised that I got it completely wrong with her. And I just walked out of the *(place of work)*[11], I never went back again. I decided I was no use. God, this is awful. No, you can't do this sort of work if you feel you've got no confidence. You are useless. And I could have gone back but I didn't. I felt I got it dangerously wrong" (P5, 135-138)

The above quote outlines the intensity of the therapist's experience of feeling unhelpful and its impact on the professional choices therapists make.

Therapist feeling relief

In the ending of an erratic relationship the therapist sometimes feels relief. She mainly experiences the work as hard to endure and she feels alleviated from the distress and anxiety that patients have provoked in her. Some therapists spoke specifically about borderline patients and patients with separation anxiety and other complex issues; they found ending with them relieving. P1 talks about her experience of ending with the patient she felt she could not connect with:

> "But I mean it was the most intriguing experience although extremely difficult. So finishing with her, it was a kind of relief because it was so hard to know what to say to make a connection with her" (P1, 237-239)

P8 describes her experience of ending with borderline patients:

> "With borderline clients, I always feel tension with them because you have to be more careful about boundaries and about frame and this kind of things (…) I have ambivalent feelings about termination because in some way there is kind of relief. Because some of them they are just not easy people to deal with. And they suffer because of they use other people and try to use therapists. So in some it's a big relief to terminate" (P8, 50-55)

[11] The name of the place of work has been omitted in this quote for reasons of confidentiality.

P2 also talks about his experience of ending with patients with whom he desired to be more helpful:

> "But she was a nightmare and a lot of times she came close to a threat of violence and I think with her it's partly relief "thank God I don't have to see her again" and also regret that, you know, I felt like I really wanted to kind of get to some better level of cooperation with her" (P2, 255-258)

P7 explains her feelings when she initiated termination with a patient in a group therapy context:

> "But it was a relief *(sighs)*. So, relief, I mean, I guess that can come into ending, or that does come into ending. I think I find a relief comes when I've been working with somebody possibly it's always somebody for whom maybe I've not been the right therapist in the first place. But somebody who has always made me feel, well "made me feel", somebody with whom I have always felt not good enough; who promotes that particular kind of anxiety or you feel that awful therapist all the time. Which is, *(laughs)* they are not comfortable feelings *(laughs)*. So there have been times when I think "oh…thank goodness for that" but not often" (P7, 261-269)

Therapist feeling worried

At the termination of some erratic relationships the therapist can feel worry and anxiety mainly concerning what would happen to these patients in the future. Her worry is enhanced when she has doubts about the time of the termination; either she feels that more work can be done or she has initiated termination for her own personal or external reasons. P2 talks about his anxiety at termination when he stopped working in a particular setting:

> "Because most of my clients have that kind of make up and, you know, how can one contain an ending…So they won't use it against themselves in the end of the day. I mean, I think, often because an anxiety is there that will a person revert to *(initial symptoms)*[12]" (P2, 134-137)

P3 also talks about her anxiety when she terminated with a particular patient who reminded her of her own history of personal losses:

> "I think I really had trepidation about *(name of patient)*[13] as a client but the parallel with the incident with me with my own *(significant person in personal life)*, there is always some trepidation when you are logging a person onto the world. So there must have been some of that with *(patient)*" (P3, 125-128)

Therapist feeling unsettled

When therapy ends prematurely and suddenly, the therapist is left in an unsettled state of mind. She feels confused and does not have the opportunity to discuss and work through the material that termination has stirred up, as P5 and P7 explain:

> "And I think, to be honest, the problem I have with people suddenly terminating on me is that I don't understand why they are doing it. It doesn't make any sense to me" (P5, 284-286)

> "And then, he rang me the day before he was due to come for the sixth time and said: "I finish, that's enough, thank you very much, I am not coming back". He didn't even speak to me personally (…) And I thought, "what was that all about?" (…) I expressed some puzzlement that he had broken off in the way that he did" (P7, 84-94)

[12] The nature of the symptoms have been omitted in this quote for reasons of confidentiality.
[13] Details of the patient and the participant's significant person have been omitted in this quote for reasons of confidentiality.

On these occasions, some therapists are also left with a feeling that the work has been incomplete and feel left with unresolved issues:

> "And I thought I worked hard and properly for her *(patient)*. And, it is funny, because I was left with very unfinished business and also wonder with what impact I helped her" (P5, 70-72)

> "So there wasn't the same involvement or if there was, it was unconscious and therefore not resolved. Perhaps that is so, that I, I think he *(patient)* and I are not quite resolved" (P3, 144-146)

> "And she *(patient)* terminated therapy and left in two weeks. Hm…it was as much my fault as hers, I am sure. But that was very difficult, very uncomfortable. Because I didn't, she didn't stay long enough for us to talk about what had happened. So I was there, with these very difficult feelings: "did I miss something important?" I tried very hard to retrieve the relationship and I couldn't (…) So that I think will go on, actually I was going on thinking about that work because I was left with so many unanswered questions. What was she thinking? What was she feeling? I felt dreadful and very upset; very distressed and very guilty. Because I felt I missed something important that she left so suddenly and we didn't have a chance to talk about it (…)Very sad, very uncomfortable, and for me with lots of unanswered questions; because I am just left guessing and wondering (…) And I think, we met maybe for two sessions, and I thought, "well, what was this all about?" And again, you never know, so you are left with all these unanswered questions" (P9, 3-13, 18-19, 51-53)

Summary

Therapists sometimes experience erratic therapeutic relationships with patients. Those interviewed discussed their diverse experiences in different settings and with different patients. They mainly talked about hateful, critical, mistrustful and attacking patients with whom the therapist felt unable to help. She felt she could not make meaningful

contact with them and that the work was really hard. Terminating with these patients often stirs up intense feelings for the therapists: frustration, worry and anxiety as well as relief. The therapist finds herself in an uncomfortable situation with difficult-to-manage feelings and she can not work them through because the patient has already left. This makes her feel unsettled, with unresolved issues.

Gender

It appears in the above quotes that "erratic" relationships are drawn from work with female clients exclusively. Participants in this study spoke equally about male and female clients and did not differentiate their experience of termination depending on the gender. The gender effect appearing is a result of the researcher's selection of quotes that best demonstrate the categories deriving from the analysis of data

Besides the diverse experiences of termination depending on the therapeutic relationship, the therapists outlined some basic general issues that characterise their endings with their patients, which will be explored in the following chapter.

Working through the termination –

"And we talk about it (ending) (...) in a preparative sort of way" (P7, 198-199)

In general, the time of termination is a time when strong feelings are stirred up in the therapists. When they think about these endings retrospectively, the therapists talked about two particular features that could generally be applied to their experiences: the *time of the ending* is considered significant and the termination is often seen as a time for *review*.

Time of the ending

Therapists in this study spoke specifically about the time of the ending regarding working through the feelings associated with termination, re-considering issues such as physical contact specifically at the time of termination, described their vivid

memories of the actual time of the patient leaving and talked about the significance of sharing their experience of endings.

Time needed to work through the termination

There is a general consensus amongst the therapists in this study that the time needed to work through the termination is between two to five months. P2 and P8 talked about their experience of initiating termination with their patients due to external circumstances and they discuss the time they felt was necessary to give notice and work towards the endings:

> "I had a reasonable notice, a three months notice. I would have told people three months or a little more in advance of my leaving. And I remember in one week of giving the message to three different groups as well as some individuals and it was a very emotional week I think" (P2, 49-52)

> "I feel that especially, when I moved to Britain for example, I had this issue, this termination with my (…) clients (…) So I think it was an element of practicality so I had to finish. Usually it took quite, two or three months at least to be able to integrate, to consolidate the material that I went through with them" (P8, 69-73)

P7 also talks about the time needed to work towards the termination in a group context:

> "And we talk about it *(ending)* over months and prepare for it, not all the times, every week, but regularly, in a preparative sort of way" (P7, 198-199)

Physical contact - presents

Two important concrete issues that are raised for therapists at the time of termination are the issues of physical contact (shaking hands, hugging etc) and the issues of presents (whether or not the therapist should accept gifts). The therapists talked about

the variety of their experiences regarding these issues and the meaning they have for them. P3 talked about her hesitations to hug her patient:

> "I think I should have, I should have asked for permission, I should have touched him *(patient)* in some way I think. I think there should have been some kind of physical contact. Which would have broken a spell I think" (P3, 47-49)

P4 talked about her common practice to shake hands with her patients:

> "And I shake hands with patients at the end of treatment, but that's very different from what some people would do" (P4, 248-249)

P10 described the meaning of the present one of his patients gave him at the termination phase of therapy:

> "(…) they *(patients)* gave me a very generous parting gift. They'd always sort of given me something at Christmas, but this was particularly generous. I mean, it just a bottle of excessively nice champagne and a box of chocolates. But it was again a sort of marker for what they felt about the therapy that it had been continuous that somehow I had never given up on him; that seemed a very important thing for them" (P10, 114-119)

Therapist's vivid memories of patients

When therapists talked about their endings in this study, they had vivid memories of a few patients and their last sessions. They could also recollect the feelings they had when the patients were leaving.

> "And when he *(patient)* went, he thanked me very much for all I had done there. And when he actually went through the door he turned back and said "goodbye". And then he kind of disappeared. And only then did I realise he had tears in his eyes" (P3, 39-41)

Therapists also distinguished patients that they remembered vividly and patients that they felt they had forgotten:

> "There were some I remember very clearly, there are others that I wouldn't even remember what they look like. So there is something about their personality, their character, what…how developed they are perhaps" (P9, 33-35)

> "Yes, I think I remember people very clearly because you do, you learn a lot from your patients. You learn a lot about their worlds, which is also their professional worlds. So you hear something on the news and you say: "Aha, I know one or two things about that". And you remember them that way and…so you remember them with gratitude through what one has learnt from them perhaps" (P7, 123-128)

Sharing the experience of termination

Therapists find it important to be able to talk to someone about their experience of termination. Supervision is considered to be quite significant as well as colleagues' groups or group supervision. Other therapists talked about having a few trusted colleagues that they discuss their feelings with. Three therapists were in personal therapy at the time of the interview whilst others used their personal network in order to share their experiences. P6, P2 and P4 discussed the significance of sharing:

> "I am going to take them *(difficulties)* to my supervision group, whereas touching on personal things I take it to my therapist. But it is a very good supervision group, most of them I know for a very long time, and we have been in the group for a number of years and I very deep trust, we'll say to one another, you know, "that's personal, take it to your therapist". So it is useful; they are trustworthy and direct" (P6, 288-293)

"Practically, I spoke with my supervisor, trusted colleagues and friends" (P2, 301)

"So I think having a process where you, as a therapist you have to be cognitive to those things and actually put things in place to make sure that you are properly supported or contained. I am aware that when I went to private practice I didn't want to work on my own, so in a way, I probably delayed doing private work for quite a while because the only way to have done it would be to work as a lone practitioner and I had no wish to do that. So…and I have moved into a relatively large practice and there is always somebody to speak to. And I like that, I like the institutional environment, I find it containing and supportive so I think, I probably have made choices that actually helped in that sense as well" (P4, 333-342)

Review

The participants focused particularly on their reflections on the therapy process at the time of the ending and described how they experience the treatments that have terminated. They also talked about how the termination of therapy informs their practice and, subsequently, their lives.

Therapists reflecting on therapy process

The termination stage is a phase of review for the therapist. She has the chance to reflect on the therapy process and consider the achievements or the mistakes that have occurred. She reflects on issues that have been worked through and issues that would need more work. Reviewing the therapy process is for some therapists an important aspect of a good experience of ending. P1, P4 and P6 talked about their experiences of reviewing and its significance.

"A proper ending is an ending that you have talked about and thought about and planned and had some time and…during which, there is a kind of real feeling of reviewing and saying goodbye I think. This sort of going through, over what has happened. And it is a planned ending

obviously, so that it gives an opportunity to work through some kind of whatever the whole range of feelings are anticipated" (P1, 389-393)

"But I think there has to be a process, for me, there has to be a process of actually trying to I think (…) actually of what the process of treatment has been and the points of perhaps it's got stuck and trying to identify why (…) Although, I suspect I am, I was thinking in some ways it is helpful to really try to identify the lessons to be learnt from that kind piece of work, whereas, supervisors sometimes can be very supportive about how difficult the work was and for me, it was important to also have some kind of sense of "what could I have done", "how I might have approached some things slightly differently" (P4, 41-50)

"It *(termination)* is a time of particularly searching for mistakes, things I got wrong, things I didn't understand, areas of the person's life that we might not have covered or we might not have covered adequately enough" (P6, 1-4)

Therapist leaving therapy like a story

At the end of every treatment, the therapist's experience of the therapy process is "replayed in a concentrated way" (P7, 213). Some therapists think about the patients' treatments like stories or novels that patients could write about. P5 talked about the mothers of children that receive treatment and how they could write an interesting story about their experience:

"it might be perhaps one of the best termination, ideal termination for me is to leave it like a novel or story. Because I have, I think I always have this feeling that every personal history is just walls to be opened, to be written down and it might be interesting, it's not less interesting than any other novels that you read" (P5, 150-154)

Termination of therapy like every loss in life

The termination of therapy with patients is perceived by some therapists as having the same impact as a personal bereavement or loss. These therapists consider their personal reflections on the endings and review the philosophies that inform their practice. P2 demonstrates it when he talked about his experience of endings when he left a setting he worked in for many years:

> "I suppose with an ending, it's a bit like a life review. If you know somebody for a long time and you see him like that and suddenly it broke down in bits and pieces that you haven't previously been thinking through consciously before (…) And then this sense of accomplishment that, you know, you sort of build up a sense of what you can do, who you are, what you can influence, and I've done a lot of work there and I've done a lot of wider professional contributions, writing and so on (…) So in a way, it was, the ending also helped me learn more about the philosophies that are very important to me and the values because somehow it faces you with what you feel as important. And the same is true I think in personal bereavement, when you lose somebody then often you take stock and you remember what they've come to meaning in their lives, what was important to them, what things and it sort of puts you in perspective really.(…) There will be a death but throughout life there is going to be lots of terminations. They are sort of givens in human existence really; where they will be managed at the moment. So I suppose it kind of reinforced that awareness and my own passing and so on ultimately. Puts things in perspective" (P2, 41-43, 98-101, 219-224, 345-348)

Summary

The time of termination is an important part of the therapy process for therapists. Whether the therapist or the patient has initiated it, there has to be a particular period of time where the ending is discussed and worked through. The therapist reconsiders issues such as physical contact or accepting presents and judges, even retrospectively,

what would be more helpful for the patient at that specific time. She has vivid memories of the patients and the way they left the therapy room at the end of the last session. She also remembers her patients as people that have taught her things about life and practice. The time of termination is a time of review for the therapist, whether the treatment has been successful or not. She re-examines critically the therapy process and searches for her achievements and her mistakes. She considers the ending of therapy with some patients as every other ending in her life, since it informs her about the philosophies of her life and practice; it gives her a perspective.

Termination through death -

"I didn't have the chance to say goodbye" (P1, 488)

Five out of ten therapists in this study have experienced the termination of therapy when a patient died. Death was a result of a terminal illness or suicide. The therapist's experiences will be explored in this distinct category that was developed to capture the her experience of this special kind of ending.

Diagnosis becoming a part of therapy process

In the case of terminal illness the diagnosis becomes part of therapy process. Therapist and patient adjust the therapy arrangements (time, place, manner of therapy sessions) according to the patient's special needs. So some therapists would visit their patients in hospital whilst others would engage in phone conversations when the patient is unable to attend the consulting room. P4, P6 and P9 spoke about their experiences:

> "(…) and it meant modifications to the treatment, very typical, purely psychoanalytic psychotherapy, which moved in fact from once a week to twice a week. That some of the modifications were very much in terms of setting, you know, towards, later, he *(patient)* couldn't sit so he would use the couch but actually facing me, sat up, you know, and I would sometimes see him at home or in hospital" (P4, 54-59)

"We have made arrangements to meet at the hospital and all sorts of unusual things" (P6, 100)

"She *(patient)* is now too sick to come and see me so we talk on the phone" (P9, 247)

Issues of ethics

When a patient dies, there are special issues of ethics the therapist regards and explores. P1 refers to her experience of writing a report about one of her patients who died suddenly:

"It was terrible because I had to write a report and I had to ring up the ethics committee of the BAP to talk to them about what I would write" (P1, 479-481)

P4 also spoke about her consideration of ethics when she thought about publishing a paper on her experience of ending with a patient who died.

"But it is also, it is remarkable, a very interesting piece of work but actually, you know, my supervisor suggested that I should raise it up for publication. But actually, ethically, I don't think I can because I don't have his permission to do that" (P4, 89-92)

Going to the funeral

Two of the therapists whose patients died attended the patients' funerals. They both talked about their strange experience being amongst the patient's friends and family, about whom they have talked but never actually met. The experience was also strange because they could not share their thoughts or disclose any feelings to the rest of the attendants.

"And I went to the funeral. It was huge (…) and I sneaked in, but that was a bizarre experience and very strange to see all these people. Of course he *(patient)* talked to me about them, he would present himself

> to me as someone they didn't like; he was a difficult man. And of course he had a lot of people who had tremendous separation for him and colleagues. But they also had some kind of a wake. I didn't go; I couldn't go (…) I felt I was there. That was a very strange experience" (P1, 482-488)

> "(…) because it was actually a very intimate relationship *(therapeutic)* that his *(patient's)* family were not involved in and there was nobody in a sense that I could, that knew him who I could talk to. I was invited to, they did know my existence at the end, and I was invited to the funeral and I went. And I was sort of pleased that I did. But it was an odd thing to be present there in fact" (P4, 75-79)

Therapist's loss and grief

The therapist experiences feelings of sadness and loss when a patient dies. However, she keeps carefully within professional boundaries in order to accommodate the patient's needs rather than hers in the final stages of the patient's illness. P9 emphasised the significance of boundaries:

> "It's much harder to be…well I…you still need strong boundaries but you also have to be very human I think and very real. But if you abandon the boundaries, it doesn't help the patient" (P9, 255-257)

P6 discussed his difficulties containing his feelings in order to adhere to professional boundaries:

> "That had been much, much more difficult because I found it very difficult to contain myself. It's the last thing they want, you know, to see their therapist burst into tears. But I found that excruciating" (P6, 101-103)

In spite of her sense of loss and grief, the therapist focuses on the patient's needs:

> "And so partly through the material, we were able to sort of address the fact that, and my sort of offer to termination, preparedness, wish, to actually be prepared to do that and, in some ways it is a very privileged position to be at" (P4, 87-89)

> "But in a way that's, the fact that she is dying, and we have a enough good relationship to sustain that level of contact…helping her to die as well as possible, as long as she is conscious" (P9, 250-253)

Despite the boundaries and the focus on the patient's needs, the therapist experiences painful feelings of loss when a patient dies. The experience of bereavement is intense and she compares it to the death of a close person in her personal life; when a person she knows very well dies.

> "I really did grieve actually, I was quite low for quite some time" (P1, 502)

> "I have also had, I think three, patients who actually died. All of them cancer and all of them who I have worked with until they died; literally until they died. And that was profoundly distressing. That was another problem because some of them to get to know them very well and you are fond of and, you know, you are expecting them to go out into life and suddenly they get a diagnosis of breast cancer, for instance" (P6, 94-98)

> "But you then have…so actually I was very…I felt all of the sadness that one feels when someone one knows very well has died. But actually without the, mostly, without the normal kind of rituals that you can engage with" (P4, 73-75)

Premature termination

A termination through death is a termination that occurs prematurely. Neither the therapist nor the patient has planned to end at any specific time; because none of them

knows when the time of death will come. Because of this, it is an abrupt and unexpected ending, even though there is a desire to have enough time to "say goodbye", as P4 described:

> "I mean in a funny way, it is a very different sort of premature termination or interrupted termination. You know, you have that with all sort of patients for all sort of reasons. But there is a very particular form of that" (P4, 93-95)

> "But I think, partly because of his experience, the thing about dying is that you never know when you are going to do it. And I think at some levels, in the, that both of us probably had a fantasy that there would be a point that we would say goodbye and of course there wasn't because you don't chose when you die. And I think as a therapist that was probably the hardest thing; that I felt I missed out on a chance to say a particular sort of goodbye. You know, I am sure that's…and I would have thought of my fantasies and wish to sort of have a kind of completion. Of course when somebody dies, you don't have a completion" (P4, 59-66)

When the therapist does not expect the patient's death and there is no diagnosed terminal illness, then the feeling of premature termination when the patient dies is more intense. This may occur due to an accident or when a patient commits suicide. In both cases, the loss is intense and traumatic; the therapist experiences the extreme case of sudden ending. P1 and P9 talked about their experience of finding out about the patient's death through a third party.

> "He *(patient)* died very tragically and suddenly and unexpectedly and (…) I found out about his death through *(third party)*. I had been expecting to see him on a Tuesday and I heard on Monday that he died. It was very traumatic" (P1, 475-478)

> "And that was a shock because I didn't know he *(patient)* had come out, that he was back out in practice, you know what I mean, in the

> population. I thought he was still in his day centre. And I felt very hurt inside about that and I wish that I had known because I didn't hear for some time (…) And I will never forget him because I don't know who mourned him. And I would like to have been able to mourn him and I heard about this too late. So that was another difficult ending (…) he had no family, there was no one. So that was another different sort of ending" (P9, 263-273)

P7 also discussed her experience of suddenly finding out about a patient's death in a group therapy context. She talked about her efforts to understand it and wondered how group therapy had affected that patient.

> "And I mean undoubtedly that was a sort of dreadful end. When I had no way of thinking about it or understanding it, I had absolutely no idea about how much, if anything, it had to do with the group. Whether had I been wrong to have taken him in the group in the first place? You know, I wondered well, maybe I should have never taken somebody who had such (…) problems. But then a friend of him came and spoke to me some years after that, very warmly about his experience in the group and what a horrible accident his death had been. That's another kind of ending, isn't it? It is an ending that should never have happened" (P7, 132-140)

P6 talks about another "ending that should have never happened" about a patient who committed suicide:

> "I never understood what happened (…) and he *(patient)* committed suicide. He knew what he needed which was a secure, understanding, containing environment and it was denied him. And he killed himself…That took ages…that was again an unplanned ending. It took me ages to recover really" (P6, 115-120)

Finality

Unlike other endings, termination through death entails a finality that makes the therapist's experience of loss more intense. The therapist knows that there is no chance that she will be able to see the patient again. P4 talks about it when she describes her experience:

> "I think the most extreme example of that for me was with one patient when the treatment ended because he died and in a sense we knew, somehow of course, but we did know that was coming. In a way, that was probably, I mean, that had a whole series of actually very different dynamics than normal termination. In a way with normal termination, there is always the fantasy that at some point you might be in touch again or you might hear something about the patient or whatever. Whereas, when someone dies that's it really" (P4, 10-18)

Summary

Five therapists in this study have experienced the death of a patient. They talked about the boundaries and the ethics and how they were flexible during therapy sessions in order to adapt to the patient's physical needs. They described their intense experience of loss and grieving and compared it to the loss of someone they like and know very well. The difference is that the therapist cannot share these feelings of sadness and loss with someone who knew the patient, due to the ethical rules of psychotherapy. So she is left with questions, especially in the cases of unexpected deaths, either through an accident or suicide. The major characteristic of the termination through death is the finality that it entails.

The Aftermath –

"Therapist's private ending" (P9, 187)

The therapist's journey through termination of therapy with patients continues after the actual termination of therapy, after the last session. The therapist experiences the

desire to contact patients after termination and to know what happens to them after therapy has ended. They experience some terminations as final and others as incomplete. They talk about patients they keep in mind after the ending of therapy. Finally, they speak about the familiarity they have developed with endings and how they have their own private endings in order to deal with feelings. The above will be explored in this chapter.

Contact after termination – "always nice to hear" (P1, 324)

One of the significant issues that arise for therapists after termination is whether or not they will be in contact with their patients.

Patient's initiative

As with termination, the basic rule is that patients should have control of the contact after termination as well. When contact after termination occurs, it has to be the patients' initiative. Even when the therapist would like to see the patient again, most therapists expressed their belief that any communication after the ending should be introduced by the patients. The therapist would then anticipate (or not) some sort of communication from the patients, feeling restrained from facilitating it. P3 talks about her experience of desire to contact one of her patients she has ended with and discusses the barriers to that:

> "I feel very tempted to…I have his website address, he has a website address, very tempted to drop a line. "How are you *(patient's name)*[14]?" I don't know, I think it has to come from him. I haven't thought it through of what it might mean for him. My instinct says, don't do it" (P3, 57-60)

When the patient contacts the therapist after termination, it might be through a letter or a request for further therapy. They can also have what therapists call the "odd

[14] The name of the patient has been omitted in this quote for reasons of confidentiality.

session" (P1, 80) or a follow-up session, depending on the setting and the initial arrangements, as P1 explains:

> "(…) occasionally patients have written a letter to me afterwards …occasionally patients come back for the odd session…one session or even for some more sessions (…) And if you ever meet them again it will be because they sought you out" (P1, 78-80, 342)

P6 also talks about his experience of a patient that keeps regular contact with him after termination, to which he replies:

> "But some people, I get a letter in Christmas. Some people I've had them for years…there was one patient (…) I saw her for about 25 years and then she moved away. I saw her less and less but I get these yearly, annual letters from her saying what she is doing or feeling and thinking…I always reply… And more than reply, finding a poem and send it to her" (P6, 217-226)

P4 also talks about her experience of patients keeping regular contact after termination, to which she does not reply, unlike P6:

> "Some patients have kept in touch in a particular way; (…) with Christmas cards or a post card every now and again. And I have always felt, to some extend, that's been their way of letting me know that they are still alive (…) But, and mostly, I have accepted that as a communication but I haven't responded. I still continue to feel quite mixed about that. I mean, often, when there isn't an address then you can't necessarily. But that has been interesting" (P4, 365-372)

Therapist's initiative

Despite the basic rule, there are occasions in which the therapist will "leave the door open" for patients to contact after termination. In most occasions it depends on the patient's needs. When therapists feel it would be helpful for the patients to know they

can contact them or to offer a follow-up appointment, they would encourage this communication overtly during the sessions. They either feel that more work could be done or that the patients need to be reassured that they can have more sessions in the future. P6 discusses his normal practice when he terminates with patients and whether or not he would encourage contact after the ending:

> "I vary enormously. The whole process varies very much from person to person (…) It varies, some people I offer a follow-up six months later. Some people take that and some people don't. If they don't they usually write and say "thank you, I don't need it, I don't want to" (P6, 200-201, 208-210)

P4 and P9 explain how they encourage patients to contact after termination when they feel that there are more issues to be addressed in therapy:

> "And occasionally I have said to people that they are welcome to get back in touch if they need. Mostly, I don't say it routinely, it will be specific to the person. Yeah, and would probably be when we both knew that there was more work to be done but that perhaps they needed time for reflection and review before they worked out what it was they wanted to do" (P4, 377-381)

> "There was another lady who came for a short time; who was sad to go and realised that she hadn't really dealt with what she may have been… afterwards and I said "well, you know where I am" (P9, 369-371)

Another occasion on which therapists will encourage the patients to contact after termination is when therapists initiate the ending, mainly because of external circumstances (moving country or jobs). P2 talks about his experience of leaving a setting and how he introduced contact after the termination to his patients:

> "Another thing that I, I think it was partly my wish but I also wanted to be sensitive, what had to do in terms of their "could they contact me"

> so in the end a lot of my clients I did give them my printed work address and said a lot of times that an ending is an ending but if they felt the need or the wish to drop a line to me at some stage and let me know how they are getting on that I would be more than happy to. I think it was giving the permission but it was also communicating my wish to hear from them" (P2, 330-336)

P8 also offered this opportunity to her patients when she moved countries because of her feelings that the work was not concluded:

> "And with these clients, perhaps there is an element of non finished gestalt, but they have (…) the possibility to phone me once a week, to Britain, and they do" (P8, 73-76)

For P5, leaving the door open and encouraging patients to contact after termination is common practice:

> "And I always make it very clear to people that they can come back" (P5, 21-22)

In general though, it is implicit in therapy that patients can communicate with their therapist after the ending of the treatment.

> "I do leave the door open…not always explicitly, in my mind I leave the door open" (P7, 173)

Therapist not encouraging contact after termination

On some occasions therapists consciously choose not to encourage patients to contact after termination. For these cases, the therapist believes that it would not benefit the patient. By not introducing further contact and sessions the therapist feels she enhances the patient's resilience. P3 explains why she does not normally leave the door open when she terminates with patients and she relates that to her maternal transference:

> "I very rarely say that "you can always come back". I think I have only said it a couple of times because, and this is my training I suppose, I don't want to give the message that I think they can't cope. But it is the kind of thing that you say to a child when you send them off to university, marriage or whatever. "your home is always here" (…) I think probably clients know that, because if you, just as there might be a danger in sending out a message that "I am not sure you are going to manage on your own", there is also a not-saying anything, there is also the message "I have cured you now, go away and be well". It depends on what the relationship has been like" (P3, 277-280, 286-289)

Meeting in social contexts

Another dimension of the contact after termination category is the situation where the therapist and the patients meet in places other than therapy context. Some therapists talked about their experiences of meetings patients in social and other contexts. In some cases, this occurs when therapists see trainees as patients; when the trainees are qualified they meet with them in various places as colleagues. P6 discussed his hesitation to meet trainees as patients:

> "I am slightly oppositional of meeting people who are in analysis training and then see them around in places all the times. That's strange" (P6, 231-232)

On other occasions, the nature of the relationship with patients changes significantly after termination and the therapist and the patient meet in social places and they become "sort of friends":

> "One or two I have become sort of friends with and their families but that is because we have kept meeting at various social situations" (P6, 233-234)

> "In the course of 30 years *(of clinical practice)* there are two people who have kind of become friends" (P7, 293-294)

P2 also talked about his feelings when he meets his patients in social places rather than the therapy context.

> "I wanted to see him *(patient)* for a follow up and I was really curious to see him as a person. And that was a really good get-together, and very touching. It was nice also not to be in therapy because I was very sort of disciplined about my therapy so I have no problem in greeting him almost a bit like a friend. You know, we did say that it would be nice to meet, I don't know in what stage, in the future. And I said, well, why not, and "why don't we have it in a café next time". I wanted to sort of get a bit away from the clinic environment. So, that was nice" (P2, 174-180)

Therapists also expressed their desire to meet specific patients in social contexts, even though this would not be possible in reality, as P3 explicates:

> "I would like to meet her *(patient)* for a coffee one day and talk…I would like to do that" (P3, 122-123)

No contact after termination

Unlike social relationships, the chances of meeting the patients without making prior arrangements are rare. Moreover, therapists find that more often than not patients do not contact after termination. Therapists make their interpretations about the reasons why this should be the case but they also expressed their intuitive feeling the have about whether or not the patients would contact them after termination, as P1 and P6 explain.

> "It is different with patients; they will not pump into you like that (…) It doesn't surprise me that he *(patient)* never contacted me because he wanted to leave that damaged child with me (…) the majority of

> patients won't ever come back. And so there is a feeling of sadness about that" (P1, 130, 287-288, 80-81)

> "And I sort of know they *(patients)* will vanish (…) I sort of have a pretty accurate hunch about whether I would be contacted again or not" (P6, 158, 216)

Desire to know what happens after termination

Whether patients contact the therapists or not, there is common consensus amongst therapists in this study that there is a desire to know what happens to their patients after the ending. This category will be explored, looking at four dimensions: why, what, how and for which patients therapists want to know.

Why do therapists want to know – "human" worry

Therapists experience a genuine anxiety and worry about what happens to some of their patients after the ending of therapy. They refer to this worry as "human" given that there is an intimate relationship that develops with these patients. Therapists associate this anxiety with their feelings of loss and separation they experience in ending with them.

> "you mind what happens to this person…of course depending on…some patients stir up more personal things or issues than some others to you…it can be lots of strong feelings about sadness and loss and feeling that you miss that person and all the feelings that come with major separation (…) Well of course I think it is a perfectly human, natural …People are usually anxious about ending (P1, 73-78, 87)

P2 demonstrates this worry when he talks about leaving a setting and the worry about the services he provided there:

> "I think there is a little bit of a kind of self-mourning, I think, because nearly all the groups, I think actually all of them I had given birth to as it were (…) I think a lot of these groups, I think all of them, there was a sense of what would happen now? Would be a bit like sort of tied coming in and what I'd built up would be washed away. Probably the same for a lot of individuals, because I very much believed in them (…) I think again I created some of the culture or made sure that service is there for people who need it. What would happen now? So I suppose mourning my legacy to that service" (P2, 53-64)

Some therapists expressed a sense of longing to know what happens to their patients after the ending. There is a feeling of nostalgia and yeaning inside them that drives the desire to know what has come upon the patients after the ending.

> "Well, I think there is a sort of chronic wistfulness because (…) I wonder (…) what's basically happened to them; are they happy, are they content, not happy, are they content (…) Generally it is a curiosity wistfulness" (P6, 227-229, 234)

Therapists are also driven by their curiosity when they desire to know about their patients they have ended therapy with. P8 talks about her curiosity when her patients continued therapy with another therapist after she moved countries.

> "And it's interesting because I am curious about what is happening. So we could talk about two different terminations: when you terminate and the client is continuing with somebody else and when you have terminated but the client doesn't have any more therapy but he has a chance to contact you. And they, these clients who works with other therapists, yeah, I have my sharp feelings because I am…because I am terribly curious, not terribly, but curious of what is happening there" (P8, 100-105)

P5 also talks about her thoughts of contacting all her patients she has ended with due to her own curiosity.

> "I had at one point been toying with sending…all my ex-patients saying something like "it is quite good practice if you would like to come after a year…come and discuss where you are at" but I knew it was just because I was curious. So I thought "bad idea". Because I would like to know what happened to them all" (P5, 325-328)

What do therapists want to know – patients' lives after termination

Therapists desire to find out about their patients' lives after the therapy termination. They would like to know whether patients fulfilled their aspirations, dealt with their personal and professional difficulties and how they have coped with their issues after therapy. Some therapists would also like to know whether patients continued therapy in another context. P1, P5 and P3 discussed their thoughts on what they would like to find out about some of their patients.

> "(…) and I knew she *(patient)* wanted to have another baby, I would never know (…) and it was nice, it is always nice to hear about people and how they are managing" (P1, 112-115)

> "I often wonder actually what happened to him *(patient)*. Whether he married the girl. Who knows?" (P5, 42-43)

> "But hopefully she found another therapist and the trust was closer to the surface. And hopefully someone else would do the job that I wasn't able to do at that time. I think about her very often" (P3, 183-185)

How therapists find out – seeking information

Therapists often find out about their patients from third parties, i.e. other therapists, people who know the patients or internet resources. Some therapists may not ask directly but they will seek some feedback about the patients' life after the termination of therapy. P1 and P3 described their experiences:

"Oddly enough, I met the person who referred her *(patient)* to me (…) and told me that she met her recently and she was doing really well, and it was nice (…) I knew from someone else that he *(patient)* had survived his father's death. So it's always nice to hear little snippets. (P1, 113-114, 324)

"And again, I wonder, how she is doing and I have heard actually, because I did at the agency where I was working (…) and I have asked, you know, roundabout way. She still goes to that (…) group and she speaks well and obviously she is doing OK. I have had some feedback" (P3, 118-122)

For which patients therapists want to know – specific patient

The therapist desires to know what happens to specific patients after termination, especially the ones for whom she has invested time and energy over a long period of time. Therapists in this study spoke about patients with whom the relationship has been intense but also those instances in which they feel that the work has not been effective. P1 and P6 explain:

"Huge investment…You get to see someone very frequently. You think how many numbers of hours you spend in intense conversation with someone about themselves and their lives and all the things that it stirs up in you. That of course you get very…you mind what happens to this person" (P1, 71-74)

"(…) particularly analytic patients whom I might have been working for three, four or five times per week, for a long number of years, of course I wonder, you know, how their lives have, what's basically happened to them; are they happy, are they content, not happy, are they content" (P6, 228-231)

Final vs. incomplete termination

This category has been developed to demonstrate two important dimensions of therapists' experience after the termination. For them, termination can be *final* or the work continues, therefore making the ending *incomplete*.

Final termination

The finality of an ending is sometimes provoked by external circumstances: death or moving job or countries. The therapists associated their experience of final ending with feelings of intense loss. This is sometimes instigated by the patients when they do not contact after termination or in the extreme case of the patient's death.

> "She *(patient)* did actually write to me a couple of times and sent pictures of her baby but I knew that it really would be an end. Most endings are, but it was a very final kind of end" (P1, 109-111)

> "And I think back over these nearly 30 years that I have been working but actually once they *(patients)* are gone, they are really gone. So the feeling of loss and sadness" (P7, 167-169)

> "Whereas at other times, it's been a real sense of the loss of a kind of a relationship. And that's the most…that has been with a number of patients. I think the most extreme example of that for me was with one patient when the treatment ended because he died" (P4, 10-13)

The feeling of finality in an ending is also stirred up when a therapist leaves a setting where she has been working:

> "And I could have gone back but I didn't (…) I just left and I knew I was never going back again" (P5, 138-139, 141)

> "Well, I think for me, termination sort of brings back a whole range of terminations that I went through just about two years ago. Due to moving from the hospital where I worked. So I think the whole range

> of services that I worked for, it was a question of terminating the individual contact with those clients. Also the groups that I was doing and many of these groups would have come to an end as well because not all of them had people to take up to run them so there were a number of situations that I was involved in dealing with the ending really. I think it still affects me sometimes. It's interesting it's difficult enough sometimes with one client or it can be but when it's a whole range when it is associated with a place you have worked in and you have been permitted to for many years and it has a deeper residence I think" (P2, 1-10)

In addition to the above, the therapist sometimes feels that when she terminates with some patients she finishes the work with no expectation of any contact after the ending. In these occasions, she feels detached from the therapy and the patients themselves.

> "I am quite good at cutting off; once I finish work I finish" (P6, 186)

> "I think you have to have, I have to have my own little ending; to say "oh, this is finished now"" (P9, 191-192)

Incomplete termination

Despite the sense of finality, termination is often deemed as incomplete by therapists. This occurs primarily in the patients' internal world through the process of internalisation of therapy, which happens at the termination of a successful treatment; the therapist remains in the patient's mind and therapy still influences and affects the patient after the ending. Due to the intensity of the therapeutic relationship, the therapist feels that she remains an intimate person in the patient's life even after the ending of therapy.

> "I think I stay with the client. Because if this being a relationship, a relationship doesn't come to a proper end, if it has been a good relationship. Even though we have two months or three months

> winding down towards an end, it still journeys on (…) So she *(patient)* is speaking aloud that she has internalised the counselling. And I think that happens in terminations as well" (P3, 234-237, 241-242)

> "And in some ways there is a sort of the work that continues but when the therapist is alive in your mind, I think the dynamic of that is different. It might actually be there but not accessible in the same way. I am sure that's real actually" (P4, 105-108)

> "(…) there is a viable therapist inside them *(patients)*" (P5, 156)

> "(…) with clients we share unique experience that they can't share with anybody else and it makes you close with these people forever in this respect" (P8, 64-66)

Some therapists also expressed their difficulties of "letting go" of the patients they end with.

> "I don't know how they experience me during that time. Perhaps I let them do the work. Because in a way I know that just because we are not meeting any more doesn't mean that I am going to let you go. Perhaps there is something about it for me. You know, closing the notes doesn't mean that I let you go" (P3, 229-233)

In the context of psychoanalytic and psychodynamic psychotherapy, some therapists believe that there is no such thing as "final ending" of therapy; they believe that the work that has been established during therapy sessions continues after therapy has ended. These are therapists who also believe that therapy should be an ongoing process for people as they develop in life and grow up. P1 explains this when she talks about the work that is conducted after the termination of therapy:

> "Obviously a lot is going on through the ending. It is often said that a lot of psychoanalytic work happens after the work has ended. You know, if the work has been good enough then you carry on working on

it inside yourself and all sorts of things happen afterwards" (P1, 394-397)

P6 talks about his belief regarding the therapist's personal therapy obligation.

> "Unlike some other people, I don't think we can really, ever, fully analyse because one's personal development goes on until you die. And we have an obligation to go on, working with ourselves, to try and avoid people getting into our complexes, or whatever you like to call them" (P6, 64-68)

P5 also expressed her conviction that therapy should be a person's part of life:

> "I always feel more work could be done. I don't think I have ever really thought "this person is cured". Now, it seems to be…it's external thing that, but that's my perception, is that there is always work to do (…) I think you do some work for a couple of years, go on to do what you want to do and then you are an older person, you come back" (P5, 52-54, 266-267)

Patients staying in therapist's mind – "he got under my skin" (P1, 370)

Therapists in this study unfolded their experience of termination by conveying narratives of treatments with specific patients. For most therapists, there was not any preparation for the interviews and they spontaneously recounted the endings with these particular patients. The reasons why these patients tended to remain livelier in the therapist's mind are explored in this category.

Intense therapy

When therapists spoke about patients that stayed in their mind, they described intense therapy processes in which the relationship was deep and moving. In these cases the therapist experiences a range of personal feelings that make the work memorable. One

of the differentiations therapists made was about the identifications they made with the particular patients' presenting issues.

> "Some patients stir up more personal things or issues than some others to you. Or feel closer to you in terms of their pathology if you like or their struggles and then…it can be lots of strong feelings about sadness and loss and feeling that you miss that person and all the feelings that come with major separation" (P1, 74-78)

> "And some people stay in mind in much more particular ways; either because there was something very moving about the work or there was something you identified with" (P4, 113-115)

Therapists also referred to the emotional intensity of the work, either in successful cases or with difficult patients. In either case, they spoke about unconscious processes that contribute to this and the patient's engagement in the therapy process. Therapists also related this to the duration of therapy.

> "I suppose even with people who just some for a short while, some people really, really stay in your mind partly because of the way they are so ready to use me and they came every time (…) and there are patients who really got so much out of it, the others are kind of angry or difficult also stay in mind. The ones you feel you can be useful, that you have something to offer, even the ones you see for a short period, sometimes that can be a very satisfying and a very, a kind of sad experience when they go. I suppose the people I see on the long term (…) then of course they feel very much part of my…they are very much there and because they've been through or we've been through together some very primitive experiences if you like and you know quite a lot of projections are going on, projective identifications, so it will feel like they've been through the mill with me and they have probably hated me at some point or another and they have been intensely engaged, then it does feel like it is very different kind of

> experience of ending than someone you have seen for a short period" (P1, 164-179)
>
> "They *(patients)* get into my unconscious as well; so some people, particularly the ones I have problems with, I tend to dream about" (P6, 183-185)
>
> "But if they call for something very deep from you, I think it would be hard to forget them because something so profound has happened. (…) I think that's what happens in the unconscious" (P9, 301-302)

Some therapists also discussed their experiences with training patients, explaining why these patients stayed in their mind.

> "But of course the patients stay in my mind too. I mentioned this particular patient who went to *(place of origin)*[15] because it was a very intense experience partly because she was a training patient and I really, really thought so much about her and wrote my paper about her. And she was a delightfully enchanting person (…) But she expressed her feelings very strongly so the whole experience was very intense and very, it was a very strong feeling of loss when she left because I knew she was going back to *(place of origin)*" (P1, 101-109)
>
> "You always remember your first client, your first, every first experience" (P8, 5-6)

Therapists being affected by their patients

Therapists also talked about their patients with gratitude. When they think retrospectively about patients they have ended therapy with, they talk about what they learned from their experience. Therapists feel that they have developed both personally and professionally through their work with these particular patients that have stayed in their mind, as it appears in the following quotes:

[15] Details have been omitted in this quote for reasons of confidentiality.

"So, it affects me now really, it is like a child, every, you know, as a parent, a child comes along and they sort of tease out things of you, you didn't know you had! So every new person does that. So in a sense they *(patients)* are our teachers" (P6, 180-183)

"So in this way, this material is always in with you and it's really, it enriches your life, my life, and even with very difficult clients, you still have things, it's not just work, to learn from them, to be almost grateful to them" (P8, 31-34)

"And that I too have been changed by them *(patients)* so I am not going to forget them. And I do have a kind of gratitude for them as well; gratitude towards them as well" (P9, 286-288)

"But from my own experience in a sense whatever you have experienced with that person *(patient)* really stays inside you so you know although you don't see the person any more there is a strong sense of that person's presence and you have been very strongly influenced and affected by that person" (P1, 96-100)

External reminders

Therapists have their own representations of their patients in their minds. Their memories are often stimulated by external reminders, as P6 and P8 described:

"But people, obviously, come into mind; you read a book, you see a film, you walk down the street and you see someone and all sorts of things" (P6, 187-188)

"Well, I would say that it's, I realised perhaps last six, seven years that you always, even when you finish your work with the client, you always come back to this material, and something in your day life time, or, I don't know, films, paintings, stories, might remind you this

material and you might have an insight about the client's material, even five or six years later" (P8, 27-31)

Therapists holding onto their patients

Therapists miss some of their patients and tend to hold them in mind after termination.

> "So the feeling of loss and sadness, it's not momentary but it doesn't stay with you for very long; I find…And after that, maybe in my mind, they become, a bit like old friends really. Whom you don't necessarily see any more but they are in there somewhere" (P7, 169-172)

> "So it is as if there are all these people in your mind, but that's why our work is so satisfying really. But it is bizarre, it is the only kind of relationship where you can have this intense connection and then you know it is going to come to an end" (P1, 338-341)

> "They (patients) need you to know or you have understood the difficulty or the gustiness, or the awfulness, or the terror, or the fear or the anxiety, or the depression. Hm…and if you go there with the patient, and you don't do with all of them…with some, don't ask me why, with some it's more than with others. But I don't see how you forget these things later. Somewhere, they are inside you. I can't explain it any other way" (P9, 316-321)

But therapists also forget some of their patients:

> "I trained myself very much that I don't take them home" (P5, 158)

> "And there is no doubt that therapists miss their patients I think and think about their patients; wonder about their patients. But I think they also forget about their patients" (P7, 104-106)

Familiarity

Therapists who participated in this study have had many years of clinical practice. Over the years the therapists argued that they develop a certain level of familiarity with endings and with the feelings that each ending stirs up in them.

"The more you do it the less it affects you" (P5, 98)

Therapists differentiated their experience of terminations in their early practice as opposed to how they deal with terminations after having post-qualified clinical experience. They believe that in their early practice they were more easily emotionally affected by endings with patients. They would tend to feel more anxious about endings, encourage all patients to contact after termination and felt more anxiety about the success of the work. In their current practice, they feel that they are accustomed to terminating therapy and can deal with this in a more effective way:

> "I think it depends on how long you have done it. Because, obviously, when I was newly working, it used to affect me a lot. But the more you do of it, the less it affects you" (P5, 97-98)

> "So I think again, with the young me and the old me, it has something to do with one's capacity to let people go, to let them be separate and not want to cling on to them. Because again, it is the difference between young and older, in my young days I might say to them "feel free to get in contact", partly out of my curiosity, whereas now I wouldn't say that out of my curiosity. I would say that because I think it was a necessity of some sort (…) this is the trap of the early work I think. You have to be so careful of not meeting your own needs" (P6, 235-243)

Therapists discussed how personal therapy has helped them deal with endings in a constructive way. Three out of the ten therapists who participated in this study were still in therapy at the time of the interview. These therapists find personal therapy very important in order for them to have a space to work through their own issues with loss and separation so that they are more able to deal with the endings with patients.

> "I would think that if you use your experiences, you've talked about them hopefully in your analysis, in your therapy. In my case…in my case I know that I would find endings difficult and sad. So I think I have a boundary about that. Otherwise I would fall to pieces every time a patient left. And that's not good for me either. So I have my history of endings. And it doesn't affect them but I hope that I can use my experiences of endings to help them have a good enough ending. Which is why I don't mind being the one left and worrying and I am a worrier anyway" (P9, 164-170)

On the whole, therapists felt they have come to terms with the endings with their patients through their professional and personal growth.

> "Sometimes, it *(feeling)* just has to wander around inside me. What does one do with these feelings? In a sense you do get used to it" (P1, 313-314)

> "I got used to it Eva. Because it was short term work (…) I had to get used to it" (P9, 71-72)

Acceptance

The therapists develop familiarity with terminations by accepting the nature of the ending given the "bizarre" kind of relationship that develops between them and their patients. P2 speaks specifically about that when he unfolded his memories of leaving a setting he worked in for many years.

> "You know, acceptance is a huge part of psychotherapy, of life really. So, I tried to apply some of that to myself. I think: "well, actually, the reality is that I am moving on and maybe there will other things useful for them in many ways" so, I got a bit of help I think to come to terms with the emotions involved" (P2, 123-127)

"Lonely place to be" (P3, 267)

The therapists in this study spoke about sharing their experiences of endings in supervision or with colleagues. However, there was a general agreement that these feelings at the end of every therapy process with patients are feelings that the therapist needs to contain and that can be quite a lonely process. The therapist experiences the separation from a person they have formed a relationship with and have worked with intensely. However, these feelings cannot be shared with the second person (patient) involved in the separation due to the nature of the relationship and the therapeutic boundaries:

> "No option really but to contain them, but to hold them. Take them to supervision, talk to peer groups. But by large, it's quite a lonely place to be. And it's part of being an adult to hold the painful things" (P3, 266-268)

> "There is this sort of detached attachment and I don't mean detached in the level of sense that it is usually used, I don't mean that one is cold or distant or anything like that; but it is a much more meditative space where you see your thoughts and feelings or images passing through and you take notice of them, that they do pass through. And you can think about them and reflect on them" (P6, 244-248)

The therapist needs to act in a way that the ending would benefit the patient, without externalising her own feelings or expressing them through self-disclosure. As a result, the therapist engages in her own *private ending*, in which she mourns privately for the loss of the relationship and deals with the separation: the aim is "to transform the abandonment into separation" (P6, after-interviews e-mail communication). P9 discusses her private endings in the following quotes:

> "So in a way you have to have your own private ending with them or your own like a private funeral. Just letting it go; the good things, the bad things, the hope for the future, the worry for the future. But you can't, if they have left you, you can't stay in, you can't keep them in mind (…)" (P9, 187-191)

> "But you have to make room for other people. I think so…Otherwise I suppose there might be a danger that a new patient gets caught up in the old patient's stuff and that's not appropriate. So you have to have a kind of, I hate another word closure, but you have to have an ending of your own. And you have to trust that they have found the power in themselves" (P9, 356-361)

P4 also considers the nature of the profession and the risks:

> "I do think that you have to ask the question: "what kind of person is it who in a way exposes themselves to that kind of, a repeated set of actually, semi-resolved basically separations" and I have no answer to that. Having said that, it is a painful but it is a painful process that you have the opportunity to work towards. And it is a different relationship; the boundaries and the containment of the relationship are very much for the patient but they also work for the therapist as well" (P4, 319-324)

Summary

Even though therapists would like to know what happens to their patients after they have terminated therapy, and they have fantasies of contacting them either via e-mail, post or a third party, they feel inhibited and search for their personal motivations. However, some therapists do meet with their patients either for follow-up meetings or even in social contexts. The therapists differentiated final from incomplete terminations. There is a general agreement that the therapy process is never finished, it never reaches closure, because the work continues after the ending. Moreover, there are specific patients that therapists think about more intensely and remember more vividly than others. On the whole, therapists develop familiarity with endings and get used to the nature of the bizarre relationship they form with their patients; it is intense but they know it will end. The therapist contains her feelings stirred up at termination and has her *private endings*.

Conclusions

The therapist enters every therapeutic relationship as a person, influenced by her personality. The therapist's own personal experiences and losses are very important in defining the way she will terminate with her patients. It was emphasised by all therapists in this study that the development of the therapeutic relationship determines the experience of termination; the therapy process and the termination process are inseparable and the former will influence the latter unavoidably. So when the relationship has been intense, reaches deep material, and the patients make changes, then the therapist has mixed feelings of joy and sadness. She experiences loss and mourns for the relationship, at the same time she facilitates a change in the relationship by self-disclosing. At the other end of this spectrum, the therapists discussed experiences of erratic therapeutic relationships with patients who were critical and hateful, and the outcome was not positive in most cases. The therapists felt relief and regret on these occasions but also were left with unanswered questions. In general, termination is a process that needs to be worked through in time but offers an opportunity for the therapist to review her practice.

