13 Termination

In the final analysis, termination, separation, and death are the bedrock of human existence, for which psychotherapy, whether it is time limited or unlimited, can offer no cure.

—H. Strupp and J. Binder

From now on, wherever you go, or wherever I go, all the ground between us will be holy ground.

—farewell message to a healer, quoted by Henri Nouwen

Psychodynamic Conceptualization of Termination

The term “termination” refers to the last stage of therapy, presumably following some sort of beginning point and then a middle “working” stage. Rice, Alonso, and Rutan (1985) and others have suggested that this final stage is the one in which students have had the least training; we agree with that. However, until the last decade, there were a number of books and articles that students could seek out as resources, even if their professors and supervisors chose not to focus on this stage. Even writers from a wide variety of theoretical orientations had quite a lot to say about termination. Recently, however, there has been a notable absence of new work coming out, either conceptually or empirically.

We suggest that there may be two reasons. Those in academic or medical settings may feel that they have little to contribute to an already large body of literature on the termination of therapy. What is new to be added, they may feel? In marked contrast, those therapists in private practice or in agencies now dealing with managed care may have given up considering termination issues out of necessity. How can one plan for termination, using any of the classically oriented models, when neither the therapist nor the client has the final say in when termination will take place? In the current marketplace, a psychologist may be seeing someone with PTSD, for example, and be authorized by the insurance case manager to work with her or him for five sessions, then told to call back and report progress. At that point, under many policies, the case manager will decide if and for how much longer the therapist can work with the client. Not uncommonly, the therapist will be authorized for five more sessions, and then told to call back for further negotiation. Some companies are fairly lenient or at least predictable, some are not. Therapists may be put in the position of having to call clients to cancel the next session because no more are authorized. (How to deal with this when ethically we are warned against abandonment has been the subject of considerable controversy.) Treatment planning becomes problematic at best, and allowing enough time for termination is an aspiration that case managers have little sympathy with, to say the least.

In this chapter, we will provide some of the traditional ways to think about termination. Some of you will be doing your training in agencies untouched by managed care, and/or may be working in the future with clients who can see you for more than a few sessions. Or you may be working with EAP referrals, who are authorized for a given number of sessions (often as few as three, but at least the number is known ahead of time.) Even if that is not the case, the issues that clients and therapists were traditionally expected to have to deal with are often still there in the managed care scene, they are just difficult to use as a basis for making many therapeutic choices. We will also provide you with some generic guidelines that we hope will be helpful regardless of the setting, client, or theoretical orientation of yourself or your supervisor.

The stages or steps of therapy are never quite as clear-cut as beginning, middle, and end. Sometimes the therapeutic alliance is never really forged in the beginning stage, and even with the most responsible clients, motivation will ebb and flow in the course of treatment, thereby making the middle stage hard to track. Still, most therapists seem to feel that they know intuitively when therapy is going well and in retrospect can often identify the turning points that marked a client’s progress. Even experienced therapists often have difficulty with the awkwardness of the final stage, however, and so therapy may simply stop.

Traditionally, termination has been considered difficult because it deals with loss (Strupp & Binder, 1984). The assumption in this classical understanding of termination is that the therapeutic relationship will have been intense and will have lasted long enough that both therapist and client are heavily invested in the process. Presumably, heavily affective, probably developmental, issues will have been explored at some length, and all aspects of the therapeutic relationship—the working alliance, the transference, and the relationship (refer to the chapters Transference and Countertransference and The Therapeutic Stance)—will have been activated. For clients, their therapist will have become their “elected surrogate parent” (Simonton, 1988), and giving up this parent is seen as a necessary piece of their separation-individuation work, just as separating from their real parent figures is. With this understanding, then, it becomes clear that this last stage of therapy can “make or break” the treatment, and difficult as it is for both parties, the issues must be explored thoroughly.
Maholick and Turner (1979) for example, spoke to the importance of this stage in their discussion of the loss and powerlessness issues that often bring clients into therapy in the first place. They suggested that these issues are likely to be reactivated by termination with their therapists, and a poorly handled termination is likely to recapitulate the negative experiences they have had in previous losses.

