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"Such sweet sorrow": The therapeutic relationship upon termination

Alison M. Cobb

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“SUCH SWEET SORROW”:
THE THERAPEUTIC RELATIONSHIP UPON TERMINATION

by

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B.A., Hood College, 1993
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presented in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
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The large body of literature on the process of therapy termination is chiefly theoretical, psychoanalytic, and focused on long-term treatments. It most often presents the therapist's speculations on the client's experience, as the client has been seen as having a biased, defensive view of the process. The general conclusion in the early literature is that termination is a difficult, if not traumatic, process. While the more contemporary literature has provided an empirically-based challenge to the prevailing view, it retains some of the unquestioned assumptions of its psychoanalytic roots. The current study addressed some of these assumptions and solicited the client's perspective of the process. It tested the idea that terminations go well when the therapist is flexible and attuned to the client's needs and expectations. It was predicted that a therapist who is generally accurate in understanding the client's perspective will accurately interpret the client's experience of termination, thereby increasing the client's satisfaction with the process. Conversely, a therapist who generally misunderstands the client, or who holds particularly rigid beliefs about termination, will misread the client's experience, resulting in low client satisfaction with the process. Data were gathered from questionnaires completed by therapist and client dyads immediately following their final session. Instruments assessed predictor variables of general empathic accuracy, termination-specific empathic accuracy, and therapist rigidity of beliefs about termination, and the outcome variable of client satisfaction with termination. Regression and correlation analyses failed to support the hypotheses, but post hoc analyses generated a number of questions and considerations for therapists conducting terminations. In general, terminations were positive experiences for the clients in this study, and their views on the process were largely reflected and understood by their therapists. Therapist “blind spots” tended to be in areas of mutual expression of feelings: they tended to be inaccurate in the extent to which clients were eager to express gratitude and to hear their therapists’ feelings and thoughts about them. It may be that the therapists’ expressions of support and liking for clients contribute more to client satisfaction with the process than the variables of empathy and flexibility.
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This research stems from a Spring, 2004 conversation with Dr. Cheryl Van Denburg about therapy process issues and the problems of termination. When that seed of an idea grew into a prospectus, she joined my committee and was a tremendous help in recruiting other therapists to participate. I am very grateful for her advocacy.

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Kathy Vaughan helped me assemble my ideas about termination issues on a long drive to Wyoming in the Summer of 2004. The topic of termination is thus forever tied in my mind to vast open plains on the eastern side of the Rockies. For that conversation, and for her daily love and encouragement, I thank her. I am also grateful for the support of my fellow grad school travelers, the Fail-to-Rejects, Jayde Pryzgoda, Wendy Rothman, and Donna Ryngala, and of my family, the Cobbs, Terjanians, Benejams, and Vaughans.

During the two years of this project, I have conducted several terminations of brief and long-term therapy relationships myself, each one a profoundly unique experience. I thank my clients for allowing me to engage both emotionally and academically in the process, and for teaching me about what’s important.

Finally, tremendous credit and thanks goes to the therapists and clients who so thoughtfully participated in this research, generously granting me access to this very sensitive slice of their lives.
Parting is such sweet sorrow
That I should say goodnight 'til it be 'morrow.

—William Shakespeare, *Romeo and Juliet*

There is no joy that is not shadowed by its transience. There is no contact with another human being, no alleviation of loneliness, without the aching certainty—no matter how we try to hold it back—that loneliness will come again. No matter how desirable what is to come, it is yet unknown; and what *is* is sweet and terrible to lose.

—*Edelson (1963)*, p. 20

How does the therapist deal with his own feelings about termination? He may write a paper about it.

—*Edelson (1963)*, p. 80
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Introduction

As death is one of life’s few certainties, termination is one certainty of therapy. The ending of therapy, whether by a “termination phase” that spans multiple sessions or an apologetic voice mail message in which the client explains she will not be returning, is a process that looms large in the minds of therapists and clients. The question of when and how therapy ends can arise in the first session and can overshadow all subsequent work; alternatively, it can be ignored until the final minutes of the relationship, exerting its influence only covertly through the course of treatment.

There is a large body of literature on the process of therapy termination. The vast majority of the writing is theoretical, clinical, or qualitative. It is largely psychoanalytic in orientation, and mostly written prior to 1990. It predates managed care, and frequently concerns therapeutic relationships that have spanned years. It most often presents the therapist or theoretician’s speculations on the client’s experience, as the client typically has been seen as having a biased, defensive view of the process. While the more contemporary literature on termination has adjusted to the current treatment climate, it retains some of the unquestioned assumptions of its psychoanalytic roots.