A special category was developed for termination through death. When a patient dies the therapist feels a profound sense of loss and mourns for the death of a person she knew very well. However, these feelings of loss do not follow the normal pathway of mourning since the therapist, restricted by the rules of confidentiality and other therapeutic boundaries. This type of termination is final, with no opportunities of contact in the future.

The therapist's journey through termination continues after the actual ending of therapy. The first significant aspect of their experiences concerns contact after termination. The therapist has a strong desire to find out about the patients' life after termination but they feel restrained from instigating any contact. When patients do not contact or when external circumstances demand it, the termination is final and the therapist experiences the sadness of the loss. In spite of such feelings, therapists tend to believe that they stay alive in their patients' mind and that work continues after the ending of therapy. Some patients also remain vividly in the therapists' minds when the work has been intense and the therapists feel they have learned a lot from their

patients. On the whole they expressed a sense of loneliness and familiarity with their feelings stirred up at the time of termination.

Alongside every termination with patients, there is a private ending that takes place for the therapists.

DISCUSSION

Therapists in this study have unfolded their personal experiences of endings, focusing on their history, the development of the therapeutic relationship and post-termination incidents. The issues that appeared in the results will be discussed in this section in conjunction with the literature. The process of termination, the focus on the therapist, the termination as loss and transformation, the parallel processes, the post-termination phase and how therapists deal with their feelings will be explored. The researcher's reflections on methodology, interviews, analysis of data and results will also be explicated as well as the implications for training. Moreover, the limitations of this study and suggestions for further research will be illustrated.

Process of termination

Fordham (1978) in his textbook regards termination as a process with its own distinct characteristics. Ticho (1971) differentiates amongst the various stages of termination focusing on the patient; beginning with the pre-therapy period (expectations, wishes, fantasies and transference phenomena before the patient meets the therapist) followed by the beginning of therapy, the middle phase, the termination phase, and the post-therapy phase (p.323). As the results of this study illustrate, the same stages can apply to the therapist's experience of termination. There is a process in place before the actual beginning of therapy: the therapist brings personal attitudes, training guidelines, previous experiences and assumptions to the therapy process. The subsequent development of the therapeutic relationship is unique for every patient and it will determine the experience of termination. The therapy process and the termination stage are indissoluble parts. The question of time is implied in this argument: as termination is defined as a process, it evolves over time. Schlesinger (2005) makes a distinction between chronological and psychological time: chronological time is "linear and irreversible" whereas psychological time is the time "experienced" (memories, dreams, fantasies) and it represents the "mind's capacity to linger in time, to reverse time, and to repeat experiences endlessly" (Schlesinger, 2005, p.9). Termination is defined in chronological time, since the patient and the therapist work through it over a number of weeks or months. However, psychological

time is an important aspect of the termination process as well, since it represents the therapist's emotional reactions to it, which can last beyond the actual ending date. This is illustrated, for example, in the cases of abrupt terminations, where patients leave therapy without adequate chronological time to work through feelings of termination and therapists are left with their doubts, questions and worries, extending the psychological time of the ending beyond the actual departure of the patient. In this study various distinct stages have been identified as part of the termination process but it is acknowledged that the ending is an ongoing process whose various stages overlap and influence one another.

Therapist exploring the therapist

During supervision, case studies and clinical reports, therapists tend to focus on the patients, formulations of cases and characters of the people who receive treatment. In this study, the focus was shifted to the therapists as real people in this dyad. Using Wiseman's and Sheffer's (2001) distinction between personal self and professional self, it became clear in the results that the two are closely connected during the process of termination. They both affect the way therapists deal with endings. The variety and uniqueness of the experiences demonstrates the relevance of personality and personal history. The research findings did not suggest any gender differences, but the ratio between male and female therapists is not adequate to make any generalisations. However, results of this study differ from previous research findings in which female therapists were found to be emotionally closer to their patients at the time of termination (Greene, 1980).

In agreement with Brugnoli's (1990) definition of the therapeutic relationship as paradoxical, it has been characterised in this study as "bizarre". The therapist forms a bond (Bordin, 1979) with her patients and she invests time, energy and emotions. The therapist and the patient develop a relationship that is instrumental in its basis (Schlesinger, 2005) but at the same time personal for both parties. Therapists need to endure the inevitable ending, which is not within their control most of the time. They need to negotiate, accept and encourage patients to end, like a parent helps their children to become independent and leave home. The therapist's professional self

maintains the boundaries and does not externalise her personal emotions, placing the patient's needs first. However, the personal self experiences a genuine separation from a person they know very well, they spent a lot of time with and develop feelings for. Even though these feelings of closeness and empathic understanding are important in order for the therapist to work with the patient ["I never had a patient who I have disliked. I can't work at that level of intimacy and not have things to respect and like about a person" (P4, 115-116)] it is inevitable that the therapist's personal self will be affected in a meaningful way. At termination, both selves are influenced but only the professional self is revealed to the patient. No matter how much therapists try to remain distant and detached, they feel emotionally close to their patients.

Termination as loss and transformation

Freud (1917) defined mourning as the person's reaction to the loss of a loved one or to the loss of some abstraction or idea. The ending phase of therapy encompasses mourning and loss for both parties. The patient identifies with parts of the therapist and the therapist also learns from the patient (Fordham, 1978). Brugnoli (1990) emphasised the therapists' experience of loss and mourning when ending with their patients. The results of this study agree with these findings, and the therapists revealed their experiences of loss of the patient at termination. However, as Freud argues, mourning can be a reaction to the loss of an idea (1917) and the therapist experiences the loss of her role as a professional or helper in a therapeutic relationship at the time of ending with patients. The therapist adapts to a role of the person who provides emotional care and protection (Pistole, 1999). At the time of termination, the therapist loses this role and is no longer needed by the patient. Novick (1997) argues that the loss of a patient does not correspond to the loss of the patient's real person but with the loss of the fantasy that is given up. This can be one explanation for the therapist's feelings of loss and mourning that was illustrated in the results of this study. However, the real relationship has a significant role and influences at termination; the real persons of the therapist and the patient in the therapeutic encounter are faced with a loss. It is suggested in the literature that patients, sometimes, as a reaction to termination, search for a substitute and form new

relationships in their external lives (Holmes, 1997). After a patient leaves, another one comes; the therapist has the opportunity to deal with the loss by developing a new relationship with a new patient. This brings the danger of imposing preconceived judgements deriving from former patients to new ones.

An extreme case of loss that was experienced by five therapists in this study is the loss of a patient through death. A range of intense feelings of loss and mourning were expressed as well as alternations in therapy arrangements in order to accommodate the patients' needs. In the literature, personal reports of such an experience are recorded and the therapists expressed their enhanced awareness of their own mortality and how they have grown and developed when their patients died; they revealed how they felt privileged and mature as a result of this experience (Curran & Kobos, 1980, Minerbo, 1998, Schaverien, 1999). They also spoke about the change of therapy frame and the necessity to maintain the boundaries for the patient's benefit (Curran & Kobos, 1980, Minerbo, 1998, Schaverien, 1999). Katz and Johnson (2006) collected the experiences of a range of professionals who work in end-of-life care. They addressed issues of countertransference and personal feelings and Katz (2006) argues that "our professional work with the dying and the bereaved is *extremely*[16]personal in nature, that we are profoundly influenced by our patients and their families as much as they are influenced by us, and that our emotional responses *do* affect the clinical moment – whether we want them or not, whether we are aware or not, whether we can *admit* it or not" (p.6).

Termination is also perceived as a time of transformation of the therapeutic relationship (Quintana, 1993). As the results of this study indicate, the therapist deliberately self-discloses something to her patients in order to present herself as a real person in the relationship and not as the expert who knows what the patient does not. However, this transformation takes place when the working alliance has been a positive one, a bond has been developed and therapy has been successful. In the cases when the relationship has been erratic and the patient has not improved or there has not been adequate chronological time to work through termination, the therapist does

[16] Italics in original text.

not self-disclose and the therapeutic relationship remains transferential/ countertransferential (Clarkson, 2003).

Parallel processes

Therapists in this study talked about parallel processes between experiences of loss and endings of therapeutic relationships. Another significant conclusion of this study is the fact that therapists tend to have similar feelings to their patients at the end of therapy. Patients have reported feelings of satisfaction, independence, pride and emotional relief at the time of termination when the working alliance has been positive and the outcome successful (Roe, Dekel, Harel, Fennig & Fennig, 2006). On the contrary, patients had a negative experience of termination when therapists did not genuinely accept the decision for termination and experienced frustration along with feelings of anger, abandonment and loneliness (Roe et al., 2006). For short-term psychotherapy, Safran & Muran (1998) mention that it is inevitable that patients would have intense and conflicting feelings (gratitude vs. loss and disappointment). Clarkson (2003) explored the issues that are raised for patients in the end of long term therapy, and these will be explored in conjunction with the findings of this study.

Patients express "satisfaction" and a sense of achievement at the time of termination, especially when they have made meaningful changes in their life (Clarkson, 2003, p.167). In the present study therapists reported feelings of joy and pleasure at the end of a successful treatment, when their patients made significant therapeutic changes. Patients feel "guilt and regret" at termination for their transference reactions towards the therapist and the end of therapy becomes a "genuine meeting of two people" (Clarkson, 2003, pp.167-168). Therapists in this study emphasised the issue of change in the therapeutic relationship: the therapist becomes a real person in the relationship rather than the object of transference. Patients reported "anger and disappointment" when the therapist initiates termination (Clarkson, 2003, p.168). Therapists reported feelings of inadequacy, worries, anxiety and relief as a response to abrupt terminations, especially when the relationship has been an erratic one. When patients leave therapy without adequate time to work through the ending, the therapists feel frustrated and left with unanswered questions.

Patients reported feeling “sadness and nostalgia” when they reflect on the therapy process at the time of termination (Clarkson, 2003, p.168). Sadness was one of the primary emotions that therapists experience at the time of termination. Especially when the therapist is nostalgic as part of her personality, then this feeling will be enhanced when she terminates with her patients. Patients reported “fear and trepidation” at the time of termination of therapy (Clarkson, 2003, p.168). Therapists in this study experience anxiety for their patients at the termination of therapy, thinking about how patients will manage during challenging and distressing times in their lives without them.

Patients reported “envy and gratitude” for their therapists at the time of termination (Clarkson, 2003, p.169). Therapists did not report envy in this present study, but they expressed their gratitude towards their patients since they feel they have learned a lot working with some of them, both on a personal and a professional level. Patients reported “relief and release” when their symptoms have been improved and have become autonomous (Clarkson, 2003, pp. 169-170). Therapists tend to feel relief at the end of erratic therapeutic relationships with patients that express continuously their negative transference. Patients also experience the residues of their “past losses” at the time of termination of their therapy (Clarkson, 2003, p.170). It has been extensively explored in this study how the therapist’s personal history of separation and loss influences the way they will experience the termination with patients.

Therapists tend to experience termination in the similar ways to patients. There are a series of parallel processes that take place at the time of termination between therapist and patients. The difference is that patients have the opportunity to speak openly about their feelings in an honest and genuine way. Therapists, on the other hand, have to adhere to boundaries and their professional-self features that do not permit a genuine sharing of emotions. Even though the relationship might change in the ending and the therapist appears as a real person, it remains a kind of unequal relationship, a “non-reciprocal” attachment relationship (Pistole, 1999, p.439).

Post-termination phase

Bowlby (1980) argued that the goal of attachment behaviours is to "maintain an affectional bond" and that "the greater the danger of loss appears to be the more intense and varied are the actions elicited to prevent it" (p. 42). It appears radical to make such a statement for therapists about they way they feel for the loss of their patients. However, on a fantasy level, Bowlby's conceptualisation applies to the way therapists experience the post-termination phase. It has also been argued in the literature that therapists might keep the fantasy of contact after termination in order to deal with the mourning of the termination phase (Novick, 1997). Therapists appear in this study to desire contact and communication after the termination. They feel that with some patients, especially the ones with whom the relationship has been deep and intense; they would like to meet again even in a context other than the therapeutic one. However, most therapists will never know because contact after termination is considered to be the patient's initiative. Therefore, the therapist's wish is not "gratified" in the therapeutic relationship and she is left wondering and guessing what happens to her patients after the ending. This supports the experience of "semi-resolved" separations for therapists at the end of treatment.

In the literature it is argued that patients should be able to return to therapy after termination (Murdin, 2000) or should be encouraged to contact after termination especially when the relationship has been long or intense (Curtis, 2002). It is generally believed that therapists stay in the patient's mind after the ending of therapy (Murdin, 2000). Therapy does not end on the date of the last session but the emotional experience of the ending continues beyond that (Firestein, 2001, Greenberg, 2002). Therapists in this study discussed their experiences of some patients staying in their mind after termination. This may be considered as an additional parallel process between therapist and patients that takes places at the time of endings.

A good therapy outcome is characterised by the patient's capacity for "self-analysis" after the termination (Graybar & Leonard, 2008, p.227). A positive termination has 'long-lasting influence of ongoing internalisation" (Bellows, 2007). Therapists are encouraged in the literature to confirm their availability to the patients and communicate openly that they can return to therapy but at the same time they need to

respect the patient's autonomy and trust that they can manage after the ending (Kramer, 1986, Ticho, 1971). In the present study, most therapists did not encourage contact after termination and when they did, it was to foster the patient's specific needs. Only one therapist applied the technique of "leaving the door open" as common practice in private therapy. However, all therapists agreed that through the process of internalisation, therapy does not entail a definite closure and the therapist feels she will remain close to the patient even if they do not meet. This supports Greenberg's (2002) argument that "termination is therefore seen as a choice point rather than as the attainment of an absolute end point" (p.358).

It has been suggested in the literature that the word "termination" should not be used for the planned endings of therapy because it has "negative and finite connotations which fail to convey the positive hopes for a new beginning that normally surround the end of a satisfactory analysis" (Pedder, 1988, p.504). As initially stated in the results section, it is suggested in this study that the term "termination" would be used to define the specific stage of therapy process whereas the word "ending" would be used to represent the emotional and other experiences of the two parties of the therapeutic relationship. However, termination does not mean closure. The process of termination does not stop on the date of the last visit. Termination can be perceived as a "new beginning" (Thompson, 1994). Growth continues after the ending and it is a process that takes place throughout our lives (Ticho, 1971).

Dealing with feelings

Personal therapy, supervision, colleagues and peer groups have been recognised in this study as important resources for the therapist to help deal with the emotions that termination evokes in her. These support networks have also been mentioned in the literature as significant (e.g. Murdin, 2000). However, as has been emphasised in this study, therapists tend to contain their emotions and not verbalise or externalise them. Sharing is generally believed to help therapists deal with their termination feelings. The question is then, what happens to these feelings that therapists cannot communicate and just drift inside them, giving them a sense of loneliness? How can therapists be helped with these repeated "private endings" they deal with in their

everyday practice? What is suggested in this study is that *therapists should accept and embrace their personal feelings when they terminate with their patients*. In an appropriate frame, therapists should find the space to externalise and discuss the *intimate feelings* they have for their patients. Therapists should be able to share feelings that do not necessarily adhere to their professional self and to therapeutic boundaries. Personal therapy could be a place for this but again it is a professional relationship, in which the therapist has the role of the patient and there is the reality that the therapist will become a colleague with her personal therapist, which may inhibit specific disclosures. Moreover, personal therapy will itself have an ending.

Therapists need resources they can turn to on an arbitrary basis, when they need it; either a colleague, a trusted person in their lives, or even literature. The results of this study aim to offer a "board for identifications" so that therapists feel that their emotions are justified and normalised. It is suggested that this way it will be easier to accept them and work through them. One of the participants of this study speculated that the nature of the profession and the repeated endings therapists experience could contribute in some cases to therapists developing physical illnesses:

> "And I know large number of female therapists who develop breast cancer and a large number of group therapists that have had heart attacks. (…) my impression would stand up any kind of objectives but I do think that you have to ask the question: 'what kind of person is it who in a way exposes themselves to that kind of, a repeated set of actually, semi-resolved basically separations' and I have no answer to that" (P4, 316-321)

It has been discussed in the literature how the repression of emotions is associated with rendering people vulnerable to physical illness (Della Selva, 2006). It has been suggested that when people have been encouraged to express overtly their feelings in a productive way, their physical health improves (Della Selva, 2006). The way people deal with stress has been considered to have an impact on the person's health (Ursin & Olff, 1993) and emotional disclosure has been found to lead to enhanced physical health, psychological well-being, physiological functioning, and general functioning (Smyth, 1998). The results of these studies should be treated with caution and

research is by no means conclusive. However, therapists are encouraged to express their personal emotions stirred up in therapy endings and to deal with them rather than denying them, as a way to enhance their psychological well-being.

Reflections

Methodology

Constructivist grounded theory was considered as a suitable method for this research project given the nature of the phenomenon studied as well as the relationship between researcher and participants. The guidelines of grounded theory offered a comprehensive framework within which participants' experiences and their meanings could be conveyed in a systematic and consistent way (Charmaz, 2006). As research progressed, it became clear that the methodology fit the data and their analysis; it allowed for the categories to emerge naturally from the data with little arbitrary interpretations from the researcher. It ensured that the analysis remained close to the transcripts (Charmaz, 2006) and the participants' narratives were presented in a way that minimised the risk of distortions of meaning that could be imposed by the researcher's underlying assumptions (Mills et al., 2006).

The techniques for the analysis of the data in this study were drawn from guidelines by Strauss and Corbin (1998), Charmaz, (2006) and Rennie (et al., 1988) the utility of which was advantageous given the diversity of the data. The flexible use of techniques allowed the researcher to explore the data in an open mind and discover new relationships without imposing rigid structure on it (Charmaz, 2006). The combination of techniques proved fruitful; in particular Strauss and Corbin (1998) offered clear and explicit techniques that helped resolve the impasses in the analysis of the data. Charmaz (2006) offered a general view of grounded theory and its method that seemed to fit the open attitude towards the phenomenon and the nature of the research question. Rennie (et al., 1988) offered a more specialised version of grounded theory as it is used in psychotherapy research and their ideas were followed, especially in the later stages of the analysis and the development of categories.

Keeping the analysis grounded on the data prevented assumptions that would not fit what therapists communicated in this study. Constructivist grounded theory allowed me to form a collaborative relationship with the participants (Hall & Gallery, 2001) that helped the building of trust and openness in these encounters. The use of constructivist/ interpretative approach of grounded theory allowed the diversity of the experiences of the participants to be illustrated clearly in the final presentation of the categories (Rennie, 1992).

Data collection

Being a therapist interviewing and conceptualising therapists' experiences has helped me understand empathically their meanings and represent them in categories (Fassinger, 2005). It was a challenge to keep an objective position during the interviews, and I openly replied to participants' questions. The relationship with the participants was characterised by mutuality (Mills et al., 2006) but it was also developed on a deeper level after the end of the interviews, given the tendency of both parties to hold on to each other. I feel privileged to have met the therapists that participated in this study. Each interview has been a unique learning experience for me, where I was fortunate enough to listen to experienced practitioners' narratives of termination. Each interview stirred up personal feelings and considerations about myself and my practice, which were separately recorded in the self-reflective diary in order to be identified and inhibited from influencing the analysis. The therapists enjoyed the interviews and some of them expressed their genuine interest since it stirred up new links and thoughts for their practice and personal reflections.

Research process and analysis of data

No matter how enjoyable and interesting the process has been, there is a frustration and a sense of doubt regarding the results. The use of qualitative research has allowed me to explore the transcripts in depth. However, when I reached the stage of building categories and subcategories for the final results, I felt anxiety about the fit between the categories and the emotional content of the interviews. The participants unfolded their experiences in a moving way, describing a huge variety of significant experiences. The final analysis of the data imposed a more rational and descriptive way of presenting the data. My frustration was mainly about this "dry" categorising

and I had the sense that I was not doing justice to the data. I was intrigued by Rennie's (Rennie & Fergus, 2006) embodied categorising method and I tried to use my subjective experience when I was forming the categories. However, I still experience doubts about the final presentation and my hope is that the reader will have an internal experience of the data; that they will be able to empathise with the participants' narratives and understand in depth their experience of termination.

There were two main questions that arose from the presentations of the results: "what was the unexpected thing I found" and "how, and if, the model that derived from the results is transferable to other therapy paradigms". These questions will be explored in the following sections.

What was the unexpected thing I found?

My initial reaction to this question would be to justify my results and highlight categories and codes that were not expected in the beginning of the research process (such as the concepts of self-disclosure in the ending and of therapist's private ending). On reflection, I realised that actually there was not any particular unexpected result in this study. These are all experiences that we all, as therapists, deal with and feel in our everyday practice. However, in this study, these unspoken experiences have been systematically analysed and a final model derived from the therapists' narratives.

It was not intended at the beginning of this project to conduct a study that would be broad enough to offer generalisable results. This study, though, aims to offer empirical evidence to help fill in the gap in the research of termination, a phenomenon that has not been adequately empirically explored. More research might be stimulated that could offer further explanations of this phenomenon.

This study aims to *provide therapists with a diagrammatic representation of the termination process in the therapy context.* The aspiration is that this representation would offer a space for therapists to identify with the narratives of the participants. It is anticipated that therapists would find, reflecting on these results, some of their personal experiences of clinical practice and this would help them accept and work

through their personal feelings. The results contribute to the attempt to conceptualise termination. Novick (1997) argued that termination is a subject which is difficult to conceptualise mainly because of the "therapist's reactions and how they interfere" (p.147). The results of this study aim to give justice and validate the therapist's personal self as it is affected in the termination stage of therapy. Therapists enter the therapeutic relationships as real people, with their history and values. There are two persons involved in this relationship and its ending affects both. Focusing on the therapist's side, this study aims to emphasise the need for therapists' self-care and well-being; endings may have an impact on the therapist's emotional and physical health, as every other loss in their lives. Expressing and finding the space to identify may help them deal with them in an efficient way and minimise possible destructive consequences.

Is the model transferable?

The grounded theory model developed in this study derived from the psychodynamic and psychoanalytic background of the therapists that participated. However, questions were raised by colleagues from various disciplines about whether the model is transferable to other theoretical orientations. In the context of this study, participants used little terminology in their interviews. Even though they all came from a psychodynamic background, the way they described their experiences was simple and understandable by practitioners with different theoretical orientations. This also reflects the language used in the results, where little is communicated in rigid psychoanalytic and psychodynamic terms; the participants did not contemplate much on theory and techniques. In a special issue of the Journal of Psychotherapy Integration (Volume 12, 2002) the issue of termination was explored with regards to three different theoretical models: psychoanalytic (Curtis, 2002); experiential (Greenberg, 2002); cognitive-behavioural (Goldfried, 2002) and an effort for integration was made by Wachtel (2002). The three practitioners from different models revealed their clinical experiences of termination and similarities were evident; the issue of tapering off the sessions towards the end, the goal for patient's improvement and relief from symptoms, the significance of the duration of therapy and the acknowledgment of the clinical, human and economic needs incorporated onto the endings (Curtis, 2002, Greenberg, 2002, Goldfried, 2002, Wachtel, 2002).

The issue of loss is not commonly mentioned in the end of a cognitive-behavioural therapy but Goldfried (2002) emphasises that "of course issues of loss need to be addressed when cognitive-behaviour therapy is modified to deal with more complex cases in which the relationship plays a very significant role" (p.371). Wachtel (2002) also concludes that "therapy is fundamentally an interpersonal process, and, inevitably, the results achieved are the results for that particular dyad" (p.382).

Hence, it may be suggested that the ending of the therapeutic relationship is deemed significant regardless of the model the therapist adheres to. In their articles, the above authors from the three disciplines outlined their doubts, worries and experiences of terminating with patients (Curtis, 2002, Greenberg, 2002, Goldfried, 2002), without differentiating their emotions according to the model they follow. Moreover, in presenting the results to practitioners from various disciplines and models, I have found that their experiences would seem to match the grounded theory model derived from this study. Further research is suggested so that the above assumption would be systematically explored.

Personal reflections

The writing up of this study coincided with a period of endings in my life: ending of academic course, endings with patients and supervisors, ending of personal therapy and of other personal relationships. The results of this study informed my practice and helped me deal with the endings with my patients. Developing my categories helped me understand more my current experience of terminations. I understood and accepted when I felt sad or frustrated with specific patients. I was open with my supervisors on the issue of endings. I was able to talk about it with colleagues and in personal therapy. I felt "liberated" that I did not have to oppress my feelings as unacceptable. I was open and honest and this has helped me deal with them in a more constructive way. This is the kind of impact I would hope this study would have on its readers.

Terminating the relationship with the participants

One interesting and moving aspect of this research project has been my relationship with the participants. I have met with most of them twice and I have communicated with all of them many times via phone or e-mail. At the end of the research process, there was a tendency from both sides to strive to continue the contact and subsequently the relationship. With two of the participants it is inevitable we will meet in different contexts in the future. One of the participants invited me for a group discussion in her work place, others sent me various e-mails and articles after the end of the second interview and another just encouraged me to contact her should I find myself in her area. Apart from their encouragements, I found myself saying to all my participants: "feel free to contact me if something comes to mind". This reflects my own difficulties with endings but also the connection I felt to these therapists who were kind enough to share with me some of their most intimate thoughts, feelings and experiences. All participants asked to see the results and I agreed, being aware that this would also give another opportunity to contact them. My desire, I assume, is to hold on to them as they have become a part of one of my most important projects. Sending the final results to the participants will hopefully bring a sense of closure to the research process and to my relationship with the participants.

Implications for training

Therapists' feelings and experiences at the time of termination are not something that practitioners tend to acknowledge, process or focus on in training. Termination is not embedded in psychotherapy training as a distinct area of study (Schlesinger, 2005). It is suggested here that termination should become an important topic to be explicitly explored in training courses. Although there is a "huge complexity" in every therapy process and it is difficult to reduce it to specific guidelines (Kramer, 1986), it is suggested that the issue of termination techniques, types of termination and the experience of it should be incorporated into courses. Trainees of all disciplines should have the opportunity to reflect on this process and learn more about it so that they become more effective in practice. Counselling Psychologists' training tends not to focus adequately on this significant phase of therapy. Even though Counselling

Psychology promotes the model of the self-reflective practitioner, it would seem that it often fails to sufficiently highlight the importance of reflecting on personal feelings in the ending process. The requirement for personal therapy is another issue related to this which will be explored further.

This study furthers the idea that the disciplines of Psychotherapy and Counselling Psychology should not be isolated as two discrete fields but rather contribute to each other. Theoretical literature and empirical research have much to offer to improve practice for both Psychotherapists and Counselling Psychologists, given there are many similarities.

Significance of personal therapy

Few Psychology courses consider personal therapy as mandatory (McEwan & Duncan, 1991). Personal therapy tends to be a requirement for therapists who conduct individual psychotherapy and its significance for the therapist's "emotional health and integrity" has been widely recognised (Guy, Stark & Poelstra, 1988, p.475). As this study indicated, therapists tend to perceive their personal therapy as an educative experience and identify with their patients as well as use their personal therapists' techniques, regarding them as role models. Counselling Psychologists should have the opportunity to have this learning experience. It is valuable for Counselling Psychologists to engage in personal therapy in order to better deal with their feelings on endings in their everyday practice. Whether in brief or long term work, they develop therapeutic relationships with their patients which will inevitably end. Moreover, there are many Counselling Psychologists working in a psychodynamic framework or even chose to have a second training in it. Personal therapy is encouraged in training courses and, should it become mandatory, trainees would become more competent for self-care in an emotionally demanding, challenging and intense work environment.

Limitations and suggestions for further research

This research project focused on a specific theoretical orientation and practice of psychotherapy. Further research is recommended on other theoretical models and

therapy contexts. A comparative study would offer deeper insights on the therapists' experience of termination from different disciplines and models. Moreover, this research project was restricted in time and as was the elaboration of the codes emergent from the data. Grounded theory methodology was implemented in a way that fit these time restrictions; the first interviews were close to each other in chronological time, which did not allow the researcher to reflect on the transcripts of the interviews in detail between interviews as suggested by grounded theory methodology (Strauss & Corbin, 1998). In order to ensure validity, the second interviews gave the opportunity for the researcher and the participants to engage in further clarifying conversations. The data deriving from second interviews were analysed and explored in conjunction with the initial data. Grounded theory offers that framework where the researcher moves backwards and forwards in the analysis of the data (Dilks, Tasker & Wren, 2008). Nonetheless, the limitations should be considered when the results of this study are regarded.

As far as the data analysis is concerned, open coding was simultaneous applied with axial and selective coding. The researcher acknowledges that the development of a grounded theory is a long-term process that allows time for reflections on data and modification of descriptive and abstract categories. The researcher felt at specific points in research (selective coding and description of categories) that, if more time were available, there would be greater variety in assumptions and interpretations of the codes. The researcher acknowledges the desire for further elaboration of the data in order to represent the richness of the interviews.

The present study offers one perspective of the phenomenon of termination of psychotherapy and it is acknowledged that it can not be generalised. The results of this study should be considered as a conceptualisation of the stories of the participants of this study, without having any implications for the population of therapists in general. The goal of this study is to expand the knowledge in this under-researched subject of termination of therapy. It also aims to stimulate researchers' and practitioners' interest so that more research is conducted in this field.

Considering the difficulties in recruitment of participants, sampling needs to be considered in a critical way. An assumption that can be made is that the therapists

who agreed to participate were the ones that had emotionally intense experiences of termination with patients (Martin & Schurtman, 1985). Further research with broader sampling from various theoretical regimes would add more validity and reliability in the exploration of the phenomenon. This would offer a wider conceptualisation of the process of termination with implications for generalisations.

Regarding the therapeutic relationship, the therapeutic alliance has been widely researched in the literature and its relation to therapy outcome (e.g., Horvath & Luborsky, 1993). In this study, the therapist as a person in the therapeutic relationship has been highlighted. It is, therefore, suggested that the aspect of the real relationship of the therapeutic relationship should be explored empirically as well, and its relation to therapy outcome as well as therapist's well-being. The impact of termination on the therapist's physical health should also be further investigated. The health effects of therapists exposing themselves to repeated losses and endings, and the significance of self-care should be explored in a systematic way. Protecting therapists' well-being should be highlighted as intensely as protecting that of the patients.

This study offered an innovative grounded theory model of the therapists' journey through termination of therapy with patients. It aimed to shift the focus to the practitioners of this challenging work that entails inevitable separations in everyday practice. Further empirical research is necessary to add to the conceptualisation of this significant phase of therapy.

PART FOUR

CLIENT STUDY

“It feels like leaving home”:

A Client Study on the Experience of Termination in Psychodynamic Long Term Therapy

PART A

Introduction and beginning phase of therapy

Introduction

I chose to present this client to demonstrate my experience of termination in long-term psychodynamic context. The exploration of the client’s issues, defences, and transference and countertransference reactions will be presented. I shall describe my use of techniques and how it progressed as sessions and supervision advanced. The significance of breaks and termination for this piece of work will be outlined.

All identities have been changed in order to protect the anonymity of the client.

Theoretical Orientation

The word “psychodynamic” will be used to describe theory and techniques used for this piece of work. The term encompasses the different schools of psychodynamic and psychoanalytic theory and it “links psychotherapy and counselling with psychoanalysis” (Jacobs, 2004, p.6). The term “psychodynamic” is commonly used to describe once weekly psychotherapy (Jacobs, 2004), which is the frequency of sessions with the client presented in this study. The theory outlined in this section is brief and focuses on aspects of practice that represent the main techniques used for this case.

The initial psychodynamic theory derived from Freud’s theoretical statements. Freud proposed a topographical model of the psychical apparatus, dividing the psyche into three parts: the Unconscious, the Preconscious and the Conscious (Jacobs, 2004). Conscious mental activity consists of what people currently think and feel, the

preconscious consists of what is not conscious but easily becomes so and the unconscious consists of mental processes and material which have no easy access to consciousness (Jacobs, 2004). Freud also developed the structural model. The mind was then divided into three agencies: the Ego, the Id and the Super-Ego (Quinodoz, 2004). The Ego decides whether to allow the gratification of an instinctual wish and blocks desires of the Id from entering the conscious, the Id has the tendency to seek pleasure that comes from the gratification of instinctual impulses (Galatariotou, 2005) and the Super-Ego functions as the moral conscience of the person and manifests itself through self-reproaches, which has to do with identifications with parental prohibitions (Quinodoz, 2004). Super-Ego is formed during the phase of resolution of the Oedipus complex through identification with the parent of the same gender (Quinodoz, 2004).

Freudian theory and practice has been evolved and recent schools of psychoanalytic theory adhere to the "object relations theory" (Jacobs, 2004). The term "object" is used to describe both real people in the external world and the images of them that are established internally (Greenberg & Mitchell, 1983, pp.12-14). Klein's theory was based on her research with children (Greenberg & Mitchell, 1983). She advocated that the infant from the beginning of life makes emotional relationships to their objects (Joseph, 2004). The child's mental life is filled with elaborated fantasies concerning their parents and creates a complex set of internalised object relations. In Klein's theory, the child experiences two "positions" during the first months of their life: the "paranoid-schizoid" which involves the separation of good objects and good feelings from bad objects and bad feelings in a form of splitting (Galatariotou, 2005) and the "depressive" position, when the infant develops the capacity for internalising whole objects (Galatariotou, 2005); the infant perceives that there is only one object, with good and bad features (Greenberg & Mitchell, 1983). In the "paranoid-schizoid" position the infant feels that all that is bad is "not-him" and projects them (Roth, 2005, p.51). Paranoid anxiety involves a fear of the destruction of the self from the outside and the depressive anxiety involves the fear concerning the fate of others; the infant worries for the safety of the good object that is now in constant danger and presents the anxiety of losing the object's love (Greenberg & Mitchell, 1983, Roth, 2005).

Anxiety serves as a signal that sets the defences into motion which need to be formed to allow people to adapt to the environment and they are unconscious processes (Galatariotou, 2005). Transference is the repetition of the former patterns of relating to significant people, such as parents, and these patterns can be manifested in the therapeutic relationship, as well as other relationships outside therapy context (Jacobs, 2004). Freud defined countertransference as the therapist's transference to the patient (Tonnesmann, 2005). These perceptions can be used by the therapist to enhance the understanding of the client's material (Tonnesmann, 2005).

The context for the work

I worked as an Honorary Therapist in a secondary care NHS Psychotherapy Department. Clients were referred by General Practices, Community Mental Health Teams and other sources. Clients were initially assessed by senior practitioners, who are psychoanalytically trained, and develop a detailed assessment report. They are placed on waiting lists according to the offer and when a vacancy is available, the allocated therapist contacts the client for an appointment.

The referral

Amanda[17] was referred to the department due to anxiety and panic attacks symptoms. The symptoms were initially manifested during her honeymoon holiday, when she learned about the death of one of her mother's friends. She was unable to leave the hotel room and felt extremely worried. Amanda requested individual therapy. The assessor agreed with her, as it would give her the opportunity to discuss her anxieties about motherhood and her difficulties in her intimate relationships. Psychodynamic individual psychotherapy would help Amanda explore unconscious conflicts and acknowledge the maladaptive nature of her defences. She would find the space to investigate the traumas of the past and how these have affected her current relationships (Greenson, 1967).

[17] The name of the client is changed for confidentiality issues.

Convening the first session and negotiating the contract

Almost a year after the assessment, an initial appointment with Amanda was arranged. She appeared reluctant to accept the offer because she felt better at the time. We discussed how she could use the sessions and the style regularly adopted in therapy and she expressed her concerns about the lack of direct guidance in the content of psychodynamic treatment. She talked about her current life, her job and family situation. I explained the contract of forty sessions and informed her of the breaks for holidays and an estimated time of conclusion of the sessions. Amanda accepted the offer.

Presenting Difficulties

Amanda came for the first session being pleasant, smiling and well-dressed. She initially talked about her issues of anxiety and panic. Amanda continued going to work every day, even though she experienced panic attacks on her way there very often. She felt if she did not continue working, she would have a "breakdown". She held a managerial high-appealing position and for this reason she felt she had to "set the example" and cope with her difficulties. The relationship with her husband was characterised by tension and arguments; she did not want to have children whilst her husband did. Eventually she had a son; she found pregnancy and labour as traumatic experiences and constantly blamed her husband for that. Amanda "loved her son but hated being a mother". In order to deal with her anxiety, she joined an online-group for people with panic, which she found helpful.

Client's biographical details

Amanda described growing up in a fearful environment. Her father was authoritarian and abused her mother physically. She had three sisters. She was third in the line. She and her sisters witnessed the abuse but never spoke about it amongst themselves or with their mother. Her father was never abusive towards them but they were always frightened in his presence. They had to be "invisible" in the house so they would not disturb him. She described her mother as a "kind and loving woman". Amanda understood how her mother tolerated this abuse for the interest of her daughters. She believed, however, that her mother should have been a stronger person. Amanda's parents divorced when she was fifteen years old; she felt relief. She continued seeing

her father rarely until she had her son, when her father began having more regular contact with her. Amanda married three years ago. Even though her husband has been very supportive and understanding, she could not help blaming him for her condition and for "putting pressure on her" to have a child. She described her work environment as stressful but felt she could not leave her job because of the expenses she had for her son (e.g. nursery). She did not have many friends but talked regularly to her mother and sisters. Despite the fact that they were very close, Amanda did not feel she could talk to them about her anxieties and difficulties. She believed she had to be a strong person. However, she was considered to be the "sensitive" one of the four, a quality which seemed to bother her. Neither of her sisters was married and only one was a single mother of a sixteen year old girl. She believed that her sisters were managing very well with their feelings whilst she seemed to be unable to deal with hers.

Formulation of the difficulties

Amanda presented for therapy with symptoms of intense anxiety she found difficult to tolerate. Anxiety is a feeling experienced by the Ego whenever it is faced with danger. In Amanda's case, the anxiety was associated with the fear of separation or loss of the object of love (mother). Her traumatic experiences left her Ego helpless and provoked the mechanism of repression to avoid the experience of the affect (Quinodoz, 2004). The fear of losing her mother had been overwhelming in her development. In Klein's terms, developmentally Amanda seemed to experience *depressive anxiety* due to the fear for her mother's safety. She had ambivalent feelings towards her mother; the mother was "good and loving" but also hated her as she did not protect Amanda from the fear and the guilt (Emanuel, 2000). The hatred was difficult to endure and it had been repressed. The rage towards her father was now misplaced to her husband, who was the recipient of that anger, and she identified with the role of the victim as she felt "abused" by her husband. In order to deal with these overwhelming feelings, she concentrated on her work and tried to be in control of situations.

Amanda's Ego mobilised the mechanism of splitting in her perception of objects as well as in the way she perceived her own Ego. She had made a clear distinction between the "good mother", idealising her mother, and the "bad father" as the perpetrator. She experienced persecutory anxiety (also evident in the transference)

and tried to protect herself from potential harm. The abusive part of her Ego, unconsciously identified with the aggressive father, was projected on her husband and she kept her own Ego split (Greenberg & Mitchell, 1983). Amanda tended to project her own hostility, as it is hard for her to sustain this affect.

Amanda's childhood experiences had been greatly injured and she felt helpless in the face of the threat towards her mother's safety; she could not protect her. Her objects were emotionally unavailable to her. She felt lonely as a child and cried alone since there was no containment or "holding" in her environment. Even though her physical needs were met, she did not experience adequate emotional care (Johns, 2005).

PART B

Development of therapy

The pattern of therapy

I offered Amanda forty sessions, from which she missed five, mainly after holiday breaks. My interventions focused on encouraging her to talk freely and I did not directly guide her or influence the content of the sessions. I remained neutral and I regularly reflected back what she said to encourage her to continue with a particular pattern of thought (Jacobs, 2004). My observations and interpretations aimed to link words, phrases or non-verbal behaviour in order to understand the anxiety or other feelings and conflicts she was not conscious of (Jacobs, 2004). I used my own empathy, intuition and theoretical knowledge, as well as supervision, to arrive at the interpretation (Greenson, 1967). I let Amanda have the first word in every therapy session so that she could provide me with her main themes, feelings and anxieties that were present at the time (Jacobs, 2004). Frequently, she would begin the sessions expressing her concerns regarding therapy. She repeated the patterns of her defence mechanisms in the transference (Greenson, 1967). For example, she would frequently activate her splitting mechanism when I would become the "good and competent" therapist (mother) but other times she would "attack" therapy by cancelling session or being late and at these times I became the "bad mother". My focus was to explore

these defences with her so in the middle phase of the session she engaged more. I focused on what she said and, at the same time, on my experience of her (Jacobs, 1967). In the end of every therapy session, she would regularly leave with a sense that "it was not enough".

Therapeutic Plan and Main Techniques Used

Amanda found it hard in the initial sessions to get in touch with her feelings or deep thoughts. She spoke freely and openly about what was happening to her but she had the tendency to intellectualise her experiences rather than showing any real feelings (Jacobs, 2004). Her defences had been ego-syntonic, in tune with her, providing her with the reward of mastery and control, which she found hard to give up in the sessions (Jacobs, 2004). Initially the focus of therapy was to understand and interpret the anxieties underlying the defences (Jacobs, 2004). The aim was to alleviate her defences by clarifying and interpreting her fears. This clarification would help Amanda's fears become available in her conscious (Greenson, 1967). Amanda had always learned to be the strong person and found it difficult being in the position of the client who had emotional needs. This was manifested in her transference reactions, where she did not experience me as supporting and caring for her and she became angry. I became a "mirror" where she found the space to develop these reactions and the defences that accompany them (Greenson, 1967, p.35).

My emotions of countertransference were used to enhance my understanding of her conflicts and defences. Her emotion was often incongruent with situations she described. The aim was to increase Amanda's awareness of these processes, by clarifying, interpreting and working through these behaviours as they occurred in the sessions (Greenson, 1967). By clarifying and interpreting what Amanda said, she would become more aware and more able to make the links between her past and her present (Greenson, 1967). I listened to her empathically, recognising her anxiety and at the same time offered explanations (Jacobs, 2004).

Experience of being with the client

This was the first time Amanda had therapy and it was also my first time I conducted long-term psychodynamic therapy. For both of us this had been a new experience,

encompassing expectations and frustrations. Initially, I felt more cautious in sessions. I felt doubts about my skills as a therapist and these reflected in the process. I would be silent more often and, even though I had made links in my mind about material Amanda presented, I would not verbalise my thoughts through interpretations. This inhibited my connection with Amanda. I often felt confused and frustrated during the session, which was at times what Amanda felt. I sensed her reluctance to trust me and be more open in the sessions. I asked her to go through some painful emotions without providing her with the safe space to do it. This was evident after the first summer break, when she cancelled her session. I felt I had done things wrong and she would not come back. Maybe this was the message Amanda wanted to give me by cancelling: "I am not really happy with what you are offering". For a woman with little emotional care in her early object relationships and with strong defences, my attitude of being passive and silent during the sessions would not help her.

When we began meeting again after the first break, I changed supervisors and this had an impact on my approach to therapy. In addition to this, I had already been in the setting for one year and therefore felt a little more confident in it. I started to become more active and more attuned to my countertransference feelings in the sessions. This helped me understand Amanda more. When I felt angry or frustrated in the sessions, I would consider whether it belonged to me or not and, when it did not, I would clarify to Amanda that "I sensed anger" in the sessions, wondering what that could be about. I often felt her absolute trust or her absolute hatred, which reminded me of the splitting mechanisms she often activated and I would clarify that to her. I often felt sad for not being able to give her the care she needed or unconsciously she would ask from me to give her more, especially when we started working towards the ending of therapy. I found it hard keeping time boundaries and sometimes I would extend the sessions for a few minutes. I wanted to please her partly due to Amanda's needs to "challenge" my boundaries and see how far I could go to help her.

Meeting for such a long time (from May 2007 to May 2008) created a strong bond (Bordin, 1979) in the therapeutic alliance. We both developed through this process. That made the ending difficult for both parties. The termination of therapy will be extensively discussed in latter parts of this study.

Key content of the sessions and techniques employed

Sessions 1-5

Amanda had concerns about therapy and worried about the pattern of the sessions and the lack of guidance. She talked about the main stressors of her life: her work and her son. She said she cried at home, always when she was alone. I linked that with how she needed to hide her feelings and be the strong person who needed to cope. Amanda spoke about her fear of "going mad". I reflected her fear of losing control and linked it to her past; her mother was abused and she had no control in that situation. She described the fears she had for her mother's safety. She discussed the worry about her mother, told me how she loved her but at the same time she did not want to be like her. She talked about the pressure she felt in her marriage and the emotional distance she kept from her son. I communicated to her my feeling that she was talking about her son like an "objective observer". She discussed her guilt giving me the impression her son was "ruining her life". We discussed her perfectionism in her role as a parent but also in her work.

Sessions 6-10

Amanda discussed how she did not want to be upset and cry during therapy. I suggested a link with her tendency to be "strong" and clarified the reflection of that in the transference (Greenson, 1967). She described memories from her childhood regarding the abuse of her mother. She saw the relationship with her husband as abusive and described incidents where the pattern of the relationship with her parents is re-enacted in the relationship with her husband (Jacobs, 2004). Turning to the transference, I reflected to her how she did not allow any distressing emotions to be expressed in the sessions. I expressed my assumption that there may be a fear of dependency to therapy looking at it is a fixed-term process and it would have an ending. I focused on her difficulties with losses and how her anxieties about losing her significant objects in the past were currently repeated (Jacobs, 2004). She managed to express her worry about not having anyone to talk to during the break and her anxiety for "managing" difficult situations. She had concerns about the efficiency of the sessions. I empathically discussed her anxiety about the ending.

Sessions 11-15

Amanda cancelled her session after the break and I spoke to her about her defences and how she may have experienced anger towards me for being away for so long

(Greenson, 1967). We discussed the ending of the sessions, the breaks and termination of therapy. She wished she could have a "four-hour session" in order to feel better in the end. She said she wanted to change the focus of therapy, as a way to avoid talking about her past. We explored her emotions and she referred to her anger towards her husband. I interpreted this misplacement of the anger (Greenson, 1967). She thought about it and then talked about how she treated her son and how emotionally unavailable she was to him. I linked that with her mother and how emotionally unavailable she was to her. She was upset thinking that she could be like her mother and she discussed her anger towards her and her sisters. She was obviously upset and spoke about her guilt for her anger especially when her mother was going to hospital for an operation. I acknowledged her difficulties with the feelings stirred up in the sessions.

Sessions 16-20

She felt disappointed and she preferred to distance herself from her mother. I observed that she seemed to be distancing from therapy as well. She acknowledged that she felt worried about the ending and that she was "counting weeks". She expressed her practical difficulties for coming to the sessions and I linked it to her emotional difficulties. She was worried that she would feel "worse" in the end. I emphasised her difficulty with separation (linking with major losses in her life) (Jacobs, 2004). She felt guilty for having the negative feelings towards her mother and at the same time having to take care of her. She spoke about her difficulty of being in the vulnerable position of the client. She brought up the issue of the termination. I acknowledged the difficulty of dealing with the sensitive and vulnerable issues we explored. She thought of therapy as "dangerous" at times and expressed her concerns for the pending break.

Sessions 21-25

I clarified her difficult emotions she felt in therapy. She talked about the "feeling in the stomach" when coming to the sessions. She linked that to the feeling of anxiety she experienced and her need to "run from" the sessions so that she was not aware of the distressing emotions. She talked about her need to control her relationship in her marriage and we explored her anger towards her husband. Amanda was upset making

the realisation that she "used" her son to "punish" her husband and her fear of being dependent on her husband. Talking about her difficulties in the sessions, she felt she would be judged at times and linked this to the feeling she had with her mother. She did not want to reach a state where she would "need" me and then I would not be there. Amanda expressed her ambivalence towards therapy. I clarified her pattern of avoiding any situation that could potentially become abusive, like therapy. She expressed her fears of "failing" therapy and therefore it was easier for her to move away from it.

Sessions 26-30

I picked up her anxiety for the content of the sessions and her tendency to control them. She related these feelings with her difficulties accepting her hatred toward her mother and her desire to "move away" from it. We discussed her anxiety for termination and focused on her anger towards me and her emotions of helplessness and despair. We talked about her feeling that I would not be able to contain her emotions and her "tears", like her husband and ultimately her mother were not able to do that for her either. She talked about her efforts to receive some love from her parents and how she felt rejected. I reflected her request for care by me and her expectation that she would be rejected as well. We talked about death and the impact it had on her but also her fears about her own "sanity". She talked about her vulnerable feelings and how she tried to avoid them.

Sessions 31-35

Amanda avoided talking about her disappointment and anger towards me. She said she was fed up talking "deep" and that she would prefer to keep it shallow and to a manageable level. She was quite negative and disagreed with my interventions during this session. I reflected her anxiety about termination and therapy outcome. She made a review of the realisations she has reached in the sessions about her significant relationships (mother, father, husband and son) and how difficult they have been to "digest" because she was afraid she put her relationships at risk. I talked about her anxiety for the ending and how she tried to control it. She focused on her anxiety and her worry that her symptoms would return. I emphasised her worry about the ending and her tendencies to distract herself from it.

Sessions 36-40

Amanda experienced difficulties coming for our last sessions and discussed her worry about ending. I clarified her needs for care and attention and her frustration when she did not receive them, linking this with the ending of the sessions. She expressed the loneliness she would feel at the end of therapy. We discussed the punitive side of herself and linked it to her past, when Amanda started crying thinking about her childhood and how she strived to cope on her own. I clarified how afraid she was of her vulnerable side and provided her with examples of how she had managed to deal with it during the sessions. I clarified her pattern between needing and withdrawing and how that had been manifested in the sessions, especially towards the ending. She focused especially on her relationships with her son and husband. She highlighted the change in her perceptions of her feelings. She began her last session saying: "It feels like leaving home". In her review of therapy, Amanda focused on how inhibited she felt in the beginning and how she resisted talking about her past. She was able to explore her feelings and her vulnerability openly. We talked about her sadness leaving the sessions. In the end we shook hands and she left the session with a smile.

The therapeutic process and changes over time

In the initial stages of therapy Amanda appeared defensive in the sessions. She did not want to speak about her past and refused to accept any link between the past and her current difficulties. I drew her attention to these defences and I suggested explanations for them. Even though she agreed intellectually, it seemed difficult for her to accept it emotionally. As therapy progressed, she acknowledged the emotional deprivation she experienced in her childhood. Her difficulties were about accepting her hatred and hurt, especially regarding her mother. She found it difficult to accept the misplacement of her anger towards her husband. These realisations provoked anxiety and for that she "attacked" therapy in the latter sessions and often experienced me as the persecutor in the transference. She identified with the role of the "victim" in a dangerous situation, such as therapy. She could not allow herself being the "vulnerable client" and especially one that owns feelings of fear and anger.

In the therapeutic relationship, I let Amanda have her space to develop her own associations and reflect on what she was disclosing. I presented my hypotheses and suggestions to her and gave her space to accept or reject my interpretations. My countertransference was significant; through supervision I tried to identify which of my feelings belong to the client (Jacobs, 2004). I often experienced Amanda having a flat or inappropriate emotion, according to the incidents she was describing, whilst her anger was evident in the sessions but she found hard to acknowledge it as hers. I discussed her intense need for care when I felt frustrated I could not offer her more or desired to give her more than I could. This way she managed to make links between patterns in her relationships and explore the influence of her past.

Amanda expressed anxiety for the breaks and worried about the ending of the therapy. Her anxiety was associated with the significant fear of loss she experienced. Furthermore, she expressed her frustration by cancelling sessions or being defensive in the beginning of the sessions (Jacobs, 2004). I tried to keep the significant events of breaks and endings in the sessions' material and encouraged Amanda to explore her difficulties and the first sessions after the breaks were very important. Towards the end, when she missed sessions and was late for some of the ones she attended, I felt worried that indeed she had become worse than better. I felt negative with the work and how she would not engage with me and she manifested a tendency to "attack" the sessions. She was "sabotaging" therapy and, with it, herself. I tried to convey that during the session but it appeared difficult for her to accept such quality as her own. I worried about the efficiency of the work. The last two sessions, though, were quite different. She engaged more and there was a shift from anxiety and pessimism, to appreciation of the work and optimism about the future. Amanda recognised her limitations and issues she could work more on in the future. She was able to relate differently to her son and husband as well as leave a distressing job. She felt content in the end.