In somewhat more existential terms, Martin and Shurtleff (1985) discuss the importance of coming to terms with loss:

Therapy, like life itself, ends. If as therapists we minimize the termination process or do not permit ourselves to be as emotionally available as we can be during the final sessions, what are we implying to the client about how to conduct one’s waking activities during an experience that has a certain end? Might we not then be teaching the need to defend oneself against loss and death instead of the need to live life to its fullest? (p. 95)

The psychodynamic model, then, assumes that the ending of the relationship will be painful for both the therapist and the client. Further, it is assumed that therapists will be unable to stay emotionally available to the client unless they have acknowledged and largely worked through their own anxiety. To expand a bit upon Martin & Shurtleff’s (1985) conceptualization of the process, therapist anxiety about termination often originates from five possible sources:

1. The therapist’s own dynamics and inability to deal with loss in his or her own life. If therapists have major unresolved losses, or if they are very cautious and afraid to invest in relationships because of possible rejection or other ending, that fearfulness will make them protective of themselves and of their clients in facing the pain that comes from loss.

2. Concern over the loss of one’s professional role. Sometimes one may get so attached to clients that it is easy to forget that one’s role was foreshadowed from the beginning as time-limited. The therapist wonders how her or his clients can manage without the therapist’s support and guidance, much as a parent worries when a child goes out into the world without the parental safety net. Similarly, if one’s work with this client has gone well and been a source of self-esteem for the therapist, the client’s leaving can feel like a partial loss of the therapeutic role. Especially if the rest of the therapist’s life is not going well, giving up this source of fulfillment and gratification can be difficult.

3. The therapist’s reaction to the client’s termination anxiety. If clients have strong reactions to leaving, and some of them will, therapists may experience countertransference feelings of guilt, self-doubt, anxiety, or similar feelings. This may be especially true if it is a therapist-initiated termination, if the therapist has felt ambivalent about the client, and/or if the client accuses the therapist of not caring, of being arbitrary, or the like.

4. Uneasiness about the implied importance of termination. Sometimes, therapists are so mindful of wanting to do a “successful termination” that they get performance anxiety, rooted in the fear that they will somehow damage their clients if they handle termination poorly. Instead of relying on their own training and experience, they may find themselves deferring to an outside expert on how to do it “right.”

5. The literal loss of a meaningful relationship. As we have discussed earlier, there is, or should be, a “real” component to the therapeutic relationship. As transference issues are worked through, presumably this component becomes stronger. Especially with clients whom therapists have felt fond of from the beginning, letting go is personally painful. As one counselor said after a particularly sad termination, “They should post a warning in graduate school that termination can be hazardous to your health.”

Any one or a combination of these sources of anxiety can lead to this last stage being so painful that therapists may make sure to end therapy abruptly rather than risk going through the third stage at all.

In the psychodynamic formulation of termination, clients are expected to have a quite difficult time letting us go. Quintana (1993) summarizes these expected client reactions to termination as “a plethora of neurotic affective, cognitive, interpersonal, and defensive reactions related to grief reactions.” Bauer and Kobos (1987) list a variety of client reactions that the therapist must be prepared to deal with: new problems or regression, desire to stay in therapy to obtain a more complete self-understanding, bargaining, anger, devaluing treatment, desire to terminate early, and therapist idealization. Yalom (1980) discusses his dilemmas in dealing with a client who was so upset when he initiated discussions of termination that she threatened suicide if he insisted on going through with it. (He did, and she did not suicide.) In short, therapists are warned that they should be prepared for quite emotional client reactions.

Other Conceptualizations of Termination

While most therapists we know who have been in practice for several years agree that sometimes termination can be painful, much of the research does not seem to bear that out. Quintana and Holahan’s (1992) survey of therapists reported generally positive client reactions to termination. Similarly, in Fortune’s (1987) and Marx and Gelso’s (1987) studies of clients’ reactions to termination, the large majority reported positive reactions.