The current study challenges some of these assumptions and solicits the client’s perspective of the process. This research seeks to test the idea that terminations go well when the therapist is attuned to the client’s needs and expectations for the process. A termination may go poorly when there is low empathic accuracy or rigid beliefs about terminations on the therapist’s part. It is predicted that a therapist who is generally accurate in understanding the client’s world view will accurately interpret the client’s experience of termination, thereby increasing the client’s satisfaction with the termination.
process. Conversely, a therapist who generally misunderstands the client, or who holds particularly rigid beliefs about termination, will misread the client’s experience, resulting in low client satisfaction with the process. The experience of termination to be examined in this study includes the client’s sense of how important the ending is, expectations of certain termination behaviors, and emotional reactions to termination. A quantitative, correlational approach will be taken, in order to contribute to the small body of empirically based findings about this unique element of the therapy experience.

Termination Defined

In one of the earliest articles on termination, Freud (1937/1964) defines termination from the practical standpoint as “when the analyst and the patient cease to meet each other for the analytic session” (p. 219). This obvious and simple definition is adequate for defining when the therapy has terminated. More complex is determining the bounds of the “termination phase,” when the therapist and client are moving toward the end of their relationship. A 1978 study by Firestein found evidence for a distinctive phase in analysis, “the period of work antecedent to the ending date when the issue of ending has become important in the analytic focus” (p. 203). This phase can vary from a few sessions to a year or more; it also may be entirely absent.

Further complicating the picture is the variety of termination situations. Ideally, the termination is planned for by both parties, and is mutually agreed on, with both therapist and client feeling the timing is right. The reality is, of course, often far from the ideal. Termination may be forced, for example, because the client or therapist moves or dies; the client cannot afford to continue; the insurance company declines coverage; or agency policy prohibits continuation. A sense of resolution is still possible in these
circumstances, but there is likely a lingering sense of unfinished business. When the therapist must terminate because of a move, a “countertransference storm” (Weddington & Cavenar, 1979) may erupt, with the therapist’s guilt and sense of responsibility creating destructive processes within the relationship. There are also unplanned terminations, with clients “dropping out” of therapy without warning. Sometimes clients start the termination process but do not attend the final session, presumably to avoid painful or uncomfortable feelings. “Unilateral terminations” (Coopersmith, 1984) may result from problems in the therapeutic relationship or a poor match between client and therapist. Terminations within “serial life span therapy” (Mander, 2003), episodic therapy with the same or a new clinician, can represent pauses rather than endings in the therapeutic relationship. Transfer terminations, when the client plans to begin therapy with a new clinician, represent the end of a relationship but not of a course of therapy. Whatever feelings the client has about ending with the first therapist may carry over into the next relationship, sometimes problematically.

Terminations may also follow “interminable therapy,” therapy that continues far beyond its usefulness. Sometimes this results from the client’s fears and dependency needs: the prospect of termination is so threatening that the client forestalls change in order to avoid it. As Levinson (1977) wrote, “For many patients, the wish to be treated far outweighs the wish to be cured” (p. 483). Freud (1937/1964) describes patients becoming comfortable once they are partially cured and reluctant to do more work: “In every phase of the patient’s recovery we have to fight against his inertia, which is ready to be content with an incomplete solution” (p. 231). He posits that the death instinct is responsible for this resistance to a cure.
Therapists might collude in resisting a “cure,” sabotaging their effectiveness or inventing new therapeutic goals in order to postpone termination. As Gould (1977) noted, “It is always easy to find reasons for a patient to continue in therapy” (p. 236). Many writers have suggested that the therapist may be motivated to avoid termination through a narcissistic quest for perfection or through dependency needs. Regardless of who is prolonging therapy and why, the interminable course risks a traumatic termination. As the participants cling to the relationship and avoid termination, the therapy stagnates and frustration mounts. Either the therapist or client might finally do something deleterious to break the stagnation, provoking an abrupt termination and leaving many unresolved issues of grief and loss (Hiatt, 1965; Levinson, 1977).