Difficulties in the work

Amanda's defences operated in a rather rigid way, which was difficult to challenge. She perceived my attempts to intervene as "threats" and therapy as "dangerous". I experienced difficulty detecting the anxiety and at times the way I communicated to

her was not efficient. It was evident that Amanda was not ready, especially in the beginning of therapy, to re-consider the use of the defences since she felt they protected her from becoming vulnerable. Too early, I tried to challenge them and that felt intimating to her. I feel I had to focus more on her anxiety rather than her defences and clarify its meaning initially. Then Amanda would feel ready to work on her defences. Amanda denied focusing on herself and avoided the experience of negative affect. When I clarified this tendency to her, she would acknowledge the difficulty with accepting the inevitable ending. The ending seemed to be difficult and worrying for both parties. It was important to listen carefully to the overt and latent content of the material and link it with Amanda's feelings about termination. Amanda was defensive towards the ending and tried to control it by cancelling sessions and being unavailable to therapy. She worked hard against any feelings of sadness or anger associated with the ending. Therefore my interventions focused on observing these defences as they occurred in the transference and encouraged Amanda to explore them. It was difficult to contain my anxiety and focus on hers, and supervision helped me considerably in this field.

Making use of supervision

Supervision has been very important for this therapy process. I received weekly individual supervision sessions. Due to external circumstances, I changed supervisors after the tenth session. This change demonstrated the impact of supervision in the therapy process as a "parallel process": the relationship with my supervisors reflected on the relationship between with my client (Jacobs, 2004).

With my initial supervisor, I experienced great difficulties engaging in the sessions. I felt unable to be open and creative about my formulations as I perceived it as a judgemental environment. I presented my sessions and then the supervisor would ask me how I felt about it. After that, the supervisor would emphasise incidents in the sessions where I was not "listening" to the latent content of the material and she made recommendations of alternative interventions. However, she focused on my personal difficulties as they presented in my sessions with the client. I felt uncomfortable at times and felt as if this was not appropriate for supervision sessions. This had an impact on the sessions with the client. Amanda felt as if she was "judged" by me in

the sessions at times, as well. I found myself thinking of the supervisor before my interventions during the sessions, worrying about the supervisor's reaction to them. This inhibited me from listening to Amanda and making useful interpretations; on the contrary, I preferred to remain silent. I was able to convey this to the supervisor and her suggestion was to discuss it in my personal therapy. After that, due to the supervisor's change of schedule, I changed supervisors.

I began my supervision sessions with another senior practitioner in the department. There, I was feeling able to focus on my difficulties and discussed my interventions in a constructive way. I discussed my formulations in an open and explorative way, which has helped me understand and comprehend better Amanda's difficulties. I found myself being more genuine in the therapy sessions and more creative and honest in my reflections, suggestions and interpretations. I was more active and I applied what I had learned in supervision. I felt able to explore my worries about Amanda's defences and my ways of dealing with it. Through supervision, my lack of proper and intensive psychodynamic training was contained and understood. We focused on the content of the sessions and how I could deal better with incidents. We emphasised defences and transference reactions prominent in each session. In conjunction with this, we enriched the formulation and explored how it guided my interventions. I was also able to discuss my countertransference feelings as guided by the supervisor, which helped me deal better with my anxiety during the sessions.

PART C

Termination and Review of Therapy Process

Termination of therapy

The termination of therapy was difficult. Having conducted qualitative, in depth, research on termination, I found it easier to discuss my difficulties and emotions in supervision and with peers. Through supervision I explored ways of encouraging Amanda to discuss her anxiety. At the same time, I acknowledged my own difficulties. Amanda my first long-term client and due to my own separation issues deriving from my personal history, it was important I worked them through in

supervision and personal therapy to deal with them efficiently and be as helpful as possible for the client. We worked on the ending from an early point in therapy, identifying Amanda's anxiety about the outcome of therapy. Therapy would be for forty sessions and I often reminded Amanda how many sessions we had left, maintaining the awareness of the termination. This also reflected my own anxiety of wanting to be useful. Feelings that accompanied the termination were associated with loss; therefore sadness was, as expected, one of the prominent emotions of the last stage of therapy for both parties.

Participants in my research project spoke about their training patients and the energy and time they invested in them. As a trainee I wrote extended notes and a client study based on my work with Amanda. I studied a lot about this case and spent many hours considering our sessions and evaluating my work. I can relate to what therapists revealed in my study and their words helped me understand my experience in this context. Even though it was a planned ending, when Amanda was missing sessions I felt worried she might have dropped out of therapy. My sense of loss was intense and I felt worried about Amanda and how she would go on with her life. Even though she appeared more aware and resilient in the end of treatment, I could not help thinking how she would manage in anxiety-provoking times.

We reviewed the therapy process towards the end, as an attempt to clarify any changes made and also discuss worries about the future. Amanda found the space to express her emotions and how they varied during those forty sessions we had together. As the participants mentioned in my study, I felt that Amanda and I went through a lot together and the relationship was a bonding one, characterised by intense engagement and investment from both parties; ending with her was like letting go of a person I cared for deeply. As I disclosed in supervision, I felt sad after Amanda left her last session. I spent a considerable amount of time thinking and "embracing" these feelings. I was sad as a person (rather than a professional) that somebody I knew had left and I would probably never see again. That made me sad and nostalgic.

My supervisor asked me whether I would offer more sessions should I have had the opportunity. I said I would, since in the last two sessions Amanda seemed to engage more with me. My supervisor inquired whether she would engage as much if therapy

was not ending in the first place. I agreed with her, saying that this was probably the explanation. However, my countertransference of wanting to provide Amanda with more help and care reflected her needs. As my supervisor considered with me, therapy continues after termination; I held her in my mind and it was probable that she held therapy in her mind as well.

My intention was to help Amanda have a good experience of ending. As derived from my research, termination is rarely final and therapy continues after the actual ending of treatment. My hope is that my work with Amanda would be an important part of her life and she would continue to use the learnings of the experience after our meetings. Even though I was aware that there were issues we had not worked through, I was able to contain that and be realistic about time and my competences. Amanda felt relieved when we could talk about issues she would need to work more on in the future. She felt that she did not have to "do therapy" in a perfect way her anxiety was contained.

I would deeply desire to find out about Amanda in the future. However, given that I moved country there is very little chance I will ever hear from her again. That is a poignant ending for me and I feel about this a sense of wistfulness. I have discussed this with my supervisor and also reflected on the results of my study as I felt encouraged by what therapists disclosed in their accounts.

Evaluation of the work

My lack of expertise in psychodynamic theory and practice are evident in Amanda's therapy sessions. As I explored the sessions through personal reflections and supervision, there were times that Amanda's therapy went around in circles without progressing or moving on. Initially, I was less active and more withdrawn in the sessions which reflected my insecurity. Looking back at this, I feel that I could have been more active, forming a more empathic relationship with Amanda. Moreover, I feel I have to develop my skills of listening to latent material. I could have been more efficient should I have remained more focused on non-verbal communication.

When I managed to develop a more comprehensive formulation of Amanda's issues I was more able to make links and interpretations during the sessions. However, I feel I need to gain more experience and study more. In spite of the fact that psychodynamic literature is massive in size and diversity, I need to keep my work focused on theory that fits better the client's issues and therapy process, bearing in mind that it is time-limited therapy. I feel I need to engage in special training in psychodynamic theory and practice so that I become more efficient in this challenging work.

Learning from the case

I feel this piece of work has been very important both for my professional and personal development.

From my experience in the setting and particularly working with Amanda, I have become more sensitive as a practitioner to transference and countertransference reactions during the sessions. I have learned how to communicate these observations and thoughts to the clients in a constructive and helpful way. I have managed to be more conscious of my difficulties in my work as a therapist and I have realised the importance of supervision and personal therapy. I have developed my use of therapeutic skills and learned new ways to deal with clients' material. I also regarded the significance of the termination of therapy. I experienced my own difficulties and at the same I strived to contain the client's issues with endings. I feel I am now more able to accept my limitations as a therapist and feel content with a "good enough" ending, instead of having unrealistic expectations of myself, the client and therapy.

Most importantly I have learned to deal with my frustration during therapy sessions. I have monitored myself better during therapy sessions and explore my feelings as I responded to the client's material. I have found how my personal difficulties can have an impact on the client's therapy. In particular, I realised how my issues with endings and separations affected my reactions to the client's ending. Moreover, through encouragement by my first supervisor, I engaged in twice weekly psychoanalytically oriented personal theory, which I have found an incredibly advantageous experience.

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LOSS, SEPARATION, TERMINATION:

A PORTFOLIO ON ENDINGS

VOLUME II

Evangelia Fragkiadaki

A Thesis Submitted in Fulfilment of the Requirements for the Degree of Doctor of Psychology.

City University, London
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APPENDICES

APPENDIX 1

CRITICAL LITERATURE REVIEW TABLES

Table 1: Gender differences in relationships

Author	Research Focus	Sample	Methodology	Main Results	Limitations
Maccoby (1990)	Children and gender roles	Children	Observations of social interactions	Girls: cooperation, intimate friendships, maintenance of relationships Boys: dominance, competitiveness	Focus on children and developmental account of gender differences
Accitelli (1992)	Relationship awareness	Couples (age range 20-42 years)	Interviews - observations	Women: talk more about relationships Men: do not talk much about relationships, when they do – less relationship problems	Use of open-ended questions led to spontaneous answers, couples were interviewed together which meant the answers were not independent
Cross & Madson (1997)	Self-construal theory	Focus on adults and development of self-structure	Review of the literature	Women: interdependent, pay attention to others, maintain relationships Men: independent, individuality, do not share emotional experiences	Data reviewed derived from Western culture research which entails bias
Gabriel & Gardner (1999)	Relational vs. collective structures	Undergraduate students	Self-report measures and diaries	Women: relational, emotional, maintain relationships Men: collective, linked with groups, maintain and support group membership	Empirical data to support self-construal theory, sampling limitations
Blazina &	Social stereotyped	Undergraduate	Quantitative	Men: when less traditional views	Cultural connotations

Watkins (2000)	perceptions and reactions to relationship problems	students	inventories	of women – less relationship problems	impacting the interpretation of the results, sampling limitations
Hojjat (2000)	Conflict management	Couples	Self-report measures (within laboratory environment)	Women: assertive when resolving conflicts, closeness Men: passive and avoidant in the face of conflicts, autonomy	Arbitrary implications when interpreting results, lack of data from observations
Alonso-Arbiol, Sharvel & Yarnoz (2002)	Dependency	Spanish undergraduate students	Self-report measures	Women slightly more dependent than men Focus on societal stereotypes rather than biological differences	Bias imposed by cultural connotations, sampling limitations
Burns (2002)	Expression of emotions	11 men and women	Qualitative	Women: emotionally expressive Men: rational, regard personal relationships as important	Implications of qualitative research on generalisability of results
Shackelford, Buss & Bennett (2002)	Infidelity	Undergraduate students	Experimental design: forced-choice dilemmas scenarios	Women: harder to forgive emotional infidelity Men: less likely to forgive and more likely to separate in the cases of sexual infidelity	Results rely on imagined scenarios and restricted range of responses
Hook, Gerstein, Detterich & Gridlney (2003)	Intimacy	Undergraduate student	Self-report measures	Men and women were similar in their regard of intimacy Women slightly more affectionate	Sampling limitations
Huprich, Stepp,	Dependency	Undergraduate students	Projective measures, quantitative	Women: focus on needs and other people's attention	Incorporation of psychoanalytic theory,

Graham & Johnson (2004)			inventories	Men: maintain distance and independency	sampling limitations
Suh, Moskowitz, Fournier & Zuroff (2004)	Agency vs. communion traits and behaviours	Community sample	Diaries of interpersonal behaviours, self-report inventories	Women adhered to communion and men to agency as personality traits, not interpersonal behaviours	Arbitrary implications in interpretation of diaries
Bartz & Lydon (2004)	Agency vs. communion and attachment styles	16 – 30 years old	Presentation of scenarios in experimental design	Men with secure attachment adhered to communal traits Men with avoidant attachment adhered to less communal traits Not significant results for women, agency is activated on the face of separation threat	Causal statements in results, sampling limitations
Sabini & Green (2004)	Infidelity	Student and non-student samples	Open-ended questions on imagined scenarios	No major gender differences – men and women expressed anger Highlight age differences in interpretation of results	Focus on imagined scenarios which restricts the interpretations of the results
Lin & Raghubir (2005)	Realism	Taiwanese undergraduate students	Presentation of scenarios in experimental design and assessment of beliefs	Women: more realistic, share more with network, more objective Men: expect happier relationships	Focus on individuals' estimations about the future, limitations about cross-cultural generalisability
Haden & Hojjat (2006)	Aggressive responses to betrayal	Undergraduate students	Imagined scenarios and real experiences of betrayal	No significant gender differences	Women were oversampled in this study – limited generalisation of the

					results

Table 2: Reactions to Relationship Dissolution and Gender Differences

Author	Research Focus	Sample	Methodology	Main Results	Limitations
Stewart & Rubin (1974)	Hope of Power	Undergraduate students	Longitudinal study – self-report measures	Men: when high on Hope of Power, more likely to experience stress and dissatisfaction in relationship, contributed to relationship instability	Restrictions imposed from using one variable, sampling limitations
Hill, Rubin & Peplau (1976)	Precipitating factors	College students	Longitudinal studies	Women: more receptive of relationship problems, more likely to compare, likely to initiate dissolution, when rejected – grief and despair Men: significance of emotional investment, when rejected – lonely, sad, sentimental	Exploration of larger range of variables, sampling limitations
Baxter (1986)	Factors contributing to continuation or dissolution of relationship	University students (who have initiated breakup)	Analysis of lists of factors generated by participants	Women: recorded more factors: autonomy, openness, equity, more pragmatic Men: more significance on romance	Sampling limitations,
Simpson (1987)	Precipitating factors of dissolution and distress	Undergraduate students	Longitudinal study	Factors: closeness, duration of relationship, finding suitable alternative	Sampling limitations, factors explored were pre-determined

				No significant gender differences	restricting the variety of plausible responses
Mearns (1991)	Negative mood regulation	Undergraduate students	Quantitative inventories	More expectancies to regulate negative emotions – less depressed and more able to cope at time of dissolution No gender differences	Restricted measures of one variable, sampling limitations
Helgeson (1994)	Long-distance relationships	University students	Longitudinal study	Women: more distressed in beginning of relationship, more prepared to deal with dissolution, more likely to consider breakup before actual ending Men: more distressed when rejected, more surprised at time of breakup when rejected	Sampling limitations, consideration of bias impacting interpretation of data
Choo, Levine & Hatfied (1996)	Experience of dissolution of relationship	University students	Quantitative inventories	Women: more prepared for separation, more likely to blame partner Men: less joy - less relief immediately after breakup, engage in distractions to deal with separation	Use of forced-choice inventories restricts the richness of data, sampling limitations
Downey, Freitas, Michaelis & Khouri (1998)	Sensitivity to rejection	Couples (at least one university student)	Longitudinal study, laboratory study (observations)	Women: high rejection sensitivity, more likely to break up, focus on loss of relationship Men: more worry about loss of status	Longitudinal data and laboratory observations combined led to reliable results, sampling limitations should be considered

Sprecher, Felmlee, Metts, Fehr & Vanni (1998)	Post-dissolution distress	University students	Quantitative measures	Women: more upset immediately after breakup, more likely to attribute breakup to partner No significant results for men	Limitations due to measures acquired from participants' retrospective accounts of reactions to breakup, sampling limitations
Arriaga (2001)	Level of satisfaction and breakup	Undergraduate students	Longitudinal study	Fluctuating satisfaction related to dissolution No significant gender differences	Sampling limitations
Chung, Farmer, Grant, Newton, Payne, Perry, Saunders, Smith & Stone (2002)	Post-dissolution distress	College students	Interviews, self-report measures	Women: more dysfunctional, more depressed than men Emphasis on dissolution of relationship as traumatic experience with consequences on health	Limitations due to measures acquired from participants' retrospective accounts, sampling limitations
Ickes, Dugosh, Simpson & Wilson (2003)	Motive to Acquire Relationship-Threatening Information scale (MARTI)	University students	Quantitative studies (also to check reliability and validity of inventory)	Higher MARTI scores related to higher possibilities for separation No significant gender differences	Sampling limitations, restricted exploration of one variable
Sprecher & Hendrick (2004)	Self Disclosure	Undergraduate students – couples	Longitudinal study	When women received more self-disclosure, less likely to break up No significant gender differences	Sampling limitations
Sbarra &	Affectional reactions	Undergraduate	Diaries	Love-anger-sadness	Assessed emotions after

Ferrer (2006)	to relationship dissolution	students		No gender differences	breakup not retrospectively but as they occur which allowed for conclusions, sampling limitations
Cameron & Ross (2007)	Negative affectivity	Undergraduate students – couples	Self-report measures	Men: negative affectivity, more likely to break up No significant results for women	Sampling limitations, responses restricted by forced-choice inventories

Table 3: Reactions to Relationship Dissolution and Attachment Styles

Author	**Research Focus**	**Sample**	**Methodology**	**Main Results**	**Limitations**
Simpson (1990)	Adult attachment styles	University students - couples	Quantitative measures – longitudinal study (measures at various times)	Three adult attachment styles Avoidant men – less post-dissolution distress	Sampling limitations, more longitudinal data needed to draw confident conclusions
Bartholomew & Horowitz (1991)	Adult attachment styles	University students	Interviews, quantitative inventories	Four-facet attachment styles theory Women: more often reported	Sampling limitations

				preoccupied attachment styles Men: more often reported dismissive attachment styles	
Feeney & Noller (1992)	Emotional responses to dissolution of relationships	Undergraduate university students	Quantitative attachment measures – longitudinal study (measures at various times)	Avoidant attachment: relief, low in distress Anxious attachment: more surprised, more likely to date new mates Men: more likely to attribute initiation of dissolution to self Women: more likely to attribute dissolution as mutual decision Avoidant women: significantly related to relationship instability	Sampling limitations, forced-choice inventories may limit participants' responses
Kirkpatrick & Davis (1994)	Attachment styles and gender differences in relationships	University students – couples	Quantitative measures of attachment – longitudinal study (measures at various times)	Avoidant men: more likely to contribute to instability of relationship Anxious and Secure women: more likely to manifest relationship maintenance skills	Sampling limitations, forced-choice inventories may limit participants' responses
Fraley & Shaver (1998)	Separation and attachment style	Community sample	Naturalistic study, self-report measures, interviews	Both genders engaged in proximity behaviours in the face of separation Avoidant women: likely to pull away from partners, less separation anxiety Preoccupied women: high separation anxiety Dismissing women: likely to	Limitations embedded due to lack of experimental control of intrusive variables in a non-controlling natural environment

				avoid partners No significant results for men	
Cassidy (2000)	Developmental perspectives of attachment patterns – interactions between attachment styles and caregiving systems		Review of literature	Early attachment styles influence adults' behaviours and patterns in romantic relationships	Theoretical paper – more empirical data necessary to draw confident conclusions
Davis, Shaver & Vernon (2003)	Attachment security and insecurity in relation to reactions to romantic relationship breakup	Internet sample	Quantitative measures	Greater preoccupation at breakup: non-initiators, anxious attachment, emotionally involvement in relationship	Limitations due to non-controlling internet environment where participants cannot be observed
Simpson, Collins, Tran & Haydon (2007)	Attachment styles from infancy to adulthood	Community sample – from infancy to 20's	Longitudinal study	Early secure attachment: more likely to express positive emotions in romantic relationships Early insecure attachment: more likely to express more negative emotions in romantic relationships	Focus on developmental accounts and observations, consideration of contextual factors in the interpretation of the results

APPENDIX 2

CITY UNIVERSITY ETHICS FORM

APPENDIX 3

CONSENT FORM

Consent Form

By signing this consent I acknowledge that I have reviewed the information sheet provided and I consent to participate in the present research project. I understand that were I to experience emotional distress during the interviews, I have the right to interrupt the process and/or withdraw my participation.

I understand that debriefing arrangements will be available.

I understand the purpose, procedure and possible risks of the research.

Participant's Name:

Signature:

Date:

Thank you,

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APPENDIX 4

COUNSELLING AGENCIES

(This is just an indicative list since participants would either be in personal therapy at the time of the interview or have been in personal therapy therefore held contact details of therapists)

The Tavistock Clinic, The Tavistock Centre, 120 Belsize Lane, London NW3 5BA, Tel: 020 7435 7111

The Institute of Psychoanalysis, 112a Shirland Road, London, W9 2EQ

British Association for Counselling & Psychotherapy, 22 Leggatts Close, Watford, Hertfordshire, WD24 5NG

Careline, Cardinal Heenan Centre, 326 High Road, Ilford, Essex, IG1 1QP, 0845 122 8622 (helpline)

WPF Counselling and Psychotherapy, 23 Kensington Square, London, W8 5HN

APPENDIX 5

INFORMATION SHEET

Dear Participant

Thank you for considering contributing to this qualitative research project. Termination of psychotherapy is deemed to be an important but sometimes emotionally intense phase for therapists. This study, using Grounded Theory methodology, aims to identify the feelings, elaborate on variables that may influence the therapist and explore ways therapists deal with these feelings.

By agreeing to participate in this research project you will be asked to attend a semi-structured interview which will last approximately one hour. Interviews will be recorded so that the researcher will then be able to conduct analysis of the data based on the grounded theory methodology.

Anonymity and confidentiality will be ensured at all times and the transcribed data emerging from the interviews will be secured.

There is a possibility that you will be asked to reply to further questions later in the process of research due to the grounded theory methodology principle of “theoretical sampling”. This means that when further data is acquired, the researcher will form additional, more focused, questions for the participants.

Opportunities for debriefing will be provided as well as details of external agencies as needed.

Thank you again for agreeing to participate. Please don't hesitate to contact me should you have any further enquiries.

With Regards

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APPENDIX 6

FLYER

Termination of Psychotherapy Study Invitation to Participants

Are you interested in sharing your experiences of termination of psychotherapy of your patients?

I am currently training in the Three Year Practitioner's Doctorate Programme in Counselling Psychology at City University. I am conducting a qualitative research project focusing on therapist's feelings towards termination of psychoanalytic or psychodynamic psychotherapy with clients. If you have completed training and currently practice as a psychotherapist, and want to share your experiences, I would be delighted to have you participate in this study.

Please contact:
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Tel: 0789 61 60 788
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Supervisor's Contact Details:
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APPENDIX 7

INTRODUCTORY E-MAIL

Doctorate Researcher Recruiting Enquiry

Eva Fragkiadaki <evafragia@googlemail.com>
To:

To whom it may concern

Greetings

My name is Eva Fragkiadaki and I am a second year student at the Three Year Practitioner's Doctorate Programme in Counselling Psychology at City University. My research project focuses on psychoanalytic psychotherapy and particularly on the therapists' feeling towards termination of psychotherapy with clients.

I am now at the stage of recruiting and I wanted to ask you which would be the best way to publish the research flier in your organisation (e-mail, ad in magazine etc).

Your advice would be of great value.

I am looking forward to hearing from you.

Kind regards
Eva Fragkiadaki

APPENDIX 8

INTERVIEW QUESTIONS

Interview Questions

What sort of feelings do you experience in the termination phase of psychotherapy with clients?

What aspects of personal history do you think influence these experiences?

How does personality influence this phase of therapy?

Do you allow yourself to become subjective in the termination phase of psychotherapy with the client?

How does this happen? How would you describe the experience?

How do you deal with these feelings?

Do the therapists continue the contact with the patient?

How does unpleasant material affect the termination discussions?

How does pleasant material affect the termination discussion?

How much do they disclose to the patients?

How did the nature of the clients' presenting issues affect your feelings towards termination?

How did you utilise supervision or colleagues' groups?

APPENDIX 9

INTERVIEW TRANSCRIPT FROM INITIAL STAGE OF DATA COLLECTION

Transcript of Interview #1

In this interview in the initial stages of the research process I was less directive and the questions were mainly open. This interview lasted one and a half hours and the participant's replies were long and she mainly described particular cases. For reasons of confidentiality, a summary of the responses is presented.

There are some prompt questions, some questions that probably could help facilitate this interview and keep the flow of it. But just before we go into more directed questions I would like to know how you think about this termination issue and what your view is on this.

She discussed the inevitability of termination and the variety of her experience of long and short term therapy with patients. The participant asked what the focus of the interview is.

I would like to look into, since you have both short and long term experience, if you feel that there is any difference in terms of how you experience the termination; but basically as you say, there are intense feelings on both sides and here I are looking at it from therapists' point of view and how they experience this psychotherapy phase that is inevitable.

The participant discussed how her own experience of termination influences the termination of therapy with patients. She talked about her experience of terminating with a training patient. She highlighted the significance of time of termination and the reasons for which the patient ends therapy. She discussed the therapist's and patient's different goals of therapy and how the therapist feels that "more work could be done" in some cases and how she deals with these cases. She talked about her mixed feelings at the time of termination.

So when the patient actually is indicating that they are making positive changes in their life, you have this feeling that they are going to speak about ending soon and it is going to end. And it makes you feel some satisfaction about the work that has been done and how the person has improved. I wonder what other feelings are there in terms of your experience; having done all this work with this person. Because it is kind of an investment of thoughts, energy…

She talks about her investment on patients, how she worries about patients and how some patients stir up more feelings than others and her experiences of sadness and loss at termination. She also talks about the case of no contact after termination.

So it is like separation and the feelings that can provoke, and you just told me that some patients may send letters afterwards or you may see somebody. I was wondering, do you keep contact with them afterwards? Do you try to have another meeting and another session after the ending or…?

She said that she does not initiate contact after termination but if patients ask whether they could contact she would encourage them to. She talked about how the majority of patients do not make any contact after termination.

How do you experience that, how would you describe that in terms of your experience; of the fact that they ask whether they could contact and then they don't.

She talked about the human anxieties for endings and the therapist's desire to know what happens to patients after termination. She talked about how "bizarre" the therapeutic relationship is and the intensity of the work which inevitably would end. She discussed how patients stay in her mind and talked about a specific case of intense final ending.

There was this "foreverness" at that ending, wasn't it?

She talked about finding out about the patient from a third party.

I am just wondering how you feel that your own experience and your personal history has actually influenced, if it has influenced, the termination phase with your patients.

She confirmed that her history influences the way she works with patients and talked about how it has influenced her. She discussed her experience of loss in her personal life and personal therapy and the significance of both. She talked about the diversity of her professional experience and discussed a specific case of a patient who contacted her and continued therapy after the termination of a short term work.

So how did that make you feel? How did you experience that; an ending that seemed like forever, and then the patient came back and then there was an ending again.

She expressed her satisfaction about that ending and how some patients stay in her mind, especially the ones with whom therapy has been intense. She said that she is "used to" endings and how patients stay in her mind even though she does not see them.

So coming back to what you said, about short and long term, you did say that long term patients tend to stay more in your mind and short term work does not influence that much. How would you differentiate your experience in these two different contexts?

She discussed how duration affects her experience of termination and how short-term patients with whom the relationship has been intense and therapy effective, tend to stay in mind as well and how it depends on how patients "use the therapist".

When you said that it depends on how patients "use you" as a therapist, would you like to elaborate a bit more on that?

She talked about a specific patient to bring an example of how patients "use her", their use of defences and how they feel about the therapist throughout the therapy process and her difficulties in it.

So the presenting issues or non-apparent issues of the patients actually influence how you will experience the termination with them.

She highlighted the influence of personality.

Their personality or your personality?

She emphasised how both personalities affect the relationship and discussed a specific case to illustrate a difficult therapy process and how hard it was to connect with this specific patient. She discussed the termination stage with this patient and her feelings of relief at the ending.

So it is this connection then, as you said before, or the importance of the personalities to match. And when this is not happening it sounds like termination has less of separation feelings and more of a thought process and some kind of relief there.

She discussed how relief is a rare feeling for her and discussed another difficult case.

So you are thinking about what happens to them after termination.

She talked about a patient who contacted her after the termination and her positive feelings about hearing from the patient.

You wonder what has happened to your patients, you would like to know what happened to them. What happens when you do not hear about them; when the termination is final?

She discussed a specific case of a patient whom she admired and who did not contact again after the ending. She expressed how she wondered what happened to this patient. She then talked about another patient to indicate how she would like to know what happens to some of her patients after they leave.

It is then mixed as you said in the beginning; satisfaction when they improve and at the same time it can be relief and sadness basically in cases where there are more things they could work on. I am wondering how you cope with these feelings. You have talked about supervision.

She talked about how she discussed cases with specific colleagues. She said about how the feelings "wander around" inside her and how she has become familiar with them. She talked about a specific patient with whom the ending was "painful". She talked about the years of her professional life and how she thinks about specific patients she has worked with, even many years ago. She repeated the notion of "bizarre" relationship; how she feels intensely connected to people while at the same time she knows it is going to end.

And then an ending comes which, as you say, it is different to social circumstances where you know you can go and contact people or search for people and talk to them. It is an ending where…

She highlighted the fact that contact after termination needs to be the patient's initiative. She discussed a specific case to indicate the patient's difficulties to end therapy as well as her worry about the patient after they will have ended. She discussed her own difficulties when she felt she needed to introduce the ending to a patient. She then discussed techniques and how she works towards an ending.

So what is actually a proper ending for you? You mentioned tailing of the sessions and how this does not provide a proper ending. I was wondering what is a proper ending then for you?

She talked about the importance of time to talk about the ending, reviewing and working through the feelings about the ending.

So it is quite a mixed process with many things in it; the therapist's personal history, the latent content of the sessions. One of my last questions is about self-disclosure. How much of your experience of termination would you disclose to the patients?

She talked about how the patients know they have an impact on the therapist. She talked about a specific patient whom she saw for a short period of time and how she would self-disclose to this patient to indicate the impact the therapy process had on her. She also discussed her personal therapy and the impact it had on her when her therapist said to her that they would be "happy to her from her" after the ending. She discussed the issue of presents and physical contact at the time of the ending. She also spoke about another ending which entailed less feelings from the side of the patient and the impact this had on her.

Well, this is all that I wanted to ask. I do not know if you would like to give me some thoughts and feedback about how it felt to talk about it today.

She talked about her worries of the relevance to the research focus and how she enjoyed the interview.

I will contact you again in the future if that is OK.

She agreed.

Just for a matter of ethics, as you told me you have your personal therapy, but at any time if you would like a debriefing meeting I am available to discuss it through.

She said that she would be OK but it was nice I offered that and emphasised her "history of loss" she can talk about when she talks about the patients she has ended with.

Thank you very much. This has been a rich interview. I will send your transcript for you to consider and then meet again to look into more specific questions.
She agreed and then we discussed about participants and how she could ask one of her colleagues to participate.
After the end of the interview she recalled a case of termination through death for which she would like to talk about. I turned on the recorder and she gave an account of her experience when one of her patients had suddenly died.

APPENDIX 10

INTERVIEW TRANSCRIPT FROM LATER STAGES OF DATA COLLECTION

Transcript Interview #7

This interview took place in the latter stages of the research process. The participant asked many personal questions and I intervened considerably in this interview. I asked questions which were more directing, formed on the basis of previous interviews. Moreover, this participant showed interest in my professional and personal practice and asked questions to which I replied in an open and honest way. For reasons of confidentiality, summaries of the responses are presented instead of the completed transcript.

So I have some prompt questions here to facilitate the discussion, but it is a semi-structured interview so I am happy to follow you to whatever you would like to discuss. So I am basically interested into seeing the therapists' side of that phase of psychotherapy. I am mostly interested in how you experience the termination.

She highlighted the significance of the therapeutic relationship and how it defines the ending. She said that it is difficult to identify her experience as there is "not an it".

There is a big kind of, different experiences there.

She highlighted the importance of how the patients end therapy and whether the therapist feels that the work has been satisfactory. She spoke about her feelings of sadness when she feels that she has been through a lot together with the patient.

So it is the kind of relationship that is important for the time of termination. Could you think of any examples, or any intense emotions that you have experienced that you can describe?

She thought about how she can contribute to the research. She described her professional experience in various settings where she applied short and long term work. She asked me what my expectations were in the interview.

Well, I don't have any kind of specific expectations in what I want to hear. But what I am trying to see in my interviews is to kind of, get a more in depth elaboration of what happens to the therapist at the termination phase. So it sounds like as if you have worked in three different settings and I am sure that you have experienced a lot of terminations in these settings so…

She assumed that what interests me are planned endings.

It is that as well but I am quite aware that there are endings that were not as planned or clients leaving abruptly, also due to external circumstances…

There were a few seconds of silence and the therapist decided to speak about a particular patient. She talked about the patient's presenting symptoms. She spoke about the relationship that "broke down" with this patient. She talked about her feelings of relief at the time of the ending. She associated her experience of

termination with the patients' level of dependency. She asked whether I have recruited participants who practice traditional five-times-weekly psychoanalysis.

Well, they haven't been specific about five times a week but most of the participants have been working psychoanalytically with patients so…

She expressed her assumptions about what I would ask in the interview and focused on the transference and the use of it in therapy. She then talked about a specific patient and the frustration she felt at the termination stage. At this particular termination the patient had terminated abruptly. She spoke about how the patient contacted her after the termination and asked for more sessions where she was able to discuss the ending, which made her feel good. She highlighted the importance of mutuality about termination and how therapists miss and think about their patients. After a short silence, she spoke about her maternal transference and her feelings of sadness at the time of the ending with some patients.

When it happens, as you said, it depends on the patient's dependency…

She emphasised how dependency is linked with regression and how in the relationship the therapist might just be "getting on with the patient". She asked me whether I agreed with that.

It depends on the relationship. Yeah, yeah, it has come up quite a lot of times about therapists talking about external reminders of patients; how they see and hear something that reminds them of their patients, about them missing their patients, some of their patients. I am wondering what defines that difference to you; as you said you feel like that with specific patients and you talked about your maternal transference.

She mentioned how it is not only the maternal transference, but also the "exchange" during the therapy process. She referred to the literature and Jung's concept of "getting in the bath with someone" and asked whether I was familiar with the term.

I don't know about this. Perhaps you could tell me a little bit about it.

She explained the term and talked about how she remembers her patients when she sees or hear something. She then spoke about one of her patients who committed suicide. She described her feelings and how she found out about the patient's death from a third party. There were a few seconds of silence and then she talked about patients that move out of the country and the finality of those endings and the feelings of loss. She elaborated on the therapist's dependency on patients and how that affects the judgement of the time of the ending.

That's very interesting to say because it has been discussed how therapists have initiated termination with patients and other therapists don't initiate termination, they wouldn't do it because they believe it is the patient's right to terminate. You have talked about your experience of open-ended therapy in private practice.

She talked about patients who enter therapy to work through specific issues and how she offers initially short term work before the patient decides what they want to work

on. She asked me if I found that few people enter in order to engage in psychotherapy with no specific complaints.

Well that is something I have not heard much about. I know that having something acute a person would enter psychotherapy; unless there is a problem few people will seek a therapist. Also, because of the pace of psychoanalytic work many times it is, well, people get frustrated because of that pace. That is why I think the other approaches have come up. That is why we have so many things we can work with.

She talked about the experience of Counselling Psychologists and how they are flexible in the way they work with their patients.

Many Counselling Psychologists engage in CBT work which is very focused and actually for some people, I work in CBT framework for two years, many people get better and ameliorate in five sessions; they function better, they don't feel anxious any more and go away. But it is likely they will come back because something will trigger the same symptoms again.

She emphasised how patients come back for therapy for the same issues or for deeper work.

Exactly, yeah. Actually as a trainee I don't have the luxury to stay somewhere for many years to see that happening.

She talked about patients continuing therapy with different therapists. She then thought about the years of her clinical practice and talked about how long her feelings of lost and sadness last. She said that patients in her mind become "like old friends".

Do you leave the door open? It has been discussed how some therapists say to their patients that they can come back. I am wondering what your experience is.

She talked about how she leaves the door open in her mind and talked about a specific patient she began working with in her early practice and how they have kept contact on an annual basis.

It sounds like a ritual.

She talked about the inevitability of termination and differentiated group analysts from individual psychoanalysts. She described her experience of conducting group therapy. She talked about the experience of termination in a group setting and how it is more powerful than individual therapy endings.

And the therapist there, how exactly do you experience the termination inside a group? What kind of feelings do you have?

She talked about how she feels proud of people that end in a group and how members of group make positive changes in group therapy contexts and how that makes her feel. She again referred to the literature and asked me whether I was familiar with the "basic fault" term.

I am familiar with the book but I haven't read it.

She explained what basic fault means; an experience of deprivation. Regarding termination, she said that the therapy process is "replayed" around the ending time. She said how she would like her patients to see how she feels about them. She spoke about the element at termination of "really loving your patients and letting them go".

As you have said, it is like letting a child go to university or wherever. It can be a really intense experience then. And it is interesting you mentioned the relational aspect of psychoanalysis and I have been in a conference on that.

She asked to learn more about the conference.

I got hold of the details from a university in the States.

She talked about how equal the therapeutic relationship is.

And you mentioned how people who become group analysts are more extroverts. I am just wondering just because I…

She said how they are at least less introvert.

That coincides with my next question about how you feel your personal history and personality influence your experience of termination.

She talked about how her personal experience has made it easier for her to deal with endings. After a few seconds of silence she talked about how she anticipated and thinks about the patients' last session. After a short silence she talked about a specific patient she had at the moment whose potential ending "troubled" her.

I am wondering how it makes it different; I am just thinking whether it would be more difficult in a group to initiate termination.

She said that it is not difficult because in the group there are more people who "mediate" at the time of the ending.

It is more worked through in the group.

She agreed. She spoke about the incidents when she "actively" initiated termination with members of therapy groups and the feelings of "relief" in the group.

How was that difficult?

She said that it was difficult for the group but she enjoyed one of these members. She talked about the feeling of relief at the time of the ending, especially when she feels she cannot help the patient.

How do you think your patients' material affects that; your experience and diversity of feelings at the time of the ending? You talked about relief, sadness…

She did not agree that the material affects but rather what is important is how the patient has grown up and developed the way they relate to people. She asked me whether I found that the material affects the experience of termination.

Well, the relationship has been often mentioned and people have talked about the countertransference and how the patient has used the sessions and the therapist; what you said actually about the object and not the real relationship. That is why I asked whether you had seen a pattern, specific cases when you feel closer to your patients and when you don't, in terms of what the patients provoke in you.

She asked me whether the patients' defences would be important.

And your experience of that would be…

She talked about how she works with the defences. There was a long silence and she considered then how the patients' gratitude affects her experience of termination. She then discussed what a good ending means for her; when it is "about two people". She then went back to my question about whether or not she leaves the door open; she would overtly say that mainly in short term work.

What for though; why not in long term work?

She said that in long term work she feels she knows how the patient will be after the ending.

You don't worry then as much, or…?

She spoke about "something being complete" in long term work. There was a silence and then she spoke about the years of professional practice and the relationship she has had with some patients after the ending of therapy. She then questioned whether or not she is helpful for the research question.

No, no, it is really rich and stimulating material. I am just thinking about what you said about these cases when the termination is not "forever" whereas in other cases the "foreverness" in entailed when the patient leaves.

She talked about the issue of self-disclosure towards the end so that the patient works through the transference and how that is a part of "good ending".

That particular issue has been discussed before. Some therapists say that they disclose, because the relationship becomes more real and is "de-mystified".

She said that this can be a marker that the patient has improved. She then talked about how therapists might "miss the depth" of conversations with patients in the social life and how inappropriate this attitude is when therapists are with friends.

Then we wouldn't have friends!

She spoke about that distinction and how therapists cannot talk about their job in a social context and linked that with the therapists' dependence to their patients. There was a small silence and then she suggested that in my research it would be interested to compare therapists from different orientations and different settings. She then talked about her family and how this affects the patients she sees privately at home. After a short silence she considered the differences between psychotherapy and Counselling Psychology and asked what my experience was in the field of psychoanalysis.

I am in two-times weekly psychoanalytic therapy.

She asked whether that was mandatory from the course.

No, the course requires forty hours of therapy in three years but I actually began once weekly and then I got into a psychoanalytic placement and my supervisor encouraged me to begin twice-weekly psychotherapy. And I did and I am one of the people that I don't have any acute problem and twice weekly sometimes seems too much. And there are other implications…But as you said it happens in the present, each session in different.

She said how she thinks that twice weekly therapy is a nice experience.

It is very interesting when I miss sessions and I get frustrated, so it is interesting.

She considered how my training must be "expensive and demanding".

Yeah, in various ways. But it is a valuable experience, I live abroad, and I was lucky, my friends are here.

She asked me whether I shared a flat.

In my first year but I don't any more. I lived with friends but then I wanted to live in my own. As you said, it is a profession that people outside don't really comprehend. I find it difficult to make my friends understand my difficult times.

She then talked about the endings of her personal analyses. She talked about the death of her personal therapist and the finality of that ending. Her second therapist became a colleague so "that did not end". She then talked about how she doesn't remember all her patients and how she feels good when she receives letters or is contacted by her patients and linked that with her maternal transference.

People talk about patients contacting, especially when they have babies; maybe it does have to do something with the maternal transference.

After a short silence, she said that her immediate association with the word termination is the anticipation of the last session and how she would expect to be emotional in it. She said that it is "like a job coming to an end"

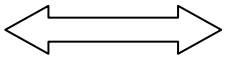
After a long silence she said: "I would love to read your thesis".

Definitely, I am now concluding the interviews and I wanted to ask you whether you would agree to meet for a second time and ask more specific questions. I would also like to ask whether you would like to view the transcript of your interview and make your comments about whether what I have written corresponds to what you have said. Then I am expecting that I will finish my writing up and send you the results.

She agreed and suggested I should contact one of her colleagues and ask her whether she would be interested to participate in the study. She asked how many participants I would need and offered to ask some of her colleagues. She expressed her interest in my research and asked what I have studied on termination.

APPENDIX 11

DIAGRAMS AND TABLES

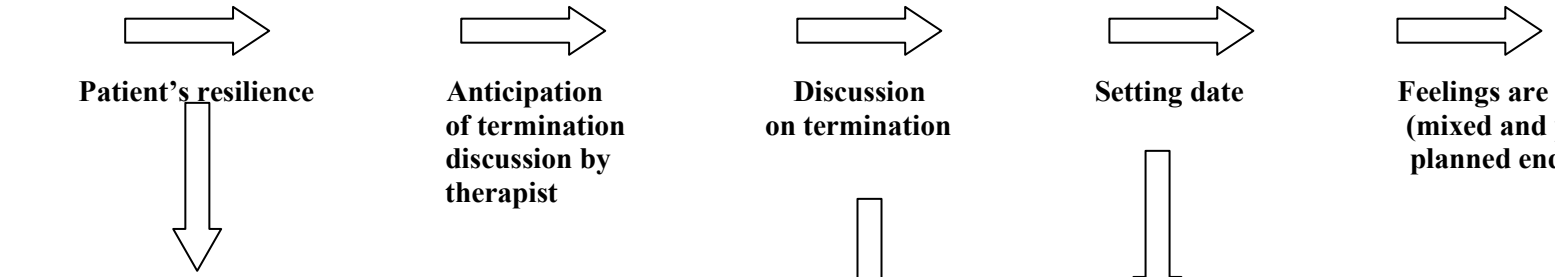
TERMINATION  **THERAPY PROCESS: THERAPEUTIC RELATIONSHIP**

REVIEW OF THERAPY PROCESS **SPECIFIC PATIENTS**

PATIENTS' PROGRESS

THERAPIST AS A PERSON – PATIENT AS A PERSON – DOES THE THERAPEUTIC RELATIONSHIP BECOME REAL IN THE END?

TERMINATION PROCESS – WHEN FEELINGS STIR UP



ALSO: when therapist initiates termination/or even patient initiated termination/time needed for working through termination – **3 months (P2 + P3) - EMOTIONAL WEEK – WHEN ANNOUNCEMENT OF TERMINATION 3 MONTHS AHEAD** – also initiated by therapist (4,9,151)

Time when patients know how much therapist loves them (7,19,215)

WHAT STANDS OUT -WHAT THERAPISTS DESCRIBE/FIND IMPORTANT WHEN DESCRIBING THEIR EXPERIENCE OF TERMINATION

Patient's Characteristics	Therapy Process	Therapist's Experience of therapy process	Therapeutic Relationship	Termination	Contact after termination	Reactions to Termination - Thoughts after termination
Initial symptoms	Difficulties	Early VS current professional practice	Development	Planned	Wanting to know what happens after termination	Patient's reactions
History	What has been worked through		Use of therapist	Premature	Worry	Therapist's reactions
Early relationships	Joy – good expeirence		Transference/ Countertransference	Initiated by patient OR therapist	"Go away and be well"	Thoughts on termination (therapist formulating own theory about what is

						important)
	THERAPISTS TALK ABOUT BIG SUCCESSES OR BIG FAILURES WHEN THINKING OF THERAPY PROCESSES			Time of termination	Patient's initiative – meaning for patient and their needs as a priority	

APPENDIX 12

DESCRIPTIVE CATEGORIES – INITIAL STAGES OF DATA ANALYSIS

Focus on Therapist	Focus on Patient	Focus on Therapy Process
Feelings at termination	Patients staying in therapist's mind	Termination
Self Disclosure	Use of therapist	Termination through death
Personal therapy	Reasons for termination	Therapy process
Early vs. current practice	Reactions to termination	Therapeutic Relationship
Professional practice	Patient leaving something for the therapist	Techniques on termination
Personal history	Patient's Characteristics	Settings
Personal admiration		Time of termination
Experience of therapy		Finality vs. Partial/Incomplete Termination
As a person		Contact after termination
Therapist's vs. patient's agenda		Therapeutic change
Literature		Duration of therapy
Thoughts on interview		Working through termination
Theories on Termination		
To know what happens after termination		
Memories of termination		
Therapist's personality		

APPENDIX 13

ANALYTIC CATEGORIES – LATTER STAGES OF DATA ANALYSIS

Contact after termination
Desire to know what happens after termination
Therapist as a person
Therapeutic relationship
Personal therapy
Patient getting under the therapist's skin
In-finality of termination
Patients know anyway
Dealing with feelings at termination
Patient's questions
Open-ended therapy
Time of termination
Feelings
Termination
Reflections on interviews

APPENDIX 14

DEMONSTRATION OF CODING AND ANALYSIS PROCESS: TRANSCRIPTS, AXIAL CODING CATEGORIES AND MEMOS FOR P1

Transcript of Participant #1

Eva: As I told you, I have looked through things before I came, and there are some prompt questions, some questions that probably could help facilitate this interview and keep the flow of it. But just before we go into more directed questions I would like to know how you think about this termination issue and what your view is on this.

P1: That's a huge question. What do I think about it? It is inevitable. At the beginning you always know there is going to be an end. And it always stirs up huge feelings. On both sides I think. And it depends on…I was thinking…I don't quite know whether you are looking at it from the point of view of long-term therapies because I have done a lot of short term work; I have worked in GP practices; where I was seeing people for six sessions, sometimes one or two and sometimes twelve or more. But obviously here, in my private practice…which perhaps what you are more interested in.

Codes: diversity of phenomenon, unavoidable, inevitability/awareness of termination, expected, large in emotional intensity; for therapist and patient, *duration of therapy, professional experience*

Eva: I would like to look into, since you have both short and long term experience, if you feel that there is any difference in terms of how you experience the termination; but basically as you say, there are intense feelings on both sides and here I are looking at it from therapists' point of view and how they experience this psychotherapy phase that is inevitable.

P1: Of course it is completely coloured by our own experience of termination. Having terminated my own therapy. Which is of course why one has to be in therapy because it helps so much to know, to have been …to have been through all of that yourself. So of course when my patients are ending, then of course I am, their experience is not necessarily mine, but of course I draw my own experience to imagine and feel what it is like from their point of view. You are interested in the therapists' point of view. I have read loads of stuff on termination. Because when I wrote my final paper, my qualifying paper, I had a patient who, during the training - we had to have a patient for a minimum of two years. I had a patient who was *(patient's country of origin)* and because she was here with her husband and they were both on some kind of a visa, they were both *(patient's profession)*. You won't, I am thinking about confidentiality, it doesn't demonstrate who they are exactly. There was a constant problem about whether they had to go back to *(country of origin)* and so it felt like the whole therapy, at least for the second year, was uncertainness about whether it would continue or how long it would continue and whether she would complete the two years that was needed, the minimum of two years to do the training. When I wrote my final paper about her, she did actually go back to *(country of origin)*, she managed to complete her time, and I read lot about termination, which I incorporated into my paper. But of course, I suppose the whole question of termination depends entirely on why you are terminating at that point. Because, I can't remember the statistics, but I don't know what proportion of patients actually end because it is the right time to end or they end because they have to move because they have run out of money or all sorts of practical things that actually get in the way. I don't know what proportion of

my patients, I think probably the majority would have decided to end because they felt they have achieved enough of what they wanted. I suppose from the therapist's point of view it's always quite tricky. I read a very interesting book recently called "the Analysant's Tale" which was telling the stories of a number of people who have been in analysis with Jung, analysis with Freud and others and what came out very strongly in this book is that the therapist may have a different agenda from the patient. So, any difficulties or when things go wrong is partly because the patient has got something different they are trying to get out of it and the therapist has got their own theory about what is going on. So as a therapist I suppose there is often the feeling that more work could be done and how long has it been and what point do you feel this is absolutely as good or good enough. I suppose that is always the question in my mind and not knowing whether this is the right time for someone to end and how to deal with it if I feel very strongly this is not the right time and try to negotiate the whole question of ending. But on the whole my experience of it is, and I was saying this to a colleague recently because I think we were going to discuss in a peer group about the whole issue of termination. I said that my experience of it is that I'd be sitting with a patient for whatever length of time it is and I would gradually be getting the feeling of "I think this person is going to start talking about ending soon" because things are beginning to feel like they are consistently better I suppose, or the person is feeling more in charge of their life and feeling they can make choices and things are going more how they wanted. Whether it's because they have a relationship that's working or the things that they were struggling with when they first came, and now feeling more able to deal with it and they are more…One of the words that stayed strongly in my mind from when I was writing my paper that it was in a book about separation I think…somebody called Quinodez…, was in the notion of buoyancy, about when a patient is beginning to feel there is a much greater strength of buoyancy when things go wrong they can handle them and they can carry on as they were without disappearing into a black hole. So there is a sense in which you become more resilient I think. And it's that kind of feeling that I am beginning to think "I am sure this person is going to start talking about ending soon". And sure enough, you know, sometimes it is a matter of weeks, sometimes months, it comes up and then we have a discussion about when it will be the right time or how long do we need. And when that happens, it's actually the feelings around termination, are always mixed but positive, it feels like there is a good piece of work done there are lots of things we can reflect on about where the person has come from and what's changed or what feels better and so it always feels like it is a good…a satisfying experience.