There seem to be three obvious explanations for this: (a) Therapists and clients are colluding to avoid the pain. (b) Termination might actually be less traumatic than the psychodynamic model suggests, and/or (c) The concept of termination has changed from a final, irrevocable but necessary break to a more developmental understanding that clients may well “terminate” and return in a few months or years. There is some research support for this last hypothesis. Kramer (1986) found that about 76% of therapists invited clients to return. Along
these same lines, Budman and Gurman (1988) found in their study that 50% to 66% of terminated clients do indeed return to therapy within a year. Quintana (1993), apparently referring to the managed care marketplace we alluded to earlier, explains this by noting that the nature of current practice lends itself to repeated episodes of psychotherapy without necessitating a formal end. Or, as one of our colleagues commented, "With only a few sessions a year paid for by many companies, clients have come to use us like they use family physicians. When something is wrong they come for help, and then leave until they need us again."

Quintana (1993) proposes that even when the psychodynamic termination-as-loss model is invoked, another understanding that might be more useful than the assumption of trauma is what he refers to as the termination-as-development model. Using psychodynamic understandings of the internalization, he suggests that loss might be less painful for clients who have used such developmental processes as introjection, identification, and ego identity internalization in their work with their therapists. He quotes Edelson (1963):

The problem of termination is not how to get therapy stopped, or when to stop it, but how to terminate so that what has been happening keeps going inside the patient. ... It is a problem of facilitating achievement by the patient of the ability to hang on to the therapist (or the experience of the relationship with the therapist) in his [or her] physical absence in the form of a realistic intrapsychic representation. (p. 23)

Or, said more succinctly by a client, "I don't think I'll miss you too much—I have the eternal Donna inside."

This construal of termination sees the shift in the client's life caused by termination as similar to other transitions the client has had and will make in the future. Part of the process of development involves interacting and learning from others, and then moving on into new stages of life. This is true, it is argued, with one's parents, with mentors, and with friends, and therapy is no exception. Part of being somewhat autonomous requires that we "outgrow" previous constructions of relationships and construct new ones that better fit our emerging identities.

lines for Termination

Our understanding, while rooted in some of the foregoing conceptualization, assumes that each termination process is unique. It grows out of the process between the two individuals involved and the issues that have been the therapeutic focus. The ending of a therapeutic relationship between a client with an eating disorder and her behavioral therapist will probably be quite different from the process between the same client and her analyst if she had instead chosen to enter long-term psychoanalysis. The guidelines we offer here are intended to be generic. We will suggest separate emphases for termination when the decision for that termination comes from each of four different loci—when the therapist makes the decision (often because of agency guidelines), when the client makes the decision, when the decision is mutually agreed upon, and when the decision is made by an unpredictable third party such as a managed care company. Before we discuss each situation separately, however, we would like to offer some general guidelines.

First, you should keep in mind that the purpose of therapy is to help the client change. Termination, accordingly, should have as its top priority the consolidation, maintenance, and generalization of client gains. Asking clients to take stock for themselves and list their original goals and how far they have come in attaining them is a focus that is often helpful periodically in therapy, but especially in termination. You should also be able to offer your own perspective of their progress to terminating clients. Additionally, many therapists talk about, or perhaps even role-play, probable scenarios that are likely to arise in the client's life in an attempt to facilitate transfer of learning to the future. When you terminate, you will want clients to have obtained their money's worth, to leave stronger or with more skills than when they entered. Further, you want them to experience these accomplishments as theirs, not to defer to you in gratitude.