The Termination Process

The Importance of Termination to Treatment Outcomes

As noted above, Firestein (1974) found a distinct, qualitative difference between the termination phase and the rest of the therapy process. Some have proposed that termination is the most important phase of therapy, with the greatest potential for mastery-based growth (Weddington & Cavenar, 1979). Research has found that there is an increase in therapy activity and a shift in focus to life outside of therapy (Fortune, 1987). It might be said that the stakes are higher in the termination process, because of the finality involved; decisions are often irreversible (Martin, 2002).

On the other hand, the impact of termination can be overstated. In their meta-analysis of process-outcome studies, Orlinsky, Ronnestad, and Willutzki (2004) conclude that, “While proper handling of termination can be important, it is probably what happens in therapy prior to termination that has the most impact” (p. 333). Perhaps the
perspective that a poorly managed termination can destroy therapeutic gains ignores the resilience of client growth. Schafer (1973) wrote of his experience of clients losing therapeutic gain during termination, “It appears as if all were built on sand” (p. 139); the evidence supporting this view, however, does not exist. For example, there is little empirical evidence for the regression that is commonly thought to occur during termination (Fortune, 1987; Fortune, Pearlingi & Rochelle, 1992).

The Symbolic Meaning of Termination

“To part is to die a little.”


Beyond the practical issues of termination, many authors have written about the phase’s symbolic meaning. Their descriptions are vivid and compelling, and theoretically rich. A brief survey turns up comparisons to an epilogue, a curtain call (Ekstein, 1965), a coda (Levinson, 1977), and finale (Buxbaum, 1950). Termination may represent a recapitulation of and preparation for other farewells (Maholick & Turner, 1979), or a farewell to one’s old self (Levinson). Existentialists suggest that it can provoke a client to come to terms with her own mortality (e.g., Goldberg, 1975). Ekstein (1965) writes, “It is a kind of Thanksgiving, sometimes a painful Thanksgiving, a good-bye and a mourning, and a cautious trying out of new wings” (p. 68).

Many authors have drawn comparison to the child’s growing independence from the parent. Dewald (1967), a psychoanalytically-oriented psychiatrist, compares the termination phase to adolescence, with the client/teen leaving behind the comforts and gratifications of therapy/childhood to enter the ‘real world’ and face problems of independence and identity. It is a painful and exciting time for the parent as well as the
child, and the therapist must learn to accept the client’s inevitable leaving. In this way, it is very like foster-parenting: again and again, therapists fully commit themselves to these somewhat contrived relationships that draw to unnaturally early ends. Yalom (1995) writes, “To us as well as to the patient, termination is a jolting reminder of the built-in cruelty of the psychotherapeutic process” (p. 366). The vivid descriptions offered by these writers are evidence that, at least for the clinician, termination is a rich and complex component of the therapeutic process.

The Role of Termination in Therapeutic Progress

As noted above, Levinson (1977), a clinical social worker with a psychoanalytic orientation, compares termination to a coda in music. She writes,

It should be a well-crafted independent passage introduced toward the end in order to bring the composition to a satisfactory close. It serves as a summation of the themes and motifs that preceded it. Thus, the ending period of treatment should usher in a discussion of termination that can serve as an evocator of the repetition of earlier topics and issues. (p. 481)

From Levinson’s perspective, then, termination is mostly a process of summarizing the course of therapy. She implies that discussing the ending can evoke issues covered earlier in the treatment. Other writers maintain that the mere fact of termination, without a direct discussion of it, can prompt a reenactment of previously resolved topics. Hoyt (1979) describes this process:

The end-phase is not merely a recapitulation and nailing-down of earlier work. Rather, all the work of the therapy may be seen as prologue to (and part of) the termination. With the impending loss of the therapeutic relationship the patient’s
fears & conflicts are restimulated, especially as they pertain to earlier losses and struggles over issues of separation-individuation. Feelings of grief and sadness and possibly guilt and anger often will surface, all signaling the need to mourn the passing of the relationship. The way in which these reemergent issues are handled will do much to determine how closely the ultimate goal of therapy, that the patient be able to live independently and well, will be met. (p. 208)

Levinson (1977) agrees that the termination process can make or break the therapy, and adds that it can also influence whether the client continues to make gains after treatment has ended.