Codes: certainty/expected, personal experience of termination, link between personal and professional experience, differentiate between therapist's and patient's experience, feelings, comprehension, conceptualise, patient's experience, literature, training, first experience of long term psychotherapy, confidentiality, uncertainty about duration of therapy, anxiety about unexpected termination (linked with training requirements), "constant" anxiety, difficulty, threat to premature termination, doubts about completion of therapy, completion of therapy, personal and professional experience, generalizations, reasons patients terminate, time when patients terminate, patient's initiative, internal reasons, external reasons, successful therapy, patient's achievements VS therapists' attitude, difficulty to deal with discrepancy between patient's initiation of termination and therapist's agenda, literature, professional experience, patients' and therapists' formulation/perception of what success in therapy is, right/wrong time, patient's goal, therapist's formulation, doubt, personal

experience of patient's therapy, action as a consequence of the doubt, settle through discussion, overview of professional experience, share experience with peers, "whole question of termination" [in vivo], dimensions of this phase of psychotherapy, "being with" the patient, anticipation of termination, time, patient's initiative, patient's control, patient's power, patient's resiliency, external circumstances, control over external circumstances, relationships, achievements, reasons, difficulties in the beginning of therapy, patient's goals, time, literature, personal/significant attention, dissolution, buoyancy [in vivo], patient's feelings, quick recover, coping strategies, comparison in time (between beginning and end of therapy), dealing with difficulties, continuation of coping strategies, despair, resilience [in vivo], therapist's involvement, anticipation of termination, planning termination, time, right time [in vivo], length of time, mixed [in vivo] feelings, positive [in vivo] feelings, success, content of therapy, positive changes, improvement, personal content/ gratification

Eva: So when the patient actually is indicating that they are making positive changes in their life, it comes to you this feeling that they are going to speak about ending soon and it is going to end. And it makes you feel some satisfaction about the work that has been done and how the person has improved. I wonder what other feelings are there in terms of your experience; having done all this work with this person. Because it is kind of an investment of thoughts, energy…

P1: Huge investment…You get to see someone very frequently. You think how many hours you spend in intense conversation with someone about themselves and their lives and all the things that it stirs up in you. That of course you get very…you mind what happens to this person…of course depending on…some patients stir up more personal things or issues than some others to you. Or feel closer to you in terms of their pathology if you like or their struggles and then…it can be lots of strong feelings about sadness and loss and feeling that you miss that person and all the feelings that come with major separation. Knowing that you probably...occasionally patients have written a letter to me afterwards…occasionally patients come back for the odd session/ one session or even for some more sessions...the majority of patients won't ever come back. And so there is a feeling of sadness about that.

Codes: investment [in vivo] (thoughts, feelings, effort), duration of therapy, frequency [in vivo] of sessions, personal considerations, intense conversation [in vivo], patient's internal and external experiences, therapist's feelings towards termination, personal worry, thinking of patient after termination, feeling close to the therapist [in vivo], patient's psychopathology and struggles [in vivo], influence on therapist, differentiation amongst patients, strong feelings: sadness, loss, miss the person [in vivo], major separation [in vivo], contact after termination, sadness [in vivo]

Eva: So it is like a separation and the feelings that can provoke, and you just told me that some patients may send letters afterwards or you may see somebody. I was wondering, do you keep contact with them afterwards? Do you try to have another meeting and another session after the ending or…?

P1: No I don't, I work towards the end. But patients sometimes ask if it would be alright if they wrote or if something happened if they could come back. And they often seem very pleased when I say "yes that would be fine". But in reality it is

surprising how many of them don't because I think knowing that they could means they don't have to.

Codes: patient's initiative for contact after termination, therapist's consent, more therapy after termination, patient's choice, knowing that they can VS actually doing it

Eva: How do you experience that, how would you describe that in terms of your experience; of the fact that they ask whether they could contact and then they don't.

P1: Well of course I think it is a perfectly human, natural …People are usually anxious about ending and I think during that period when you talk about ending, each break you have, there is a feeling this is maybe what it will be like, the patient is feeling it will be like this forever, I won't come back again. I mean, I say to people, of course I would always be interested to hear and "if you wanted to make contact with me I would be happy to hear from you". Hm, so it seems an entirely natural human desire actually and it seems, it is a very bizarre kind of relationship that you share all this with somebody in this very intimate way and possibly the therapist knows you more than anyone else with these very intimate details of your life and you are never going to see them again. But from my own experience in a sense whatever you have experienced with that person really stays inside you so, you know, although you don't see the person any more there is a strong sense of that person's presence and you have been very strongly influenced and affected by that person.

Codes: human/natural [in vivo], anticipated need, desire [in vivo], generalisation, anxiety [in vivo] as a consequence of termination, ending [in vivo], breaks [in vivo] of therapy, rehearsal of feelings of termination, "humanise" therapist's feelings, finality, foreverness, therapist disappears from patient's life, contact after termination, encouragement by therapist for contact after termination, anticipated need, bizarre relationship [in vivo] (therapeutic relationship), content of sessions, intimacy [in vivo], closeness, compare therapist with others in patient's life, therapist knows the patient [in vivo], finality after termination, no meetings after termination, personal experience of therapist, compare with patient's experience, assumptions about patient's experience, internalisation, therapist stays in patient's mind [in vivo], therapist's influence and affect on patient [in vivo], changes, therapy progress, therapist's presence

Eva: By the analyst you mean, the patient is going away with a strong picture of…

P1: Yeah, but of course the patients stay in my mind too. I mentioned this particular patient who went to *(country of origin)*, because it was a very intense experience partly because she was a training patient and I really, really thought so much about her and wrote my paper about her. And she was a delightfully enchanting person, a very complex person and perhaps being *(origin)* she was very - and this is a cultural stereotype - but she always spoke about how *(origin)* are more open than British people. But she expressed her feelings very strongly so the whole experience was very intense and very, it was a very strong feeling of loss when she left because I knew she was going back to *(country of origin)*. She did actually write to me a couple of times and sent pictures of her baby but I knew that it really would be an end. Most endings are, but it was a very final kind of end.

Eva: It was a kind of "foreverness" in that ending, wasn't it?

P1: Yeah, definitely. And knowing, and I knew she wanted to have another baby, I would never know…Oddly enough, I met the person who referred her to me who is actually an analyst and also *(same origin as patient)* and said that she met her recently and she was doing really well, and it was nice, it is always nice to hear about people and how they are managing, but a lot of time you don't.

Codes: patient's presence in therapist's mind, training period, training patient [in vivo], trainee therapist, investment [literature], personal admiration, patient's personality, patient's psychopathology, patient's engagement, culture [in vivo], openness [in vivo] of patient, strong expression of feelings of the patient [in vivo], strong feeling of loss [in vivo], awareness of finality, contact after termination, generalisation of ending situations, special ending, awareness of patient's aspirations for the future, therapist's wish to know their fulfilment, success or not, positive connotation to hearing about the patient, to learn about patient's life after termination, reality of not knowing

Eva: I am just wondering how you feel that your own experience and your personal history has actually influenced, if it has influenced, the termination phase with your patients.

P1: Of course it has influenced. Everything about my history influences the way I work and the way I am with my patients. It is difficult to separate out how it has affected me. Obviously I am aware of my own feelings but I am trying not to act them out. I would rather think about what I am feeling and it is the difficulty of trying to get the balance of being spontaneously involved and engaged and at the same time not just popping my thoughts and feelings on somebody. I mean from my own experience I suppose, my mother died in a car accident when I was 19 suddenly, I never saw her again and the whole question about termination in my own life in general it has been hugely coloured by that. And sadly my first, I had an experience of therapy, it was my first one, before I trained – when I trained as a therapist I saw someone for 10 years - it was important to me to have a good experience of ending, and I have been in contact with her since, the person stayed alive long enough to finish, I have been in contact with her since, it is because of the profession, I used to bump into her the whole time and wrote the odd letter, we are also kind of colleagues. It is different with patients, they will not bump into you like that. I suppose separation is always, so many patients over the years, a hundred GP practices I have worked in. In fact I saw somebody in a GP practice, I think I saw them for about 20 times, which was longer than I would normally have done, but he formed this intense transference to me immediately and at the end of that time, I did refer him to someone else, about 4 years later he rang me up, he kept hold of my number, and he came to see me in my private practice. And it continued to be a very intense engagement that he had with me, he had a very deprived experience with very little parental, real parental emotional contact, they were just busy surviving. Actually ending with him was a very satisfying experience, but it was something important that he kept me in mind, he felt it was important to come back, there was something about, other things happened, his father died in the meantime, he tried to know his father, there was a whole issue of termination and loss and separation that he was working through. But there was something important happening between him and I which he wanted to continue.

Codes: personal experience, influence, professional practice, being with patients, personal history, awareness of own feelings and thoughts during sessions, act feelings out [in vivo], express feelings, disclosure, personal consideration of feelings, countertransference, be genuine/involved/engaged [in vivo], express personal thoughts and feelings [in vivo], disclosure, personal history of loss, unexpected and final loss (death) in personal history, influence on terminations of life, experiences of termination of personal therapy, significance, personal need, contact after termination, different relationship with therapist after termination, unplanned meetings, nature of external circumstances, not meeting patients after therapy, professional experience, frequency and amount of terminations in practice, short-term therapy, intense transference [in vivo], intense engagement [in vivo], continuation of therapy in another setting, patient's personal history, patient's experience with own parents, little parental emotional contact [in vivo], significance in the therapeutic relationship, therapist stays in patient's mind [in vivo], patient's experience of parental loss/ death, patient's difficulties with termination/ loss/ separation [in vivo], significance relationship/ between patient and therapist [in vivo], patient's initiative to continue therapy, therapist's experience of satisfying ending [in vivo]

Eva: So how did that make you feel? How did you experience that; an ending that seemed like forever, and then the patient came back and then there was an ending again.

P1: In that case it felt good actually, it felt right, the patient wanted to know specifically if he could come back, and that was a few months ago. Patients sometimes ask me if they can make a specific time to come back. I always say if you want to come back I am sure we can find a time. He particularly stays in mind - there are some patients who do - because they use me in a particular meaningful and intense, what felt like a special kind of way. So the ending, I think, I have worked with so many patients over the years that you kind of get used to it, the patients stay in your mind anyway, it's like there are all kinds of things that can remind you of a patient, it could be just walking in the street, or a piece of music they like, something one patient said that reminded you of what another patient had said. So it's like, although I don't see them again, they are kind of in my mind. If that's possible, besides the fact that I have seen hundreds. I used to work in a GP practice, and a patient saw me in the street, and she talked to me, it was obviously someone I hadn't seen for very long, she obviously kept me very strongly in the her mind, she recognised me, she wanted to come over and see me and I felt bad I hadn't remembered who she was. But certainly anyone I have worked with for any length of time, there's no question about it…I worked with a patient for 6 months, she resolved whatever she had come for, and she called me about 4 months ago and she said "Hi *(therapist's name)* it's me" and she thought I knew who "me" was. But I recognised her, I recognised her voice. But I thought it was very interesting that she kept me in her mind so strongly that she could just ring me up and say "it's me" but in the knowledge that I would understand who me was.

Codes: patient's initiative for contact after termination, follow-up session, therapist's encouragement, patients stay in therapist's mind, how patients "use" the therapist [in vivo], meaningful and intense way of use [in vivo], amount of terminations in professional experience, familiarity with termination, reminders of patients in

external circumstances, walking in the street/ piece of music/ what other patients say [in vivo], short term therapy, duration of therapy, patient stays in therapist mind/ therapist remembers them [in vivo], contact after termination, recognise patient's voice [in vivo], patient's expectation for therapist to remember them, therapist stays in patient's mind

Eva: And you recognised her voice…

P1: Absolutely… People's voices, I suppose people use them, particularly when you use the couch, it's what you are listening, and when hearing on the phone, it immediately comes to mind.

Codes: patient's voice [in vivo], therapists use the voice [in vivo], use of the couch [in vivo], sense of hearing/ listening, communication over the phone [in vivo], recollection/ memory of voices, coming to mind [in vivo]

Eva: So coming back to what you said, about short and long term, you did say that long term patients tend to stay more in your mind and short term work does not influence that much. How would you differentiate your experience in these two different contexts – long term and short term endings?

P1: I suppose even with people who just some for a short while, some people really, really stay in your mind partly because of the way they are so ready to use me and they came every time and particularly in a doctor's practice, where people don't always come, and there are patients who really got so much out of it, and others who are kind of angry or difficult also stay in mind. The ones you feel you can be useful, that you have something important to offer, even the ones you see for a short period, sometimes that can be a very satisfying and a very, a kind of sad experience when they go. I suppose the people I see on the long term, I have a patient at the moment whom I've been seeing for about 12 years, she is the longest, and then people I see very frequently, 3 or 4 times a week, then of course they feel very much part of my…they are very much there and because they've been through or we've been through together some very primitive experiences if you like and you know quite a lot of projections are going on, projective identifications, so it will feel like they've been through the mill with me and they have probably hated me at some point or another and they have been intensely engaged, then it does feel like it is very different kind of experience of ending than someone you have seen for a short period.

Codes: short term patients staying in therapist's mind [in vivo], patient's readiness to use the therapist [in vivo], patient's commitment and punctuality, GP practices – patients missing sessions, patient's benefit and improvement, therapist's anger and difficulty to keep patients in mind [in vivo], therapist feeling useful [in vivo], therapist's ability to help and offer [in vivo], therapist's satisfying experience [in vivo], success of therapy, sadness for termination [in vivo], long term therapy, frequency of sessions per week, patient's physical and mental presence, therapeutic relationship, primitive experience/ defence mechanisms/ transference/ regression/ projection/ projective identification [in vivo – literature], together [in vivo], patient's intense emotions towards therapist, patient hating the therapist [in vivo], intense engagement [in vivo], different termination experience for short and long term

Eva: When you said that it depends on how patients "use you" as a therapist, would you like to elaborate a bit more on that?

P1: It is impossible to know really, you can't know 100% what someone's experience of you is. Because I have a patient at the moment who I think, she always talks about how much she gets out of therapy and how different she feels after, lots of very positive things have happened but I find it very difficult to get through the sessions, I constantly get through them but I find myself…it's very hard to think and I always try to think what it is about and obviously, I always try to understand what is the feeling that doesn't get expressed. I think she is a very shy person that finds it very difficult to… it takes a lot time to trust somebody. It's quite interesting, she is extremely competent and ambitious, but I always try to understand what is this primitive level she finds so difficult…. and she always engages herself in abusive relationships. On the surface with me she is terribly polite and friendly and she finds it very difficult to be angry with me. And I can think of another patient who is quite an obsessive patient and she had to tell me all the details, about the bus journey, and everything had to be described in the most immense detail. It was very difficult to interrupt ….. and she had to learn about her feelings and how to express them. And so what I try to say about these people, how people use me is about how we can engage in an emotional experience and maybe I am using those two examples of people who found it difficult to engage emotionally with me because their defences were such that they find it very difficult to trust someone and the obsessive lady, was sort of using, so taken up with the obsessive thoughts that it was difficult to be spontaneous with her feelings. Of course she was very anxious and I think obsessive disorders are the hardest ones to get underneath emotionally, all defences are there for a reason but they seem so rigid. But some people, I have a patient at the moment, who again had a very traumatic childhood with an alcoholic mother, was beaten up and she was very scared as a child, she had a father at least who was very much around, she is an immensely engaging person, she was so unlike the lady who was obsessive. She is bright and it is interesting why people form the defences they do because on the surface she is very open and lots of people love her and she has many friends and relationships with men, she is very, very,…. There is something about how engaging she is and she can deal with all kinds of things in her life, she seems to be able to get people on her side and yet she is also very manic and terrified and the mania is covering up those terrors. And sometimes it feels she seems to know how to use me, very easily and get a lot out of the experience, because she is very open despite the terror.

Codes: patient's use of therapist, professional experience, differentiation between manifest and latent content of patient's presenting issues, patient's personality, when patient is shy [in vivo], patient's difficulty to trust people [in vivo], patient's way of interacting in relationships in their lives, primitive level [in vivo], obsessive patient [in vivo], patient's difficulty to express emotions towards therapist, emotional engagement [in vivo], spontaneous with expression of feelings [in vivo], patient's anxiety [in vivo], patient's personal history, patient's personality, open patients [in vivo], love in other personal relationships [in vivo], how patient is outside therapy sessions, patient's defences [in vivo], patient's terror [in vivo] but ability to express and be open [in vivo], patient's achievements, use of therapy, get a lot out of the experience [in vivo]

Eva: So the presenting issues or non-apparent issues of the patients actually influence how you will experience the termination with them.

P1: I suppose it is the personality isn't it? I mean I had another lady that ended recently and she was the hardest patient I ever had because she never talked. She sat in the chair and would look at me. She would not initiate any conversation. I think she was very traumatised young woman and to begin with, but in the early sessions, it was really hard knowing how we could work together because she could not, she would not engage. She was terrified; she didn't know how to communicate. I learnt to just, she would have the odd expression. We learnt to find some way of getting through the sessions together. I would just sit here and sometimes I would say something and she would say that what I say is rubbish and I was wrong and it was not what she had said last week. She was terribly negative, she hated her mother. I think she had very good reason why the whole experience of trying to communicate with me was, not impossible, we managed in the end. But it got easier because I got less worried about it and got used to this is how it is and also a little bit of feedback from her from time to time and whatever it was we were doing together was useful. I am not sure why, but she had an eating problem which was better in the end, I don't know why. That termination happened because *(patient's external financial circumstances)* and she managed to get herself into a group. And then when she would raise money she would reconsider to come back. In some ways her ending was a relief because it was the most extraordinary piece of work. It was nothing like I've ever experienced, I had silent patients before, but I suppose what was not said was so intense. She was so hateful in a way and so critical and she did her best to make me feel like a lot of rubbish but nevertheless, she kept coming on time and she was saying when she was not here it was a relief but secretly she was getting something out of it. And I think something did shift in terms of what she felt. But I mean it was the most intriguing experience although extremely difficult. So finishing with her, it was a kind of relief because it was so hard to know what to say to make a connection with her. Because she got better, but initially she would not respond, she would make me feel everything I said was complete rubbish. Occasionally she would give me a little sign that I got through to her and helped me carry on. She was obviously very unwell, she told me she had seen a couple of people as a teenager and she said they were complete rubbish so it was very hard to find any kind of way to connect with her.

Codes: patient's personality, particular patient, hard patient [in vivo], lack of verbal communication, silence (interaction), the patient didn't initiate termination, patient's personal history, therapist's formulation, traumatised patient [in vivo], beginning of therapy, difficulty to work together [in vivo], patient's lack of ability or will, patient's responsibility, patient's inability to communicate, therapist's learning [in vivo], interaction, both sides' learning [in vivo], get through the sessions together [in vivo], therapist's approach, therapist's interventions, patient's response, therapist's feeling incompetent, rubbish [in vivo], negative patient [in vivo], patient's feelings towards parent, hate towards mother [in vivo], transference, patient's personal history of loss through death, therapist's understanding and empathy, later stage of therapy, time, therapist less anxious, patient's feedback [in vivo], improvement, patient's symptoms, eating disorders [in vivo], external reasons for termination/ financial reasons, therapy in another setting after termination, consideration for more therapy with same therapist, therapist's experience of termination, relief [in vivo], extraordinary piece of work [in vivo], no previous experience, intense silence [in vivo], patient's

intense feelings, patient's hatred [in vivo], patient's criticism [in vivo], therapist feeling incompetent, patient's commitment, patient's relief when not in sessions [in vivo], secret benefit [in vivo], intriguing experience [in vivo], extremely difficult [in vivo], hard - lack of connection [in vivo], improvement in a later stage, lack of response in the beginning [in vivo], occasional responses [in vivo], previous therapy experiences of patient, same feeling towards previous therapists, therapeutic relationship

Eva: So it is this connection then, as you said before, or the importance of the personalities to match. And when this is not happening it sounds like termination has less of separation feelings and more of a thought process and some kind of relief there.

P1: It is rare to feel relief actually. I saw a patient who was quite obsessive, extremely ill actually and he would, sometimes he couldn't get through the door because he had so many obsessive thoughts. And sometimes in the middle of the session he would be bombarded with these awful obsessive thoughts. And it was very hard to feel that you could somehow get behind this huge defence mechanism. Would I say it was relief when he ended? I don't know, I am always fond of people, and even this young girl who was so difficult. I should wonder what happened to her and how her life is.

Codes: frequency of experience of relief, rare [in vivo], obsessive patients [in vivo], obsessive thoughts in therapy sessions, relief at termination [in vivo], personal admiration for patients, being fond of patients [in vivo], difficult patients [in vivo], curiosity/ interest/ wonder [in vivo] what happens in patient's life after termination

Eva: So you are thinking about what happens to them after termination.

P1: Another patient whom I saw twice weekly for about four years and she was doing a *(area of training)* training and recently sent me Christmas cards. I can't remember how many years ago it was when she ended, the reason she did this was because she started a *(second area of training)* training and obviously the reason she had therapy again which stirred up memories of her therapy with me. But she sent me all this information about her, what happened, her children, she had *(number of children)* children, and she had a lot of difficulties around separation herself…it was nice to hear from her and she was still with her husband. She seemed to be passing through the milestones of her life.

Codes: specific patients, contact after termination, time since termination, patient's external circumstances/ professional/ personal life, patient sharing information in contact after termination about life, difficulties of patient with separation [in vivo], nice to hear from her [in vivo]

Eva: You wonder what has happened to your patients, you would like to know what happened to them. What happens when you do not hear about them; when the termination is final?

P1: I saw another patient for about seven years who would have really, this was a man, who I met twice weekly and once weekly, and he amazed me because he had the most horrific experience in his childhood, but it was horrific, and how he managed to

extricate himself from that situation, he was intelligent and he went off to university. And again, how somebody would sustain, it was amazing how he would have that horrific experience and at the same time function very well, his main aim was to get away from home. And he came in his *(patient's age)* and he amazed me because he had such a hectic life, he was very ambitious, and so he would come in the mids of this very crazy working life he had, to be able to sit with me for 50 minutes and share these horrific experiences with me and then to be able to go back o this very demanding working life he had. He would be an example of someone who I felt sad about leaving because there was an area of his life he hadn't resolved, there were many issues he was feeling better, but there were issues in his marriage. Particularly, the details were so awful, I felt sad knowing this area of his life was still problematic for him. And I remember having many conversations with my supervisor about maybe sometimes the things that happened to people were so damaging they are not able to get over them and lead a really full life. And I remember him saying when he left that he knew, he actually wrote down some of these stories, events, and he said it was as if he could leave that very damaged child safely with me and he would be able to move on. So I think of him saying that and recently, and I don't know why I did this, I looked up his name on the internet, and I must have stopped seeing him years now, I don't remember how many, and for some reason, curiosity, and I discovered he was doing this particular job which really pleased me and interested me, he was doing this job that he wanted and it was really meaningful to him, kind of healing, reparation for the things that had happened to him. What happened in his personal life with his wife, I will never know and he is somebody, it doesn't surprise me that he never contacted me because he wanted to leave that damaged child with me. Whether, when he said that, obviously he has to carry that damaged boy still with him but what he is doing with that part of him, obviously he is becoming very busy and effective. Another patient, a training patient, he was alone and he had taken a massive overdose at some point and I don't know how he survived. When he stopped seeing me, he was married and he had *(number of children)* children and he was still working. And I don't know what happened, it was a miracle, and again he was somebody like the other patient, he hardly ever spoke about himself, he was a very withdrawn man. And it was as if he could come to life in the presence of someone else. He was coming three times a week and towards the end he came once weekly. And I kind of knew I wouldn't hear from him when he ended because he was this kind of man who would have, quite a cut-off kind of person. I wonder what has happened to him, whether he sustained his marriage because he had problems with the business he was running, whether he would manage to get a different job. And again, because he was a training patient, I would spend lots of time, each session, I would write up every session. And particularly for people like that it would be nice to know but I will never know.

Codes: specific male patient, frequency of sessions per week, personal admiration, patient's coping mechanisms, patient's resilience, patient's personal history, patient's release from childhood situation (extricate [in vivo]), patient's aim in life, admiration for patient's achievements, patient's commitment to therapy, patient's resilience, patient being open in therapy, patient's use of sessions, sadness for termination [in vivo], therapist's feelings, patient leaving with unresolved issues [in vivo], patient's issues in personal relationships, use of supervision, enhance understanding about patient's presenting issues, recollection of last session, patient leaving the "issues" with the therapist, patient staying with therapist, therapist's curiosity, patient's personal and professional life, time since termination, therapist's pleasure for

patient's achievements, therapist's interest, wish to know what happened after termination, patient leaving therapy behind, expectation about contact after termination, training patient, patient's difficulties, patient's isolation and withdrawal, patient's history of suicide attempt, patient's changes during therapy, patient's improvement, miracle [in vivo], frequency of sessions, fewer sessions towards the termination, how patient felt in therapist's presence [in vivo], therapeutic encounter, expectation for no contact after therapy, wonder what happened [in vivo], patient's professional and personal life, investment of thoughts/ energy/ writing for training [in vivo], people like that [in vivo], nice to know [in vivo], finality

Eva: It is then mixed as you said in the beginning; satisfaction when they improve and at the same time it can be relief and sadness basically in cases where there are more things they could work on. I am wondering how you cope with these feelings. You have talked about supervision.

P1: Supervision group, colleagues, peer supervision with a colleague we got together after we qualified. And that was very kind of personal, intimate group. Then for all sorts of complicated reasons this group came to an end. But this one colleague came with me in the other group now I am part of. When I have something in my mind I have a group of colleagues, a colleague who works here, she and I talk about things quite a bit. Peer supervision and one or two really close colleagues and I also have been involved in another analysis. Sometimes, it just has to wander around inside me. What does one do with these feelings? In a sense you do get used to it. I had another patient, whom I saw three times per week, which was very intense. Partly because he was a man who had been, he used to describe his internal life as a barren landscape. He had been an extreme alcoholic for years, it was a miracle a, he survived and b, when he came to see me he was dry and behind that alcoholic there was a very damaged emotionally cut-off man and on the surface he was very charming. When we got those very kind of deserted places of deserted memories of being all alone and soothe himself and take care of himself. That was a very painful experience, it was painful when he ended actually, he did write to me a nice letter. I knew from someone else that he had survived his father's death. So it's always nice to hear little snipetts. I used to be a social worker. I worked on the long and short term. And I had a number of long term clients, and there one in particular, a young boy, tragic family life, I wrote a court letter for him and he was sent to some juvenile offenders place. He used to work in the grocery store and I often drive pass it, years ago, 30 years ago I used to work with his young man, and I still wonder what happened to him and if I am going to see him in this store. And I had another family, I worked with for a long time, and their baby died in a tragic way, it was a cot death, and I drive past their flat sometimes …. I used to do home visits and I am thinking of the mother. I think about these people from all my working life and I wonder what's happened to them. It is as if as a whole, I suppose it happens when you meet people and you lose contact with but it is not the same socially because on the whole you find your friends, even if you haven't met them for years, and you meet them again and you have this kind of good conversation. But with patients, probably, you never will. So it is as if there are all these people in your mind, but that's why our work is so satisfying really. But it is bizarre, it is the only kind of relationship where you can have this intense connection and then you know it is going to come to an end.

Codes: deal with feelings of termination, supervision group, colleagues, peer supervision, personal and intimate group [in vivo], colleague that works in the same place, one or two trusted colleagues [in vivo], therapist's personal therapy, feelings wonder around inside the therapist [in vivo], not sharing the feelings, specific male patient, frequency of sessions, patient's presenting issues, alcoholism [in vivo], miracle [in vivo], patient's recovery, latent/ internal experience, damaged [in vivo], overt behaviour, deserted places [in vivo]-depth of therapy, patient's personal history, patient's painful experience, therapist's painful experience of termination [in vivo], contact after termination, learn about the patient from a third source, nice to hear [in vivo], occupation before training, long and short term, long term clients, specific client, tragic [in vivo] family history [in vivo], external reminders, drive pass the place of work [in vivo], time since termination, wonder [in vivo], tragic death in a family [in vivo], drives pass their house [in vivo], special consideration for mother [in vivo], possibility of meeting, patients staying in mind, all working life [in vivo], wonder what happened after termination [in vivo], comparison with social life, possible to meet again [in vivo], never meet patients again [in vivo], satisfying work [in vivo], patients stay in mind [in vivo], bizarre relationship [in vivo], intense connection [in vivo], awareness of termination

Eva: And then an ending comes which, as you say, it is different to social circumstances where you know you can go and contact people or search for people and talk to them. It is an ending where…

P1: And if you ever were to meet them again it will be because they sought you out. I have another patient whom I have seen for years and we are at the stage where I think probably she does need to end but she finds it is very hard for her to end. She was very anorexic when I first met her. She had been abused. We have talked many times about how do we know it's time to end and how she should end. And she has done remarkably well but I think on my part there is always that feeling that, actually I was thinking, she is actually *(patient's age)*, she always looked much younger, she was always very small because she was anorexic. And we have talked about whether or not she should live with that man and whether she would have children. And I was thinking, she is *(patient's age)* and if she is going to do it she is going to have to get on with this. And there is this part of me that would like to see her having made the next move into being able to live with this guy. I would really like to feel that she would have settled down with her life with this man. I probably think we could end but it is my desire to do it when she would be settled but it will probably happen before I know that. And maybe life won't be perfect for her. But she is resilient. I mean little things, like seeing someone from her family. But she knows how to protect herself, she doesn't get as ill as she used to. She is quite fragile. Maybe she won't have that good life we both want for her. She is someone I sometimes think "well, we are going to have to bite the bullet", and what is it, she doesn't really know when the time is to end. And I don't have the heart to say, I don't think I want to say "I think we can end". I kind of wait for her to say "I think it will be alright". I have said to her "you could always come back if you wanted to see me at some point". But I think it is that separation. And I don't know why, this is someone I started seeing in a GP practice many years ago, and we did various periods of short term work, she went off travelling, and then she came back to me and said, started talking to me about this abuse experience she had never talked about before and set her off in the spin of falling apart. And she said to me she didn't think she could bear to see someone else

and asked me if she could see me privately, it is a difficult transition, some people say it should never been done. But it has worked. Somehow, she got under my skin because, I knew she would be a difficult patient to work with and she was, and I knew what I was taking on. And somehow she refused to go to somewhere else. And I thought, "OK, I know enough about you, I can bear it". And there was this absolute desire to hang on to me for the first time probably in her life. And that's probably why it is so hard to end because she got under my skin. So, it's often, we have talked about ending but we haven't done it yet. The other question that comes up is whether it's good to….. I know some people work like this, to tail off, you know, so if you are meeting three times, to meet twice, then once, then once a fortnight, then once a month. Personally, I don't work like that because there is something about the quality and the intimacy of the work. If you tail it off like that you don't really have an ending, a proper ending. It kind of just dribbles off and it becomes much more superficial. They just tell you what they have done over the last month. And it feels like it has become something else so I don't work like that. But I do supervise someone who has done that. He had a patient for 16 years, and I think it did make enormous changes, she found it very hard to end and he did tail off with her, even now, the reason he told me he, that even now once a year, she contacts him.

Codes: patient's initiative for meeting after termination, example of female patient, long term therapy, patient's difficulty to initiate termination, therapist's thoughts about termination, discussion on termination, time of termination, strategy of termination, patient's presenting issues in the beginning of therapy (anorexia), patient's history of suicide attempt and admission to hospital [in vivo], difficult patient, patient's improvement, patient's external situation, therapist's desire for patient to move on [in vivo], move on=settle down, cohabiting, children [in vivo], therapist's wish to witness it, therapist's wish to know what happens after termination, therapist's worry, patient's resilience [in vivo], patient's coping, therapeutic change, therapist's emotional difficulty to initiate termination, therapist's belief about termination, therapist's reassurance for contact after termination, breaks in therapy process, got under my skin [in vivo], attachment, separation [in vivo], separation anxiety, therapist's decision to work with difficult patient, satisfying work, technique of termination stage – tail off, reduction of the frequency of sessions per week, quality of therapy [in vivo], intimacy of therapy [in vivo], no ending [in vivo], no proper ending [in vivo], superficial therapy [in vivo], content of sessions, external life, transformation of sessions (or of depth of sessions), long term therapy, changes during therapy, regular contact after termination

Eva: So what is actually a proper ending for you? You mentioned tailing of the sessions and how this does not provide a proper ending. I was wondering what is a proper ending then for you?

P1: A proper ending is an ending that you have talked about and thought about and planned and had some time and…during which, there is a kind of real feeling of reviewing and saying goodbye I think. This sort of going through and over of what has happened. And it is a planned ending obviously, so that it gives both of us an opportunity to work through some kind of whatever the whole range of feelings are anticipated. Obviously a lot is going on through the ending. It is often said that a lot of psychoanalytic work happens after the work has ended. You know, if the work has been good enough then you carry on working on it inside yourself and all sorts of

things happen afterwards. I was talking to a colleague about this, not long ago, a year, she ended a 10 year-analysis she was going 5 times a week and she was saying that she felt a tremendous feeling of freedom inside herself, it's an internal sense of freedom. But she wouldn't remember at the time she was ending because there were so many sad and mixed and complex feelings about the ending itself and loss. So, certainly as a patient, there is a tremendous sense of loss. It takes ages to kind of work it through. But she is now saying. Well actually, she has that sense of freedom inside her. This is what we all aim for in a good piece of work. A lot of people who come to me might benefit from intense work but they won't do it either because they don't have enough money, money is a huge factor and it is a real world and they have to go and live... So you do what you can, and I might want to work more intensely with someone but I may not be, I might feel it would be useful but it might not be what they are up for.

Codes: proper ending [in vivo], discussion about ending, thought about ending [in vivo], review of therapy process [in vivo], saying goodbye [in vivo], planned ending [in vivo], time to work through the feelings on termination [in vivo], work after the termination, continuation of work after sessions [in vivo], internalisation of therapy, discussion with colleague, therapist's personal termination, freedom, feelings at the time of termination (sad, mixed, complex [in vivo]), feelings after termination (freedom [in vivo]), loss [in vivo], aim of therapy [in vivo], patient's benefit [in vivo], intense work [in vivo], financial/ external reasons [for not engaging], real world [in vivo], therapist's assumption, therapist's choice to work intensely [in vivo], therapist's feeling of whether it will be useful [in vivo], patient's readiness

Eva: So it is quite a mixed process with many things in it; the therapist's personal history, the latent content of the sessions. One of my last questions is about self-disclosure. How much of your experience of termination would you disclose to the patients?

P1: I think there is something about the patient knowing that they have had an impact on you. I mean, hopefully they know that anyway, even if you don't say it as such, they would feel it and it's part of what has been stressed in that kind of engagement. It depends on what level, I saw a lovely young woman who came originally because her partner was diagnosed with cancer and he was only *(partner's age)*, and it was very traumatic, and then she left and they got married and he would have treatment and they would hope he would get better. 6 months later she would come back to tell me he died. So she came back, for about 6 months, and we did, she knew how to really, really kind of use me really well. I didn't see her for very long and she came with a very specific issue, she was very competent in lots of ways, I am sure I would probably say to someone like that the work important for me too. It would be something very simple, like "of course this would have an impact on me". So I suppose, I am trying to think what words I might say, an acknowledgement that the missing would be on both sides. I remember talking to my current analyst about ending, and he said something which was immensely, which quite surprised me because he is a psychoanalyst and he doesn't self-disclose at all. But he did say something like "well, I will always be pleased to hear from you in the future" and I thought that was such a nice thing to say, probably I will or I won't, I am still seeing him, probably I would, maybe a bit. But it was such a human thing to say because otherwise it seems such a weird thing really to be so intensely involved with someone

and then bang it is alive and yet, unlike anyone else in your life you can't continue contact with them or you can't have that kind of different contact with them. And of course, occasionally patients bring you presents; they brought me a big bunch of flowers. Occasionally people bring you presents or they want to give you a hug at the end or shake my hand. Which is terribly British, I think in other cultures, I think in some cultures people shake hands in the beginning and in the end of the sessions, which is a bit some kind of taboo in psychoanalysis, a different boundary in the end, which I would respond to. I think if someone wanted to give me a hug and I drew back it would be really hurtful. I supervised someone, ho had a very intense and I think probably good analysis, and I don't know what happened in the last session because she didn't give me the details but whatever it was, it was very upsetting. Whenever she made reference to this ending she would cry so whatever it was, I think she must have felt horribly hurt or crushed in some way in this last meeting and she says "I really felt like going back and just have another conversation". It just seems to me a bit of humanity to. I couldn't give you a rule, you know, I'd say this or the other, it would very spontaneous really, in response to how the person was dealing with it. I had another man who I saw for 2 ½ years who was very kind of matter-of-fact, this is a man who in the end he brought himself up, he didn't know his father and his mother was very busy trying to survive, and he has been a huge survivor. And he came because he was married with children but he was obsessed with *(patient's symptom)*. And that reduced considerably and he was in control of it. I would have liked it to completely go away but that's not real life. Maybe in reality there will always be a little of return to it and struggling, a bit like bulimia, you can feel fine and then something happens and you go back to it. Anyway, he felt he was much in control of it, but the way he left was so interesting because this is a man who made enormous use of me but he was very afraid of being needy and vulnerable. And the way he left was so matter-of-fact. He was a big *(patient's place of work)* and he was, "OK, right, thank you very much, and off he goes! Whereas, there was this other man who ended at the same time, it was so different, it was so kind of emotional and with tears, and he was much more available emotionally, to know what the experience of parting was for him. Whereas, the one I just mentioned, he could have done a lot more work really but I think he had done enough for what he wanted at the time. He may come back or see someone else. But it was such an interesting experience, after he left I thought, this is not surprising really. I didn't expect it to be so extreme, he was so business-like and he treated it as if it had been an interesting business meeting. Because he wanted this space to be a kind of rational exploration of what the issues were, it was so hard to get him. Actually, unlike the obsessive woman who would go into details the whole time, he was very engaged but he wouldn't want to know too much about what it meant to come and see me.

Codes: patient's awareness of influence on therapist, impact on therapist [in vivo], awareness without therapist's disclosure, feeling [in vivo], therapeutic encounter, specific female patient, use of therapist [in vivo], short term, specific presenting issues (loss of partner through death), patient's resilience/ competence [in vivo], important work for therapist [in vivo], patient's impact on therapist [in vivo], therapist missing the patient [in vivo], acknowledgement to the patient [in vivo], personal analysis, human, nice, [in vivo], therapist's attitude, personal feeling for contact after termination [pleased, in vivo], consideration for termination of personal therapy, contact after termination, weird [in vivo], bizarre relationship, intense involvement [in vivo], no contact after termination, opposite to social relationship,

possibility for future meeting, presents [in vivo], physical contact, different boundary at termination [in vivo], culture, taboo [in vivo], response, patient's initiative/ request, draw back [in vivo], hurtful [in vivo], back to therapy for conversation when hurtful ending [in vivo], human [in vivo], patient's emotions in termination, not generalised [rule, in vivo], spontaneous [in vivo], not planned response, patient's action/ interaction [dealing, in vivo], manner of termination, use of therapist [in vivo], action in last session, male patient, resilience, patient's personal history/ parental experiences/ professional life/ presenting issues, patient's control [in vivo] on symptoms, patient's agenda and goals VS therapist's agenda and goals, reduction [in vivo] of symptoms, disappearance of symptoms, real life/ reality [in vivo], patient's regression to symptoms, eating disorders/ perversions, improvement, patient's fear, needy/ vulnerable [in vivo], patient's action in the last session, emotional/ rational [in vivo], available emotionally patient [in vivo], more work could be done [in vivo], continuation of therapy in same or other setting get through the patient, patient's engagement

Eva: Well, this is all that I wanted to ask. I do not know if you would like to give me some thoughts and feedback about how it felt to talk about it today.

P1: I am worried I have been repeating things. It wasn't very coherent. It has been amusing.

Eva: I will contact you again in the future if that is OK.

P1: Yeah, sure.

Eva: Just for a matter of ethics, as you told me you have your personal therapy, but at any time if you would like a debriefing meeting I am available to discuss it through.

P1: I think it will be OK but I think it is very nice you offer that. Because as you say, I have been talking about quite a lot of patients and probably the ones I mentioned are the ones that particularly stick to mind. But still there is a long history of loss there which I can talk about. But anyway, that's a nice offer.

Eva: Thank you very much. This has been a rich interview. I will send your transcript for you to consider and then meet again to look into more specific questions.

P1: OK. How many people do you need? I have a particular colleague who is particularly interested in the topic.

After the end of the interview she recalled a case of termination through death for which she would like to talk about. I turned on the recorder and she gave an account of her experience when one of her patients had suddenly died.

I was just saying the one person I didn't talk about was a patient who died, he was in his *(patient's age)* and he died very tragically and suddenly and unexpectedly and as he was someone who worked on *(place of work)* I found out about his death through it. I had been expecting to see him on a Tuesday and I heard on Monday that he died. It was very traumatic. Again, a patient who was very unwell patient in many ways, but a man with tremendous talent and extremely funny. It was terrible because I had

to write a report and I had to ring up the ethics committee of the BAP to talk to them about what I would write. And I went to the funeral. It was a huge funeral and I sneaked in, but that was a bizarre experience and very strange to see all these people. Of course he talked to me about them, he would present himself to me as someone they didn't like, and he was a difficult man. And of course he had a lot of people who had tremendous separation for him and colleagues. But they also had some kind of a wake. I didn't go, I couldn't go. That was a very strange experience because I didn't have the chance to say goodbye. He would always say that he wouldn't make it to old age. He died in a very…it turned out it was something like *(patient's disease)*. I saw him on the Friday and he wasn't well, he said he would go to the doctor; the doctor was the last person who saw him because he died in his flat. And there was the thought whether he had killed himself but fortunately he hadn't. But that was a long time before I knew he hadn't killed himself and that was a horrible thought. I didn't really think it was, because he wasn't in that frame of mind when he left me but I knew he would live life on the edge and I didn't know if he had done something extreme. The way he was found, his private life was difficult. It was difficult, because he was a man I had tremendous kind of sympathy for, because I mean he was trying to use his hurt and loss creatively in his career and at the same time it was a very kind of manic and hyper kind of life which met some of his needs but made quite hard for him to live a normal satisfying life. He was very troubled and troubling…to end in that way. I really did grieve actually; I was quite low for quite some time. That was a few years ago now. I still hear a piece of music or I know there are particular things he liked on television that when they come I think, gosh…and I think of him.

Codes: patient who died [in vivo], sudden/ unexpected/ tragic death [in vivo], therapist's traumatic experience [in vivo], expecting to see the patient, learn for death from third party, patient's issues, patient's positive characteristics, report on patient after death, ethics [in vivo both], contact with patient's family, attendance at the funeral, therapist being unnoticed, see people the patient talked about [in vivo], patient's personal relationships, not-saying goodbye [in vivo], strange/ bizarre experience [in vivo], suspicion/ thought of suicide [in vivo], horrible [in vivo], sympathy [in vivo] for patient, admiration, grief [in vivo], low mood [in vivo], time, external reminders

MEMO
PARTICIPANT #1

After my open question, she said that what she thinks about termination is that it is a "huge question" (line 6). This may mean that the subject is "large in size and amount" (dic) , it has a **big variety of dimensions.** She wanted to indicate how broad it is. **Do others think like that? How is it huge and broad? Does she think it is immeasurable?** She then reflects on her thoughts and mentions it is "inevitable" (line 6). This may mean impossible to avoid, certain to happen, so frequently seen or heard or experienced that it is familiar and expected (dic). I am wondering if it means that it impossible to avoid or she is just familiar with it. Maybe she means that it is expected. I will have to see further in the data the meaning of it; whether it is meant to be compulsory. She goes on saying that she is aware of the expectation: "in the beginning you know there is going to be an end" (lines 6, 7): she indicates an **awareness of the expectation.** She also says "always" (line 7) which mean **all the time, on every occasion, again and again, often and repeatedly**. Or she may just point out the period of time: the period of time **in which therapy lasts.** In Strauss & Corbin they mention the "waving of red flag" where the bias of the respondent is recognized. However, in this it seems to be more of a practical reality: the **fact that the therapy/therapeutic relationship with the patient will end**. She uses "always" (line 7) again, maybe meaning that **the termination causes feelings on every occasion.** Line 7: "stirs up" meaning that it causes, provokes her into action, evokes. This unavoidable part, she is aware of, causes something.

What does it cause? She mentions "huge feelings" : again, she mentions the great variety, how large they are in size and amount (in feelings it can mean: large in intensity and how many different feelings one can have). Here, she may mean that the feelings are **intense**. She uses the word "feelings" (line 7), maybe meaning what she **feels through the mind and senses**. **What do feelings mean? Is it only sensations or does she refers to thoughts as well? To see further in data and perhaps literature for comparison (?)…**She goes on to say that this happens for "both sides" (line 8). By that she means for **the patient as well as for the therapist.**

There are experiences she would like to talk about regarding the termination of short term work as well. This stirs up questions: **how does she experience the termination of short term work, how is it different from long term, does it have to do only with the amount of phases of termination or the intensity as well?** She shares her professional experience of short term work and she defines **what she means by short term** (line 11). She then speaks about her private practice, where I assume therapy is **open ended.** This stirs up questions: **what does long and short term mean, how is it different for termination?** *This also has implications for my research question: apparently there are feelings in both long and short term psychodynamic and psychoanalytic work. Even though it was not initially included, it can't be omitted from the research enquiry if it is significant for the participant*. In this interview, it came early, as a natural association to the participant, therefore it is deemed to be important. Also (line 12), she talked about her assumptions regarding the research aim; is she trying to make it more specific? Would that help her focus more to discuss about her experience? **Does this apply to other respondents as well?**

She begins her next paragraph with "of course" (line 13): means certainty, obvious, expected (like "always", line 7). She continues in **absolute** terms: "completely": in every way possible, totally. She mentions the word "coloured" (line 13): interesting and vivid details, qualities, distinctive quality. She may mean that this is what **influences** her own experience of termination with patients. She mentions then that it is "coloured" or influenced by her own **experience of termination of her own therapy (in vivo code) (line 14)**. This raises a lot of questions: **did she have long-term personal therapy, when, how did it influence her experience of termination with patients?** I want to look for these concepts further in the data. She goes on to make the **link between the experience she had in termination with her patients with the experience of termination of her own therapy. How though?** She then mentions that "it helps" (line 15): it is useful, make it easier, assist, improve the situation. She may then present it as a strategy [note: all therapists are expected to have their own personal therapy]. She explains that the **strategy** is to "have been though that yourself" (line 15): she **links** again her personal experience of termination with her experience of terminating with patients. Again, "of course": **certainty, absolute, expected**. Questions raised: **how does the personal experience influence?** She goes on to explain that with her patients: professional experience, of termination (line 16), again with **certainty**, like again it is expected of her. In lines 16 and 17 she mentions: the experience; by this she may mean the process of gaining knowledge or skill over a period of time through seeing and doing things rather than through studying or to have experience of something, to feel something, having experience in a particular field of activity. *Experience is not used here as knowledge but as an activity, the activity to feel*. She then differentiates what belongs to her and what belongs to the patient, and that this experience "is not necessarily" hers (line 17) [note: all therapists use this kind of differentiation in therapy sessions to make sure they differentiate their own feelings from those of the patients'/ concept of countertransference?]. The important thing here is that apparently **there is an experience in the therapist**. What needs to be asked is: **what comprises this experience, what does it mean to the therapist, what kinds of feelings does she experience?** Again with **certainty** "of course" (line 17) she "draws her own experience" (line 17): she means that she draws her attention to, cause something to be noticed but she may as well use this as a strategy. Again, this is the **link** between one's personal experience of termination and the professional experience of it with patients. This raises the question: **why and how is this strategy useful?** She goes on to explain: to "imagine" (line 17): to form a mental image, to think of it as probable and possible, to conceive, to conceptualise; and "feel": to explore, to be aware of an experience of something physical or emotional, to have the impression that one is something. I think what she wants to indicate in this sentence is the **strategies she uses in order to understand better.** She then continues saying that she wants to understand "their point of view" (line 18): I think she means the patient's experience; **again she presents as strategy, as action, the link between her own experience and how she uses it to understand the patient's experience.**

Questions raised: **how has the literature, the training, influenced her experience of termination?** She mentioned that she read a lot about termination while writing her final paper for her training patient she needed to have for two years (lines 19, 20, 21): **training**, long term therapy experience, **first experience of long term psychotherapy with a patient.** She uses the word "because" (line 21): to illustrate a cause of an event, for the reason that, "they were both on some kind of visa" (line 22):

the fact that the patient had **restricted residency in the UK, there was uncertainty about how long they would be permitted to stay.** Then she mentions the notion of "confidentiality": to ensure the patient's anonymity and privacy and she mentions that she "thinks about it" (line 23): concern, worry. **The worry about confidentiality (in vivo code) reflects** the difficulties of the decision to participate in the research. She goes on to talk about "constant problem": indicating the period of time, the whole time, the time that therapy lasted, how **uncertain it was whether therapy would be concluded or not (code repeated)**. This is the issue **of external factors contributing to the completion or not of therapy. How do external factors influence the termination experience? What kind of external factors? It also reflects on the multicultural nature of therapy work.** It also reflects on the uncertainty and the anxiety of the therapists about whether or not the patient will stay. **How does this uncertainty influences the way they will experience the termination?** These factors seem to be important and need further exploration. **How much control do therapists have?** She mentions that this is a "constant problem" (line 24): negative connotation, it was a difficulty. What was this difficulty? Lines 24-27: anxiety, premature termination, doubts about continuation of therapy, doubts about completion of training requirements, there is an element of anxiety for premature termination and the completion of training – **link**. Was the unexpected and the "uncertainness" that caused this anxiety? How did this anxiety influence the termination? **Was there a "constant" (in vivo) expectation of termination?** She gave me the outcome of this anxiety: **the resolution**, what happened eventually which gave her **relief**. What was this relief about though? The patient "completed her time" (line 29): she finished her therapy. Did she really finish though? **Who defines how long is "her time"?** In this case, it was the time needed for the completion of training and to write the paper **(training requirements)**. She linked the literature with the practice, and "incorporated" (line 29) (made literature a part of her "paper", reading on termination was one of the training requirements).

To be explored: issue of control of termination – how does the uncertainty influences? How does one define when the completion comes – who defines it?

She goes on to say that she "assumes" (line 30): she thinks, she believes or assumes that something is true or takes something as a fact, or even she makes the suggestion that. Then she says: "the whole question of termination" (line 30): she moves from talking about her **personal and professional experience to a generalization**. She mentions the word "question" (line 30): meaning sentence, something that asks for more information, a matter that needs to be settled or expresses doubt or uncertainty. The "question of termination" may mean that it is an **issue not adequately researched on or something that we need more information on.** This sentence raises a lot of questions: **do therapists feel uncertain about termination, is it an issue/concept with many dimensions?** I assume it is and I will look for more data to compare it with. She says that this question "depends" (line 30): like she is sure or she is expecting that something will happen. **Again she speaks with certainty or about something expected.** She says that it relies "entirely" (line 30): meaning completely or with **certainty.** She says "why you are terminating": she speaks about the patients and about the reasons they are terminating. Then she says (line 31) "at that point": meaning at that particular time or instant. **Here she makes a link between the reasons why patients terminate and the instant/the specific time they choose to terminate. This raises questions: how does this statement affect the way she**

experiences termination, why are the reasons important, why is the time important? She goes on to explain the reasons why she is saying that and she is referring to the literature, **again she moves away from personal experience and refers to literature and "statistics"** (line 31). She is not sure ("I don't know" (line 32)) for the "proportion" (line 32): she now divides the patients in parts, part of a whole, **depending on the reasons and the time they terminate.** She then refers to the reason linked with the time (line 32): saying that it is the "right time" [in vivo code], here she mentions that the **right time is because of internal reasons, like the patients have improved, and this is the "right time"** ***[to be more explored: which is the right time, who decides, what are the reasons linked with the right time?].*** then she refers to **external reasons** for which patients terminate (lines 33, 34): is this the "wrong time" the? Does she refer to the fact that patients have to improved and the terminate for other reasons like: "money and all sorts of practical things": meaning the external reasons. And these reasons "get in the way" (line 34): are these external reasons seen as **obstacles,** like they force the termination **against the patient's will. How does the external reality affect the phase of termination?** Then she moves on with **uncertainty** ("I don't know" (line 34)) to speak about the "proportion of her patients" (lines 34, 35): she now divides her own patients to parts, she **moves from the general to her own professional experience**. She then says with uncertainty ("probably" (line35)) that the "majority of her patients" (line 35): that means the greater number of her patients, she gives emphasis to a specific incident and she **links that to the time and the reasons why patients terminate.** She also emphasizes that "would have decided to end" (line 35): **here she implies that the patients take the initiative to actually terminate.** She links that initiative of them, they came to that **conclusion**, by the fact that they "felt they have achieved enough of what they wanted" (line 36): they have the **sense/thoughts** that they have **succeeded as much as necessary**. Here she talks about the certainty the patients feel when they feel they have **improved and they come with specific goals to therapy.** She then explains that the patients have **their own goals and what they desire from therapy is specific and they take the initiative of termination.** Then she makes another **assumption** ("I suppose" (line 36)) **based on her own professional experience (even though she refers to it in a general way "therapists" (line 36))**. She then refers to "therapist's point of view" (lines 36, 37): I wonder if she actually refers to **her own attitude,** presenting it in a general way. She uses the word "always" (line 37): this is where her **bias** comes in front (red flag phenomenon). Then she characterizes that attitude as "quite tricky" (line 37): this may mean that it requires skill and good judgment, **or as something difficult to deal with**. I assume that for her she finds it difficult to deal with it.