Next, we agree with Kramer (1986) that termination needs to be discussed overtly—not just at the end of therapy, but from the early sessions on. Endings of relationships are so frequently nonverbal and/or impulsively acted out that, as Kramer says, there is much to be gained by bringing the termination process into the open where it can be discussed freely. With time-limited therapy (as in a counseling center with a ten-session limit) it is especially important to keep the termination date in perspective as one of the limits built into the therapeutic relationship that serves to channel and focus the client's energy and attention. Lamb (1983) provides a model for the content of each of the last seven sessions so that termination issues are highlighted and virtually inescapable. Even if no specific termination date is set, however, the fact that therapy will not continue indefinitely should be in the client's awareness all along. No client, if it can possibly be avoided, should have to repeat earlier traumatic abandonment experiences by being subjected to an abrupt termination.

Another general guideline we offer for your consideration is that you maintain your therapeutic stance with the client right through the final moments of the last session, rather than dilute the experience by becoming "friends," even if the client is insistent. We are aware that there is some controversy over this issue, but we feel strongly that it is almost always in the client's best interest to follow the conservative "once a therapist, always a therapist" approach. It should be obvious that we are not proposing a rigid formality to your style that would preclude any warmth or self-disclosure. Rather, maintaining a therapeutic stance means that you honor your primary commitment to the client's growth and needs and do not allow yourself to slide into a social, chatty relationship simply because that makes you feel better. Boyer and Hoffman (1993) found support for the hypothesis that counselors who have had more severe grief reactions following a personal loss experienced more dysphoria during termination. This seems to confirm the psychodynamic assumption that it behooves the therapist to work through his or her own losses in order to be emotionally available to terminating clients.
Finally, a guideline regarding possible future contact with your client. Some clients may ask if the two of you can be “friends.” Our impression is that the client who suggests this probably does not mean that he or she wants an equal, reciprocal relationship but instead secretly hopes that the therapeutic alliance (which called for your offering the best of yourself in the service of their needs) can simply be continued indefinitely, for free. This is, after all, probably the only way he or she has experienced you, and it is not unreasonable to want to continue having access to such a warm, wise person. In our experience, it is quite likely that clients will feel disappointed and betrayed if you interact with them in a new social way that suggests that you are no longer primarily focused on their growth, may sometimes be distracted and irritable and bored, and in fact may cancel or even forget social engagements with them. In short, we feel that therapy and friendship have somewhat different foundations and that it is ill-advised and potentially damaging to the client to try to shift the structure from one set of goals and norms to another. (We are also aware that in small communities it can be quite difficult to keep relationship distinctions from getting blurred, but we feel that therapists in such situations should at least avoid the trap of naively assuming that all clients can be believed when they insist they can handle equality.)

You will need to think about your position on later contact and find a way to share that in a nurturing way with your client. A position taken by one therapist we know is, “I’m touched by your request for more contact with me. You have been important to me, too, and saying good-bye is hard. I will miss seeing you so regularly. But I don’t know how to care differently about you. The way that I listen and feel when I am with you, the ways that I think about you and the areas where I feel responsibility for helping you—are these parts of how I am with you that it’s too late for me to change! ‘Watering that down’ to a friendship level is something I can’t manage.” What she is saying is that her therapeutic stance is something that is indigenous to their relationship and that there is no way to remove it and still have a relationship.

Having stated this rather conservative stance, we also acknowledge that our reservations are not universally shared. Salisbury & Kinnier (1996), in their study of counselor behavior and attitudes, found that almost two thirds of the counselors they surveyed felt that under some circumstances such posttermination friendships might be acceptable. Certainly, professional ethical codes do not specifically prohibit such relationships. Nonetheless, as Herlihy and Corey (1992) warned, in dual relationships there is indeed a risk for harm, and that potential harm must be the counselor’s primary concern. (For an excellent discussion of the ethical issues involved in a variety of posttherapy relations—including, but not limited to, friendship—see Anderson and Kitchener, 1998.)