Other writers have described how the termination process can evoke new material and thus can bring about deep change. It can play the role of a corrective emotional experience (Gould, 1977), in which the client learns to cope with separation and loss. Glenn (1971), in his discussion of residents taking leave of patients on a psychiatric ward, writes that termination can teach a liberating lesson:

It is important to learn that one can sustain a loss and endure. Able to move apart as well as come together, individuals can free themselves from a crippling object hunger which makes them hang on too cruelly here, avoid becoming reinvolved there. (p. 445)

Other new material may manifest regarding the nature of the relationship between the therapist and client, with effects on both. "It is at this time that the meaning, in affective terms, of the course of therapy and the nature of the therapist-patient relationship is most keenly experienced by both," writes Schiff (1962, p. 77), a psychiatrist at a community outpatient clinic. Termination gives some urgency to
processing the therapeutic relationship. Schafer (1973), a psychoanalyst, elaborates on this point:

> It is during termination that all the unspoken promises, expectations, transferences, and resistances on the part of both persons in the therapeutic relationship may come to light; all their fundamental assumptions about illness & human existence, and about the role and duty and merit of the therapist as well as his satisfaction and pride in his work; and all the collusions by which issues were skirted during the therapy. All are asserted in such various and devious ways that the patient and therapist can easily be bewildered and disheartened. The objective assessment of change, of the course of the work and of its reasonable prospects, then suffers considerably.” (p. 140)

In a 1963 monograph on termination of intensive psychoanalytic psychotherapy, psychiatrist Marshall Edelson outlines three major themes and their accompanying emotions that can be resolved during termination: narcissism, accompanied by panic, rage, and a pervasive sense of worthlessness; mourning, involving guilt and grief; and the struggle toward maturity and independence, provoking competitiveness, defiance, envy, jealousy, and associated anxiety. The termination process, then, can evoke new issues and old, giving the leave-taking an enhanced emotional intensity and increased productivity that can lead to greater therapeutic progress.

**Client Reactions to Termination**

Edelson’s three themes, along with the analogies between termination and death or adolescence described above, demonstrate the field’s traditional view of the process as a powerful, intense, and particularly painful experience. In the literature of the 1960’s,
70’s, and 80’s, writers indulged in detailed, almost gory descriptions of negative client reactions to termination. Dewald (1965), for example, reports on a client who made suicide threats and fainted outside his office door during the termination process. Another required hospitalization because Dewald was taking a week-long vacation. Beatrice (1983) describes clients who ended prematurely, threatened suicide, required hospitalization, and suffered psychotic breaks at the end of therapy. Levinson (1977) describes clients “acting out”: rejecting the therapist before they can be rejected by missing appointments, becoming resistant, or exploding at the therapist. She writes of her clients’ “variety of intimidations, seductive enticements, adorations, and dependent demands” (p. 489) in response to the prospect of terminating. Hiatt (1965) describes “a petulant, pitiful ‘How can you do this to me?’ attitude” (p. 612), and suggests that clients act out by creating new environmental stressors. Weigert (1952) writes that every analytic patient suffers at an unconscious level:

In the terminal phase of each analysis, facing the separation from the analyst, the patient becomes more aware of his narcissistic fixations, his unconscious adherence to an eschatological hope for an all-gratifying mother.... The unconscious expectation of the patient is that the analyst should remain forever the supporter who guarantees a parasitic security. (p. 470)

Stephen Firestein (1978), an analytic psychiatrist, attempted to establish empirical support for the literature’s portrayal of clients’ emotional and behavioral reactions to termination. He interviewed eight beginning analysts, their supervisors, and one of each analyst’s patients. Concerning client emotions, he noted that the termination literature has emphasized separation anxiety; he too found it prominent, “but one must add to it
separation rage, separation elation, separation disappointment, separation sadness and
grief' (p. 205). His subjects reported client behavioral reactions such as falling behind in work, scheduling a trip abroad, wanting to quit early, and deciding to visit a father's grave. They reported client wishes to give gifts, become analysts themselves, get pregnant, and see the analyst after ending. After the termination, clients attempted self-analysis, wrote letters expressing misery or progress, yearned for and fantasized about their analysts, and began work with other analysts.

Firestein's 1978 study is distinctive from the early literature on termination because he solicited client reports of their experiences. His research, however, shares other limitations of the literature during his era, with an emphasis on long-term analysis and a non-representative pool of subjects. It may be the literature's narrow vision that is responsible for the prevailing view of termination as a traumatic event. As Kauff (1977) notes, "the affects most commonly associated with termination seem to span a short, bleak continuum that ranges from sad to downright morbid" (p. 3-4). A succinct example is Coltart's (1996) comment that "some patients experience the agreement to end as a death sentence" (p. 150).