She then mentions the literature: "I read a very interesting book" (line 37): she moves away from the specific (her experience) and goes back to generalization. Action: read the book and consequence: what came out: **by reading the book she wanted to indicate that the book suggests in a firm way ("strongly" (line39))**. I wonder here how she talks about general and objective situations to describe how she experiences a phenomenon. It may mean that she is using the literature to find out concepts that describe her experience. The consequence of her referring to the literature (action) was that "the therapist" (line 40): again she talks generally but I am wondering if she is referring to her own experience, if she using the book to characterize her own experience. "Different agenda" (line 40): meaning that the therapist and the patient have their own pre-assumptions and plans and goals, the way they define what the

problems of the patient are and how they can be dealt with (that is the therapeutic agenda, **search more in literature or search for more codes in the data.** However, regarding the "agenda" (line 40) she goes on to explain what she means (line 41) [drawing from her own experience?] that when there are "difficulties or when things go wrong" (line 41): she links what the outcome of her experience of the book (consequence) with the negative situations that *can occur* in therapy ("when" (line 41)), she refers now to the **actual process of therapy** liking it with the negative consequence. **What does it mean, when do things actually go wrong? Does she mean when the patient terminates prematurely? Or, to link with the data before, when the patient ends and it becomes "tricky" for the therapist, when the therapist's attitude is not *compatible,* does not agree with the one of the patient?** She makes the statement then to explain that she means by "wrong" is for the reason that "the patient has got something different they want to get out of it" (lines 41, 42): this means the patient's goals, aspirations, personal thoughts about how the problems can be dealt with in therapy, **what the patients think they want to "achieve" (comparison with previous data). I assume now that what she means is that the patient and the therapist have got different perception of what comprises the success of therapy, *different attitude about when therapy is successful*.** She moves on to say that the therapists have "their own theory of what is going on" (lines 42, 43): this means that the therapist forms their own conceptualization, **formulation** (in therapy terms) of the patient's problems. **What does it mean that they have different formulation? How does this affect the termination phase? Is it one of the reasons why patients terminate when therapists feel it is not the "right time"?** She explains afterwards what she means by different formulation saying that "as a therapist" (line 43): this can be a generalization or she may refer to her own experience, there is a link of the two before in the data as well. Here I assume she would like to generalize that concept. She assumes then that, or takes it as a fact ("suppose" (line 43)) "often" (line 43), where she gives a frequency in time, stating that it happens many times, in many instances, and then she **conceptualises that difference in the therapist's formulation:** when therapists "feel that more work could be done" (lines 43, 44): this may mean that they feel that the therapy has not been successful (linking it with "achievement" previous mentioned in data), or that what the patient experienced as success did not coincide with the therapist's belief ("feel" (line44)). But **she links it with time**, saying that should the patient stay for longer, then more issues could be worked through in therapy and she questions the time (line 44). **What does she mean exactly by this time dimension? How long does therapy have to last? How important is the duration?** Again here I can link it with previous data about **long and short term psychotherapy**. Then she **links** the above generalization with her own professional experience, with her own practice as a therapist. She mentions again "always"(45) indicating her **bias** but also reflecting on her own practice. She then expresses her **doubt** ("question" (45)): this may mean that she doesn't trust the patient's beliefs and perception about success of therapy, or that she believes that some issues have not been resolved (linking with previous "more work could be done"). She then brings in "her mind" (45): she now talks about her personal professional experience. She expresses her uncertainty ("not knowing whether" (45, 46)): she explains the doubt she mentioned before and she brings in the time dimension again, the "right time" (used as in vivo code) for the patient to terminate. This implies that **it is the patient who makes the decision to terminate** and that this has consequences on the therapist's beliefs, either agreement or disagreement regarding the specific time/ instant that the patients took this decision.

Then she brings in an even more specific situation, when she "strongly feels" (47), when she believes then that it is the "wrong time" for the patient to terminate, linking it with previous data, that therapy has not been successful or the patient thinks that they have achieved what the "wanted to get out of" therapy. Then she brings **action/interaction,** that she needs to "negotiate" (47): to settle this disagreement by discussion (as a therapy **strategy)** the "whole question of ending" (47, 48): here she may mean the expression of her doubts about the time of ending/ termination. She comes across as wanting to challenge the patient's decision, to change it and to bring forward her own formulation, when she believes that more time is needed or that "more work could be done"; if the patient left at that particular time then therapy would not be successful.

Codes: literature, personal professional experience, patients' and therapists' formulation/perception of what success in therapy is, right/wrong time, patient's goal, therapist's formulation, bias, doubt, personal experience of patient's therapy, action/interaction as a consequence of the doubt, settle through discussion, strategy

She goes on to say "on the whole" (48) like now she is giving a more complete picture of the situation, basing it on her experiences ("my experience of it is" (48)). So now she **links what she said in general previously with the overview of her own professional experience**. She then diverts from her own experience and she mentions the **motive**, which was to "say this to a colleague" (48), which brings the issue of peers: **what did she say to peers, how did this affect her, how often does she speak to peers, does she talk to all her peers and how she decides whom to talk to?** Then she refers the **subject** of the discussion with the peer group (line 49, 50). She mentions the "whole issue of termination" (49,50). Here it is like she is attributing to the *property of this phase of psychotherapy multiple dimensions*. I assume that she considers the subject/ point/ matter/ dispute as something that implies many questions, doubts (compared with previous data) and at the same time the implications this has on practitioners, given that she discussed it with peers. Therefore she implies that **there is an influence on the therapists.** ***What is this influence? How exactly does termination affect therapists?*** She moves on giving the narrative of her own professional experience (50) (generalising her own experience now) and she says that she "would be sitting with the patient" (50): this has many meanings, especially in the field of psychotherapy, it may mean *listening, "being with" (from literature)* and in general it implies a specific **encounter or relationship** between the therapist and the patient. In this encounter, the therapist has the role of listening and of *helping* the patient depending on *techniques and strategies.* **What does "sit with the patient" mean to her? Does she feel/ experience specific situations? How does this relate to the issue of relationship?** Then she says "for whatever length of time" (51): again she brings the concept of **time** in it, like it does not depend entirely on time or she cannot really define how much time is needed for her to experience the specific situation she is talking about. ***Therefore it is assumed here that there are many dimensions in the concept of time*.** **When does the therapist feel that therapy has been successful? When do patients feel therapy is successful?** ***My assumption is that it will be difficult to find the dimensions as strictly in time (eg, 6 months, 1 year…) but that there will be phases and incidents in these phases that will determine the action/ interaction.*** Then she says that she "would gradually be getting the feeling" (51): this is the **incident, situation**, this is the **consequence** defined by the **time dimension**, she mentions that it changes/progresses/ advances by regular or

continues degrees, **this again may imply the time needed,** and she gets this "feeling" (51), or the experience, the thought, the sense that something is happening. **How exactly is this sensation obtained gradually? What does it mean for the therapist or the patient? What exactly is happening for that sensation to be developed? How is it felt? *[note: time is a concept, having properties and dimensions, it is NOT a dimension itself]*** So what is this sensation: "this persona was going to start talking about ending soon" (52): she again places it in time (soon) and how important it is as a concept, that shortly after that sensation, she *believes (bias)* that the patient will "talk about ending" or initiate ending, start thinking about ending, start working through/towards the ending. **How does she understand that? What exactly happens that she experiences the anticipation of ending?** She gives the explanation, the reasons why ("because" (52)) "things were beginning to feel like they are consistently better" (52,53): meaning that there is a constant improvement in the patient's life. She may mean *external circumstances are improving in a coherent and continuous way* but there is a positive connotation regarding the **patient's progress**. What is it that exactly happens then? She goes on to give examples, **moving from general to more specific** (53): "the person is feeling more in charge of their life" (53, 54): the "person" apparently is the patient, who *gains more power/ control over their life, again pointing out the external circumstances*, like the patients feel more in control of these external circumstances. She goes on with explaining "feeling they can make choices" (54): meaning that they can now select from different possibilities the one that they desire, again the concept of **control, power** and a sense of **resiliency. Do patients feel more in control of their therapy as well, does this control over external circumstances is reflected on gaining control of therapy, how does this affect the therapists in terms of the termination? What happens when therapists don't agree? How about the internal world of the patient?** Does it mean that when they feel more able to control the external circumstances, they start "talking about ending" despite of the "theory" therapists have? "things were going more how they wanted" (54, 55): again this is a **positive connotation about the patient's progress during therapy**, she may mean that they "got what they wanted", they feel the sense of achievement and success in therapy. Again, she explains further by giving the reasons why they may feel this way (55) "they have got relationship that's working": the issues of **personal/ romantic relationships come first,** or she may mean a relationship with a relative or a working relationship. **To ask further in data collection about the relationships of the patients and how they affect the termination.** Then she moves on (56, 57): "things they were struggling with when they first came": she may mean the initial difficulties, again giving the concept of **time** and specifically the **first stage of therapy** and she mentions the difficulties the patients had, the goals they had set or the things they chose to work through therapy. "and now feeling more able to deal with it": she may mean that they have recovered, she may mean this resiliency and how the patients feel stronger, more in control or power (compare with previous data) or again they feel they have **achieved what they wanted "to get out of it"**.

She refers to literature again (57,58,59): "a word that stayed strongly in my mind" meaning that she read something for the paper she did on training patient, the patient where termination was always a threat, and there was one significant word/concept for her *(personal attention drawn on one concept)*, she gave **personal attention** to a book regarding the **dissolution** (implying or meaning that there is a kind of relationship concept). She spoke about a specific **idea** ("notion" (59)) of**: "buoyancy"**

(59) [in vivo code]: literately it means lightness, an object that floats, or a price tending to rise or **recovering quickly from disappointment.** She explains how she uses this code: (60, 61): she talks about **dealing with difficulties** ("when things go wrong" (61)) it is the **patient's feeling [in vivo]** and she compares it with *the initial stage of therapy (?)* saying that now (time) the patients feels a "greater strength" (60) of buoyancy, meaning that **over time the patient has developed coping strategies to deal with difficulties in the external circumstances (compare with previous data).** Then she compares it with the phrase "without disappearing in a black hole" (61,62): this is a **metaphor** and the meanings vary, she may mean that the person does not give up, they don't feel despaired or that they cannot cope. **Comparing it with previous data, this concept can be used in the *flip/flop* coding, using it as the opposite to the "much greater strength", like she uses it in the interview.** Then she explains it based on her **personal perception** ("I think" (63)) that it is the **patient's feeling** (even though she uses "a sense in which you become" (62)) but comparing it with data she means that the patient develops a specific feeling (again giving the **time dimension**, like a process that is progressing through time) that the patient "becomes resilient" (62) [in vivo code], comparing it with previous data (54, 55) it means that the "patients are more in charge of their lives", therefore coping strategies are developed for external circumstances. *Again, what does this mean for the therapist? How does it affect the termination phase? Or, to link with previous data, does this mean that the therapist agrees it is the "right time"? Why is this the right time for the patient? Since they feel more control of their lives, do they feel more control of therapy? But therapy and termination is in their control, they initiate the termination.* When this action is taking place (when there is the "feeling" (63)) [action] then she has the perception ("beginning to think" (63)), *referring to her personal experience*, that the patient will initiate the *discussion about ending, she anticipates the ending*. She makes a **link:** [maybe in terms of action/ reaction] that when the patient is feeling that the external circumstances are better and they have developed coping strategies, then the therapist picks up this feeling and anticipates the ending. Then, with **certainty** ("sure enough" (64)) she talks about **time**, but this time she doesn't talk about phases/ developments/ stages but she talks a specific **period of time** that this **discussion about termination comes up, after the "feeling", after the anticipation of termination.** *Is this supposed to be deemed as short or long time?* After this a discussion is initiated with the **therapist's involvement (action, strategy) focused on specifying the actual time of termination (planned termination)**. She again brings the concept of **"right time" [in vivo] and the concept of time ("how long do we need" (66))**. Also in this line (66) the therapist's involvement is more obvious and she talks about the time that both sides need for termination. *Who determines that time? What does "right time" mean again? Why is time a need for the therapist as well?* During that point in time/ in the process of therapy ("when this happens" (67)) the feelings of the therapist about termination stir up ("it's actually the feelings around termination" (67): with this she means that at the time when a termination time has been planned with the patient, this is when the therapist has the feelings around termination. *What are these feelings? How can they be described? Why are they caused?Research question implications: how does the anticipation, the planning and the actual phase of termination affect?* The first characteristic/**property** she gives to "feelings" is "mixed" (67): by that maybe she means that the feelings have **a variety of dimensions,** that different kinds of feelings are combined, maybe even opposite feelings, positive and negative (compared with previous data: *what are these feelings when the therapist feels it is not the "right time"?)*. Then she goes on to

say “mixed but positive” (67, 68) so it is not about negative and positive, only about positive feelings, and these positive feelings occur (action/ interaction) when the patient is resilient, when there is a “good piece of work done” (68): she expresses this as a “feeling”, so she refers to her personal experience, how she experiences the phase of planning the termination, and she talks about the **success of therapy**, the positive outcome of the therapy process and that the patient is feeling better. *How exactly is this indicated? When does this feeling occur? Does it occur only in the phase of planning termination? What if the patient wants to terminate and the therapist does not feel this positive about the outcome?* She goes on to explain by “good piece of work” she means “there are a lot of things to reflect on” (68,69): she refers to the content of therapy, the fact that these feelings occur when there are a lot positive things (“good piece”) to talk about in the sessions, in the sessions particularly leading to termination, it is like there is this positive feeling that she wants to sustain in the sessions. in lines 69, 70 she explains further what are these **positive things** to “reflect on”, talking about “what has changed”, “where the person is coming from”, “what feels better”: there is a comparative nature, comparing this stage of psychotherapy with the beginning of therapy and the improvements that have been made. So, in this stage of planning termination, she tends to **reflect on positive changes, difference in the patient between now and the beginning and indicate the success of therapy.** “it always feels like it is a good, a satisfying experience” (70): she brings her bias again, her personal perception of the experience and how much **gratifying** it is for her to go through these positive changes, it satisfies her, her perception of the work is positive, feels content with herself.

“Huge investment” (71): investment of thoughts and energy and time (**coming from interviewer’s question**), to give time and effort, the therapists’ involvement (**compare with literature, where I got this concept from)**. She goes on to talk about time, *how much time the therapist “invests”, gives effort and time, to the patient.* What does she mean by investment though? Is it only about time? First she talks about the **frequency [in vivo] of the sessions** (therapists see their patients at least once weekly, in the psychoanalytic context it is often two or more weekly), but here she says “you get to see someone” (71): she may mean that she meets with the patients, compared to previous data “you” and “someone” refer to “therapist” and “patient”. So, when the therapist meets with the patient many times, then the investment is more intense. *How does the duration of therapy affect the termination? How does the frequency of the weekly sessions affect the termination? Could it be that the more they meet with the patient, the more the investment, the therapist’s personal involvement, and therefore the more intense the termination phase is?* Then she personally considers, “you think” (71) the amount of hours (length of time) “you spend”, meaning that the therapist is spending time with the patient (*note: many interviewees have been referring to their personal experiences as “you”)*. How exactly is this time spent? Does she feel that she spends her own time, her personal time, her professional time? “in intense conversation” (72): when patients and therapists discuss, talk about , the patient’s inner experiences and feelings, about issues that belong to the present, the past of the future, but which are **emotionally loaded, very strong** emotions in these conversations (note: she does not refer to “sessions” or other clinical and technical terms but she speaks about conversations. How does that reflect her personal involvement?). what is the content of these conversations that makes it so “intense” (72): she explains by talking about the **internal experiences of the patient** (“talking about themselves” (72)) and about the

external experiences of the patient ("about their lives" (72)). So there are **intense conversations [in vivo], emotionally strong conversations, about the external and the internal experiences of the patients.** What exactly does internal and external mean? Internal may mean feelings, thoughts, emotions, physical condition and whatever comes from within. External may mean the circumstances of their lives, their relationships (compare with previous data), their work and other issues having to do with the environment and other people. This is the **action**: the intense conversations (interaction). She goes on to describe her personal experience about these intense conversations and she talks about what it "stirs up for you" (73): meaning thoughts and feelings, but she could also mean responses, physical condition, "being with" the client and she may mean it with positive or negative connotation. She goes on to describe what "it stirs up" for her: "you mind what happens to this person" (73, 74): now she expresses her **personal worry** about the patient or her **personal thoughts and feelings** about the patient about their lives, internal and external condition, when they are not in therapy any more. She may mean that when she will no longer be **able to meet** with that person and how that person **stays in her mind**. Literally it means to "be careful" for the person, but here I assume it is more about a personal worry but I will have **to see further in the data for explanation of the thoughts and feelings of the therapist about the patient after the termination of therapy.** Then she **differentiates among patients** saying that "it depends" (74) and that "some patients stir up more personal things or issues" (75): so here she places conditions and she may mean that **not all the patients stir up these personal things**. What are these personal issues that patients stir up? How does the therapist experience that? What are the properties and the dimensions of the patients' internal and external experiences that stir up these feelings? How are some patients more influential than others? When does this happen? She goes on giving a narrative of her personal experience saying that these patients "feel closer" (75): this may mean that they are more familiar, they remind the therapist of their own personal difficulties and struggles, they make the therapists feel and think about their personal issues/ matters. Because then she explains that they feel closer "in terms of their pathology and struggles" (75, 76): so the patient's symptoms and difficulties make the therapists think of their own **personal experiences** and then the feelings and thoughts are more intense. This gives a notion of **cause and affect** when she differentiates the patient's presenting issues according to how **close or familiar** they feel to the therapist. *There is a personal account then, a personal experience of the therapist is there; of the therapist is reminded of their own difficulties in their own internal and external experiences, then the patient influences them more.* Then she talks about her personal feelings towards termination speaking in terms of *dissolution of therapy* since she talks about a variety of "strong feelings", "sadness", "loss", "you miss that person" (76, 77): here she talks about her personal experience of the "loss" of the therapeutic relationship, the **patient's absence**, and her negative feelings towards that, comparing this with "major separation" (78): this code will be used in vivo, as the feelings as well, because they give a clear picture of the fact that even though it is a narrative of the professional experience, it is connected/ linked to the personal experiences of losses and relationship dissolutions and actually **there are personal feelings of the therapists "stirred up" because of some of the patients' "issues" and "pathology". So the therapist's feelings are presented as a consequence of the action/ interaction.** *What makes these patients be more influential? What is it in their symptoms that stirs up these feelings during the termination stage?* Then there is another idea of **contact after termination**, either by letter or having one or more

sessions (78, 79, 80): how does this affect the therapist's feelings, does it give any kind of relief *to the worry knowing what happened to them afterwards*? But then she says that "most patients won't come back" (80, 81): so what does this mean for her? How does it affect her worry when she doesn't hear back from them? She feels "sadness" (81) [in vivo].

(Interview question: do you tell them to keep contact?) Then she says that she doesn't tell them that they can contact. She "works towards the end" (82): meaning that the work is going to end, therapy will have a termination and that she wouldn't ignore that or postpone it. She mentions that it is the patient's initiative when they enquire about contact after termination (82, 83): again here there is an implication of the patient's control of the process. *There can be an assumption here, linked with previous data, that even though the therapists are worried about some of the patients, they will not try to relieve their worry by asking patients to write, but again the patients have control of the contact after termination, as they have the control for the termination. How does this affect the therapists' feelings of sadness and loss? Even though there is a parallel with a "major separation", it is only controlled by the one side. How does this happen? How do therapists deal with this peculiar balance in the relationship? Even though the feelings resemble relationship dissolution, it is not acted on these terms. How do therapists experience/ deal with it?* Patients may even ask for more therapy (83) and she would give her consent (84) (action) and the consequence, as she sees it, it is that the patient is "pleased" (84) and this is the affect that it has on patients the fact that they **can contact after the termination**, but it has to be their initiative (also technical and clinical implications to that). She goes on to say that even when she gives her consent, most of the patients **do not contact after termination**. She hypothesises that **they just want to know that they can, without feeling "they have to" (85)**. Again here there is the issues of **control of therapy and control of contact, that again lies with the patients.** It seems that even though she experiences the feelings of loss, she cannot act on them, and it is the patient's choice about whether or not they would want to contact the therapist after the termination. Where does this leave the therapist?

What is her experience of the above? She then "normalises" these feelings, giving her **personal opinion** that it is "human" (87) [in vivo] and "natural": may mean that it is **anticipated** that she will have these feelings. Why is that? she then gives a parallel with a more *generalised view* of how **people in general experience the termination (87, 88)**: she mentions the feeling "anxiety" [in vivo] and the situation :"ending" [in vivo]. How are these two related? How is the feelings people generally have on endings associated with the feelings the therapist has during the stage of termination? Here it seems that she finds herself being "human", meaning that even though she has to be a professional figure, **she can't help having these feelings and she thinks it is expected from therapists to have these feelings.** She then makes it more specific to specific situations in therapy that these feelings are stirred up (88, 89): mentioning the **discussion about termination and the breaks in therapy** (comparing to literature and own practice, she means the holidays or any other planned or unplanned breaks). She brings these **situations/ stages in therapy as "rehearsals" for the termination:** she goes on to say that this is what the patient might feel or experience during the actual termination (90) and she mentions that it "will be forever" (90) and that the patient might feel the therapist will not "come back again" (91): this has two very important meanings of **finality and foreverness and also the fact that in the**

patient's eyes the therapist disappears forever. There seems to be a specific connotation in this sentence, explaining the "anxiety" that is human during separations and *how this is applied specifically in the therapeutic relationship*, when she makes assumptions about what the therapist might feel. Then she talks about how she deals with (strategy) that finality and what she perceives as patient's anxiety, saying that she encourages people to make contact after the termination (91, 92), but answering their enquiry, if they bring it up, because (comparing with previous data), they have the control of the contact after the termination. The therapist seems to just give their consent. Then she talks about the **impression** she has gotten out of this **encounter/ therapeutic relationship** and she **links it with the personal/ human/ anticipated desire [in vivo] or need (93).** Does she only talk about the patient here? Does the patients have this desire? What is this desire exactly? Is it to have contact again with the therapist? But the therapist gives the consent, not all patients ask for it and even those who ask, not all of them contact in reality (previous data). How is this applied to the therapist? How do they experience this need, either theirs or the patient's? Then she talks about the **nature of the therapeutic relationship** that it is "bizarre kind" (94) [in vivo]: she may mean that this is an odd or unusual relationship, maybe breaking the link with the personal or other relationships, **to differentiate the therapeutic relationship with the rest.** But how is it bizarre? What makes it bizarre? And then she explains it from the **patient's view** *(note: in this narrative (95-100) she uses the personal pronoun "you" and she refers to "person" rather than staying with patient-therapist words. I wonder how much of what she says are generalisations that apply to both therapists and clients)*. She says that the patients " share all this with somebody" (94): she refers to the **content of therapy sessions**, what is been discussed, may mean the external and internal experiences of the patient (link with previous data). And then she shows the **way this content is shared (95):** "in an intimate way" [in vivo], meaning how **close** the patient is with the therapist and the **effect of this sharing of these experiences**. Then assumes (95) that "the therapist knows you more than anyone else": she may mean that the relationship is so close, so **intimate**, that the patients shares this content and this information about internal/external experiences that the therapist "knows them" much better than anyone, she **compares the therapist with the other people close to the patient in the external circumstances**. She does explain that this happens as a consequence of the fact that they are sharing "intimate details of their life" (96) and then, **comparing with these other relationships in the external life, to explain the bizarreness of the therapeutic relationship,** the patient "will not see the therapist again", giving the *finality and the nature of the termination as what makes the relationship bizarre.* Then she refers to her "own experience" (97): by this she may mean the experience of her own therapy termination or her experience with patients terminating; this is unclear. Then she says "whatever you have experienced" (97) referring possibly to the therapy experience, the content, the discussions and what the patient has shared. Therefore, by "you" she refers to the patient and then she speaks about **her experience as being a patient (assumption).** *How has her own experience of the termination of her personal therapy affected the experience of termination with the patients?* From the data, it may be assumed that by her experience, personal experience, she assumes about what the patient might feel. She says "the person" (97), possibly referring to the therapist, "stays inside you" (98): there she may mean the function of "internalisation" (literature) or simply the fact that the patient is thinking of the therapist after the termination of psychotherapy. And even though the termination has taken place, they don't meet any more (98), the "presence" (99) of the

therapist is still strong in the patient's mind. She explains that this is a *consequence* of the "influence" (99) [in vivo] the therapist has on the patient, and the "affect" (100) [in vivo]. *What is this influence and affect? Does she refer to the changes? Does she refer to how different the patient was in the beginning and in the end of therapy? Have the patients learnt these new "coping strategies" that they apply after the termination phase?*

Do patients stay in therapist's mind? She agrees (101), implying the patient's presence in the therapist's mind (compare with previous data). She brings the example of her training patient and she characterises it as "intense experience" (102) as being a "training patient" (103): by "intense" she may mean strong emotionally (link with previous data) and she attributes that to the fact that she was a training patient and that she gave "much thought" and "wrote her paper about her": this brings up the issue of **investment** (previous data) since she spent time, energy and thought on that particular patient, paid special attention, given that she was still in training. How is she different now? Does she experience termination as intense now? Why was it different when she was a trainee? (*note: differences between training and after-qualifying).* How does the therapist's professional experience affect the stage of termination and how "intense" it will be? Then she talks about how she *personally felt about the patient's personality*. She expresses her *personal admiration* (104) and she talked about the patient's psychopathology (104) and the fact that she was "open" (106) and she brought the concept of "culture" in it as well (105). This stirs up important **properties of the concept "patient": the personality, the symptoms and the engagement. How does the personality of the patients affect the therapist? Does it contribute to how "close" the therapist will feel (previous data)? How does the patient's presenting symptoms affect the termination and how the therapist will feel? How does the patient's engagement affect the therapist's feelings towards termination? Is this what she meant when she has said "not all patients stir up feelings"? Are these the three factors that will determine the impact the patient has on therapists? And if yes, how? What are the particular properties and dimensions of these concepts and what is the consequence of this action/ interaction?** And she spoke of the situation inside the sessions (107) and the **patient's way of sharing in the sessions;** in this particular case, it was "intense" the way the patient expressed her feelings, and overall, the therapy process, was "intense" and she associates that with a "strong feeling of loss" during the termination. *So here, along with the above concepts, there is also the concept of* ***how the patient expresses themselves in the sessions, giving cultural connotations to this concept (dimensions)***. But what made the "loss" so "strong" (108) was a consequence of the fact that the patient was (108-109) **leaving the country – external circumstances that made the finality of the termination unavoidable.** And the therapist was aware of this finality. There was some contact after termination but the interviewee expresses a strong sense of finality and her **awareness of it**. She generalised it but in some way this was special for her (110-111). What made it special? The concepts regarding the patient? The intense experience? What was this intense experience about? What happened?

Then she talks about being aware of some of the patient's aspirations for the future (112) and what the patient desired for the future. She expresses the awareness that she wouldn't know the outcome of this desire, whether she succeeded or not. (113). How did that affect her? What feelings does this awareness provoke? Do therapists want to know what happened to the patients after the termination of therapy? She then says

that there was some contact after termination and she did find our about that patient (113, 114) and the she **generalises** expressing this **wish to know what happened to the patients' lives after termination of therapy** (115): does this have to do with curiosity or what does this desire mean for the therapists? The responded just gives a positive connotation to that (also smiling…). However, the reality doesn't usually gratify that wish. How does that affect her? Is that what causes the sadness during termination?

After question about personal history and how it has influenced her experience of termination, she answers that she strongly believes it has influenced the termination phase and in fact, "everything" (117) about her personal history influences the professional life and the way of "being with" the patients (118). She doesn't explain how so that raises the questions: what parts of her personal history have influenced, does she only refer to her personal history or other aspects, how does her personal life influence her professional practice, what exactly does she mean being with the patient, does she imply the relationship?

She then says she finds it difficult to distinguish how her personal history (119) affected the way she experiences the termination of psychotherapy. This may mean that she hasn't thought about or worked it through. *[note: many interviewees have expressed the lack of opportunities to talk about this issue before the interview]*. She mentions her "awareness of her own feelings" (120): that means that during the sessions she **monitors herself, her thoughts and her feelings**. However, as a **reaction to this awareness,** she "doesn't act them out" (120): this may mean that she doesn't express these feelings during sessions, meaning that she doesn't disclose herself, or simply she doesn't act upon her feelings, her reactions during the sessions are not based on her emotions (*technical term: how to deal with countertransference)*. What does this mean exactly? What does she do with these feelings then? How does she try not to act them out? She goes on to explain that she "would rather think about what she is feeling" (120): this is an indication of **personal consideration of the feelings, of the fact that she is monitoring herself and she is reflecting on her feelings when they occur.** However, she goes on to talk about a "balance" in the technique and practice (121-122), she feels she needs to be "spontaneously involved and engaged" (121, 122): this may be a technical term, meaning that the therapist should be genuine and open to their own feelings in the session, to be true in the sessions, to be able to monitor themselves and "be with" the patient (link with previous data) and then she **puts an effort in this "difficulty" (121) [in vivo]** to create this balance between that and the fact that she doesn't express her own personal thoughts and feelings to the patient [in vivo] (123): this implies I assume two components: **therapist's personal feelings and thoughts in the session, countertransference (literature), disclosure (literature)**. She then speaks about her **personal history of loss, the finality and unexpected nature of it (123, 124)** and the fact that it **influences the termination of her life in general (125).** *How does this history influence the way she would experience the termination with patients? What happens when the patient leaves unexpectedly, when the termination is not planned? How are these two linked for her?* Then she spoke about two experiences of termination of personal therapy (125-129): She spoke about her first one, before she trained and she used the word "sadly" (125), implying a negative connotation to this experience, and placing it in time, "before she trained" (126) (she didn't complete her sentence) and then the second one was **while she was training, lasted for 10 years**

(127) [long term personal therapy], and she mentioned her personal need and significance of a "good ending" (127, 128) and also she has kept **contact after termination, the relationship is different (colleagues (129)), meaning that they meet in external situations, the external circumstances are favourable for the therapist not to disappear.** Then she says that it is different with patients because they don't become colleagues and the external circumstances do not favour any unplanned meeting (129, 130). Here she stresses the difference between her own therapy and therapy with patients in terms of **meeting after therapy, linked with previous data, she talks about knowing what happened, how the therapist disappears and the patients as well, and how unplanned meetings can help with this "worry", how therapists "mind about the patients", since they can't develop a different kind of relationship, there is simply none.**

She goes on to talk about the big **frequency and amount of terminations in her professional experience (131)** and she spoke about her experience in GP practices (131-132), which means **short-term therapy (link with previous data)** and short term means that there are more terminations in the practice and more frequent. Then she narrows down the narrative, **making it more specific,** speaking about a **particular patient (132)** and they had short-term therapy, in the GP practice. What was so significant with this patient? She said that this patients developed an "intense transference" (134) [in vivo] and **look into literature for more information and further in the data.** What does she mean with this phrase? How is this intensity expressed? How does it influence the termination? Does this have implications for the relationship? Then she places that intensity **in time, in therapy time,** and she says "immediately" (134), meaning from the **beginning of therapy**. Does this make it more intense? How and why? And then she goes on to talk about the termination (134), that she made a referral for another therapist to see this patient, but she **stayed in the patient's mind** (139,135): because this patient continued therapy with her in another setting, where they could engage in long term therapy. She then mentions (136) that it was an "intense engagement": with that linked to "intense transference", does she mean that the patient was involved, open in therapy, expressed their thoughts and feelings, implications about the relationship, that engagement **"he had it with her"** (136-137), therefore implying a nature of the relationship between the two. How does this relationship influence the termination? How is the relationship influenced by the intensity of the "transference and the engagement of the patient"? How does this intensity then affect the termination? What is this intensity? How is it expressed? Then she talks about the **patient's personal history and difficulties (137)**: "little parental emotional contact", "deprived", neglected (137, 138) as elements of the person's history. Did these elements made the engagement intense? Was it that he was deprived that he needed to make this intense transference? How is the deprivation of parents linked with being with the therapist? Can therapist become parental? How and why? Why was it important that he was neglected by his parents to link with the intensity? Then she talks about how **she experienced termination with this particular patient** (138, 139): she characterises it a "satisfying experience" [in vivo] (139) and then she talks about the significance of the therapist staying in the patient's mind [in vivo] (139-140), the significance for the patients to continue therapy with her, and the external circumstances that influenced that decision (141): patient's personal experience of loss of a parent through death (142) and how important he termination/loss/separation was for the patient as issues of therapy (142) [in vivo]. After that she stresses out the significance of their relationship and of the fact that

"there was something important happening" (143) [in vivo]: does she mean it in a real or symbolic level, she refers to **the transference or the real relationship? I assume, linked with previous data, she refers to the transference (literature) and the intensity, how emotionally strong it was, how the patient expressed themselves in therapy sessions**. she links these elements with the "patient's initiative to continue therapy with her" (143). So what is this special relationship? She talks about her personal experience of death of a parent and the patient's experience of death of a parent. Are these two linked? How? Why does this make the relationship significant? How is the transference significant? How does the loss of a parent affect the termination of psychotherapy? Why was the ending with this patient satisfying for her? Was it a successful piece of work? What made it successful? Was it that the transference was intense and that the patient's engagement was intense? How does the patient's personal history and engagement in therapy affect the termination? Or how does it affect the fact that the patient stays with the therapist? How did the fact that the relationship continued by continuation of therapy?

She goes on to explain why she agreed to see this patient again and how it felt (144): that "it felt right" [in vivo], it was the patient's initiative to enquire and to request to see her again for continuation of therapy (145). She also stresses the fact that **patients request a specific arrangement for after-termination session (follow-up, experience)** (146) and she **encourages them to take their own initiative. This can be seen as a <u>strategy</u> to deal with termination and to tackle the anxiety (comparison with previous data)**. So there is the concept of *continuation of therapy, follow-up appointment and the therapist's reassurance that this would be "fine"*. I am wondering how this *links with the therapist's worry* and anxiety and the desire to know what will happen to the patient after the therapy termination. Then she goes back to the concept of the **patients who stays in the therapist's mind (147)** and she gives the reasons **why:** she distinguishes some patients who stay in her mind (148), and she explains that these patients "use her" (148) [intense transference and engagement, link with previous data]. But what does she mean exactly with this? How do patients use her? What is this "meaningful and intense way" (149)? What makes it "special" (149)? How is it different to the patients that **don't** stay in the therapist's mind? (*To look further in the data and compare!!!)* Then she talks about the termination of psychotherapy, linked with the fact that some patients stay in her mind. First she refers to **the amount of terminations that she experienced** (150) in her professional experience and then she expresses her **familiarity with this situation** (150), that she "is used to it" [in vivo], like it is an **expected part of her professional practice and that it is anticipated [link with previous data, with anticipated ending and with the "bizarre relationship"]**. Then she generalises about the patients who "stay in her mind anyway" (151) and she **generalises it in her practice**. And then she talks about **reminders from external circumstances** (151-153): walking in the street, piece of music, what another patients said [in vivo]. So then she concludes that even **after the termination** the patients **stay in therapist's mind** (154) and she generalises it in her practice again, in her professional experience (155). This brings in mind **previous data where she talks about the fact that the therapists stay in the patients' mind and how they "internalise" the therapists and keep them in their mind.**

Then she speaks about her experience of working in a setting of **short term therapy** (156) and she couldn't remember one of her patients she had there and she gave a

negative connotation ("I felt bad" (157)): *does the fact that she saw patients on a short-term basis contribute to the fact that she couldn't remember the patients? How does the duration of therapy contribute to the notion of the patient staying in the therapist's mind?* Then she discussed about a **situation** where she saw a patient for "6 months" (time) (158) and then the patient **contacted after termination** and the therapist could remember this patient **and also the patient expected from her to remember her (159)**. *Does this mean that the patient expects the therapist to remember them after termination? Again, link with previous data, what makes a patient rememberable?* She said then that she "recognised the patient's voice" (160) meaning that there was an **external reminder, the voice.** Then she relates that to the **notion of the therapist staying "strongly" [in vivo] in the patient's mind** (161).

She analyses the issues of the "patient's voice" [in vivo] (162), saying about their "use" [in vivo]. I wonder if she means their use by the therapist. How does a therapist use the voice of the patients? It is a sense, a sound or when someone expresses their feelings. Then she makes it more specific to *psychoanalytic practice* and she mentions the "use of couch" [in vivo] (162): this is typical in the practice of psychoanalysis that patients lie on the couch and the therapist sits behind them (experience and literature) so the therapist can't see the patient's face but they can only *hear the patient's voices.* This is what she says: "what you are listening" (163): so this is the **sense** that helps therapists remember the patients? Then she also mentions one more **means of communication that enhances this sense** (163) the "hearing on the phone" and then the **recollection or memory** comes to mind "immediately" as she says (163).

Then I asked about the difference between short and long term psychotherapy. She says that she assumes that (164) **even** in the short-term therapy, **patients stay in therapist's mind [in vivo]**. Now she gives the properties of the reasons why these patients stay in the therapist's mind even in short term therapy *[so time is not the only concept, or not even a concept, linked with how the patients stay in therapist's mind after the termination of therapy]* Then she talks about the patient's **engagement** in therapy and their **readiness to use the therapist (165) [in vivo]**. Again the "use of therapist" comes. What does this mean exactly? How does she experience this? She also talks about the patient's **commitment** to therapy (166) and how **they don't miss sessions (as it happens in GP practices)**. So here there is the concept of **setting** and how committed patients feel in every setting. There is a **bias** then about GP practices and how patients engage in therapy in these settings. Then she differentiates the patients who **benefited from therapy** (167) and the ones to **whom the therapist has felt angry and has found difficult to keep in mind**. What are these patients? What happened in therapy with them? (flip/flop): Are these the patients that have not benefited, are these the patients that it has not been a good piece of work and their therapy has not been successful? Was their engagement not intense? Then she turns it to the opposite again, and she speaks about the patients that stay in her mind and these are the ones that "she feels useful" [in vivo] (168): that means that the therapist has been able to help the patient, that the patients has resolved their issues (previous data, 158) and that they have been able to "use the therapist" *(here she switches the therapy success from the responsibility of the patient and she places the therapist up front and how useful they have felt)*. Then she speaks again that therapists have something to "offer" (169): meaning again that they have been able to help the patient with their issues and that therapy has been successful or useful? Then she says that **this also occurs in short-term therapy, so there is no true differentiation between short**

and long term but the main concepts that define the dimensions are: patient's readiness to use the therapist, patient's commitment, patient's not missing sessions, patient's benefiting from therapy, and the therapist not to feel angry or not find it difficult to keep in mind. Then she says again that even in short term, it can be a "very satisfying" experience [in vivo] (170). Then she turns to the termination phase and she talks about the feelings of "sadness" (170) when "they go" (again implying the patient's initiative for termination, also personal loss implications?). She talks about long-term patients, even 12 years (171, 172) [in vivo] and she also refers to the **frequency of the sessions per week, 3 or 4 time [in vivo] (172-3)**. Then she feels that patients "are very much there" (174): meaning that she feels strongly the **patient's presence**, possibly meaning in her life, like the frequent meetings makes them more familiar with her life, having personal implications, meaning physical and mental presence – the patients stay in the therapist's mind. Then she talks about the **therapy process and what happens in the sessions,** (174) and she refers to how she "has been through" the patient, "together" (174) [in vivo] very "primitive experiences" (175): referring to the patient's past, to the therapist's transference (literature) and symbolic relationship, the patient's regression (literature). Then she refers to the defence mechanisms (literature) that the patient is using in the sessions like "projection and projective identification" (175-6), again referring to the process (176) and the **patient's strong emotions towards the therapist such as "hate" (177) and that they have been "intensely engaged" (178).** There is again the notions of intense engagement and it seems that she believes that in the long term there is enough time for these primitive experiences and defence mechanisms to be developed (link with previous data of therapy process, hoe patients have changed and how they have used the therapist). And she finds this "intensity" to be the "difference in the ending" (178-9) between short and long term.

What does she mean by "use of therapist"? She mentions the awareness of the therapist, how "impossible it is to be sure" (180) indicating her **bias** again, **the patient's experience of the therapist.** She talks about her **current professional experience, about a particular patient,** (181) who appears to be "getting much out of therapy" (182) (previous data) by what she verbally expresses. Then she goes on about the **patient changing, positive attitude towards therapy, what is overtly manifested during the sessions (182)**. Then she talks about her own experience during sessions and the difficulty to "get through the sessions" (183) and to "understand" (185) the "unexpressed feelings" (186): so here there are the notions of the content of the sessions, of the **manifest expressions** of the patient and the **latent feeling.** She talks about the **patient's personality, how they are a "shy" (187) person** and the patient's "difficulty to trust people" (187): these are the patient's characteristics, how they influence the relationship and how she uses the therapist, is something that she hasn't talked about; to look further in the data. She continues to talk about the patient's personality (188) and as a **therapeutic strategy** she tries to understand the "primitive level" (189) to understand the patient's symptoms (190). She talks again about the patient's personality (190) and the **patient's difficulty to express intense emotions towards the therapist (191)**. How does that relate to the way she is using the therapist? Does this mean that she is not? She then talks about another patient (191) and their obsessive symptoms (191) and about the content of the **manifest conversations during therapy sessions (192)**. She describes the **manifest level of the discussions during the sessions** (193) and about the therapy goal of the patient to "learn to express their feelings" (194). And then she goes on to her

argument that by "use me" she means **how therapist and patient are** emotionally engaged with the therapist by using opposite examples to indicate it (194-5-6). She then makes these issues more specific saying that it is difficult for the patient to "trust" (198). So **the types of patients she finds difficult are the patients who can't engage emotionally easily: who stay on the manifest level of the content of therapy sessions, obsessive patients (literature), patients who find it difficult to trust (in general), and patients who "are not spontaneous with their feelings" (199) (she used these example for her own feelings as well (compare)), anxious patients (200) (obsessive patients are characterised by anxiety (literature)), patients difficult to reach the latent content of their presenting symptoms (201), with rigid defences [in vivo] (201).** *Are all patients with these symptoms difficult to use the therapist? How does she deal with it? How does it influence the termination experience for the therapist? So when patients actually engage emotionally and she can reach the latent content of their presenting issues, then they use her, and then she experience termination more emotionally intensely.* She then brings an example of a patient that actually engaged emotionally and she describes the patient's **childhood experience, the primitive feeling and the parental figures (202-3-4)** and she describes her as an "immensely engaging person" (204): she goes on to describe what she means by describing the **patient's personality ("bright" (205)), open on the manifest level (206), she describes positively the patient's personal relationships (206-7) and the patient's effective coping strategies for the external circumstances (208) and the patient's defences and feeling of terror (210).** The concept of using the therapist then is about (210-1) is when the **patient gets a lot out of therapy and is open.**

I asked about the patient's presenting issues and she spoke about the **personality** (213): like the personality of the patient influences the way the therapist will experience termination because it will determine the relationship, the engagement and the involvement (I am assuming, linked with previous data). She gave me an example of another patient and she **focused on the content of the discussions in the sessions, or the lack of content.** This patient was a female (as the previous examples) (213), and that she was a "hard patient" (214). What made the patient so hard? The patient did not share any of the content of her feelings and thoughts, so it was the **lack of communication, even on the manifest level (214).** The interaction was hard? She said that the patient would be **inactive**, meaning that she wouldn't talk or act in the sessions (214-5). In this atmosphere, the patient would not initiate termination (215) [in vivo], and the therapist would not initiate termination because this has to be patient's initiative. Then she talks about the **patient's personal history**, **the therapist's formulation – hypothesis about the patient's issues (216).** Then she talks about the **strategies in the session** in the beginning and later stage of therapy (216): in the beginning of therapy, the therapist found it hard to "work with" the patients, "together" (217) and she gave the reasons, **it was patient's responsibility because of lack or ability or will to engage** (217-8). Then she gave her formulation (218) giving the patient's feeling (terror) and the unawareness of ways of communication. She gave one of the patient's way of interacting (219). Then she used "we" (219) to indicate the "**learning for both"** (210) to "**get through the sessions**" (it implies an effort) (219): what was this communication, this interaction? It was that the therapist would "sit with the patient" or would **intervene/ interpret** (strategy) (220) and the patient would be **negative to her interventions** (221-222) characterising them as **"wrong**" and **"rubbish**" [in vivo]. Then, in terms of

explaining this, the therapist talks about the patient's **personal history and her feelings towards her mother (222) (transference) and the patient's personal experience of loss through death (222).** Then she expresses her understanding and **empathy** (literature) (223) and she speaks about the **later stage of therapy (time)** where they "managed" (to communicate) (224). How did they manage? Because the therapist "did not worry about it" (225) meaning that she was feeling **less anxious about the communication or accepted the patient's way of communicating**. She also used (strategy) the **patient's feedback about the interaction (226).** Then she talks about her **uncertainty for the reasons of improvement** (227) and the patient's symptoms **("eating problems", 227).** The reasons for termination were **external, financial (228-9)**. (then the patient seeked alternative therapy and then she may consider going back to her [discussing about after termination therapy in another setting or the same] (229-30)). **The therapist felt/ experienced "relief" (231)** [in vivo] *[note: is relief a feeling? Go through literature to differentiate between experiences and feelings. What is a feeling?]*. Why was it a relief? Because it was an **"extraordinary piece of work" (232)**: does she mean difficult or intense, is it about the patient saying that she is rubbish and dismissing her interpretations or it can be seen as (flip/flop) as the opposite to "good piece of work" (comparison with previous data). Why was it extraordinary for her? Because she hadn't experienced this kind of therapy process before, she hadn't dealt with a patient like this one, so **"no previous experience" (232-3),** "what was not said was intense**"** (233-4) so there was an intense experience of the latent, silent content of the therapy sessions, also the patient's intense feeling of hatred (234) and the patient's attempt to **diminish the value of the therapist's interventions ("rubbish" (235))**. However, there were the **positive elements (235)** such the commitment of the patient, that she was **secretly** getting something out of therapy (236) even though it was a "relief" for the patient not to be there. For the therapist, it was **an "intriguing experience" [in vivo] (238) although "extremely difficult" (238):** so she gives a positive connotation, like it was a challenge even though it was difficult. She repeats that the termination was a "relief" (239) because **she didn't know what to say**, implying that she didn't know how to use strategies and clinically she felt **incompetent, useless (previous data: feeling useful)**. And she couldn't **"make a connection"** with the patient (239), feeling that she was not "close" (previous data) (flip/flop). Even though in the end (time) (240) she saw **improvement**, in the process the patient **"would not respond" (240)** and as a **consequence** she would feel incompetent (**rubbish, 241).** What **helped** the process (242) was the patient's **response, that the therapist "could get through" (242).** The patient was "unwell" (242) – patient's symptoms, and she talked about the **patient's previous therapy experiences and she felt the same for all of them, that they were incompetent.** She repeats the difficulty to "connect" (244): she was not close (previous data), she didn't feel useful or they (as in "we") could not engage emotionally, there was no intense transference (previous data).

She talked specifically about **how frequent she experiences relief (245)**. She then goes on to talk again about an **obsessive patient** and how the **obsessive thoughts affected the therapy sessions – how intrusive they are (246-8)**. She again defines **her experience as "hard" [in vivo] (248)**. What makes it so hard? What makes it a relief to terminate with these patients? The difficulty was to **get behind the defences (249)**. Does this mean that she can't get through the patient (link with previous data) or that the therapy is not successful and the patient cannot benefit from therapy. Then, when she **wonders whether or not it was an ending (249-50)** she refers to her

personal admiration for the patient saying that she is "fond of people" (250) even "difficult patients" (251). She also says that she **wonders what happens to them after the termination of therapy (251)**. This implies curiosity but also personal worry and **interest to the patient's life and external circumstances.**

Then she talked about a specific patient and the **contact after termination (253), about the time since termination (254), patient's external circumstances (255), therapy in another setting (256), share information of patient's life (257), family relationships (259-60), difficulties of patient around separation (258) and patient's personal history of loss though death (258-9).** She expressed her personal feeling towards this contact, that it w**as nice to hear (260).**

I ask what happens when she doesn't hear from the patients after termination? My goal: to find out what happens when termination is final and she actually doesn't satisfy that wondering/ curiosity/ interest.

She spoke about another s**pecific patient** (262) and the **frequency of sessions they met for** (263). She used the verb "amazed" (263) to describe the **impact the patient had on her.** What amazed her was the fact that even though the patient had "horrific childhood experience" (264), he managed (264) to extricate himself (265) meaning that he **achieved to release himself from that experience,** to get through it and to be successful in life (265). She seems to **personally admire this patient** (it is amazing how…(266)) and focus on his good functioning and achievement of his life aims (267) to get away from home (268).She again expressed her **personal admiration for the patient's coping strategies (269 – 272).** Then she speaks about the termination phase, her feelings and her "sadness" (272) [in vivo]: her sadness here was linked with the fact that the patients left with an **issue unresolved (273)**. Does this imply the fact that therapy was not successful? This contradicts the previous data where termination has more intense feelings…or it doesn't contradict actually but it gives the different **properties and dimensions of the issue of therapist's feelings towards termination linked with every situation.** So she says that this patient showed improvement (274) there were unresolved issues in his personal relationships (274). Also, this specific example of patient presents also the notion of **resilience**, given that the patient "was able to function very well" (267) despite his "horrific experiences" (266-7) and there was a personal admiration expressed from the therapist (266, 268). She used many times the word "amazed" (263, 266, 268), indicating possible her surprise and her admiration, but also that it is something that she didn't expect and that she respects and admires in some sort of personal way. She describes the patient's internal and external characteristics and how he was **committed and open in therapy (270-1)** and then he was "able to go back to his life" (271). So there is the **personal admiration for the patient's resilience and at the same time the patient's commitment and honesty and use of sessions (link with previous data)** that contributed to the "sadness" at termination (272). **Another concept that had sadness as a consequence** was the fact that the patient terminated with **unresolved issues** (273): so even though he was able to use therapy, it wasn't completely successful, he didn't resolve what the therapist believes is an issue (different agenda, previous data) and maybe this contributed to the **therapist's worry** (link with previous data). When is that personal admiration felt? With what patients? How did the fact that there were unresolved issues affected the worry and the wonder about what happens afterwards? Is that what brought sadness; the worry? *[to look further in the data, and previous*

data, to compare the different situations that cause sadness, that is the different properties of the concept "sadness"]. She goes back to how "awful" was the **patient's material, personal history** (275) and how that contributed to her sadness, since this could not be **worked through in therapy and it remained "problematic" (275**): so what happens when patients leave therapy and therapy has not been successful, is this what made her sad, how does this link with the therapist's and the patient's different agendas, how is this linked with the previous notion of "a good piece of work"? Then she spoke about her **supervision** [in vivo] [literature] (276) and the content of it, **like an effort to understand or enhance her understanding of the patient's presenting issues (278)** and she compares this patient's situation with that of others who have had "damaging experiences" and about the belief that these issues will never be fully resolved, "they are not able to lead a really full life" (278). It seems here that she is **providing the explanation** as to why this patient left without resolving this issue. How does supervision help? How did it help do deal with these emotions? (link with previous data – talk to colleagues) Then she "remembers" (278) the last session, and what the patients said, how he communicated his history via writing "stories" (279) and how he could leave this "damaging" side of himself, this damaging "child" (280) in the therapy room, with the therapist (280) for the patient to "move on" (280-1). I am wondering whether this means that the patient uses therapy to off-load their damaging stories or **how the patients stay with the therapist, which side of themselves stays within the therapy room, with the therapist "safely" (280).** Then she talks about the therapist's **curiosity** (282) to search for information about the patient's life after termination (link with training patient and found out about what happened to her after therapy) and how much the **patients had fulfilled** their goals (284) and she has also given the **time since the termination (282-3)**. The fact that the patient had achieved in his professional goals gave her **pleasure (284)**, having a personal connotation and **interest (284)** and then she goes on to talk about the meaning of that job to the patient (285-6). She then goes on to talk about the patient's personal life (287) [in vivo] and in his personal relationship (marriage) (287) and she said that "she will never know" (287) *[how much is this an expression of a wish to know, wondering what happened]* but she expected (288) that he hasn't contacted after termination because he wanted to leave his "damaged self" (288) in the therapy room, with her. Then she mentions how the patient "copes after termination" (289-91).