**Client-Initiated Decision**

Premature termination is a term with decidedly negative connotations. The use of it presupposes the therapist’s objective assessment that the client is acting out his or her resistance to the exploration of important clinical material. Sometimes, of course, this is so unmistakable that even the client would not deny it. The sub-

stance abuser who resumes the use of drugs and misses his next session, the abused spouse who calls to cancel because she is moving back in with her husband, the anorexic client who no-shows after losing three more pounds—these clients, if pressed, would probably acknowledge that they had made choices that would be considered dysfunctional but that they preferred the immediate gratification of their present behavior to therapeutic exploration.

Other clients, however, may terminate simply because they have different goals from their therapists. Wolberg (1986) found that most clients regard symptom relief as the best measure of positive gain, which, to say the least, is in contrast to the analyst’s criterion of the resolution of transference or the self psychologist’s expectations that the self will be stronger. Symptom relief, from many clients’ perspectives, must seem considerably easier to attain! Other clients may terminate because they do not believe they are being helped, because of financial considerations, or for a variety of other reasons. In short, we urge you not to automatically make hasty, negative judgments regarding clients’ motives for considering termination.

If clients simply cancel or fail to keep appointments and do not reschedule, you will be on safer grounds both ethically and legally (dissatisfied clients occasionally sue on malpractice grounds) if you communicate by letter to indicate your willingness to continue meeting with them and/or to refer them to another professional. Some therapists additionally offer a free session to help the client explore his or her reasons for terminating. The goal here is to offer continued professional help without in any way attempting to coerce the client into remaining in therapy.

Assuming you have the opportunity to discuss with clients their reasons for terminating, it will be important to avoid taking an adversarial stance. If, in fact, you want your clients to become more autonomous, you must be able to support their independence, even if that means they leave therapy against your advice. You may still, of course, offer your clinical opinion, but we suggest you do so as nonlogically as possible. You may, for example, want to say something like, “My concern is that you have more work to do in the area of... I will respect your opinion, since you must make the decision, of course, but I’d like for you to consider what I’ve said. Can you tell me your reaction?” If clients insist on terminating after all, we believe you will have the most therapeutic impact if you back off at that point, review with them the progress you have seen them make, and then suggest that at some later date, if old or new issues arise, they may want to contact you or another professional. If you are quite worried about their well-being, one possibility is to say something along the lines of, “I really do hope things will go OK for you. I'd feel a lot better, though, if I knew that if your depression/anxiety/anger worsens, you'd contact me or another professional. Will you do that?”

**Therapist-Initiated Decision**

There are two kinds of situations in which you as therapist may find it necessary to discontinue therapy with a client. We will consider these separately, since both your own motivations and the client’s are likely to be quite different in the two scenarios. In the first, more common situation, your decision has nothing to do
with a particular client. The decision to terminate is demanded by your own situation. You are an intern, and it is time to rotate to another unit, or you work in an agency that has an eight-session limit and you of course must adhere to that limit, or you accept a new position somewhere else. Or perhaps you decide to retire or change careers. Whatever the precipitating cause, your clients' dynamics have not and cannot influence your decision. Depending on your clients' reactions to being helpless, they will find this either more or less easy to tolerate and understand than if your decision in fact had anything to do with them (as it does in the next scenario). You can assume that none of your clients will be very grateful for the disruption, but their relative helplessness will be a relief to some of them. For these individuals, knowing that at least they were not at fault will help them accept the situation. They will not need to wonder, as perhaps they have when experiencing other losses, what they could have done differently. Other clients, however, especially if they have been abused or neglected historically, may find their helplessness to influence your decision almost intolerable. It may provoke intense feelings of abandonment, rage, or despair.

Given these considerations, it should be obvious that your clients need to be given as much notice as possible about your plans. Preferably, you can tell them at the beginning of therapy, so they can pace themselves accordingly. We would also encourage you to allude often to the time frame during the course of therapy (as in, "Well, we're about halfway through our ten sessions. Are we on the right track as far as accomplishing your goals?" or "What did you want to focus on in our last four sessions?"). We suggest that you ask specifically what your clients' reactions are to finishing up therapy with you, that you listen nondefensively to any strong feelings they have, that you acknowledge the legitimacy of their situations, and that you demonstrate that you are somewhat affected by their reactions, even if you cannot change the final outcome. Expressing some regret and any positive feelings you have for them can serve to lessen their sense of powerlessness. Obviously, you will also offer a referral and facilitate it as much as possible if the client wishes. Helping clients see what choices are still available to them can also reduce their feelings of helplessness.