When clients in non-analytic therapy are asked directly about their experiences of termination, very little evidence for this morbid reaction is found. For example, Marx and Gelso (1987) assessed termination reactions of clients at a university counseling center through a questionnaire administered one week after the final session. The clients had received an average of 10 sessions from therapists with a broad range of experience levels and with predominantly interpersonal, eclectic, and psychodynamic orientations. The researchers obtained participation from 74 clients from a pool of 95; to ensure that
their findings would not be affected by a selection bias, they compared client satisfaction between participants and non-participants, and found no significant difference. The clients in the study reported significantly more positive affect than negative. The majority felt satisfied with the termination process and believed it was important to discuss their feelings about termination. Asked to indicate their feelings about termination on an affect adjective checklist, at least half of the participants endorsed words such as cooperative, calm, agreeable, good, healthy, and thoughtful. Fewer than 3% of the participants endorsed words such as miserable, enraged, irritated, furious, and forlorn.

Marx and Gelso (1987) acknowledged the possibility that clients are in denial about their negative affective reactions to termination; perhaps therapists are able to detect dysphoric reactions that are outside their clients’ awareness. Countering this argument are two points. First, the scoring technique they used was developed specifically to control for this problem. Second, a 1992 article by Quintana and Holahan replicated Marx and Gelso’s results when they asked the same questions of counselors. They found that when asked about client affective reactions, counselors endorsed positive and negative adjectives at similar rates as did the clients in the earlier study. This suggests that if clients are in denial about their negative affect, so are their therapists.

In the same year as Marx and Gelso’s article, Fortune (1987) published a study challenging the perspective of termination as a traumatic event. In a structured interview format, she asked 59 Master of Social Work practitioners about their recollections of their clients’ reactions during terminations of the past year, and found that the most common were positive affect and evaluation. Specifically, the reactions frequently endorsed were
evaluation of progress, evaluation of therapeutic experience, and feelings of pride, selfaccomplishment, and independence. She analyzed client reactions in relation to practitioner variables such as gender, age, experience, and number of clients and terminations. When she controlled the significant effects through partial correlation, only one variable was still significant: theoretical orientation. She found that those who considered their practice most influenced by Eriksonian psychosocial theory were more likely to report negative client affect than those based in family systems, behavioral, humanist, or other theories. She found evidence for negative reactions, such as a sense of loss, but noted that destructive responses such as regression and nihilistic flight were rare. She warns therapists against searching for negative affect at the expense of capitalizing on the clients’ sense of mastery and their tendency to evaluate successes, which can be an essential component of consolidating progress toward the end of therapy. This advice has been offered by others as well (e.g., Quintana & Holahan, 1992; Malan, 1976; Miller et al., 1983).

Fortune’s (1987) findings are a strong challenge to the long list of authors who have described “the well-known fact” (Ekstein, 1965) that clients regress during termination, with old symptoms recurring “frequently,” “almost always,” “expectably,” and “with regularity” (e.g., Dewald, 1965; Firestein, 1978; Glenn, 1971; Gould, 1977; Hoyt, 1979; Hiatt, 1965; Lamb, 1985; Levinson, 1977; Reich, 1950; Schafer, 1973; Schiff, 1962; Weigert, 1952). Symptom recrudescence has traditionally been interpreted as an unconscious attempt to postpone termination, or as an expression of anger toward the therapist. The idea is further challenged in Fortune’s follow-up study (Fortune, Pearlingi & Rochelle, 1992), which found symptom recurrence to be one of the least
common reactions to termination. Sixty-nine Master of Social Work practitioners
participated in this questionnaire-based study, reporting on client reactions to termination
of moderately long-term treatment (average 36.5 sessions). Again, the strongest client
reactions were positive affect and evaluation of the therapy experience, progress, and
success.