Then she talked about a **training patient** (292) [in vivo] and his difficulties (social isolation, loneliness, suicide attempt] (293-4). Then she talked about the improvement and the positive changes that occurred during therapy (295-6). She characterised this as a "miracle" (297), meaning that it was a surprise for her, she was amazed (link with previous data), she did not expect this level of improvement. She talked about how open was the patient pr how "withdrawn" (298) and about the frequency of sessions (299-300) and how he felt in "her presence" (299). They had fewer sessions towards the termination (300). She then said that she **expected the patient wouldn't contact her (301)** because of the patient's personality (cut-off kind of person, 301-2) meaning the patient's tendency to isolate and the social skills that he has. She again **wonders what happened to him** (302), again, regarding the patient's personal and professional life. She then stresses the fact that **he was a training patient** (304) and her investment of thoughts and energy she spent on him (write up every session) (305) and she said that for **people like that (305-6)** maybe meaning his presenting

symptoms (depression), his personality (withdrawn) and that **it would be nice to know (306).**

How does she cope with those feelings? She talks about supervision, and mainly about group supervision (307-8) and she especially talks about a "personal and intimate group" (308) and then how she moved with a trusted colleague to another setting (309-10). Then she talks about a specific colleague **with whom she works at the same place (311)**. Then she summarises: peer supervision and one or two close colleagues (312) and she also is in **personal therapy**. Then she turns the focus on herself and how the feelings **wonder inside her (313)**: by that she may mean that she stays with her feelings, she thinks about them, she works through them, **without necessarily sharing these feelings**. Then she wonders what one does with these feelings and to explain she brings the examples of another **male patient** (314), she mentioned the frequency of sessions per week, and she characterised the experience as "very intense" (315); how was the therapy with him intense? What made it so intense? Was it the content of the sessions? She goes on to describe the patient's presenting issues (316-7): alcoholism. And she again uses the word "miracle" (318): does she mean again that she didn't expect this improvement? The improvement she didn't expect was that the patient managed to distance himself from alcohol, he didn't drink while in therapy. *Does the personal admiration for the patient's effort/ coping skills and changes contribute to the experience of termination? How? Do they make the therapy sessions intense and the relationship /encounter deeper?* She uses the word "damaged" again (319) to describe the patient's presenting issues and personal history, this time mentioning the emotional side of it. She differentiates between the overt behaviour and how people in general saw the patient and the latent feelings (319, 320). She used the phrase "deserted places" (320) to describe the depth of therapy sessions and she describes the patient's personal history of loneliness and isolation (320-322). She characterises the impact of these experiences and defines them as "painful" (322). She also characterised the **termination as painful (323)**: does she mean that she was sad? Does she link it with the patient's personal experiences? How was it painful? What made it painful? He contacted her after termination (323) and she managed to learn about the patient's life after termination from a third source (323) and how the patient coped (324). Again she says: **it is nice to hear (324).**

She talks about her job **before training to become a therapist** (325) and she had short and long term clients (325-6). She talked about two specific examples and gave their characteristics: young boy (326), symptoms (drug use), "tragic" family history (327), her interventions. Then she speaks about the reminders, how the external circumstances remind her of the patients, when/ **on the occasions that she drives pass** his place of work (329) and she mentions the **time since termination** "30 years" (329) and she **still wonders** whether she will see him (329-30). So this client stayed in her mind, she still wonders about him, and I am wondering what made it so **intense**? Then she spoke about a family she worked with at that time (330), on the long term, and **she again uses the word "tragic" (331) (like damaging, horrific and terrible, link with previous data)** to describe a **death of a child in the family**. With them, she is reminded when she drives pass the house she used to visit them (332) and that she is thinking of the mother of this family (connection with one family member, because of he tragedy) (332-3).

The she talks about the concept of **possibility of meeting the patients again, after the termination.** She keeps these people in her mind (334), she considers them from all her "working life" (334) [in vivo]: meaning before, while and after she trained as a therapist, but she was in the field of social support, still working with people, and she still **wonders about them** (334-5). Then she **compares this concept in therapy and social work, with the social life** (335) and the **difference** is that in the social life you can meet with them again (like when she said that she meets with her therapist in the professional context, but it is more possible to meet them) (337), even if you lose them and have this "good conversation" (338). But with the patients **this possibility to meet** is not the same, "probably will never happen" (338) but the **stay in mind – all these people** (339): she again gives emphasis on this and by all these people I assume she means the many examples she has presented to explain her experience of termination and she gives a **positive connotation to this**, presenting it as a reason for the work to be **satisfying** (339). She again talks about the **bizarre relationship (link with previous data) (340)**: it is bizarre because the **connection is intense** (intense transference, intense engagement, therapeutic relationship) and then there is **an awareness of the termination** (341) which means that there is a finality because **you will never meet them again, opposite to the social situation** (compare with previous data).

She says that it **will have to be the patient's initiative to meet again with the therapist after termination (342)**, the patient will need to "sought out" the therapist. She gives an example of one of her current patients (343) who is having difficulty for terminating, she speaks about the duration of therapy – long term (343) and the therapist's thoughts for terminating (344) and the patient's difficulty in initiating that (**the therapist doesn't initiate termination, it has to come from the patient, link with previous data).** Then she reviews how the patient presented in the **beginning of therapy (345)** (anorexia) and the patient's personal history of sexual abuse (345) by family figure (346). Then she mentions the **discussion on termination (previous data)** (346) and specifically about the **time and way of termination** (346-7). She mentions the patient's improvement (347) and the patient's **current dilemmas in personal life (cohabiting and having children) (350-1)** *[note that when interviewees talk about the patients' improvement they almost always mention the fact that the patient is settled down in marriage or equivalent with children – is this the therapy goal?]* Then she talks about her personal considerations about how the patients needs to **move on with this goal** (351-2) and the therapist's desire/ wish to see the patient moving on (352-3-4). Again she mentions that **she will not know after the termination (355-6)** and she wonders how the patient's life will be after termination (356) and how "resilient" (356) the patient is, how the patient will cope with life stressors (357-8) and the changes she has done during therapy (358). She expresses her worry about the patient's coping (fragile, 359) and her thoughts about patient's life after termination *[is she saying that she will never say that the patient is ready to terminate, that the patient will always need more support?]* She uses the metaphor "bite the bullet" (360), maybe to indicate the difficulty of the situation and the patient's **unawareness of when it will be time to end** (361). She says that "she doesn't have the heart" or the desire to initiate termination (361-2): is it her **emotional difficulty to terminate**? And she waits for the patient to agree that she feels "alright" terminating (362-3). To make it easier for the patient (assumption) the therapist has provided her with **reassurance for contact after termination** (363-4) but then she attributes the difficulty in the separation (364): is it separation anxiety [literature], is it

the difficulty of the patient or the therapist to separate? She mentions the "breaks" (previous data) they have had over the years of therapy and the different setting they met initially (364-5-6) and that in the last bit of therapy (the long term) the patient was able to talk about personal history, for the material to be **deeper and more intense (367-8) and the consequence in the therapist well-being (368).** Then she uses the phrase "she got under my skin" (370) meaning that she is greatly interested or attracted to the patient, the patient stays intensely in her mind, she was very interested in this piece of work (to look further in the data). She links that though with the difficulty of the patient, previous admission and suicidal attempt history (371-372) *(how these concepts contribute to the concept of difficult patient, along with the anorexia?)* But the therapist was aware of the difficulty (372-3). It was the patient's desire to see the same therapist – to continue therapy with her (373) and the therapist thought that she can "bare it" (374), again indicating her awareness of the difficulty but also the strategy, the fact that she could cope with this patient (satisfying, good piece of work, therapist's narcissism???). And then she compares the therapeutic relationship – the relationship with the therapist in comparison with the other personal relationships, and the difference in the connection – "hang on to me" (374-5). Then she mentions that these are the reasons for the difficult termination (375): the patient's hesitance to terminate, patient's dependency on the therapeutic relationship, the significance of it for the patient. But then she brings again the phrase "under my skin" (376) maybe indicating the **therapist's attachment [literature]**. She again mentions the discussion about termination but the lack of acting on it (376-77).

She talks about some further personal considerations regarding the **strategy/ technique of termination** and how some therapists (379) manage it. This technique is the **reduction of the frequency of the sessions per week** (379-80). She says that it is not her practice and the way she **interprets** that is that the **quality and intimacy as qualities and properties (of the therapeutic relationship) are involved** (381). *How is the quality and intimacy of the therapeutic relationship involved in the termination phase? Does she mean that she wants to maintain the depth of the relationship (previous data) even in the termination stage? How is it lost if she reduces the frequency of sessions?* She says that if somebody follows this strategy, they will probably **not have an ending** (no termination of therapy) or a **proper ending** (382): *how does the frequency of the sessions per week affect the termination stage? Why is it important for the therapist to keep the same frequency? How does it affect the ending?* She says that the reduction of the sessions **makes the sessions superficial** (383): she may mean (linked with previous data) that there a change in the quality and in the intimacy, that there is less intimacy in the therapeutic relationship or that it is **not deep (link with previous data)**. *What does she mean by superficial?* She says that the **content of the sessions** will be about "what happened over the last month" (383-4): by that she may mean that the **external circumstances** will be the main issue of therapy and that the **internal, emotional engagement** will be neglected (?). She doesn't engage into this strategy because she feels that the therapy sessions are **transformed** (become something else, 384). *[to look further in data and other participants how this reflects on their practice and what defines their decision]*. Then she talks about a supervisee who did it under the circumstances (385-88): **long term, changes during therapy, therapy success, difficulty in termination stage, reduction of frequency of sessions as strategy, contact after termination.**

She goes on to define what is a **proper ending** for her (389) and she comes up with the concepts [in vivo]: **discussion on ending, thought about ending, planned ending, time, review of therapy , say goodbye** (389-91). There is the sense that there is a **preparation**, like a ritual, around termination. I have the assumption that **time** is really important as well as the **content and frequency (previous data) of the sessions**: she feels that she has a proper ending when there is time to work through the feelings around termination and to "say goodbye". *What does she mean with saying goodbye? Is there a notion of melancholia in it? How is the concept of loss link into it? She speaks only for patients, but I am wondering how her needs and expectations are met with the above strategy?* She explains further about "going through what has happened" (391-2): again she brings the concept of **review** but I assume that she refers to the **therapy process and content and the therapy work; those need to be reviewed.** She expects (392) that a **proper ending is a planned ending** and, looking in the opposite (flip/flop), it cannot be a premature ending or an unexpected one. She mentions "opportunity" (392) which I assume she means **time**, that a proper ending allows time to "work through anticipated feelings" (393): meaning that she **expects the patients to come up with feelings on termination but doesn't clarify whether she means her own feelings as well.** She expects again, she speaks with a specific certainty (394) that there us a lot "going on through the ending" (394): now, she mentions "through" therefore I assume that the ending is not only the last session, but it is a whole **process that develops in time and helps both parties to deal with it, or is she referring only to the patient?** *Does the ending stir up feelings only to the patients? How about her own experience? Is there a proper ending for her as a therapist?* There is a **general consideration** (394) in the psychoanalytic approach that work happens after termination (395): this can be linked with the notion of the **therapist staying in the patient's mind (previous data)**. She goes on to explain that if therapy is successful ("work has been good enough" (396) then there a continuation of this work, **of the patient's learning,** inside the patient (396) after the termination. *Does she mean the fact that the patient internalises the therapist (link with previous data)?* Then she talks about a colleague and that therapist's experience of personal therapy termination (397) and she was engaged in long term analysis and frequency of 5 sessions per week (398). That therapist's internal experience of the termination was **freedom** (399-400). At the time of termination though her feelings were **sad, mixed and complex (400-401) about the termination and the loss.** *does this mean that there are different feelings of the patients at the time of termination and different feelings a short time after the termination?* She emphasises the role of **loss** for the patients (402) (like the previous concept of separation). Then she emphasised the **time** needed to work through the feelings associated with the termination phase (402). Then she mentions the internal sense of the colleague, how after experiencing the loss, she is left with a feeling of freedom (403-4) and that should be the **aim of the therapy (404).** She says though that there are patients who don't want to work that **intensely (intense engagement, intense transference, frequency of sessions, time/duration of therapy)** (405) and she attributes it to external, financial reasons and that it is a "real world" (406) differentiating it from the context of therapy. Then she mentions her **personal considerations about the patient's therapist and how she feels towards the work**, saying that it she may want to work or not (407-8) depending on how **useful** that piece of work will be for the patient and that they might not be "up for it" (409), meaning maybe that they are not ready.

After interviewer's question on self-disclosure:

The patients are aware of how they influence the therapist, of the "impact they have" (410). She expresses a wish that the patients are aware of it even **without the therapist's disclosure** (411). She refers to it as a **feeling** in the therapeutic **encounter** ("engagement", 412). Then she talks about a specific female patient (413) who was in therapy for a short time (6 months, 417) with a specific issue (loss of spouse through death, 416). What was specific with her was that she was able to "use the therapist" (417-8) and she was resilient and competent (419). She said that therapy with this patient was **important for the therapist as well (420): what made it important was that the patient had an impact on her (421).** She also acknowledges **to the patient** that she misses the patient as well (422). The ending was something she spoke about in her personal therapy, where the therapist's attitude is very non-disclosing (423-5) and her therapist reassured her about contact after termination, revealing his feeling (pleasure, 426). She found it "nice" (427): she said that it is nice to **hear this from the part of the patient.** Her **therapy is ongoing**, she hasn't terminated yet (427) but she reckons she will keep contact after she terminates (**she thinks about termination of her own personal therapy)**. Listening her therapist saying that, she found it **human** (428) and then she uses the opposite, **if he hadn't said that**, it would be **weird (428-9) [bizarre relationship]** and then she explains again what she means with that, the fact that there is **intense involvement (429)** and then you can't continue contact (430) **[no contact after termination]** and there is **not that kind of relationship** (opposite to social situation) (431). Then she brings two more concepts of the termination stage (432-4): **presents (flowers, 432), and physical contact (hugs, shaking hands 433-4)**. Then she brings the **cultural connotation (434): it is British to shake hands in the end but in other cultures it is a routine to shake hands in the beginning and in the end of the sessions** (435). But she considers the physical contact as a **taboo in psychoanalysis (436):** it is a kind of cultural (is psychoanalysis a culture itself?) or a general agreement (in the field of psychoanalysis) not to do or say something. She finds that there is a **different boundary in the termination phase (436):** meaning that in the rest of the therapy sessions the physical contact in the duration of therapy is a more strict boundary, forbidden, but in the termination stage it is different. So in that stage, **she would respond (437)**: meaning that she would drop that boundary and that she would permit physical contact in the sessions. *what does this mean for her feelings towards the patient in termination? Does she do that with all the patients? How does she judge who she would permit this contact?* Then she explains that it has to be the **patient's initiative** (437) for physical contact **(hug, 437)** and she flip/flops and talks about the opposite, if she weren't responsive to this request, then it would be **hurtful** for the patient (438): she uses the phrasal verb "draw back" which may mean to choose not to take action because one feels cautious or nervous – *does the physical contact or the presents make the therapists nervous during the termination stage? How is this taboo affecting their response to the patient's request?* To indicate the opposite, she gives the example of one of her supervisees who was **hurt** in the termination of her own analysis and how she would **cry** when she referred to the last session (438-441). The **consequence** was that the therapist wanted to go back and have a conversation with the therapist (contact after termination) (443). She then says that she considers it as **human** (444) and that it is expected to respond in this way as a hurt patient, to have the need to have one more discussion about the ending, even though it is this bizarre therapeutic relationship. She then says that she can't **generalise the rule** (444), that it actually depends on the patient's actions (445) and how they are dealing with the

ending and that the therapist's reaction would be **spontaneous** (445): that it is not planned and that the reaction is different, that there is no rule and, as a human thing, it is not fixed but it depends on the situation (*"on learning from the patient"*).

Then she brings the examples of three patients to indicate the differences in the **way/ strategy the patients terminated and what was different in the use of therapist concept.** The first is a **male patient (446)** and she talks about his personal history and the parental figures who were absent in his childhood (447-8) and as a consequence, he was a very **competent/ resilient** patient (448). His had a personal relationship in marriage but his symptoms were his homosexual tendencies (449-50). Then she talks about the different agendas: the patient terminated when the symptoms were reduced whereas the therapist would like the symptoms to disappear completely (450-51): again she talks about the **control** the patients feel on their symptoms and how they tend to terminate at that point, regardless what the therapist feels (link with previous data). She talks again about **real life and reality (451**) which can be linked with the concept of "real world" mentioned before: *how do the external circumstances influence the process and termination of therapy? What properties are there in the external/ real world that have an impact on the termination?* Then she says that she e**xpects the patient to regress to his symptoms after the termination** (452): again, this has to do with the therapist's expectations and agenda for therapy and how they expect specific patient to return to their symptoms and she compares that to the **eating disorders** (452). *What kind of patients influence this concept and in what way? Do obsessions, eating disorders, perversions have a greater impact on the termination as symptoms? Why has she not mentioned other disorders? Are these the ones she feels more "close to" or they are able to "use the therapist more"?* She says that even though there is an **improvement in the patient's symptoms (452)** that she expects this regression to take place (453) and how termination takes place when they feel more in control (453). Then she speaks about how the patient terminated, or more specifically, how the patient acted in the last session (453): she characterised it as "interesting" (454) which has a negative connotation because of the patient's fear to be needy or vulnerable (455) even though he "used the therapist" (454-55). The "way he left" (455) was **sharp and not emotional (compare with next patient example) (456-7)** and she associated that with the patient's professional life and the patient's experience of therapy as "business" (456, 464): without emotions, without tears (like the other male patient, 458, who was more **available emotionally**, 459). *She expects that the patients who have used therapy to be emotional in the termination and when this doesn't happen there is a negative connotation, interpreted as coming from the patient's fear.* Then she brings the concept of "more work could be done" (460), again pointing out the differences between the patient's agenda and goals and the therapist's. she stayed with this feeling **after the termination** and thought about it and that she actually **expected it** (462): the patient wanted the therapy space for **rationalisation** (465) (so no space for emotions?). so, as opposed to the obsessive patient, the patient was engaged but did not want to be much aware in the therapy sessions of his issues (466-7).

Then she talked about a **patient who died** (474): so this is another concept of termination through death. She mentions his age (475) and the fact that the death was **tragic and unexpected (375).** She learnt about the death through third party (476). She was actually expecting to see the patient when she found out the day before (476). She refers to her experience as "traumatic" (478). She talked about the patient's issues

(478) and the patient's positive characteristics (479). She had to write a report and she consulted the ethics committee. She also **contacted the patient's family** (482). She **attended the funeral (482)** and she remained herself unnoticed ("sneaked in", 483). She defines as "bizarre" and "strange" her experience (483-4) because she saw the people of the patient's external life that he talked about in the sessions (484) and his personal relationships and how he was in these (485). She mentions the loss these people felt (486), and "felt like she was there" (487-88). What was also strange, was that she **did not have the chance to say goodbye** (489): there are the notion of planned ending, the time needed to work through the feelings and discuss on termination (flip/flop). The patient was physically ill (490-2) and how there was a **thought and suspicion of suicide and how "horrible" that thought was for her (493-4)**. She felt though that she knew the patient would not do that but would do other things in his life (494-5). She mentions two personal feelings towards the patient (498): her sympathy and the admiration for the patient's use of symptoms and way of living (499-500). **She grieved and went through the mourning [literature, mourning and melancholia], low, process for "quite some time" (502) and she also mentions emphatically the external reminders: things she sees or hears that remind her of the patient (503-505).**

AXIAL CODING

In the parentheses the first number indicates the participant number, the second one demonstrates the paragraph number in the transcript and the third one shows the line number where the relevant quote can be found.

CONTACT AFTER TERMINATION

- Patient writing letter (1,5,79)
- Odd session – one or more (1,5,80)
- Patient won't come back (1,5,81)
- Therapist doesn't introduce contact after termination first - patient's initiative (1,6,82) Patient's initiative (1,6,82) – patient's control of contact after termination
    - Therapist's consent and encouragement (1,6,84)
    - Consequence: patient's pleasure (1,6,84)
    - They seek the therapist out – their control of contact (1,26, 342)
- No contact after termination by patient – therapist's surprise and interpretation of it (1,6,85)
- Patient desire to confirm whether they can continue therapy after termination with same therapist (1,6,83)
- Patient continuing therapy after termination with same therapist because of events in external circumstances (1,12,141) – patient's initiative
- Patient continuing therapy after termination with different therapist (1,18,229)
- NO contact after termination – therapist's desire to know what happened in patient's life (1,9,112) **[see card "know what happened"]**
- Difference between personal therapy and therapy with patients – therapist don't become colleagues with patient (as in personal therapy) (1,11,130) – the **nature of the relationship changes** and the possibilities to **meet in external circumstances are higher** (1,11,129/130)
- Follow-up session (1,13,146)
- When (situation) patients want to "leave the damaged child with the therapist" - no surprise/it was expected when NO contact after termination (1,21,288)
- When (situation) patient is "cut-off" person - therapist's **anticipation** of NO contact (1,22,300-1)
- Patient writing a letter (1,23,323)
- Difference from social life (1,25,337) – higher possibility for contact with friends after losing touch with them (1,25,338)

DEAL WITH FEELINGS

- Use of termination: Discussion about patient's unresolved – difficulty to resolve issues (1,21,276) – interpretations, enhance understanding of patient's presenting issues
- Group supervision (1,23,307)
- Colleagues - peer supervision (1,23,307)
- Personal and intimate peer supervision (1,23,308)
- Particular colleagues – colleagues with same career path and long term relationship (1,23,309) – one or two really close colleagues (1,23,312)
- Personal therapy – analysis (1,23,313)
- Colleagues in the same setting (1,23,311)
- Feelings "wandering around inside the therapist" (1,23,313): therapist working through their feelings
- Therapist **developing familiarity** with these feelings – getting used to them (1,23,314)

DURATION OF THERAPY

- Short and long term (1,3,10)
- Number of sessions (1,3,11)
- Until patient develops resiliency (1,4,62)
- Frequency of sessions per week (1,5,71) – investment of time
    - 6 months – recognise patient (1,4,157)
    - Short term VS long term (1,16,164)
    - Long term (years of therapy) and frequency of sessions – patients become part of therapist's life (1,16,171/173)
    - Once or twice weekly (1,21,263) – still the impact was intense – amazed
    - Three times weekly – once towards the ending **[reduction of frequency of sessions towards the end – tail off]** (1,22,299-300)

- Long term: intense engagement and "difference in ending" VS short term (1,16,178/9)
- Long term and short term work before training as a therapist – as a social worker (1,24,325/326)

FEELINGS ON TERMINATION

- No contact after termination – finality of termination – sadness (1,5,81)
- For both sides (1,3,8)
- When (situation) personal feelings – sadness, loss, separation (1,4,77)
- When (situation) the time and the date for termination are set in the therapy process (1,4,67)
- Personal history of loss and separation (1,5,74)
- Coloured by own experience of termination (1,4,13/14)
- What belongs to whom (1,4,16/17)
- Therapist "minds" about patient – what happens to patients after the termination - worry (1,5,74)
- When in therapy process the patients acquires **resilience** – the feelings are mixed and positive (1,4,67/68)
- Human and natural (expected) (1,7,87) **therapist as a person**
- Anxiety about endings (1,7,88) **therapy termination – as endings in general**
- Patient's openness - strong expression of feelings (situation – action/interaction) (1,8,106/108) – Consequence: Strong feelings of loss at the termination and finality of termination (1,8,109) – **LINK with "use of therapist" card**
- Strategy: awareness of feelings/monitor feelings (1,11,120) – NOT act them out (1,11,120) – not express feelings without thinking about it first
- Strategy: deal with feelings of termination (1,11,120), think about the feelings (1,11,120) **[link with difficulties of patient's to be spontaneous with feelings]**
- Sadness when patients leave (1,16,170) LINKED patients staying in therapist's mind
- Strong feeling of loss (external circumstances – look at **finality VS partial card**) (1,8,105-109)
- When (situation) patients stir up personal things – therapist feeling closer to patients in terms of their pathology (1,5,75/76)
- Relief: when extraordinary piece of work (1,18,232) – difficulties with patients, patients non engagement – non communication, difficulties in working together (1,18)
    - First time therapist encounters such difficulties in process and relationship (1,18,232/233)
    - Silent patient (1,18,233) - what is not said is very intense (1,18,234)
    - Hateful/ Critical patient (1,18,234)

    - Patient's psychopathology (eating disorder, 1/18.227) (obsessive, 1,19,245 – obsessive thoughts intruding therapy process, 1/19/248)
    - Patient making therapist feel like "rubbish" (1,18,235), therapist feeling "rubbish", incompetent (1,18,241)
    - Therapist's difficulties to make a connection with patient (1,18,239)
    - Therapist's difficulty to "get through to" and "connect with" the patient (1,18,242/244), get "behind the defences" (1,19,249),
    - Frequency of feeling of relief **(rare)** (1,19,245)
- Sadness: when patient terminated because **there were areas in life NOT worked through/resolved in therapy** (1,21,272) [**LINK with "Therapist's VS Patient's agenda" card]**
    - Therapist fond of patients and coping mechanisms (1,21,268 -) – admiration for patient's achievements
    - Patient engaged – communicated in therapy sessions (1,21,270) – patient's commitment to therapy
    - Patient improved in areas – issues remained unresolved (1,21,274)
    - Patient's "awful" personal history (1,21,275)
- Painful ending (1,23,323)
- Anticipated feelings when proper/planned ending – opportunity to work through them (1,28,393)
- Patient's feelings: (judging from a therapist's experience of termination of personal therapy) (1,28,402)
    - First mixed, sad and complex – tremendous sense of loss (1,28,401)
    - When worked through – freedom (1,28,399/403)
- Therapist – **parental figure** (1,12,137/138)

FINALITY OF TERMINATION VS "PARTIAL" TERMINATION

- **Finality:**
    - It will be forever – patient's anxiety **[link with human anxiety – Feeling card]** (1,7,90/91)
    - Never see patients again (1,7,96)
    - Patient leaving the country – external circumstances – strong feeling of loss (1,8,105-109)
    - Therapist aware that ending would be final (1,8,111)
    - Strategy: deal with finality: therapist encouragement for follow-up session (1,13,147)

- When (situation) patients want to "leave the damaged child with the therapist" - no surprise/it was expected when NO contact after termination (1,21,288)

- **Partial termination**:
  - For patient: therapist stays in patient's mind, therapist stays "inside" the patient (1,7,98) – internalisation
    Therapist's and therapy's influence and affect on patient (1,7,99/100)
    Strong sense of person's (therapist's) presence (1,7,99) / patients' presence, they are very much there (1,16,174)
    Continue therapy with same therapist (1,12,135)
    - For therapist: patient staying in therapist's mind (1,8,101) **[e.g. training patient**: intense experience for therapist (1,8,102): therapist giving it much thought and wrote paper on it (1,8,103)

    When patients use the therapist in a meaningful and intense way (1,13,149)
    External reminders (1,13,151/153): in the street, a piece of music or what other patients say
    Strategy: encouraging patients when they ask for follow-up session (1,13,147)
- **If it has been a good relationship – doesn't come to a proper end** (3,20,235) – patient's internalisations of therapy/patient thinking about

THERAPISTS' EXPERIENCE OF KNOWING WHAT HAPPENS TO PATIENTS AFTER THE TERMINATION OF THERAPY

- Desire to know (1,19,112) – whether patient's aspirations have been fulfilled (1,19,113)
- Therapist finding out about patient through third party – hearing about the patient (1,19,114)
- Strategy: Therapist's encouraging the patients for follow-up session (if patients ask – always patient's initiative) (1,13,147) LINKED with tackling the human desire and anxiety **[see Feelings card]**
- Therapist wondering what happened to **difficult patients** after the termination (1,19,251)
- Therapist finding out about patient's life years after termination – patient initiating contact (1,19,252/258) / learning about the difficulties and their progress
- Therapist's **feeling** after they find out – "nice to hear" (1,20,260)
- Time since termination – years after termination (1,20,260) (1,21,283)
- Therapist's **curiosity** (1,21,283)
  - Look up the patient's name on the internet (1,21,282)
  - Find out about patient's professional development – whether they achieved their aspirations (1,21,284)

    - Therapist's feeling of **pleasure** and **interest** (1,21,284)
- Therapist will not know about patient's **personal life – unresolved issues** (1,21,287)
- Therapist thoughts on how patient copes after the termination (1,21,290) – assuming what happened to patients after the termination
- Therapist **wondering** what happened to patient after termination with **training patient** (1,22,302) – whether problems were resolved (1,22,303-304)
- When (situation) therapist has invested time/writing/training patient - "nice to hear" (1,22,306)
- Find out from "third party" about patient's events of life (1,23,324) – "nice to hear" (1,23,324)
- Wondering about clients in previous profession– time since then (30 years) (1,24)
- Thinking/wondering for people from all professional life (1,25,334) – **comparing to social interactions: when (situation) meet people and lose touch with them** (1,25,335)
- Therapist expectation **not to know** what happens to patient after termination – **link with time if termination LINKED with how therapist desires to see the patient** (1,26,356)
- Patient wondering whether patient continued therapy – or whether they would (1,30,461)
- Thoughts on patient's life after termination – worry (1,26,359)

PATIENT'S CHARACTERISTICS

- Training patient (e.g. 1,8,101) – patients therapist is treating during their training – not analysts – patients, training patient (1,22.292)
    - Investment of time/writing up each session (1,22,205)
- Patient's psychopathology (1,8,104) – complex – therapist feel closer to specific patient's psychopathology (1,5,75), **obsessed patients – difficulty to "use the therapist"** (1,17,199)
- Patient's personal characteristics (1,8,104) – enchanted, patient's personality – shy, difficulties in trusting people (1,17,187), ambitious (1,17,188) (1,21,269), charming (1,23, 320)
- Culture (1,8,105) – open patients (open to express their feelings and thoughts in therapy) (1,8,105)
- Patient's personal history (1,12,137) – parents and relationships with parents (1,12,138), brought himself up (1,30,447)
- Patient's presenting issues in therapy (1,12,142 on) – personal history of loss
- Patient's intense engagement / intense transference – something important has happened (1,12,137/143), (1,30,467)
- Patient's initiative to request further therapy after the termination (1,13,146)
- Patient's expectations for therapist to remember them (1,14,159) – <u>therapist staying **strongly** in patient's mind after termination – a lot of work is happening after the termination</u> (1,28,394)
- Patient's voice – use of couch in psychoanalytic practice – remembering the patient through the sense of hearing (reminder) (1,15,162) / recollection of voices (1,15,163)

- Therapists thinking of particular patients for the interview (1,1,2) (1,17,181)
- Patient's difficulty to express intense emotions (1,17,191)
- Patient's personality - bright, interesting, positive relationships (1,17,206)
- Patient's parental figures – personal history (1,17, 202)
- Patient's personality (1,18,213)
- Patient's personal history – feelings towards parent, death in family (1,18,222)
- Patient's psychopathology: eating problem (1,18,227) – **LINK with all the difficulties in engagement**
- Patient's inability to resolve all the issues – STILL function and "lead a full life" (1,21,278)
- Patient's presenting issues – isolation and loneliness (1,22,294) – suicide attempt (1,22,294) – withdrawn (1,22,298)
- Patient "cutting off" after termination (1,22,301)
- Patient's psychopathology – alcoholism – damaged emotionally (1,23,319), patient's loneliness (1,23, 321)
- Patient's psychopathology – anorexia (1,26,345)
- Patient's difficulty in termination (1,26,344)
- Patient's personal history of sexual abuse (1,26,345)
- Patient's resilience (1,26,356)
- Fragile patient (1,26,359)
- Patient's suicidal attempts – admission to psychiatric hospital – desperate patient (1,26,372)
- Patient's tendency to **hang on the therapist – see same patient in different time** (1,26,375) – Compared to other relationships in patient's life (1,26,375)
- Patient's pathology – symptoms coming back - like eating disorder/bulimia (1,30,452)
- Patient's fear of being needy and vulnerable – leaving therapy in a sharp and unemotional way – matter of fact (1,30,456)
- Patient wanting rationalisations – not meanings (1,30,465/466)
- Hateful/ Critical patient (1,18,234)

PATIENT LEAVING SOMETHING FOR THERAPIST

- Patient leaving the "damaged" side of them with the therapist – in the therapy room (1,21,280)
- Patient **writing down** their stories (1,21,279)
- Patient giving presents (1,28,432)

PATIENT'S REACTION TO TERMINATION

- Physical contact in the last session (1,29,433)
    - Patient giving a hug to the therapist in the last session (1,29,433)
    - Patient shaking hands with therapist (1,29,434) **[cultural connotations** (1,29,434)
    - **Taboo** in psychoanalysis (1,29,436)
    - **Different boundaries** in the termination phase (1,29,436) – therapist responding to it (1,29,437)
    - Therapist's responding to patient's initiative for physical contact (1,29,437)
    - Therapist's expectation that it would be **hurtful** for patient if they didn't respond (1,29,438) if therapist draws back
- Human reactions to termination (1,29,444)
- Therapist being spontaneous in response to the way patients deal with ending (1,29,445)
- Patient being available emotionally (1,30,459)
- Unemotional patients at termination VS emotional (1,30,457-458)

PATIENT'S REASONS FOR TERMINATION

- <u>Improvement of external circumstances</u> (1,4,53):
    - More able to deal with situations (1,4,55)
    - Feeling in charge of own life (1,4,54)
    - Able to make choices (1,4,54)
    - Things in person's life are going as person wants to (1,4,54/55)
    - Personal relationships "working" (1,4,55)
    - More able to deal with issues they had at the beginning phase of therapy (1,4,56)
- Patients got what they wanted out of therapy (1,4,42)
- Patient's resiliency (buoyancy) (1,4,60/62)
- Patient's NOT initiating termination even when they don't communicate in the sessions (1,18,215)
- External circumstances – money (1,18,229)

PATIENTS STAYING IN THERAPISTS' MINDS

- Short-term VS long-term therapy (1,16,164) – <u>time is not a factor</u> influencing the concept
    - There is a **difference** though **in the intensity of the ending** (1,16,178/179)
- <u>Factors for patients staying the therapist's mind</u>
    - The way patients use the therapist (1,16,164)
    - Patient's engagement and commitment (1,16,165)
    - Patient's using therapy VS angry patients and difficult patients (the latter don't stay in mind) (1,16,167)
    - Therapist is feeling they have been useful (1,16,168) – patient has made changes, therapy has been efficient
    - Therapist feeling they have something to offer (1,16,169)
    - Patient's engagement, intense transference, commitment (1,12,137-143)
    - Therapy has been a satisfying experience for the therapist (1,16,170)
    - Therapist and patients – being together through primitive experiences (1,16,175)
- Remembering specific clients from previous profession – social worker (1,24)
- External reminders – drive past where clients worked or lived (1,24,328-332)
- Having "all these people" in mind (1,25.339) and never meet them again [**LINK with bizarre relationship – therapeutic relationship card]**
- Patients **"getting under therapist's skin"** (1,26,370) – interested, intense, difficult patient to work with (1,26,371)
- Therapist remembering patients (1,14,159)

PERSONAL THERAPY

- All therapists are expected to have personal therapy (1,4,14)
- Therapist's personal experience of termination of personal therapy (1,4,13)
- Therapists finding it useful to have "been through it themselves" (1,4,15) – <u>strategy – link with **Feelings card**</u>
- Use therapist's personal experience of termination of personal therapy to "imagine/feel what it is like for the patients" (1,4,16/18) – <u>Strategy</u>
- Experience of termination of personal therapy (1,11,125/129)
    - Contact after termination – change of nature of relationship – <u>colleagues</u> (1,11,129)
    - Importance of good ending (1,11,127)

TECHNIQUES ON TERMINATION

- Strategy – Technique on termination: "tail off the sessions" – reduce the weekly frequency of the sessions when working towards termination (1,27,379)
- Patient improved in areas – issues remained unresolved (1,21,274)
- Therapist's reassurance for contact after termination as a strategy for patients to deal with the termination (1,26,363) – deal with separation (1,26,364)
- Strategy – Technique on termination: "tail off the sessions" – reduce the weekly frequency of the sessions when working towards termination (1,27,379)
    - Cons of that: impact on the quality and the intimacy of the therapeutic work (1,27,381)
    - No proper ending: (1,27,382)
    - Therapy work becomes superficial (1,27,383) – less intimacy and quality in therapeutic relationship and therapeutic work
    - Therapist's tailing off as a strategy/way to deal when they find it hard to terminate (1,27,386)
- Strategy: awareness of feelings/monitor feelings (1,11,120) – NOT act them out (1,11,120) – not express feelings without thinking about it first
- Strategy: deal with feelings of termination (1,11,120), think about the feelings (1,11,120) **[link with difficulties of patient's to be spontaneous with feelings]**

TERMINATION

- Inevitable (1,3,6): expected, unavoidable – "bizarre relationship" (see therapeutic relationship card)
    - ***In the beginning you always (in all occasions) know there is going to be an end (1,3,6/7)***
- Stirs up huge feelings (large in amount and variety, felt through mind and/or senses) (1,3,7)
- Therapist feeling what it is like to for the patient at the termination (1,4,16/18) **[link with personal therapy termination]**
- Therapist's thoughts on termination: When feeling that it is **time to end** but the patient doesn't take the initiative (1,26,344)
- Patient leaving the country – finality of termination **[therapist's strong feelings of loss]** (1,8,109)
- Frequency of terminations in professional practice –amount of terminations (in short and long term) (1,12,131)
- Satisfying experience for the therapist (1,4,70) – when the engagement is intense (1,12,139) / good piece of work done (1,4,68) VS patient leaving with unresolved issues (1,21,275)

- Therapist developing familiarity with the termination – used to it, anticipated (1,13,150) – developing familiarity with feelings as well (1,23,314) **[link with Feelings card]**
- Reflect on therapy process - reflect on changes - patient feels better (1,4,69)
- Recollection of last session (1,21,278)
- Finality of termination of therapeutic relationship – different to social relationships (1,25,341)
- Therapist **not having the heart to initiate termination** (1,26,361) [when therapist believes it is time to end and patient finds it hard to end] – **therapist's emotional difficulty to terminate (as the patient's)**
- Therapist's waiting for patient to be ready to terminate (1,26,362-363)
- Deal with separation (1,26,364)
- Proper Ending (1,28,389):
    - Discussion on ending, thought on ending, planned ending, time for saying goodbye (1,28,389-391)
    - Reviewing: going through over what happened in therapy (1,28,391)
    - Planned ending: time/opportunity to work through feelings (1,29,392)
- termination process – what happens through the ending phase (1,28,394)
- Loss for patients (1,28,402)
- Time to work through the feeling of loss (1,28,402) – LINK with planned ending
- Different boundaries in termination (1,29,436) LINK with physical contact
- Significance of termination – can be traumatic/upsetting/hurting (1,29,442)
- Patient's initiative to terminate (1,4,54-60) (1,26,361) - therapist's hesitation to terminate (1,26,362)
    - Planned and ***mutually*** agreed termination VS therapist terminating with setting/unplanned (1,8,107)
- Cultural connotations:
    - Culture (1,8,105) – open patients (open to express their feelings and thoughts in therapy) – very British in terms of physical contact (1,29,434)

TERMINATION THROUGH DEATH

- Patient who died (1,33,474)
- Patient's age (1,33,475)
- Tragic/sudden/unexpected death (1,33,475)
- Find out about death through third party (1,33,476)
- Therapist's traumatic experience (1,33,478)

- Patient's symptoms and personal characteristics/therapist's personal admiration (1,33,479)
- Issues of ethics (1,33,381)
- Therapist's contact with family (1,33,482)
- Attendance at the funeral – therapist trying to remain unnoticed (1,33,482/283)
- Bizarre/strange experience for therapist (1,33,483) – seeing the people and the relationships the patient described (1,33,484) – because the therapists **didn't have the chance to say goodbye** (1,33,489) **[flip/flop of planned/proper ending]**
- Horrible thought of the possibility of a **suicide** (1,33,494)
- Therapist's personal feelings towards patient – sympathy/admiration (1,33,498)
- Therapist grieving (1,33,502) – therapist feeling low (1,33,502) Therapist remembering the patient from external reminders (1,33,503)

THERAPEUTIC RELATIONSHIP

- ***Bizarre relationship (1,7,94): nature of the therapeutic relationship:***
    - Because: content of therapy sessions – how much material patient shares (material) and in an intimate way (way-manner) **[process - situation]** (1,7,94/95), the therapist knows more about the patient than anyone else in the patient's life **[comparison of therapeutic relationship with other relationships]** (1,7,95) **LINKED with the fact that** the therapist never sees the patient again after the termination (1,7,96) – **difference between therapeutic relationships and social relationships – difference in contact after termination** (1,25,336) [you find your friends] – having this **intense connection but the relationship will come to an end with little chance of meeting again** (1,25,341) / weird that **intense involvement** but then **no contact – or no social circumstances contact** (1,29,429)
- Therapist's personal admiration/esteem/regard/recognition towards the patients [some patients] (1,8,104)
- Strong expression of feelings – intense relationship (1,8,107)
- Patient's intense transference (1,12,134) – time/beginning of therapy (from the beginning/immediately) (1,12,134)
- Patient's intense engagement (1,12,136)
    - Therapist – **parental figure** (1,12,137/138)
- Being together through primitive experiences (1,16,174/175) – **link with therapy process**
- **Negative transference –** patient's difficulty in engaging with therapist, hare towards parent (mother) – negativity towards therapy and therapist (1,18,222)
- **Difference between personal therapy/therapy with trainees therapist and therapy with patients** (1,11,129/130)
- Therapist's difficulties in **connecting with the patient** (1,18,244)
- Previous therapy experiences of the patient (1,18, 242/243)

- Patient's tendency to **hang on the therapist – see same patient in different time** (1,26,375) – Compared to other relationships in patient's life (1,26,375)
- **Difficulty in ending** – patient getting under therapist's skin (1,26,376) – connection
- **Intimacy and quality** (1,27,381)
- Patients being aware of the impact they have on the therapists – engagement in therapy (1,29,412)

THERAPIST'S VS PATIENT'S AGENDA

- Literature (1,4,39): therapist's agenda VS patient's agenda
- When something goes wrong (1,4,41): because (reason): different attitudes about when therapy is successful/efficient, what patients want to achieve VS therapist's formulation (1,4,42/43)
- Time of termination (action/interaction) when (situation) patient terminates in the wrong time (according to therapist's formulation) the (strategy) therapist is negotiating the ending (1,4,46/47)
- Realising the patient will terminate (in the therapy process) (1,4,51/52) LINKED anticipation of therapist for discussion about termination (reason) (1,4,51/52) LINKED patient's resilience (1,4,53) (1,4,63): patient's improvement in external life
- When therapist feels it is **time to end** but patient doesn't take the initiative (1,26,344)
- Therapist's **personal desire about time of termination** – when patient has improved and "settled down" – when therapist sees the patient as they wish to see them (1,26,355)

THERAPIST'S EXPERIENCE OF THERAPY
Therapist's difficulties

- Difficulty to "get through the sessions" (1,17,183)
- Therapist's efforts to understand the patient – "the unexpressed feelings" – the latent content of the sessions (1,17,186)
- Therapist's efforts to understand the "primitive level" of the patient's communications (1,17,189) – <u>strategy</u> – to understand patient's presenting issues (1,17,190)

- Therapist's experience of **hard patient** (1,18,214) **– lack of communication, lack of content, even on manifest level** (1,18,215)
- Therapist's hypothesis about interpretation of patient's difficulties in engaging into therapy sessions (1,18,216/218)
- Difficulty in understanding – find the strategy to work with patient (1,18,217)
- Beginning of therapy – difficulty in engagement VS therapy experience – **both therapist and patient learning how to get through the sessions together** (1,18,219) – later stages of therapy: learn how to work together, patient more able to communicate with therapist (1,18, 224) – Strategy: **as a consequence of the therapist worrying less for it AND using patient's feedback that therapy is useful** (1,18,225) (1,18,242) (indication that therapist got through to the patient)
- Patient challenging the therapist – **patient's response to therapist's interpretations** (wrong, "rubbish") (1,18,221)
- Patient being **negative** – therapist's association with feelings of patient **(hate)** towards mother (parent) (1,18,222)
    - LINK with **relief on termination, see card [feelings]**
- Extraordinary piece of work (1,18,232)
    - First time therapist encounters such difficulties in process and relationship (1,18,232/233)
    - Silent patient (1,18,233) - what is not said is very intense (1,18,234)
    - Hateful/ Critical patient (1,18,234)
    - Patient making therapist feel like "rubbish" (1,18,235) – patient's attempt to diminish value of therapist's interventions, therapist's feeling incompetent
    - Patient's conflict about coming to sessions: committed to coming BUT expressing relief when not there – therapist's interpretation of patient's secret benefit (1,18,236)
    - INTRIGUING EXPERIENCE (positive connotation) VS EXTREMELY DIFFICULT (negative connotation) (1,18,238)
    - Therapist's difficulty in making connection with patient (1,18,239)
    - Therapist's effort to **get through to the patient** (1,18,242)
- Therapist finding it hard to get behind the patient's defence mechanisms (1,19,248-9)
- Therapist's personal admiration/likeness – fond of – patients, even difficult ones (1,19,250)
- Therapist's personal admiration (amazement) for patient's effective coping skills (1,21,263) – having "horrific" experiences and at the same time be able to "function" (1,21,267) Therapist's personal admiration/esteem/regard/recognition towards the patients [some patients] (1,8,104) –see therapeutic relationship card
- Patient's impact on therapist (1,21,267)
- Depends on the patients – some stir up more personal issues in therapists than others (1,5,75) **[see Patient's Characteristics card]**
- Intense experience (1,23,315)
- Satisfying work (1,25,339)
- More work could be done (1,30,460)
- Therapist's personal thoughts about patient's life decisions and time of termination – therapist's **anxiety** for patient's progress in life (1,26,351/352)

- Therapist's **personal desire about time of termination** – when patient has improved and "settled down" – when therapist sees the patient as they with to see them (1,26,355)
- Therapist's feeling they can "bare the patient" (1,26,374) – decision to work with difficult patient/difficulty in ending/ satisfying work (?)

THERAPIST'S PERSONAL ADMIRATION

- Therapist's personal admiration/likeness – fond of – patients, even difficult ones (1,19,250)
- Therapist's personal admiration (amazement) for patient's effective coping skills (1,21,263) – having "horrific" experiences and at the same time be able to "function" (1,21,267)
- Patient's impact on therapist (1,21,267)

Therapist's memories of termination

- Recollection of last session (1,21,278)

THERAPIST'S PERSONAL HISTORY

- Influence of personal history in therapy work (1,10,117/118) – in the way the patient is "being with" the patient (1,10,118)
- Personal history of loss (1,11,123/124) – for interview 1: unexpected termination through death
- Therapist's profession before becoming a therapist – social worker (1,24,325)

THERAPY PROCESS

- Patient's resilience (1,4,67/68)
- When therapists feel closer to patient's pathology – stirs up more personal feelings (1,5,75/76)
- Intense engagement (1,12,136)
- Frequency of sessions and duration of therapy **[see Duration card]**
- Intense conversations (1,5,72) – feelings of therapists during therapy process (1,5,73)

- Intense conversations about patients, themselves and their lives (1,5,72/73)
- Termination phase – therapists mind what happens to patients (1,5,74)
- Depends on the patients – some stir up more personal issues in therapists than others (1,5,75) **[see Patient's Characteristics card]**
- Breaks in therapy process – rehearsals for how the termination will feel like (assumption) (1,7,88/89)
- Patients sharing information in an intimate way (1,7,94/95)
- Balance between spontaneous involvement VS expressing thoughts and feelings (1,11,122/123) **[link with monitoring feelings and not act them out]**
- Patient's presenting issues – patient's initiative to continue therapy with same therapist (1,12,140/143)
- Being through together (patient and therapist) primitive experiences (1,16,175) – patient's use of defences (1,16,175/176) [projection, projective identification) **[meaning of intense engagement – LINK with duration of therapy]**
- Patient's feelings towards therapists – hate / intense engagement (1,16,177/178)
- Patient's use of therapist (1,16,164) **link with cards "patient staying in therapist's mind" and "patient's use of therapist"**
- Patient's feeling they are "getting much out of therapy" (1,17,182) - manifest and overt positive attitude towards therapy (1,17,182)
- Manifest and overt expressions of patients VS latent content of patients, during therapy sessions (1,17,183/186) **concept: content of the sessions**
- Obsessive thoughts intruding therapy process (1,19,248)
- Patient's use of therapy sessions (1,21,270)
- Get to "deserted places" and "deserted memories" (1,23,320-321) – **being through deeply regressed places** (6,14,163)
- Discussion on termination date and time (1,26,346)
- "Blocks" of therapy in different settings and time (1,26,365-369) linked with patient's difficulty to see another therapist (1,26,369)
- When "tailing off" towards the ending: work becomes superficial/focused on external events of every day life (1,27,384)
- When "work is good enough" (1,28,396) – stays inside the patient (1,38,396)
- Aim of therapy: for patients to be able to work through loss and feel freedom (1,28,404)
- Intense VS not so intense: frequency of sessions, financial reasons, therapist's sense that it would be useful for patients, patient's being ready for it (1,28,405 – 409)
- Patient's improvement BUT therapist accepting the fact of not complete improvement (1,29,452)

THERAPIST'S SELF DISCLOSURE

- Patients being aware of the impact they have on therapists (1,29,410)

- Patients' feeling of how they influence the therapist without the therapist's disclosure (1,29,411)
- When (situation) resilient patients - competent – able to use the therapist, then therapist would be more open about their feelings RE therapy process (1,29,421)
- Therapist acknowledging that they will miss the patient (in the above situation) (1,29,422)
- Having as a model: personal analysts and their self-disclosure (in this case – encouragement for contact after termination) - **surprise to therapists-patients** (1,29,424)
    - Feeling towards therapist's self-disclosure: "nice thing to say" (1,29,427)
    - Human thing to say (1,29,428) – LINK with therapist's human feelings of termination **[feelings card]**

THINKING – ANALYSING PHENOMENA
THERAPIST'S THEORIES

- thinking about termination (1,1,1)
- Huge question (1,3,6)
- Confidentiality – worry about confidentiality of interviews (1,4,23)
- Question of termination – generalise (1,4,30), uncertainty on termination, issue of termination (1,4,49/50)
- From professional practice (1,4,33), from literature (1,4,32) (1,4,40)
- Overview of professional practice (1,4,48)
- Discussion in peer group (1,4,49)
- Discussion in supervision (1,21,276)
- General psychoanalytic consideration: a lot of work takes place after the termination (1,28,396)
- Talk to colleagues on termination (1,28,397)
- Therapist experience of termination – long history of loss (1,32,473)

TIME OF TERMINATION

- Therapist's control (or lack of control) (1,4,23) – uncertainty
- Patient's initiative (1,4,35)

- "right time" (1,4,32) – difference on when it is the "right time" (1,4,42) – how much time is needed for therapy to be efficient (1,4,45)
- Time needed for "work to be good enough" (1,4,45)
- Therapist's perception that more work could be done (1,4,43/44)
- Therapist's goals VS patient's goals **- link with cards: Termination and Therapist's expectations VS patient's decision**

- Reasons for termination (subcategory) (1,4,31)
  - Patient's reasons: achieved enough (1,4,36) – internal to therapy / "right time" (1,4,32) **[time of termination if used as a separate concept]** / external circumstances (1,4,33): money (1,4,33) (1,18,229), practical reasons (1,4,34) / patient's initiative (1,4,35)
  - Therapist's reasons: difficult to deal with (1,4,37) / therapist has different agenda (1,4,40) / more work could be done (1,4,43/44) / uncertainty about when it is the right time (1,4,46) / deal if it is not the "right time" – negotiating (1,4,47)
  - Time: at which point in time (1,4,31) / point in time – for how long – how much time is needed for good/good enough work (1,4,45): duration LINKED efficiency, discussion about date and time and **way** of terminating when patient finds it difficult (1,26,346)

TRAINING – EARLY WORK (VS CURRENT WORK?)