In the second scenario, you are not forced to end therapy with a client because of outside forces; instead, you choose to initiate termination because in your professional judgment staying in therapy with you will not enhance the client's growth. If clients were not grateful for the disruption in their lives in the previous situation, you can be sure that in this instance they will be even less so. Some will react stoically, some will withdraw or terminate precipitously at the first hint of rejection, and others may act out to the point of threatening suicide, as Yalom's did. Before you make such a decision, it is crucial that you consult with your supervisor or, lacking a supervisor, with other professionals.

Your choice to initiate termination will probably be based on your view that the client is holding onto symptoms out of dependency on you and a desire to avoid termination. We have also seen situations such as a husband's wanting to continue therapy indefinitely because as long as he keeps coming, his ambivalent wife remains hopeful that their relationship will improve and puts few demands on him. Sometimes the reason for clients' position is obvious to you; at other times, the cues are so subtle that it is only gradually that you come to understand that the client may never choose to terminate if left to his or her own devices.

Whatever the specifics of the case, the judgment is made in consultation with your supervisor that therapy is not providing help to the client. At this point, you will, following ethical guidelines, have to decide whether to encourage your client to let you make a referral or to suggest that she or he terminate therapy altogether. Clearly, decisions such as this are some of the most difficult ones therapists are called upon to make. In most cases, you will be able to suggest termination as a possibility, discuss it with your clients, help them work through their reactions, and they will accept the suggestion over time. Occasionally, this may take place quite quickly, especially if the client was feeling "ready" but needed your permission to leave. At other times, several weeks may be required. Our point is that you will usually be able to avoid the power struggle that ensues when clients feel "kicked out" if you emphasize your clients' strengths and progress made and suggest that the time has arrived for them to try their wings. If that is too fearful for them to imagine, you may suggest that at least they try a "vacation" of several months away from therapy. Keeping your approach positive and supportive, as opposed to critical and impatient, is very important. No one, including clients, likes to leave important relationships feeling rejected.

The instance of court-referred clients merits separate discussion. You may be working with clients, often spouses or parents convicted of abuse, who are seeing you as a condition of parole or probation. Some of these clients are truly invested in using therapy as an opportunity to make change. But we have seen students move into overdrive trying to accommodate and motivate clients whose agenda is to jump through the required hoops as painlessly as possible, rather than to make substantive change. We strongly encourage you to make it clear to them that you will be glad to help them change, but that you have specific expectations. Clarify the limits under which you will work, and then stick to them. If you instead collude with them to "work the system" and pretend that change is taking place when it is not, or if you find yourself working much harder than they are to schedule appointments, for example, you have not only not helped them, you have reinforced any ideas they have that manipulation works better than true change. Should you start feeling "settled," that is the time to matter-of-factly remind them of the limits and clarify that you have no choice if the limits are not honored but to notify the court of noncompliance. (We expect that you will have already obtained a release of information to communicate with relevant parties.) Mandated therapy works when the client himself or herself somehow takes responsibility for investing in the process; your job is not to accommodate clients' lack of investment, but to help them make changes.

**Mutual Decision**

Ideally, and more frequently than you might imagine, you and your client will agree with each other that therapy has run its course. That does not mean that
there will be no pain in its ending but rather that acceptance and a mutual acknowledgment of the meaningfulness of what has happened will be a predominant theme.