- Write paper on patients for training purposes (1,4,19)
- Training patients LINKED with training requirements (duration of therapy, frequency of sessions) (1,4,19/20)
  - Read a lot – write about the patient (1,4,29/30)
  - Patients to conclude the years of therapy required by the course (1,4,21…)
  - Anxiety about unexpected/premature/unplanned termination (due to external circumstances) (1,4,21/24) – uncertainty about whether the patient will continue (1,4,24)
  - First experience of long term therapy (1,4,21…)
  - "constant problem" – continuity of the anxiety RE unplanned and premature termination (1,4,24)
  - Training patient – intense – much thought – wrote paper (1,8,102/104)

PATIENT'S USE OF THERAPIST

- Use of therapist (1,16,164 – 1,17)
- How patients experience the therapists – therapist's thoughts (1,17,180/1)
- Patient's difficulties in expressing intense emotions in therapy sessions – indicated by the manifest content of the therapy session (1,17,182, 193)
- **Patient's use of therapist = patient and therapist engaging into "an emotional experience"** (1,17,196/7)
    - Flip/flop: difficulty to engage for **obsessive patients** (1,17,198): anxiety in therapy sessions, difficulty to be "spontaneous with feelings" (1,17,199) – therapist's difficulty to understand the latent content – "get underneath" (1,17,1201)
    - Flip/flop: difficulty to trust and engage emotionally – therapist's difficulty to understand the primitive level (1,17,182/3)
    - Patient's "immense engagement" VS obsessive patients (1,17,205)
    - Therapist's ability to understand the latent content of patient's presenting issues (1,17,209/210) – therapist's interpretations
    - Patient's **knowing how to use the therapist** (1,17,211)
    - Patient's **easily** using the therapist (1,17,211)
    - Patient's **getting a lot out of therapy experience** (1,17,211) – patient being **open** (1,17,212) [on the manifest level, able to express feelings and on the latent content, able to engage emotionally despite anxiety and defences)
- Patient leaving the "damaged" side of them with the therapist – in the therapy room (1,21,280)
    - Patient **writing down** their stories (1,21,279)
    - Patient giving presents (1,28,432)

Transcript Participant 1
Second Interview

Before the beginning of the recording we discussed the purpose and the structure of the second interview and started recording when it was time to ask the questions. The parts of the interview that were coded in memos for the final categories are highlighted with bold letters.

Eva: The first thing is…you talk about these patients that you feel quite closer to their pathology – those were your words. I can find it in the transcript if that helps you – it's in page 3, in the middle of the first paragraph: "or feel closer to you in terms of their pathology" and this is where you talk about how patients stir up more personal things for you than other patients. So I was wondering whether you could talk a bit more about what you mean when you are saying: "feel closer to their pathology".

P1: Well, there are always patients who I suppose **I can relate to the way – to what the person is saying to me; much more closer in terms of my own personal experience. Or my own personal way of dealing with difficulties** I suppose. And sometimes, it wouldn't be that I would see someone and think: "oh that person is like me". It's often that you don't know until you work with someone for a while where it is that you **connect in that way**. And it's not necessarily obvious but **different patients bring out different parts of one's own personality in a way or their struggles and issues.** But I know that when we were training, because there was always this notion that you get the patients that you need; the ones that are working on issues that are difficult for you in some way. You end up with those kinds of patients. Now, whether they are the ones that necessarily fit your own pathology or not is of no matter but it's often, I don't know whether it's true or whether it is just the kind of therapy, but it is as if there is this kind of unconscious fit that the right person comes to you at the right time that you are dealing with a particular issue and somehow there it is when your patient comes with it.

Concepts: personal history, specific patients – connection – stir up different things, bonding relationship, unconscious fit

Eva: I don't know if you have identified a particular cluster or type of patients…for example you have talked about obsessions, about eating disorders…

P1: Yes, that's true. And in the past I have worked a lot with bereavement. It is interesting I haven't really talked about that very much. **I have worked in an eating disorders clinic and that interests me in particular because I suppose I had a patch in my 20s,** I wasn't diagnosed with anything, but **I can relate to the eating disorders mindset**. So I applied for this job at *[setting of work]* and got it and I found it very interesting working with patients with eating disorders, it was something that I could relate to; the kind of perfectionist notions. And there is a kind of obsessive string around eating disorders as well. And yeah, **that's something that I can understand from my personal point of view**. Although I don't have any issues around eating disorders, it's just that it's a state of mind that I can relate to. And because I have worked in an eating disorders clinic and I am on *[register in specific association]*, I get quite a lot of referrals from there anyway. I wonder if there is any other cluster…because I suppose colleagues, when they refer patients to me, **they**

must refer patients that they think I would be good with. But if I try to think about that…sometimes it feels relatively random when patients come to you but I am sure **there must be something about the patients that people refer to you**. I think probably people have referred patients to me who they might feel frightened and scared, you know, when you are very put-off by someone who is terribly stern and I don't know what I come across as…but I think colleagues would see me as someone who could work with a wide range of people, particularly people who haven't had any therapy before and are quite worried about getting started. So there might be someone who is quite timid I suppose. I have a colleague who referred someone to me but the patient never came, she never turned up who sounded like she was not a very suitable patient in terms of psychoanalytic psychotherapy. I think she had a lot of very real, everyday, life issues that she would like to talk about. She has had some therapy before but the therapist said that, she said that: "I don't if this is a kind of patients you could do much therapy with". And I wondered why she referred her to me and I wasn't sure what to make of that really. But this isn't the norm; people don't say that regularly to me.

Concepts: personal history, intense engagement, "I can relate to", specific patients – special connection, reputation – specialty,

Eva: It's about difficult patients then.

P1: Yes…It's hard to know because…it may be a certain sort of difficult patients because I am probably not…I've got colleagues to whom I would refer very disturbed patients; probably borderline personality disorders or people who need a very firm hand because they would kick all the boundaries all the time. I am not sure my colleagues would see me as one of those. I mean I don't…for instance I supervise someone who is looking for a therapist for someone who she sees who has got all these issues around sexuality so, you know, I found a colleague who works at the *[place of work]* to take this patient. But I don't suppose colleagues would think of me in particular as offering that kind of…being particularly good with patients like that. Although in the course of one's working life a whole range of people do come. **But I am sure there is something about the kind of reputation you get**. I mean I can think of a psychoanalyst who has worked a lot with violent patients and I am sure she must get a lot of violent patients for whom she has written a lot so, yeah, I thought of her with this particular man…so I suppose there is someone who has written about or is known to work with particular patients…Now, what her history is and why she has been working with violent patients I don't know.

Concepts: therapists' reputation, working with specific patients

Eva: Another thing I would like to ask is something you have talked about when you talk about your training patients and how much you feel you "invested" in them, in terms of writing and thinking about them. So I am wondering, because you haven't talked about it specifically in this interview, about the termination and about how you experienced it, if you have found that there are any differences before and after your psychoanalytic training. Many participants talked about their personal therapy and analysis during the training or how you worked with patients before the training and how you work with patients afterwards. If we could try and focus on the termination phase would you say that there are any differences in how you experience it.

P1: Before training and after training…Training seems quite a long time ago so it is hard to remember actually. **But I am sure there are loads of changes because the training is such an intense experience and then also after my training I finished my own, I ended my own therapy, my first experience with someone I have been with for ten years. So that in itself has a huge influence I think on your experience when you are ending with people.** Because I suppose I have done a lot of work before my training anyway, I have worked in the eating disorders clinic, I was in the middle of my first training, not the psychoanalytic one, at the time and I have worked with a lot of people at the doctor's surgery but that's short-term work. I think it is very hard for me to separate out now. Maybe if we talked about it two years after I had done the training I would have been more able to answer that. Because it has been quite a while now since I trained. **I think the thing that has made a huge difference is my second analysis actually, which has made a huge difference to the whole way that I work. And my experience of different supervisors, and also I am part of a peer supervision group and I go to quite a lot of scientific meetings. So it is very hard to separate out what affected me…**I think when you are doing your training you are so overwhelmed by the experience which is very time-consuming and very intense – you focus very much on these two patients – and I suppose at the time of the training you are not sure what it is going to be like to end with these patients you have worked with so intensely. I wonder if with time you get used to…for instance, my training patient, the whole experience was a very intense partly because of her and partly because she was my training patient, and the fact that she was constantly possibly going back to *[place of origin]* in the middle of this training, so the whole thing was terribly intense. **And then the ending was very intense because I knew I would never see her again,** which is often the case, but because she was going to *[place of origin]* I would never see her again. So I suppose it is not quite the same afterwards. I don't think that is entirely true, I mean there are **some patients who stir up these intense feelings afterwards**.

Concepts: before and after training, before and after personal therapy, influence of personal therapy, influence of supervision – peers, final termination, specific patients stir up intense feelings

Eva: But I guess, it was that, because you have talked about that feeling of uncertainty for your training patient, "she will stay, she will leave"; this notion of uncertainty, I am wondering how it was for you.

P1: It is very anxiety –provoking; *[a trainee therapist losing her third patient]* She said that she was destroyed because the notion that this training is going to go on and on and on and on for years, and then given that you will be in therapy and pay your supervisor for years and years and years; it's very exhausting and worrying. But you invest such a huge amount of yourself in your training and it's a big decision to train and **when patients don't stay it's difficult to start again**. I mean, sometimes you learn a lot through that process so it's never lost but at the time it feels very difficult. I didn't have that experience myself but a close colleague of mine did and I know she felt she wasn't able to carry on really. **So when you are training the patients have that kind of power in you and they know you are a trainee**. They can't possibly know exactly what that means but they know they are **tied up in some thing with you that they have some power.**

Concepts: abrupt termination, patient's power in training

Eva: How about the uncertainty you may feel with your patients now? You know, someone now, after all this experience that you have had, if someone is very ambiguous about staying and continuing and this anxiety about the patient staying or leaving. I mean, does it affect you that much now or…?

P1: No, I am just thinking about this patient whom I did mention when I first saw you and I just re-read it, who did leave in the summer in very peculiar circumstances really where **she left me without knowing if she would come up**, very ambiguous. She said she would contact me after the summer and she never did. It gets more complicated than that even. **And, it still affects me, yes**. I suppose to a certain extend **you get a bit more philosophical** and you get to feel that, well, people come and they **do use you** and you do your best and then either they use you as much as they can or they can't. But there is always that feeling I think: "**well, maybe if I'd done something different or I had taken to supervision more or**…", you know, there is always that feeling that. I suppose that is what is interesting about the fact that you **never get bored because you never feel certain about your job**: "oh yes I know what I am doing". You can't get arrogant and say people do what they do and if they don't like it they can go. But there is always that struggle of thinking: "well, perhaps I missed this or perhaps **I didn't work properly enough with that or if only I hadn't said that or"**. I think if I didn't feel this anxiety or questioning that I think I would be worried because I'd be a bit too pleased with myself and I think part of the ongoing learning which we all have to do particularly when discussing with colleagues is that we have to still be more creatively thinking about our work**. I mean each patient stirs up different things** and new papers and new thinking is always happening so it's really good **if you can be hearing it and listening to it and engaging in that thinking process all the time**.

Concepts: uncertainty about therapy – effect, "philosophical", patient using therapist, reviewing, ongoing learning - process

Eva: So it is a continuous process. It is…this is interesting and makes things more clear for a few bits and pieces in this transcript. I am not sure if you would like to add anything or turn the recorder off even.

P1: (looking at the transcript). I can't think of anything but perhaps what I need to do is re-read the transcript more carefully and see if I have any thoughts.

Eva: I am happy for you to contact me again if you feel you would have more things to say or discuss thoughts.

P1: There were a few things where I thought that: "did I really say this?" but nothing major but I will go through it again if there is anything.

MEMOS

In the memos, data from all interviews were used in conjunction with the codes and categories from P1's first and second interviews. The main category that derived from P1's interviews was the concept of the ***bizarre relationship*** *as it has been described in the relevant memo. Three more memos (time of termination, feelings, termination) have been included to demonstrate the analysis of data deriving from P1's interviews along with the rest of the data.*

THERAPEUTIC RELATIONSHIP

What is important is that the therapist is experienced as a person (the patient knows about the therapist's life anyway) but also the therapist is experienced in the transference as a "parent" or as a "symbol" of comfort/strength and understanding. The relationships seems to be stronger/deeper when the patient feels understood. So there are two dimensions:

- Therapist as a person
- Therapist as a symbol

Also in terms of the transference AND feelings on termination:

- Difficult patient: rubbishing therapist/parallel with personal history – **sadness**
- Patient's needs for strength/support and Therapist's Confidence at termination/good timing for termination/good piece of work/therapist feeling **useful – Happier at termination** (3,7)

TERMINATION is associated with LOSS – for both therapist and patient (P4) = loss of the relationship/loss of potential relationship (P5)

The therapeutic relationship is a bizarre relationship. What makes it bizarre is the nature of the termination and its finality as well as the fact that the therapists cannot be spontaneous with their feelings but actually monitor them and not act them out. This is what makes it different to the social relationships. The therapist perceives each therapeutic relationship as deep or shallow. This has to do with the therapist and what they bring in the relationship, the way the therapist perceives the patients and the actual process of the development of the relationship. The therapist and the patient go

into vulnerable and primary places and then they have to finish the sessions and finish the therapy. The dynamics developed are those of the parent and the child: there is a form of dependence, power imbalance and how the difficulties in the patient's childhood are projected on the therapist in the way that the patient is using the therapist as the child is using the parent. The patient involves the therapist; the material is deep and the engagement intense. There is also the factor of therapist's personal admiration coming to this; how the therapist is fond of some patients. What adds up to the bizarreness of the relationship are the feelings of the therapist towards her patients, how attached and dependent they might be themselves as well as how much she loves them. In this sense, it is quite bizarre when she really loves her patients but lets them go – intimate relationship that comes to an end. In the beginning of the therapeutic relationship the patient sees the strength and the power in the therapist. At the termination, the patient needs to own this power and strength in them. The patient shares information in an intimate way.

At the time of termination the dynamic changes. The patient needs to grow up and not be the child any more. The patient needs to be released from the transference. The therapist faces her own maternal transference. She finds herself sad, worried, angry etc. Termination triggers previous losses for her and depending on her personal history she struggles in specific ways to keep herself within boundaries. The therapist meets the patients as two grown ups meet. The therapist self-discloses in order to become a real person in the relationship – demystify the therapeutic process. Therapist and patient meet as two people who have done some work together. There are the cases when the therapist wishes to meet the patients as friends, in social places and in general places other than the clinical setting. At the termination stage the patient owns that power; the strength is not with the therapist any more. When the relationship has been good and the ending is proper, then the therapist discloses something consciously about herself, she is giving something to the patient, it depends whether the patient wants to know, wants to make the relationships real or keep it on the symbolic level, the therapist is giving back the transference and comes across as a person rather than the symbol (mother, comfort etc). The therapist releases the patient from the transference.

Another important change in the therapeutic relationship occurs when the therapist and the patient become colleagues. That happens after the therapist's personal therapy and when she sees trainees as patients. That entails the fact that there is going to be contact after termination and they are going to meet in places other than the therapeutic setting. The same happens with some ordinary patients. The therapist expresses the desire, or even the reality, of meeting patients after termination in social places. This again is a change of the relationship that occurs at termination.

The boundaries are different at termination. The therapist is re-considering issues such as physical contact and presents. An extreme example comes when the therapist has a patient who is dying. In these cases the setting and the place of therapy could change. However, the therapist keeps the boundaries so that they are helpful. Otherwise, the patient will not be helped by a tearful therapist. However, the therapist is honest and human. This is something that is applicable to all forms of termination of therapy. The therapist is human and open in the end. For some therapists the self-disclosure increases deliberately at the termination in order to make the person of the therapist and the relationship more real. But the boundaries change also in other terms such as the physical contact and presents (16+17). Therapists actually respond to the patients' invitations for physical contact and some therapists even regret not having this physical contact with patients.

The therapist knows the long-term patient very well. She knows them better than anyone in their lives. They share their material in an intimate way and then they end and never see them again. The therapist and the patient have this intense connection and then there is no contact. The termination of therapy reflects the ending of sessions as well – the boundaries are the same, in which the patient shares and the therapist keeps the time-boundaries and reminds the end after 50 minutes or 50 sessions. However, it is not only how much intimate the patients are but also how close the therapist feels to them. The therapist really loves her patients but then she lets them go. The therapeutic relationship is also influenced by the breaks and other terminations during the therapy process.

The important for the termination stage is for the patient to have become independent.

What makes the relationship intense?

The intense therapeutic relationship entails intense transference. The material is deep and therapist and patient have reached primitive, regressed and deep levels of experience. The patient is getting under the therapist's skin. The patient feels the therapist's understanding. For some patients the therapist feels a special connection, the therapist feels she understands them more and for them the termination is more difficult and the therapist has more personal worries and concerns about what happens to these patients after the termination. It has to do with mainly how engaged and involved and committed the patient is in the therapeutic relationship. The important aspect is the *therapist's and patient's history* which represents what the therapist and the patient have been through together. The good relationship is a deep, trusting, real one, evolving from both therapist and patient. It is a fertile relationship. The therapist enjoys the patient and there is personal admiration. When there is regression in the therapeutic relationship there is also the element of the patient's dependence. In a good relationship there is a rich exchange and content during the therapy sessions. The conversations are rich and intense. The manifest and latent content of the sessions is intense and the patient feels that she is getting much out of the therapy sessions. The therapist is "getting in the bath with someone" (Jung). The therapist is pulled in transferentially and the therapist and patient have worked hard together. The transference and the engagement are the important elements and they need to be intense. When regression and engagement on a primary level are happening in the therapy relationship then the patient's history and early object relationships are being re-enacted in the relationship with the therapist. The deeper the regression the more intense the attachment in the relationship. The patient and therapist reach "deserted places" and go through deeply regressive places. The therapist then gives more of herself, is working harder and it is qualitatively different than other patients. Therapist is becoming a part of the patient's life. The therapist forms a long term relationship with the patient and she feels maternal: she feels like the patient's mother, is involved in the patient's life, the patient is growing up with the therapist, the patients bring their babies/send pictures of babies to the therapists, the therapist's transference is maternal (as opposed to countertransference). What are significant are the frequency of sessions and the duration of therapy. The more frequent the sessions weekly, the more intense the engagement and the patient internalises and unconscious processes

occur. The therapist and the patient are going through together some primitive experiences and the patient uses her defences and has feelings towards the therapist (hate to affection, attacking to engaging – evolvement of therapeutic relationship).

There is also the therapist's dependence on the patient: financial and attachment-wise.

At the termination stage the therapist feels sad, pleased with patient's achievements and worry about the future. The deeper the attachment the more painful the termination. The patient internalises the therapist and there is the connotation of the in-finality/incomplete termination. There is a "viable therapist inside them". When the work has been good enough, it stays inside the patient.

When is the relationship difficult?

When the therapist experiences difficulties with the patient and there is a negative transference from the patient. There is the tendency to blame the patient for the negative quality of the relationship but the therapists point out that it is an equal relationship, there is not so much distance between the therapist and the patient and highlight that there are two in the relationship. The difficult relationship is characterised with attacking and rubbishing the therapist from the patient. It is characterised with grievance. The patient doesn't trust the therapist and doesn't show any appreciation for the effectiveness of therapy process. The difficult relationship is rocky, fluctuating, therapist and patients are not getting on well. The shallow relationship and superficial is characterised by the therapist and the patient just getting on well. In the case of a shallow relationship "it doesn't matter whether the therapist sits in the chair or not". When the relationship breaks down during therapy process, it is necessary for the patient to continue therapy with another therapist.

At the termination stage the therapist feels relief. When the relationship has been shallow the patient doesn't stay in the therapist's mind that much.

TIME OF TERMINATION

When is the best time for the therapist for the patient to terminate?

When the termination comes in the material the therapist is actually exploring whether it is a manifestation of the patient's anxiety, pain and uncertainty about the therapy process or whether it is a pragmatic desire to terminate.

It has to do with the therapeutic change. The patient is independent, resilient, has solved personal relationship issues and they are fuller people. Then the therapist believes that it is time for the patient to move on – to go. At this time it is right for the patients to go on in the world without the therapist. The therapist wants to help the patients grow up and have fuller lives.

When a notice needs to be given (either by the therapist or the patient) there needs to be adequate time to work through the termination. This time is mostly defined as 2-3 months.

Under this comes the important distinction between planned and abrupt termination with all the implications for the therapist regarding the factor: way of terminating –

Significance of last session

The last session seems to be quite important. One of the therapists talked about her own experience of termination with her own therapist. There she felt she had a difficult last session because she couldn't articulate/talk about her emotions. For this reason, she couldn't begin her new therapy; her new therapist suggested she needed to go back and have again one more/last session. And she found it very helpful. Moreover, another therapist talked about one of her patients that terminated abruptly over the phone. But then he came back and have a few more sessions where they could talk about and work through the termination. Then the therapist felt better with the termination – even through it was premature. Some therapists use a specific formula for the last session given that the therapy has been successful and the patient wants to know – the therapist discloses consciously information about herself and the two meet as grown ups.

how patient leaves:

- planned/time to work through the termination
- abruptly/little or no time to work through the termination [leaving therapist guessing/trying to understand the meaning of termination]
- at time of therapeutic change
- there needs to be a mutuality at termination – patient and therapist need to work through termination together – *terminate together*

In terms of techniques, termination is a time for review but some therapists don't do a list of achievements but some others ask the patient to write a letter.

The most difficult for the therapist for the open-ended therapy for the time of termination is whether the patient terminates prematurely or doesn't terminate at all. Most of the therapists believe that it has to be the patient's initiative. However, one therapist will initiate the discussion on termination if she finds this is the right time for the patient. This also entails the differences between the therapist's and the patient's agenda, especially regarding the fact that most of the times more work can be done. However, one therapist thinks that not one therapist can do it all with a patient. A new therapist can offer a new experience for the patient to work on more, different issues (P4+P8).

How much time is needed to work through the termination?

Yes, it is 3 and more months and time is needed to actually work through the termination in the sessions. And when the patient leaves without allowing that time, then the therapist is left with unresolved issues and unfinished business. However, it is not the actual timing (for example after 2, 3, or 15 years) but it is more how the therapist feels at the time of termination. The therapist may feel good about it and have no doubts about it OR she may feel trepidation and worry at the time of termination. It has to do with how ready the patient is as well as how the therapist feels regarding how useful she has been for the patient.

FEELINGS

The general characteristics of the feelings at termination are: variety/intensity/for both sides. So they acknowledge the experience of feelings at the termination phase. And there is a variety in the responses looking at the variety of the feelings, what feelings they expressed and how intense it was for them for each patient. I guess what I need to define is **the factors that had an impact on this variety – what exactly makes the experience various**. Feelings are **stirred up when the time/date of termination is set in therapy process**. Another important factor is the **setting: NHS (fixed term) and private practice (open-ended).**

Therapist experiences termination as a *parental figure* where the therapist is the parent and the patient is the 21 year old child leaving home – going to university. Therapists are intellectually and emotionally aware of this at termination)/ sadness of mother when child becomes independent**.**

FEELINGS ARE FOR BOTH SIDES:

- Understand what belongs to whom
- Therapist feeling like the patient – parallel process (same feelings for patient and therapist)**– 2 P's**

FEELINGS STIRRED UP FOR THERAPIST:

Personal history

- Personal history of loss and separation
- Termination triggers previous losses (also for the patient: see MATERIAL where the patients reveal more at the termination stage)
- Coloured by own experience of termination
- Therapists to look into own complexes
- When patients stir up therapist's personal issues – therapist feeling closer to patients in terms of pathology
- Therapists judging from personal therapy how patients will feel at termination – personal therapy as model (mixed-worked through – freedom)
- Difference at termination before and after personal therapy

Therapist as a person

- **Human and natural – therapists are expected to have these feelings – therapist's own experience of personal therapist showing "human face" (good experience)/anticipated feelings/need to be worked through (deal with feelings) – it is OK to have feelings/use personality VS blank screen/termination stirs up feelings for any of us – *therapist as a person* – *CAN THIS BE A MORE ABSTRACT CATEGORY?***
- Therapist misses patients – "I miss my addicts"
- Deeper feelings when termination with setting – **personal leaving** (reasons for leaving setting/leaving services he gave birth to/professional growing up) – **personal leaving 2: client left me in a personal way/patients leave you** (after patient grew up/patient leaving/mother letting child go)

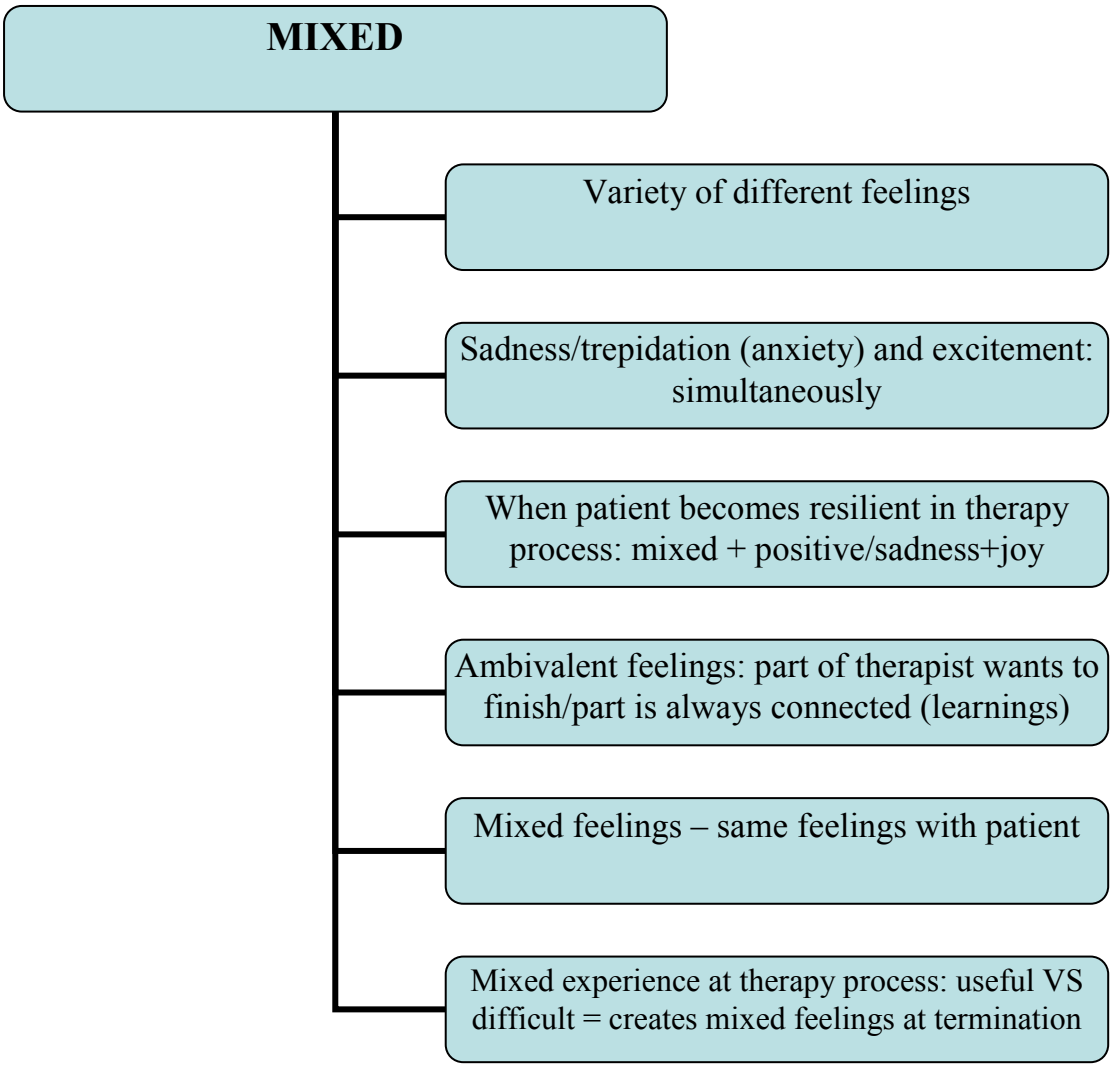
TIME

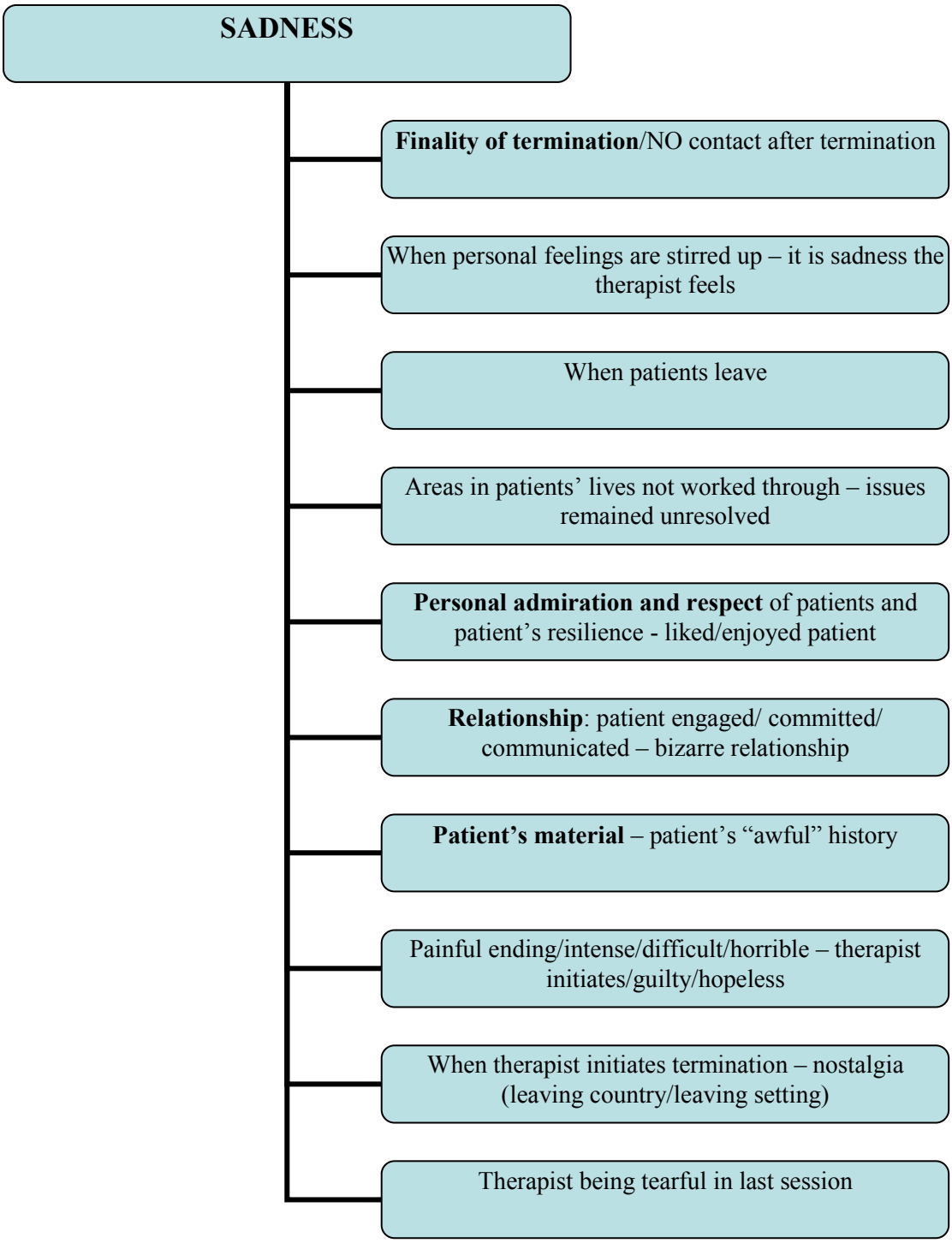
Time – when feelings are stirred up

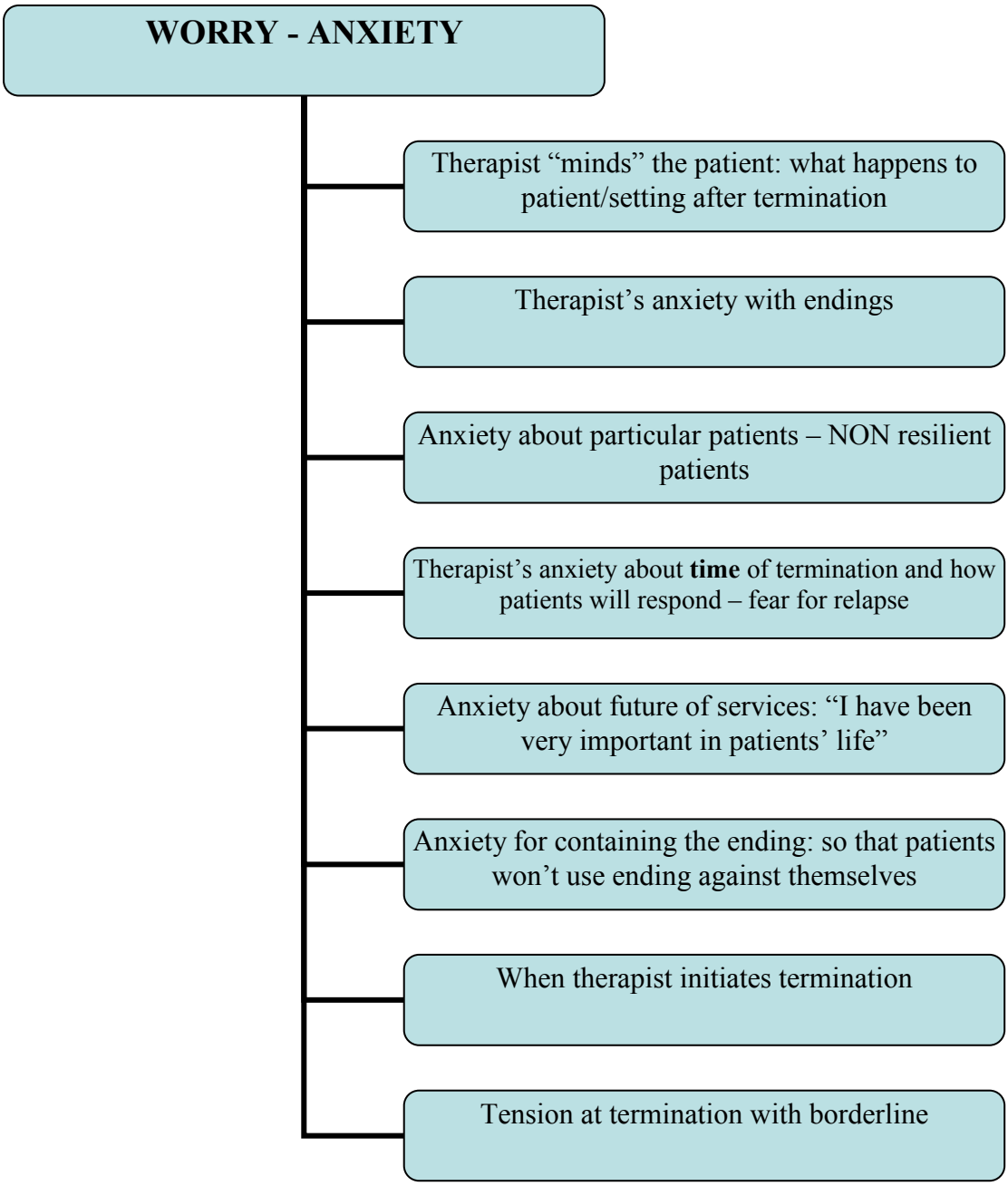
- Emotional week – when therapist announces termination/when patient talks about termination
- When patients are not ready to terminate

Duration

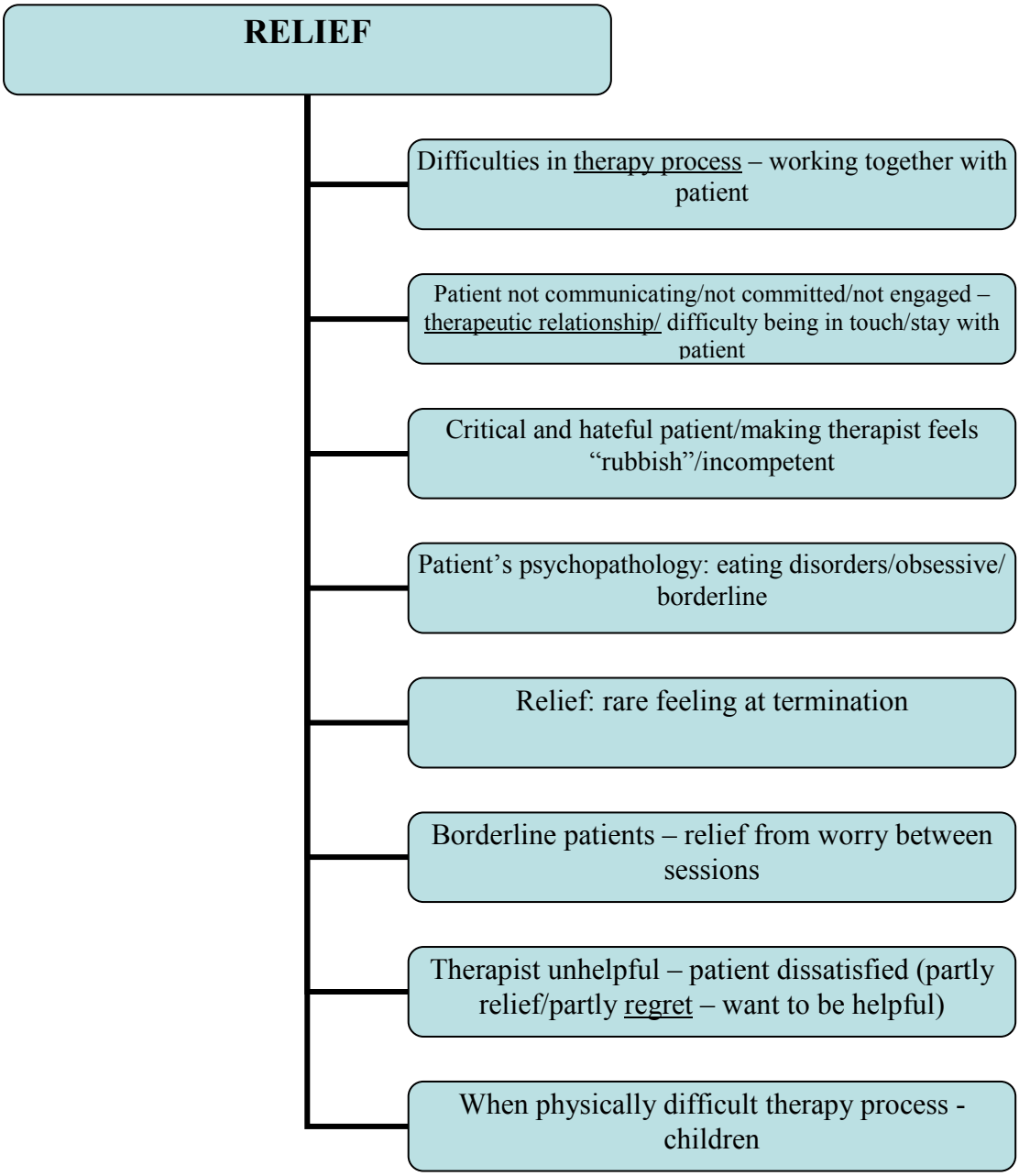
- They don't last for long – another patient comes
- They last even years after termination – termination with setting
- They are not momentary but don't stay with the therapist very long.
- The therapist has to be available for the nest patient – when touched by material or termination, it is not time for deep reflection but therapist needs to become available for the next patient.


MIXED
Variety of different feelings
Sadness/trepidation (anxiety) and excitement: simultaneously
When patient becomes resilient in therapy process: mixed + positive/sadness+joy
Ambivalent feelings: part of therapist wants to finish/part is always connected (learnings)
Mixed feelings – same feelings with patient
Mixed experience at therapy process: useful VS difficult = creates mixed feelings at termination


SADNESS
Finality of termination/NO contact after termination
When personal feelings are stirred up – it is sadness the therapist feels
When patients leave
Areas in patients' lives not worked through – issues remained unresolved
Personal admiration and respect of patients and patient's resilience - liked/enjoyed patient
Relationship: patient engaged/ committed/ communicated – bizarre relationship
Patient's material – patient's "awful" history
Painful ending/intense/difficult/horrible – therapist initiates/guilty/hopeless
When therapist initiates termination – nostalgia (leaving country/leaving setting)
Therapist being tearful in last session

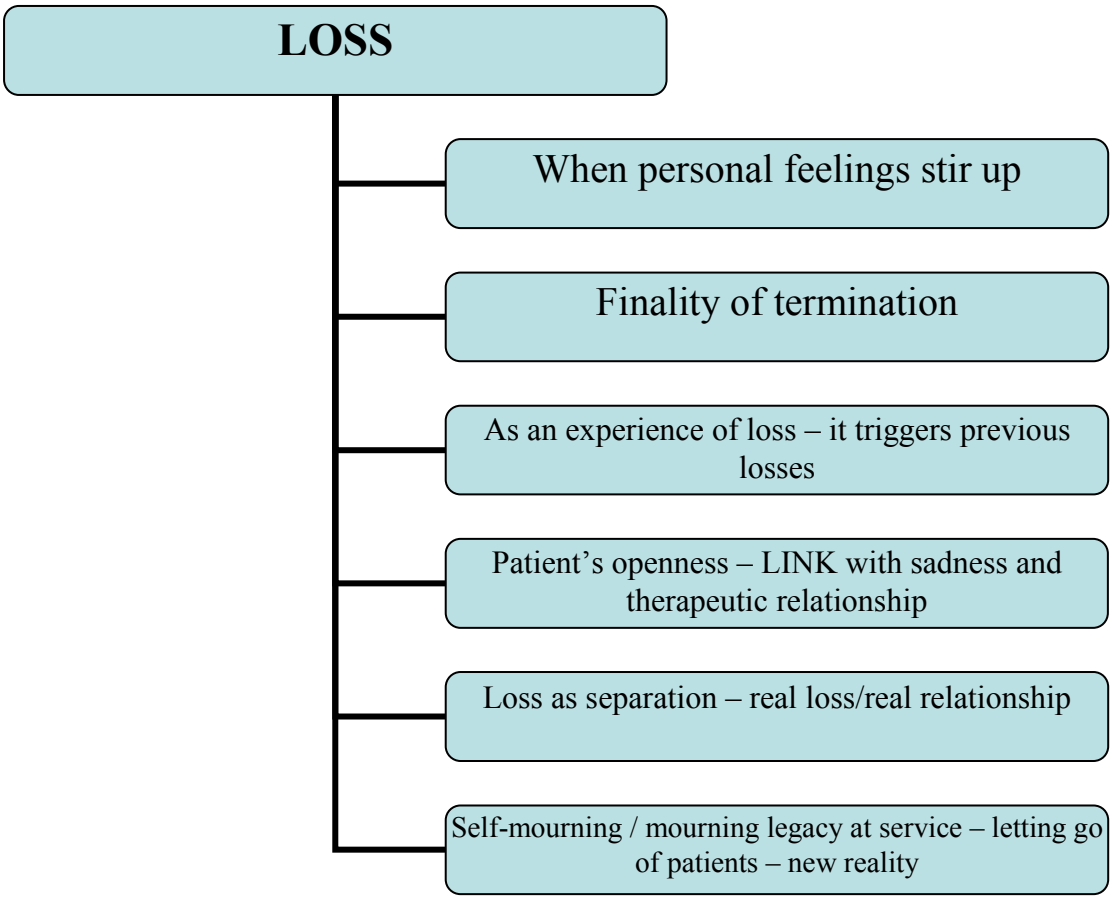


<u>As a way of dealing with the worry therapists accept termination and believe in patient's resilience – focus on optimism at time of termination.</u>

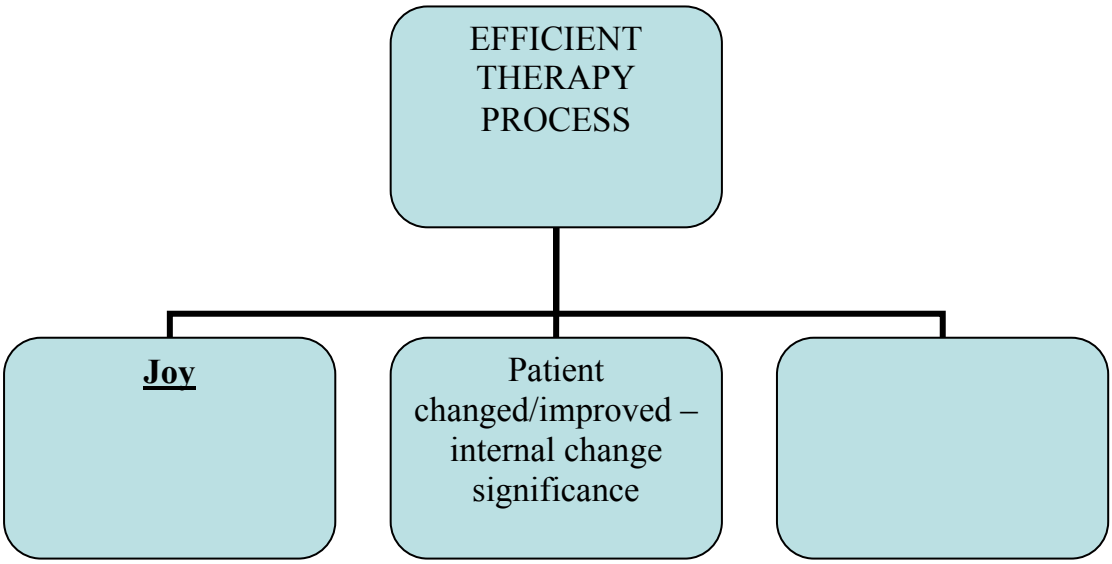


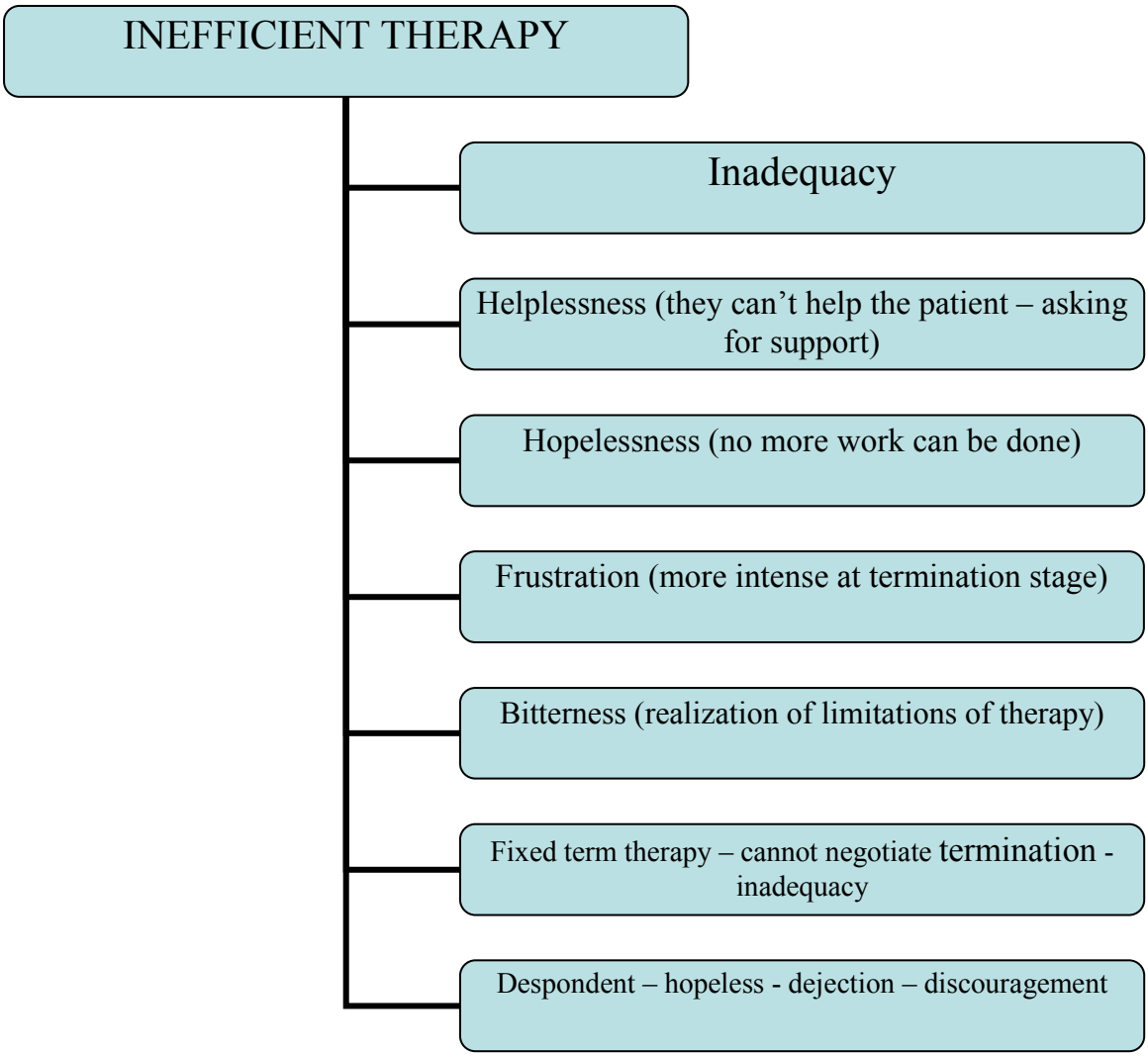
The relief is caused by non-engaged patients – sadness is caused by engage patients – therefore I assume that the therapeutic relationship, patient's characteristics and the therapy process *(three separate categories)* play a crucial role for the experience of termination.

Relief is rare – sadness is more frequent.



Therapeutic relationship becomes real at termination – real loss for therapist…





When therapist initiated termination: along with the above there is also guilt as well as the sense of responsibility and completing the job – by ensuring continuation of therapy with another therapist / making sure there is a right handover / leaving the door open.

Do they feel the termination of therapy as they feel the endings in their life?

The feelings are more intense when the therapist identifies with some of the characteristics of the patient and feels closer to their pathology.

The feelings are more intense when the relationship is good, and the therapist has been committed and felt connected to the patient. Then the therapist always stays connected with the patient. On the contrary, if the relationship is not good, the patient has been critical and rubbishing the patient and the therapist needs to live with the feeling that “nothing is ever good enough”, then the feeling of relief is intense. This happens when the therapist finds it difficult to get through to the patient and stay with them. Again the relationship plays a crucial role in determining the experience of the termination for the therapist. The effectiveness of therapy also is very important. The therapist feels relief and regret that she has not been helpful.

When they talk about inefficient therapy there are two prominent feelings of relief and regret and sadness. Actually it depends on the relationship and how close the therapist feels to the patient.

TERMINATION

As I read through the descriptive category of termination I find the subcategories as separate cards that I have developed. This has made me think how mixed the phenomenon is but also how specific codes are linked to other categories rather than this. I do feel that termination is the main category under which all come. However, perhaps, the best way to go about it would be to do the something VS something categorizing and then develop the CORE CATEGORY. From this category though I can sense what the CENTRAL CATEGORIES are.

Termination is a process – it is a phase that develops.

It triggers previous losses (both for therapists and patients) – It is associated with loss (P4) – p1 – p6

The experience of termination is variable: it varies across patients/settings/stage of therapy practice

Regarding PARALLELS: Relationships with son and son's leaving and relationship with patient's leaving – Feelings of therapist at termination and feelings of patient at termination.

Termination is inevitable/expected/anticipated: it entails the bizarreness of the therapeutic relationship – TERMINATION IS A GIVEN OF HUMAN EXISTENCE. Life has inbuilt terminations and therefore the therapy experiences with patients have inevitable terminations.

Termination is not a closure (P4)

Vivid memories of last session

Termination – like losses in every day life, provokes a *review* and gives perspective – philosophies informing the practice.

The difficulties/feelings arise when the therapist/patient announces the termination – when beginning the discussion on termination

Changes for therapist after termination: change of routine/every day life (when leaving the setting) but also about patients leaving and the therapist feels they know them well and sees them often (especially analytic patients) and then they leave.

Patient's initiative - The right to terminate belongs to the patient VS therapist initiating termination

It has great significance – it can be traumatic

Duration of therapy
Fixed term VS open ended
Short term VS long term

Mutually agreed termination VS therapist terminating/patient terminating (prematurely, no time to work it through)

Final VS partial termination – see "finality" card
Finality when termination with setting – termination of services
Finality when moving country
Worry about patient he won't be seeing in the future

Personal leaving
Termination as time for life review – like endings in real life

Poignant termination

Feeling of completing job/responsibility – therapist's VS patient's agenda - flip/flop: one therapist cannot do it all for patient

Thoughts that the therapist has when they feel that it is the time to terminate and the patient doesn't take the initiative: P1 and P5 – therapist doesn't have the heart to initiate termination – waiting for patient to be ready to terminate

Right time: It is when patients are resilient – the power is no longer with the therapist but the patients feel they have the power.

Termination with group (many individuals happening at the same time) VS individual

Reasons for termination

- Patient's reasons: 1. Internal to therapy: achieved enough: "right time" VS feeling it is enough - feeling it is not what they want, and 2. external to therapy: money, practical reasons
- Therapist's reasons: difficult to deal with, therapist has different agenda, more work could be done, uncertainty about when it is the right time, deal if it is not the "right time" – negotiating – **External circumstances: leaving setting/country OR internal to therapy when they can't work with patients**
- Time: at which point in time - point in time – for how long – how much time is needed for good/good enough work: duration LINKED efficiency, discussion about date and time and **way** of terminating when patient finds it difficult – work through termination **(when therapist thinks it is not time to terminate and patient does VS when therapist thinks it is time to end but patient doesn't take the initiative)**

Another important aspect mentioned is how important the therapist is for the patient and how much appreciation the patients have indicated to the therapist for the work they have done together. When the patients don't show appreciation then the termination is not so emotional.

Time needed to work through the termination: 2-4 months

Cultural connotations of termination:

1. Culture – British associated with physical contact
2. Matter of fact – business like termination

Time of termination:

When patient becomes resilient: P1

When material becomes superficial: P5

When patient has been in therapy for very long – when is this patient going to end ?: P7

When therapist feels that it is time for termination: P4

There were a couple of participants that have had a problem with the word termination. They are saying that the word terminating entails the notions of closure. However, there is NO closure at the termination process of therapy with patients. This has mainly to do with the factors influencing the incomplete nature of termination. They have used the work "ending" more frequently in the interviews, as if avoiding the word termination as people tend to avoid endings. When the participants initially talked about termination they associated it with loss as well as the fact that "there is not it" and how the experience varies according to relationship and patients and way of termination. The terminations have an impact on therapists (as indicated in feelings card and memo). However, there is a notion of having an impact in the physical health as well.

The therapist is exposed to repeated semi-resolved separations. In the termination of personal therapy it is different because the therapist is able to share the experience of termination with her therapist. However, being in therapy with patients **"it is a lonely place to be"** since there is no-one to share or work through the therapist's personal, internal and subjective experience of termination.

The therapist develops a familiarity with termination. She has experienced many terminations in health services and other settings and also in her private practice. She anticipates for the termination, she finds it an anticipated/expected/inevitable process and stage of the therapeutic relationship and this is what makes it different to social relationships; the fact that two people get to know each other very well – or the

therapist know the patient very well – and then the finality comes since in most occasions the therapist will not see the patient again. Especially in short term work the terminations are more and happened more rapidly. The therapist always says goodbye to her patients. The therapist and patient *end from the beginning*.

Termination is the patient's initiative – as everything that happens after termination as well. The patient has the control of the ending. The therapist if left or termination is actually worked through. Still the therapist misses some patients – some patients stay stronger in her mind than others. Even when therapist feels that it is time to finish, she waits for the patient to bring it in the material. This is contradictive with specific occasions when the therapist actually finds herself terminating:

Termination is a separation; it is a loss and creates feelings for both sides. Therapist's ambivalent feelings about termination have to do with the disagreement with patients terminating: it is not a good ending when a therapist either really wants to terminate or she doesn't want to terminate at all. The good balance which brings the good ending is when the therapist is actually thinking that it is OK to terminate and OK with continuing at the same time. This ambivalence has to do with the fact that there is no perfect therapy. That there are many occasions in which the therapy lasts for ever and as the person grows and change so therapy can be helpful in each stage of the person's life. There is loss experienced by both sides – especially for therapist when she thinks about the loss of the potential relationship (i.e. social relationship) as well as the loss of the potential work therapist and patients could have done (i.e. when more work can be done). Termination is compared to personal loss and bereavement in terms of what it evokes in the therapist. It offers the opportunity for the therapist to review the therapy process and the practice. Moreover, the therapist thinks on what she has learnt from her patients – her own learnings about the world in general as well as her practice – how the previous practice informs the current practice. It gives a perspective and helps the therapist review the philosophies informing their practice. That is why there are so many different experiences of termination. That is why each therapist has a different perspective and philosophy regarding the termination. The termination is a real loss for the therapist *when the relationship has been a good one.* Termination is a real loss and the extreme case of loss is when a patient dies.

The therapists have used strong personal language to describe their experience of termination. Some of the words they used indicate the "therapist as a person" connotation of the narratives: my addicts, my prisoners, he left me in a personal way, say goodbye to them, have been through a lot together, saying goodbye etc.

What also makes a huge difference is the fact that the therapist has the opportunity or not to meet with the patients after termination. It has to do with specific patients and specific relationships that the therapist forms with patients. The finality or not of termination is quite important in terms of the therapist's experience of termination.

The therapist at the time of review at the time of the termination has a view of whether or not she has been helpful to the patient. The fact that she has been useful VS useless is going to make a great difference regarding her difficulties in termination. When new material or issues come at the time of termination then the therapist feels helpless and useless and therefore termination can create frustration.

The therapist can be left with unresolved issues. This happens mainly when the patient terminates abruptly. Then the relationship has not been resolved. The therapist is left with unfinished business. This is mainly when therapist believes that there is a premature termination taking places. Moreover, the therapist exposes herself to repeated semi-resolved separations. That is why the termination needs to be a mutual process. The patient and the therapist need to work together towards the termination.

In terms of techniques, some therapists tail off sessions (maybe become superficial – just sharing their life facts – like the patient does when she wants to terminate and the therapist starts believing that she is going to talk about termination). However, this can be a way of avoiding the termination since the therapist and the patient continue meeting even when the work is not deep. Termination is a review – review of the therapy process when the therapist is considering mistakes and achievements, how helpful or unhelpful she has been for the therapist, things that she missed, areas worked through or not.

What does **attachment theory** have to do with termination? Therapists talk about loss and separation like when a person you know very well leaves or dies. One therapist

(7,18,207) talked about attachment in relation to how pleased and proud she feels of the patients when they have made changed and have terminated in a “good way” (whatever that means – look above) and she linked it with the patient’s regression, i.e. maternal transference.

APPENDIX 15:

EXAMPLE OF NEGATIVE CASES

NEGATIVE CASE ANALYSIS

The following demonstration of negative case analysis derives from the category Therapist's Awareness of Termination and especially the concept oft Patients initiating termination. Almost all participants spoke about the "basic rule" that the patient must initiate the termination. However, a few of those interviewed spoke about their tendency to actually instigate the ending of therapy when they feel it is a necessity. All data were finally used in the presentation of the final results. The following are the initial codes and quotes from the axial coding stage that led to the above:

Patient's initiative to terminate (1,4,54-60) (1,26,361), **Basic principle: patients should have control of the ending** (6,17,201) VS therapist NOT initiating termination even when they feel it is time, therapist's hesitation to terminate (1,26,362) (6,3,31/32) – **contradiction:** therapist should terminate when therapy is not efficient (6,15,192) – reflection in therapist's limitations (193) – psychoanalytic practice: the **right to terminate belongs to the patient** (8,6,68)

Therapist's experience of instigating termination: twice in professional life: ***"I have actively got rid of somebody from a group"*** (7,25,245): when mistake to take patient in group/patient's "destructiveness"/ **presented as "inappropriate to continue"** (7,25,249)/difficult and angry patient – **when therapist feels useless** (7,25,253)/therapist encouraging patient to terminate (7,25,256): "what a good idea"

APPENDIX 16

CENTRAL CATEGORIES – FINAL STAGE OF DATA ANALYSIS

1. Therapist as a person

1.1. Personal History

Personal history of loss

Dealing with previous losses

Termination with patients and parallels with personal losses

Reactions to endings as they reflect the therapist's personality

The choice of the therapeutic model fits the therapist's personality

1.2 Personal Therapy

Therapist currently in personal therapy

Termination of personal therapy as a model

Judging how patients would feel from their own feelings at termination of personal therapy

After termination of personal therapy

Death of personal therapist – loss

2. Therapist's Awareness of Termination

Termination is inevitable

Anticipation of last session – feelings

Patients initiating termination

Awareness of duration of therapy

3. Therapist's Experience of Therapeutic Relationship

Bizarre relationship

Equal relationship

Self disclosure – therapist's boundaries

3.1. Bonding in Therapeutic Relationship

Therapist's intense engagement

Therapist's personal admiration

Therapist as a symbol in the relationship

Being through a lot together – therapist and patient

Long term therapy

3.1.1. At termination

Planned ending

Therapist's experience of loss

Therapist's personal concerns for patients

Change in the nature of the therapeutic relationship

3.2. Erratic Therapeutic Relationship

Patients' negative transference

Therapist's inability to connect to the patient

Challenging therapeutic relationship

Ineffective therapy

Short term therapy

3.2.1. At termination – despondent termination

Premature termination

Therapist feeling unhelpful

Therapist feeling relieved

Therapist feeling worried

Therapist feeling unsettled

4. Working through the termination

4.1. Time of the ending

Time needed to work through the termination

Physical contact - presents

Therapist's vivid memories of patients

Sharing the experience of termination

4.2 Review

Therapists reflecting on therapy process

Therapist leaving therapy like a story

Termination of therapy like every loss in life

5. Termination through death

Diagnosis becoming a part of therapy process

Issues of ethics

Going to the funeral

Therapist's loss and grief

Premature termination

Finality

6. The aftermath

6.1. Contact after termination

Patient's initiative

Therapist's initiative

Therapist not encouraging contact after termination

Meeting in social contexts

No contact after termination

6.2. Desire to know what happens after termination

Therapists motivated by "human" anxiety

Therapists' desire to know about patients' lives after termination

Seeking information

Specific patients

6.3. Final vs. incomplete termination

Final - external circumstances/cutting off

Incomplete – internalisation/ not letting go/ work continues after termination

6.4 Patients staying in therapist's mind

Intense therapy

Therapists being affected by their patients

External reminders

Therapists holding onto their patients – *also forgetting their patients*

6.5 Familiarity

The more you do it the less it affects you

Acceptance

Lonely place to be

APPENDIX 17

DEMONSTRATION OF CONSTRUCTION OF CENTRAL CATEGORIES: CONTACT AFTER TERMINATION AND DESIRE TO KNOW WHAT HAPPENS AFTER TERMINATION CATEGORIES

AXIAL CODING – DEMONSTRATION OF QUOTES

CONTACT AFTER TERMINATION

- Patient writing letter (1,5,79)
- Odd session – one or more (1,5,80)
- Patient won't come back (1,5,81)
- Therapist doesn't introduce contact after termination first - patient's initiative (1,6,82) – basic principle of patients having control of the ending (6,17,201)
- Patient's initiative (1,6,82) – patient's control of contact after termination
    - Therapist's consent and encouragement (1,6,84)
    - Consequence: patient's pleasure (1,6,84)
    - They seek the therapist out – their control of contact (1,26, 342)
    - Patient's choice whether to contact (8,9,91)
    - "It has to come from him" – patient must initiate contact after termination (3,4,58)
- No contact after termination by patient – therapist's surprise and interpretation of it (1,6,85)
- Patient desire to confirm whether they can continue therapy after termination with same therapist (1,6,83)
- Patient continuing therapy after termination with same therapist because of events in external circumstances (1,12,141) – patient's initiative – **continuation of therapy with same therapist**: therapist desire to continue therapy with a few patients/start new themes/new goals (8,5,60-2), Few client therapist would continue therapy with (8,8,90)
- Patient continuing therapy after termination with <u>different therapist</u> (1,18,229) – patient contacting therapist for details to continue therapy with other therapist (6,3,33)
- NO contact after termination – therapist's desire to know what happened in patient's life (1,9,112) **[see card "know what happened"]**
- <u>Difference between personal therapy and therapy with patients – therapist don't become colleagues with patient (as in personal therapy)</u> (1,11,130) – the **nature of the relationship changes** and the possibilities to **meet in external circumstances are higher** (1,11,129/130) – oppositional for having trainees as patients – strange to meet them in other places (6,19,231) – Therapists keeping regular contact with personal therapist after termination of personal therapy (8,27,309) – communication of insights/interesting things about life (8,27,309)
- Follow-up session (1,13,146)
- When (situation) patients want to "leave the damaged child with the therapist" - no surprise/it was expected when NO contact after termination (1,21,288) – therapist **knowing patient will not contact after termination/will vanish** when positive changes have been made (6,13,158)

- When (situation) patient is "cut-off" person - therapist's **anticipation** of NO contact (1,22,300-1) – therapist's **hunch** about whether or not patient will contact (6,18,216)
- Patient writing a letter (1,23,323)
- Difference from social life (1,25,337) – higher possibility for contact with friends after losing touch with them (1,25,338)
- Encouragement by therapist for patients to contact after termination – come back for therapy: **varies from patient to patient** (6,17,200)
- Leaving the door open: separate process itself (6,17,202)
- Therapist reassuring for contact after termination – depends on patient's material/presenting issues (6,17,205) – when helpful for patient (6,17) – impact on patient/when patient doesn't expect it – **therapist responding differently to patient's expectations** (6,17,207)
- Therapist **offering follow-up** appointment to **a few patients** (6,17,208) – patient coming/not coming/**patient's control** – writing letter (6,17,209) – individual/different for each patient (6,17,211)
    - **Therapist relieved/pleased to see patient for follow-up session** (9,19,131) – when maternal/worries at termination (see par.) – glad to see patients in follow-up (9,19,144)
- **Regular contact** after termination – card every Christmas (6,18,217) – long term therapy (25 years) / termination due to external circumstances – annual letters (6,18,223) – **Therapist responding to letters / encouragement of regular contact / therapist sending poems (more than reply)** (6,18,225)
- Meet patients in **social places** – have become "sort of friends" (6,19,233-4) – therapist's desire to meet patient in *social context* (3,6,123)
    - Two people have become sort of friends (7,32,293)
    - Becoming friends due to external circumstances – neighbours (7,32,297)
- Therapist's desire to **see every patient they have worked with** (8,5,59) – bias – exception of one patient (59) – LINK WITH P5 – tempted to write letters to all
- Therapist **encouraging contact after termination when forced termination/external circumstances/instigated by therapist** (8,6,75)
- Two different terminations (8,9,101): 1. when patient continues therapy with other therapist and 2. when patient doesn't – **possibility of contacting the therapist after termination** (8,9,103)
- Therapist's desire to meet with patients after termination (2,11,170) – a few of patients
- Therapist initiating contact after termination with patients – meeting with patients after termination in different to therapy contexts (2,11,172-173) – permission for writing/***motivated by curiosity to arrange for a follow-up – curiosity to see patient as a person VS as a patient*** (2,11,174)
- Therapist meeting with patient after termination: good and touching get-together (2,11,175) – nice NOT to be in therapy context (2,11,176) [how therapist is in therapy – disciplined – how different/comfortable greeting patients as friends in out of therapy context] (2,11,176-7) – arrangements to meet with patient in the future in setting other than therapy/social context (2,11,179)
- Specific patients therapist desires strongly to meet after termination (2,12,181) – certainty for meeting a few/arrangements (2,12,183) VS little possibility to meet others (2,12,182)

- Going back to building after termination with setting – for one patient (2,16,243) – when termination with this patient (premature) – second ending/leaving (2,16,249) – visual reinforcement by going back/second ending (2,16,250)
- Therapist encouraging patients to contact after termination - therapist's wish BUT also wanted to be sensitive to termination (2,25,330-1) – "ending is an ending" but if patients felt the need to contact they could/therapist giving contact details (2,25,333)
  - Giving permission
  - Expressing wish to hear from patients
  - Therapist expressing "I would be more than happy to hear from you" (2,25,335)
  - Encouraging patients to contact after termination
- Patient keeping regular contact between sessions/breaks (cards) **during therapy process** - therapist expecting contact after termination (3,1,44-45) – REALITY; no contact after termination
- Therapist's **temptation to initiate contact after termination – through website** (3,4,57) – wondering how patient is after termination/what has happened to them (3,4,58)
- Considering meaning of contact after termination for patients (3,4,59) – LINKED with how the therapist must not initiate but it "it has to come from the patient" (even though therapist is tempted)
- When patient's fear about premature termination **- therapist's intense desire to encourage contact after termination (via e-mail)** (3,22,250) – therapist's fears of patient's use/abuse of transferential object (3,22,252)
- Therapist rarely leaving the door open – encouraging contact after termination (3,26,277) – LIKE avoiding communicating to patients they can't cope (2,26,279) – ensuring "home" for child going to university (3,26,280)
  - Danger of giving patients the message they can't manage (3,26,287)
  - ***Depends on relationship (3,26,289)***
  - ***"Go away and be well" (3,26,288)***
- More frequently – NO contact after termination, either therapist's or patient's initiative (4,6,97)
- Fantasy of meeting after termination VS reality (4,6,99) – developmentally: children's fantasy about parents/especially when difficult relationship (4,6,100) – adult fantasy before someone dies: another meeting (4,6,102)
- Therapy continues after termination as therapist stays in patient's mind – but NOT accessible (4,6,108)
- Therapist initiating termination when helpful for patient – patient can CONTINUE therapy with same or different therapist (4,10,173)
- Patient keeping in touch after termination in different ways (4,21,365)
  - Christmas cards/postcards (4,21,367) – patient's way to keep therapist informed of what they are doing/how they are (4,21,368)
  - Therapist **NOT RESPONDING to letters** (4,21,370) – therapist feeling mixed (371)
  - Follow-up session: review sessions that therapist is asked to do – **it is not therapist's initiative** (4,21,373) – strange but interesting (experience of review sessions) (4,21,375)
  - Review session; content for both sides – references to work done – focus on future (4,21,376)

- Therapist's encouraging patient in REVIEW sessions to contact if desired – NOT ALL PATIENTS/FOR SPECIFIC PATIENTS (4,21,379) – when both therapist and patient think more work can be done (4,21,379)
- When termination in group therapy – therapist encouraging patient to contact after termination (4,23,421) – patient doesn't feel judged (4,23,424) – patient being aware of possibilities for further therapy (4,23,425)
- Training patient: having the "odd sessions" after termination when important life events (5,1,5)
- When patient terminates **abruptly** (unexpectedly /suddenly) (5,3,18) – in open- ended/private practice therapy
    - External reasons – move out of the country (5,3,18)
    - Therapist's difficulty to identify a pattern as to *why patients leave* (5,3,19)
    - Lack of *working together towards termination – work towards termination*/does not happen like that (5,3,20)
    - Make it "clear to patients they can come back" (5,3,22)
- Therapist's ***common practice: leave the door open*** (5,4,23)
- Patient continuing therapy after termination: same symptoms or ready for more work (7,13,163)
    - Patients don't always continue therapy with same therapist (7,14,165)
    - "once they are gone they are gone really" (7,14,168)
- Therapist leaving the door open as common practice – **"not always explicitly"** (7,15,173)
    - It is implicit at termination that the patient can contact/have more sessions – without the therapist saying it explicitly (7,15,173)
    - More often for short term work (7,30,289) – more inclined to say to patients explicitly "let me know how you get on" (7,30,290) VS long term: "you know how they are going to get on" (7,31,291)
- Keeping regular contact with patient from early practice at health service – meet in social context – regularly (once a year) (7,15,178)
    - Patient's desire to let therapist know that they are OK (7,15,177)
    - Content of sessions after termination: issues/current life/relationships (7,15,180)
    - Patient NOT desiring more therapy – more regular sessions (7,15,182)
- Therapist hearing from patients after termination: NICE (7,39,362)
    - Receive photos of babies (7,39,363)
    - Maternal transference (7,39,364)
- Health service: patient continuing therapy with therapist: therapist NOT SURE whether patient would continue (9,14,62) – considering 10 session therapy termination as FINAL (9,14,63)
- When patient terminates with unresolved issues: therapist encouraging patient to contact after termination (9,46,371)
- When patient doesn't contact: they managed – good enough work (9,46,372/374)
- Patient "pick up the door is open" (9,46,378)
- When external driver of termination – leaving the door open – change of setting of therapy (10,3,108)
- Therapist would encourage further therapy after termination depending on level of disturbance (10,5,185)

- review appointment with patient – learn about second therapy (10,15,376)
- Therapist tends to leave door open (10,16,380) – BUT doing termination probably/feeling that work is finished (10,16,383) – same as loss/ but not same as death – leave opportunity for patient to come back (10,16,384)

THERAPISTS' EXPERIENCE OF KNOWING WHAT HAPPENS TO PATIENTS AFTER THE TERMINATION OF THERAPY

- Desire to know (1,19,112) – whether patient's aspirations have been fulfilled (1,19,113)
- Therapist finding out about patient through third party – hearing about the patient (1,19,114)
- Strategy: Therapist's encouraging the patients for follow-up session (if patients ask – always patient's initiative) (1,13,147) LINKED with tackling the human desire and anxiety **[see Feelings card]**
- Therapist wondering what happened to **difficult patients** after the termination (1,19,251)
- Therapist finding out about patient's life years after termination – patient initiating contact (1,19,252/258) / learning about the difficulties and their progress
- Therapist's **feeling** after they find out – "nice to hear" (1,20,260)
- Time since termination – years after termination (1,20,260) (1,21,283)
- Therapist's **curiosity** (1,21,283)
    - Look up the patient's name on the internet (1,21,282)
    - Find out about patient's professional development – whether they achieved their aspirations (1,21,284)
    - Therapist's feeling of **pleasure** and **interest** (1,21,284)
    - **"Curiosity wistfulness"** (6,19,234-5)
- Therapist will not know about patient's **personal life – unresolved issues** (1,21,287)
- Therapist thoughts on how patient copes after the termination (1,21,290) – assuming what happened to patients after the termination
- Therapist **wondering** what happened to patient after termination with **training patient** (1,22,302) – whether problems were resolved (1,22,303-304)
- When (situation) therapist has invested time/writing/training patient - "nice to hear" (1,22,306)

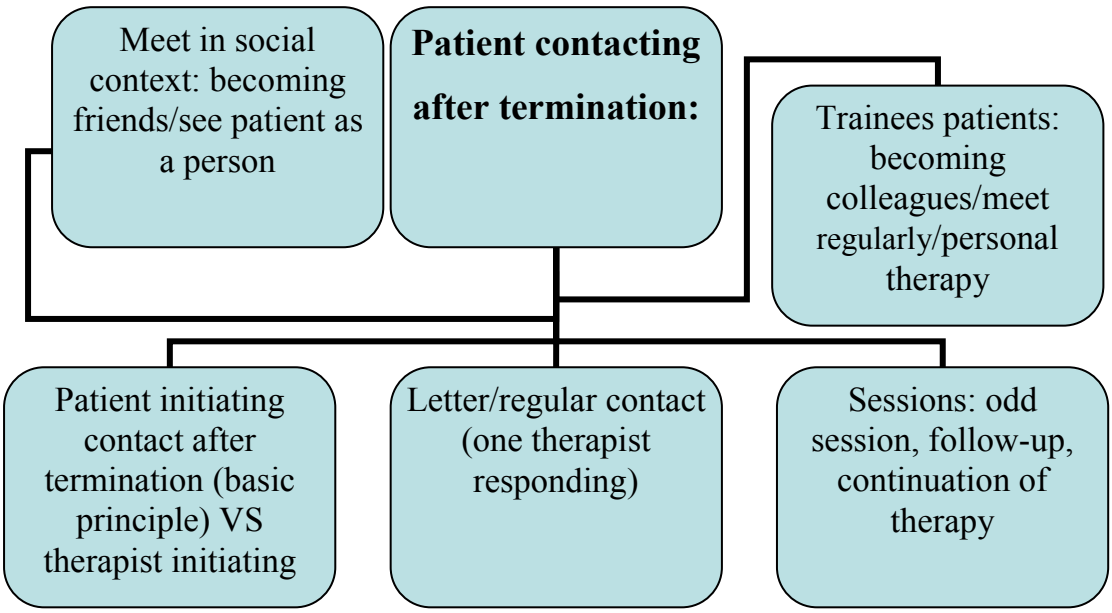
- Find out from "third party" about patient's events of life (1,23,324) – "nice to hear" (1,23,324)
- Wondering about clients in previous profession – social worker – time since then (30 years) (1,24)
- Thinking/wondering for people from all professional life (1,25,334) – **comparing to social interactions: when (situation) meet people and lose touch with them** (1,25,335)
- Therapist expectation **not to know** what happens to patient after termination – **link with time if termination LINKED with how therapist desires to see the patient** (1,26,356)
- Patient wondering whether patient continued therapy – or whether they would (1,30,461)
- Thoughts on patient's life after termination – worry (1,26,359)
- Therapist's expectations of what happens after the termination (6,8,97) (LINK expecting them to "go into life" VS cancer diagnosis)
- **"Constant wistfulness"**: melancholy, sadness, yeaning and longing (6,19,227) – particularly analytic patients (see frequency of sessions and duration of therapy)
- **"wondering what happened to them"** (6,19,230)
- **Later practice** (VS young practice) – able to **let patients go** (6,19,236) – early days: encourage patients to contact after termination (238) – therapist's curiosity VS necessary for patient (6,19,240)
- Therapist's **nostalgia** – thinking of patients after termination (8,5,62)
- Therapist's curiosity: tendency to ask other therapists who work with patients ("my clients", 8,9,100), curious about what is happening – especially when therapist is initiating termination earlier than they would otherwise (due to external circumstances) (8,9,92) – action: doesn't ask (of course) (8,10,114): therapists are not expected to ask the new therapist about patient – therapist "would like to know but shouldn't" (8,10,117)
- Two different terminations (8,9,101): 1. when patient continues therapy with other therapist and 2. when patient doesn't – **possibility of contacting the therapist after termination** (8,9,103)
- With children: find out from parents' reports (8,17,191) – children keeping therapists in mind (8,17,192)
- After termination with setting: (2,6,57): worrying/wondering what happens to groups (he created) after the departure/termination – worrying about "what I had built up would be washed away" (2,6,58) – believed in services/pioneered (59) – creating new services for service users/what would happen after departure (2,6,64)
- Continuation of patient's group in another setting/self run – gratifying for therapist leaving (2,6,83)
- Therapist's **temptation to initiate contact after termination – through website** (3,4,57) – wondering how patient is after termination/what has happened to them (3,4,58)
- Wondering what happened to patient after the termination (3,6,118) – therapist asking from third source about how patient is / therapist *not asking directly* (3,6,121) – have feedback
- When therapy NOT efficient: therapist thinking about patient after termination – wish for patient to continue therapy (3,11,184) – somebody else to do the job therapist couldn't do (3,11,185) – **therapist's sense of failure**
- NOT thinking about patient after termination – Shallow relationship (3,14,218)

- **Therapist's uncertainty about whether or not they will be worries about patient after termination – even in that they are interested about what happens to patients after termination** (4,17,262-263)
- Therapist wondering what happened to patients after termination – wonders about patient's personal relationship (5,5,42)
- **Therapist feeling sad because:** enjoyed the patient/NOT know what happens after termination (5,37,324)
- Therapist dealing with "foreverness" of termination (5,38,325)
    - Dwelling on sending letters to ALL patient for follow-up (3,38,325) – context of good practice (5,38,326)
    - Exploration of therapist's motivations: OWN curiosity (5,38,327)
    - Therapist wish to know what happened to all patients (5,38,328)
- Therapists think about their patients – wonder what happens to them after termination (7,6,105)
- Therapists <u>forget their patients</u> (7,6,106)
- **Worry after termination**: when therapist doesn't know how patients will be after termination (9,52,428)

MEMOS

CONTACT AFTER TERMINATION

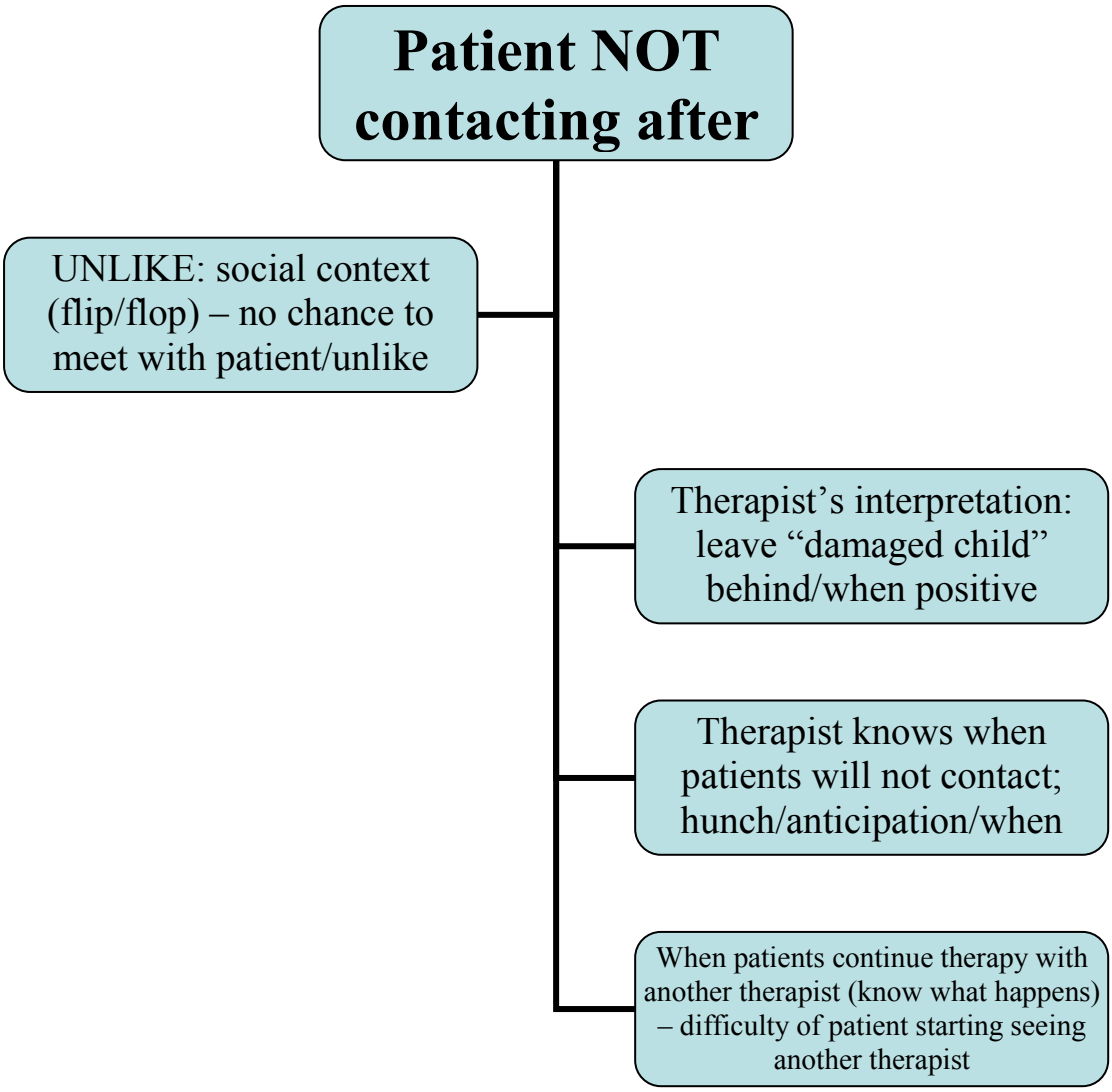
This category includes **3 subcategories**. These come under either **patient's or therapist's initiative**. Another factor is **patient's expectation or therapist's expectation**. I assume another important category would be **therapist's and patient's reactions**.

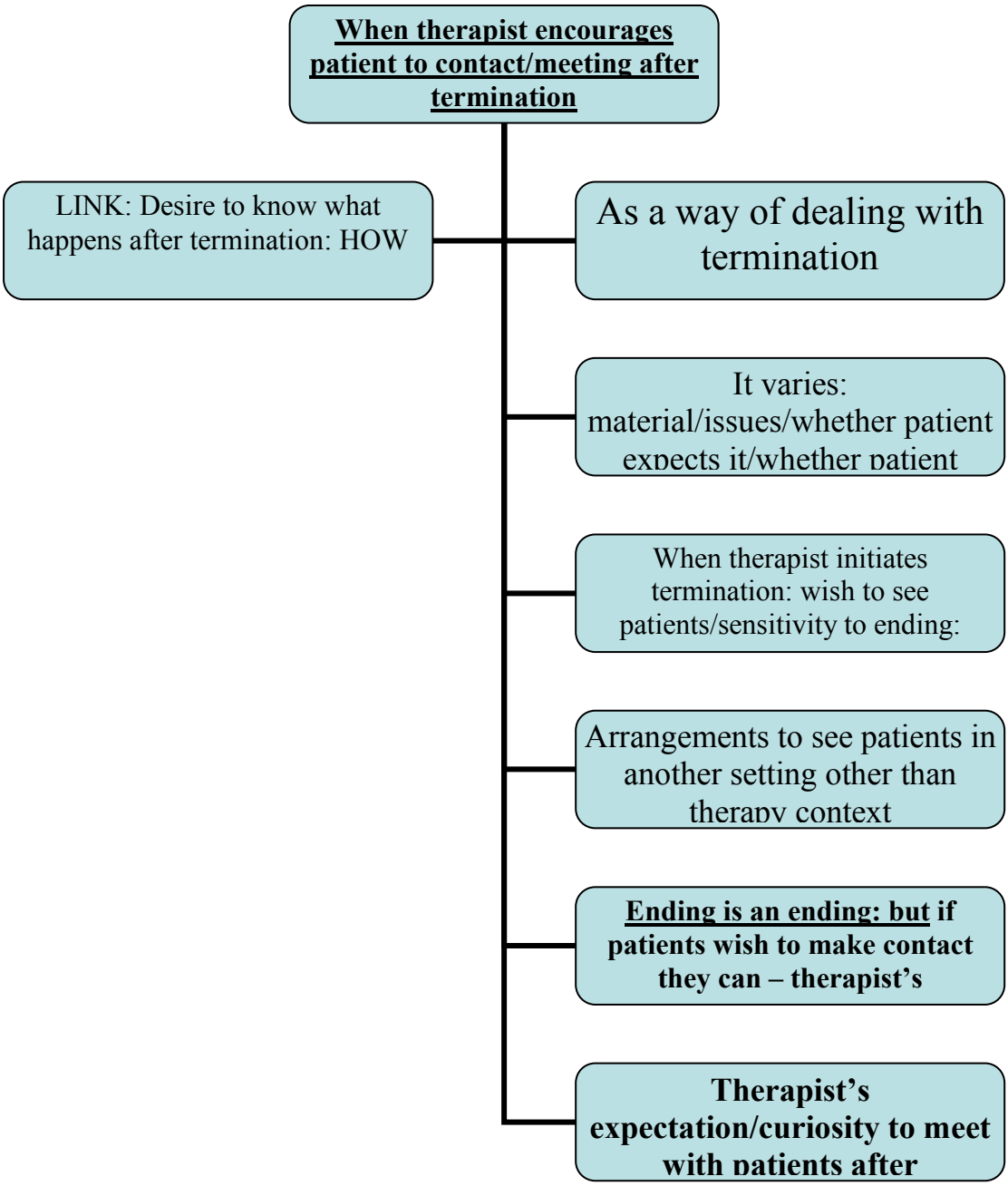


Patient's feelings when contact: pleasure/surprise when they don't expect it

Therapist's feelings: "nice to hear", "happy to hear"

When social places: more comfortable/therapist is different than in therapy context

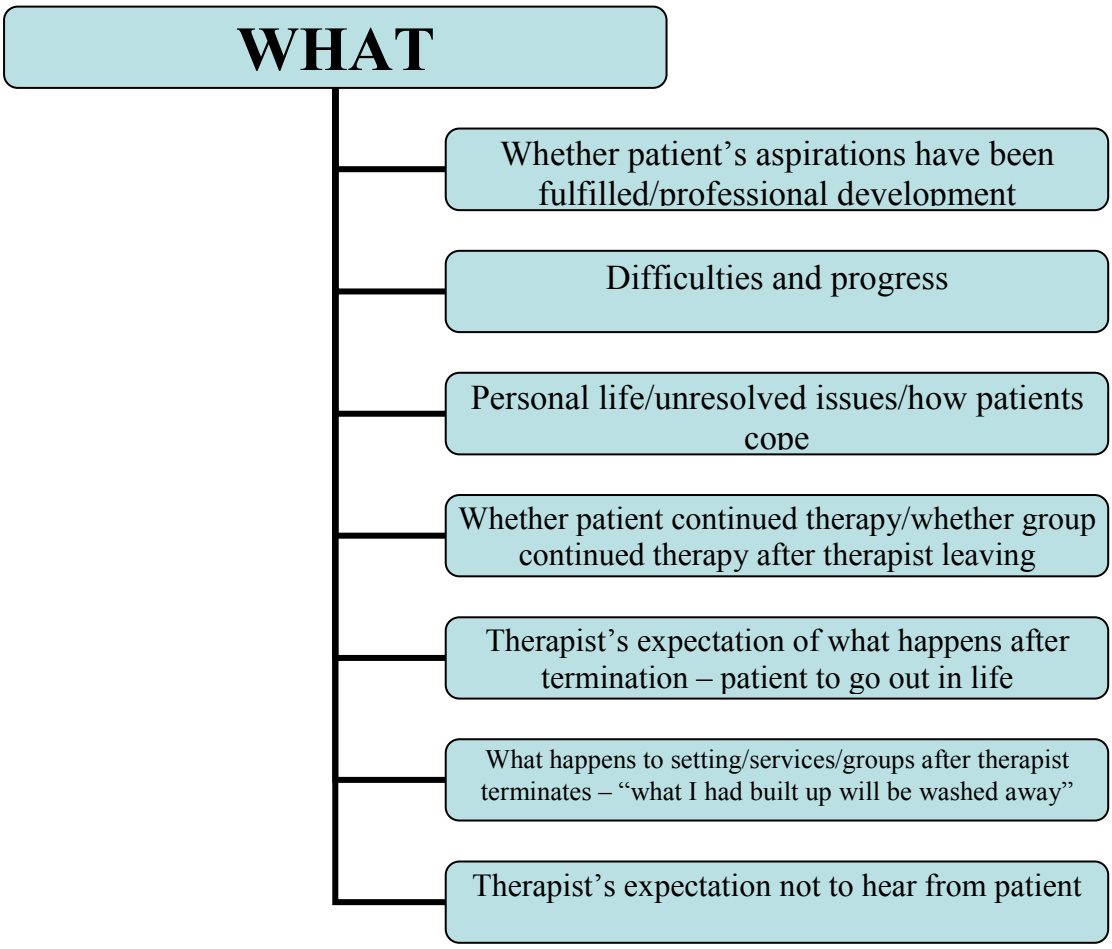

Patient NOT contacting after
UNLIKE: social context (flip/flop) – no chance to meet with patient/unlike
Therapist's interpretation: leave "damaged child" behind/when positive
Therapist knows when patients will not contact; hunch/anticipation/when
When patients continue therapy with another therapist (know what happens) – difficulty of patient starting seeing another therapist

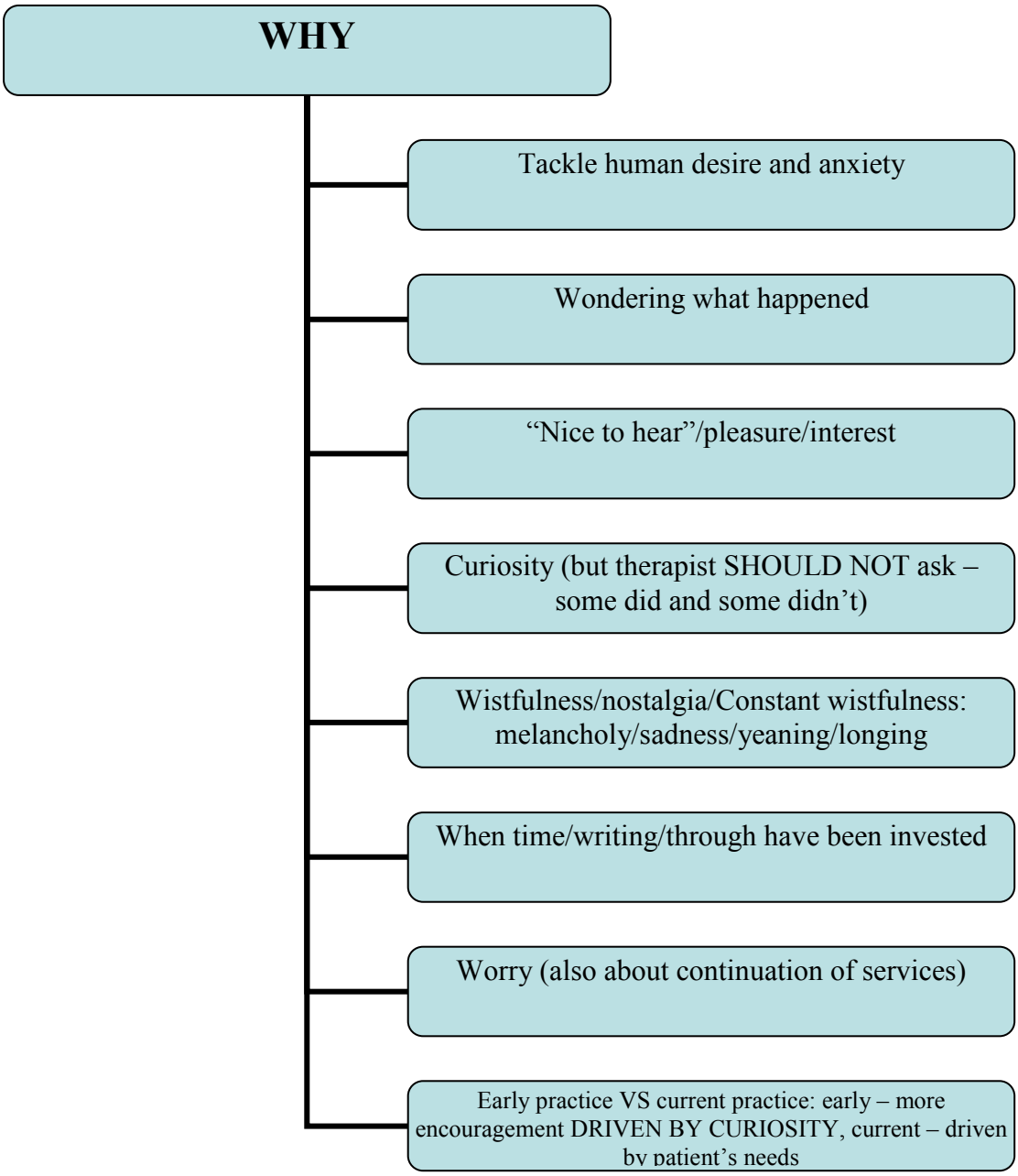


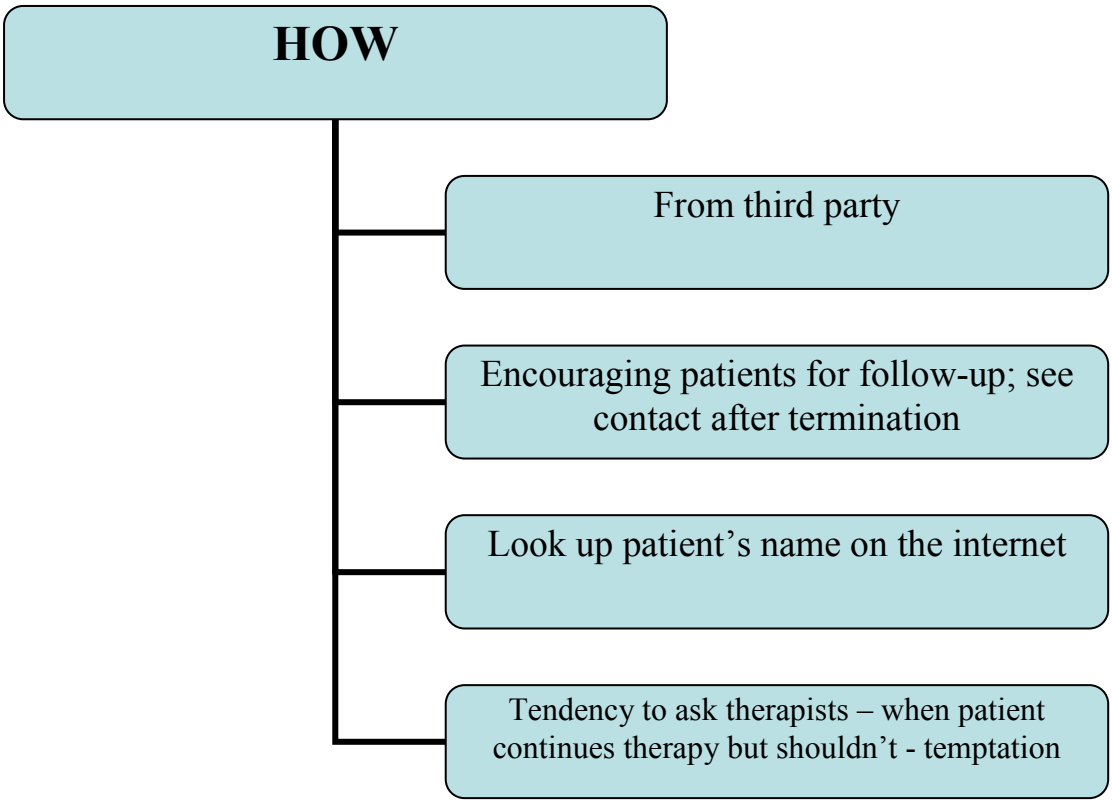
I assume what I need to see here is in which occasions therapists initiate contact after termination and go against the "basic principle". Moreover, I guess it does affect the termination process and how they experience it given that it makes a difference to the therapists to hear or not hear from patients after the termination. This card can be LINKED with two others: know what happens/finality of termination – the finality of termination can be LINKED with the "NOT contacting" subcategory.

DESIRE TO KNOW WHAT HAPPENS AFTER TERMINATION

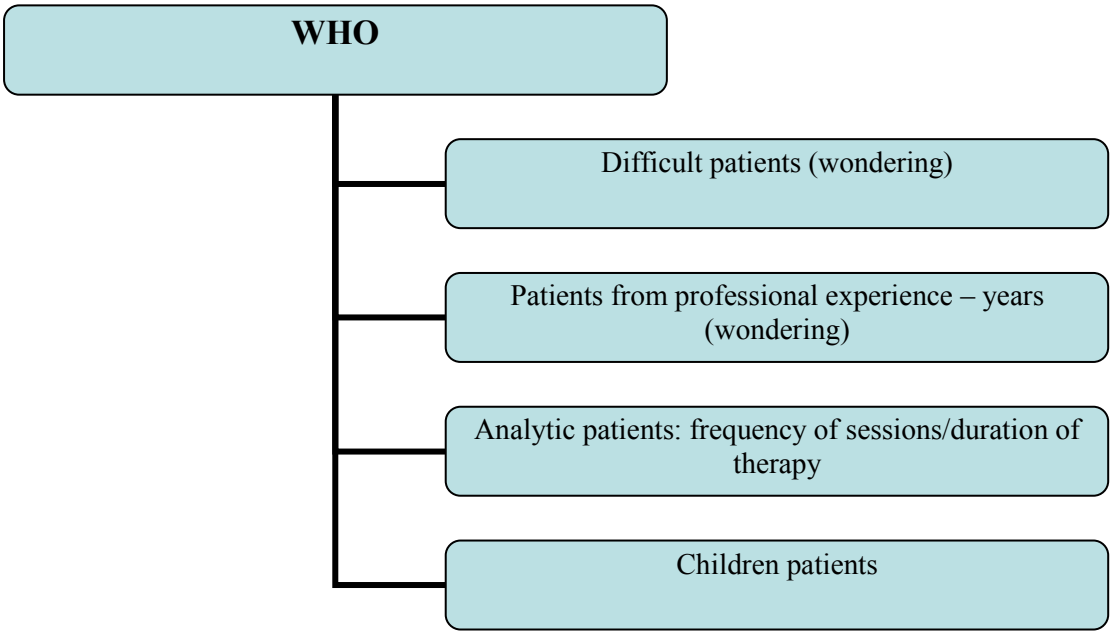
ALL therapists expressed desire to know what happens after termination. There are variations for the situations and the reasons why (what motivates them), what do they want to know, how they find out, who – which patients therapists wish to know about, when therapists find out/hear from patients. **As flip/flop: different from social life.**




WHY
Tackle human desire and anxiety
Wondering what happened
“Nice to hear”/pleasure/interest
Curiosity (but therapist SHOULD NOT ask – some did and some didn’t)
Wistfulness/nostalgia/Constant wistfulness: melancholy/sadness/yeaning/longing
When time/writing/through have been invested
Worry (also about continuation of services)
Early practice VS current practice: early – more encouragement DRIVEN BY CURIOSITY, current – driven by patient’s needs



The HOW differentiates whether patient continues therapy with another patient or not.



It's like the therapists have 2 parts: one part wants to let patient go – the other part wants to stay always connected (same with leaving setting? One part wants to stay in contact the other wants to leave).

Early practice: encourage contact after termination for own curiosity/before personal analysis: unsatisfied with termination and exhausted
Current practice: encourage contact when patients need to/after personal analysis: confident patients will manage after termination and more able to see patients' power

When patients become friends and colleagues…

There is also another important variable regarding the encouragement for contact after termination: the therapist thinks that if she actually encourages the patient to contact after termination then she may be communicating the message that "they can't cope" and that they are not going to manage. On the contrary, if she doesn't encourage then it is more likely that the patient will think that the work been done and feel more resilient. So that makes me think – along with the early VS current practice thing – that the encouragement for contact is more about the therapist's needs rather than the patients'.

FINAL CATEGORIES AND CONCEPTS

6.1. Contact after termination

Patient's initiative

Therapist's initiative

Therapist not encouraging contact after termination

Meeting in social contexts

No contact after termination

6.2. Desire to know what happens after termination

Therapists motivated by "human" anxiety

Therapists' desire to know about patients' lives after termination

Seeking information

Specific patients