Various writers have suggested "cues" that signal the emergence of this third phase of therapy. Kramer (1986) concurs with the traditional view that transfer-ence issues tend to be replaced by a more egalitarian exchange between the therapist and client. Roth (1987) reports that themes regarding loss and separation, especially in patients' dreams, precede and coincide with termination. You may see similar cues, as well as others, such as an expressed desire on the part of the client to decrease the frequency of sessions, a lack of things to talk about, or clearly self-congratulatory client expressions of progress. Whether the therapy has been within a specific or open-ended time frame, such cues are signals that, if you have not already, it is time to begin the overt discussion of termination.

As in the previous discussions of more unilaterally initiated termination, much of your job will be to affirm the gains the client has made and facilitate the consolidation and generalization of changes. You will also need to be available to encourage and help the client explore the full range of his or her feelings—from gratitude and acceptance to anger and grief. Some clients will not have a lot to explore. For them, the ending of therapy may represent a graduation, a chance for more free time and more money to spend, or just a simple acknowledgment that they have accomplished what they came for and are ready to move on. Our impression is that difficulty in termination is often a function of the intensity of the previous work, the psychopathology of the client (hopefully, not the therapist!), and/or the level of transference. As you help these clients recognize their feelings, their assumptions, and perhaps their coping styles, you may find that quite stressful. At this final stage, perhaps more than at any earlier time, your faith in clients' strength and resiliency will be tested.

What you need to strive for is to be as helpful and emotionally available to the terminating client as you would be if the person were discussing losing someone else important in their lives. In that situation, we imagine you would ask them to explore their feelings, perhaps challenge self-defeating assumptions they were making, acknowledge the reality of the loss, offer support and confidence in their strength, and perhaps consider targeted grief-oriented interventions (letting them write a letter to you and perhaps read it aloud, providing an imagery experience where they tell their therapist how they feel and what they want to keep and use that therapy has offered, etc.). The important thing to remember is that the focus is on them, and that while they may need responses from you regarding your own feelings and impressions, this is not the place for you to deal with your loss issues.

Unpredictable Decision by Outside Party
Managed care is under increasing consumer and legislative attack, and many mental health professionals are hopeful that within a few years the situation will improve. But for the foreseeable future, an outsider whose commitment may be to company profit rather than to client welfare will be making decisions about the kind of work you can do with managed care clients. Working under these increasingly common situations is quite difficult. As indicated earlier, not having any idea how long you can work with a client makes treatment planning problematic and a termination "stage" almost obsolete. It is very important to be honest with clients about the situation you are both in, so that they can monitor their dependence on you and the process.

Many therapists find that therapy of this sort tends to be problem solving. Diagnosis is crucial, since this is usually the basis for case managers' allocation of authorized sessions. The first session, then, is less of an intake per se, and instead utilizes a diagnostic-problem definition approach. Obviously, it is important to identify as quickly as possible the major issue, and then our impression is that most therapists, regardless of their preferred theory, do cognitive or solution-focused work as an "opener." This needs to be done without sacrificing the therapeutic alliance. In fact, very brief therapy usually requires even more attention to the alliance so that you can keep to a minimum client defensiveness or misunderstandings. If those therapeutic approaches prove unsuccessful, you will need to renegotiate with the case manager, perhaps with new diagnostic information.

With no specific termination stage to rely on, it becomes even more important to ensure that clients are consolidating and generalizing their learning. Therapists often use homework assignments between sessions to maximize client investment during this therapeutic interlude in their lives, an approach that lessens the destructive effect of abrupt endings. The therapeutic stance tends to be more overly supportive than usual, since it is often crucial for clients' sense of efficacy to increase quickly. If the managed care company provides coverage of no more sessions, you should consider offering a final one at reduced or no charge, especially if you sense that you have become very important in the client's life.

Final Session
Given the awkwardness and mixed feelings both you and your clients will likely be experiencing, it may be tempting to reach for an easy, systematic approach to bring therapy to a close. We urge you to remember that one of your primary responsibilities is to stay emotionally available to your clients, and hiding behind a set of procedures will hardly facilitate that. At the same time, it is generally not helpful to your clients to encourage them to explore new, difficult material in the last session.

Generally speaking, the last time you meet with a client will be a time for the two of you to say good-bye. As Lamb (1985) indicates, this can be accomplished in a variety of ways, including further expressions by therapist or client on the meaningfulness of therapy and leave-taking, or review of progress made by the client and an exploration of her or his future plans. Sometimes clients, especially after long-term therapy, wish to give a gift to the therapist. While the acceptance of gifts, even during the last session, is somewhat controversial, it is our position that the ritual of gift giving is an important one for some clients and may help them
accept the finiteness of the situation. We see the therapist’s willingness to accept small gifts as a symbolic acknowledgment of the client’s feelings, and in most cases we think it is more helpful to accept graciously a small gift than to encourage the client to explore the motivations behind the giving. (Expensive, valuable gifts are infrequently given and in our opinion should not be accepted.)

Another thing that therapists occasionally do, especially if they have routinely done this throughout the course of therapy, is to solicit their clients’ feedback. If a therapist has never done this with a given client, it would be inappropriate to shift the power balance of the final session by doing so now. But if some mutual give-and-take and focus on the therapeutic relationship has been part of your style all along, then briefly asking the client what he or she found helpful or difficult in therapy may provide you with valuable feedback. If you ask, be prepared to live with some ambiguity, since what you get will be the client’s very subjective assessment. Asking for in-depth clarification, even if you are bewildered by his or her answer, would be an unfair burden to a client in a final session and would probably increase the client’s defensiveness.

Finally, we remind you that in addition to acknowledging the range of your clients’ feelings about you— including their gratitude for your help—you nonetheless should give them much of the credit for their progress. It may be tempting to let them idealize you and your therapeutic power, but they need to leave therapy in touch as much as with their own strengths and resources. Your acknowledging the value of their struggles and gains will help them further internalize your belief in their abilities.

**Binary**

In some ways, the approach to termination has shifted in the last decade, as the traditional model of a clear ending to longer-term therapy has often given way to a model wherein clients seek therapy as needed, often to deal with situational issues. What termination means varies with each case. It is based on the kinds of expectations, therapeutic issues, and therapist-client relationship that had previously evolved. Your goals as therapist will be to maximize the possibility of continued growth and change when clients are no longer seeing you, and to explore, if appropriate, what their losing you might mean for them. They will need your continued emotional availability until the end, as well as your support and acknowledgment of their progress.

**Discussion Questions**

- What kinds of clients do you think you will have the most trouble giving up? What is it about them that would make it difficult for you? If you can imagine being in their shoes, having had you as a therapist and now finding it time to say good-bye to you, what therapist attitudes or behaviors make that easier or more difficult to do?

- Do you think there is merit to the traditional approach to viewing termination as a necessary separation-individuation loss? What cultural or gender biases might underpin that understanding?

**BIBLIOGRAPHY**


CHAPTER 13


PART TWO

Overview

We conclude this book with three chapters. We have set the first two apart because books on psychotherapy typically do not use these topics as chapter headings (an exception would be Yalom, 1980), and yet, in our view, these are two ideas that are used repeatedly by a wide variety of psychotherapists. Whatever the therapists’ theoretical orientations, we believe that they think about their clients’ relationships with others, and their clients’ capabilities to be responsible. Almost any typical definition of mental health includes, either implicitly or explicitly, these two constructs. Yalom suggested that psychotherapists “throw in something” in therapy that they don’t (or perhaps can’t) describe, which is nonetheless an essential ingredient in their work. To this we add that therapists, if you listen to them at all, slip into using certain constructs over and over, even if those constructs do not occupy a central role in their stated theory. Responsibility and relationships are two such constructs that we believe are part of what is “thrown in” that makes therapy effective.

We are also adding some comments about therapy. Although in this edition we have modified each chapter to include a brief approach into our conceptualizations, this final chapter offers a more systematic overview of the basic elements of brief therapy as it is typically practiced.