A compelling finding of Fortune, Pearlingi & Rochelle’s (1992) study is the
correlation between negative client affect, therapist difficulty in terminating, and poor
therapy outcome. It appears that clients and therapists are most likely to experience
painful terminations when the therapy did not go well. While causation is undetermined
in this study, the authors suggest, “it is not the ending of successful treatment that
generates the problematic reactions permeating the treatment literature” (p. 178). This
research suggests that the problematic reactions to termination described throughout the
literature may be due more to unsuccessful treatment than to client pathology. Other
researchers have made similar suggestions. Quintana and Holahan (1992) found that
when treatment outcome was poor, clients devalued therapy more and expressed more
frustration about ending. Fitzgerald’s (1995) study found that successful treatment was
the most powerful predictor of a smooth and productive termination process. These
studies call into question a common interpretation of clients’ depreciation of therapy
upon termination. For example, Gould (1977) explains this stance of “I am not really
losing anything of value” (p. 240) as a defensive reaction against the pain of termination.
The evidence cited above suggests that, to the contrary, the clients’ criticisms are reality-
based evaluations of their experience in therapy. Perhaps the interpretation is actually the
therapist’s defense against a painful sense of failure.
Interpreting client emotions as defensive reactions, not reality-based responses, is quite common in the literature. For example, as Fortune, Pearlingi and Rochelle (1992) point out, Greene (1980) categorized positive and pleasant affective responses as “denial” in his research. Glenn (1971) sharply criticizes the prevailing view in residency training, which he says portrays “the patient—oral-dependent-clinging-infantile—[as] a furious raging infant. Other affects are interpreted as defenses against his anger, attempts to shift focus. Such a view further infantilizes the patient” (p. 440). Echoing this, Kramer (1982) quotes an experienced therapist who participated in his study as saying, “We are taught in school and supervision that termination is a big deal, and we convey this attitude to our clients” (p. 94). It may be that the clinical lore, a legacy of psychoanalysis and not necessarily relevant to many current therapy approaches, fragilizes and pathologizes clients. Certainly, some clients do feel traumatized by termination; research suggests that many do not. It can be problematic if a therapist, perhaps influenced by the compelling and dramatic clinical lore, expects one reaction to prevail and thereby misinterprets the client’s true feelings. This sort of mistake is at the heart of the present study.

**Variation in Termination Reactions**

If client reports of their own emotions, and therapist reports of their clients’ responses, are to be believed, termination generates a wide range of reactions. Research lends validity to Schafer’s (1973) comment that “The potential for virtually every significant human emotion resides in the termination situation” (p. 146). While positive reactions appear to predominate, Fortune, Pearlingi & Rochelle (1992) found weak negative reactions present in most cases, as reported by therapists; these reactions were
mostly a part of ambivalence about ending therapy. Therapist report in Quintana and Holahan’s (1992) study indicated that a minority of clients expressed concern, frustration, fear, aloneness, and loss. At least one fourth of the clients in Marx and Gelso’s (1987) research endorsed feeling afraid, alone, and nervous. While positive feelings outweigh painful ones by a wide margin, negative or ambivalent feelings do clearly surface. Glenn (1971) encourages therapists to focus on the polyvalence of client reactions to termination, as focusing too narrowly may be disruptive to the process. He describes how one client might experience helplessness, relief, jealousy, gratitude, guilt, closeness, estrangement, and anger throughout the termination.

Some researchers have attempted to identify correlates of specific reactions to termination. Analyzing his own experience of terminating with twelve clients in order to move his practice to another city, Dewald (1965) found that type of treatment and stage of therapy seemed to be important variables. Those whom he was treating with supportive therapy had mostly positive transference attitudes and feelings of sadness, regret, or concern. More negative feelings of rage or anger arose among those with whom he was using an insight-directed approach. Those patients who had already completed the majority of their therapeutic work were not as deeply affected by the forced termination as those who were still in the middle of it. Similarly, those who began working with Dewald after he had announced the closing of his practice, and so knew in advance that their therapy was time-limited, were relatively undisturbed by the termination. In fact, they seemed to profit from the limitation, being inspired to make optimal use of their time.
As described above, Fortune, Pearlingi & Rochelle (1992) found a correlation between therapy outcome and reactions to termination. They also found that who first raised the possibility of termination was an important variable affecting the client's reaction. Asking 69 MSW practitioners about their clients' responses to termination, they found that when clients brought up termination first, they were more likely to evaluate progress and to engage in both positive and negative flight into new activities and relationships. Alternatively, when the therapists raised the issue of termination first, the clients spent less time evaluating their progress in therapy, and were more likely to engage in nihilistic flight (defined as negative ways to avoid termination).

Other correlates with termination reactions that have been examined include client loss history, the precipitant of termination, and demographics. Researchers have identified client loss history as predictive of lower depression upon termination and of greater appreciation for discussion of termination reactions (Marx & Gelso, 1987; Saad, 1984). They have also found that when terminations are forced or unplanned, clients experience more anger, mourning, anxiety, and frustration; planned terminations lead to more reactions of pride, excitement, and determination to finish (Cicchitto, 1983; Goldthwaite, 1986; Saad, 1984). Contradictory results have been found with variables of client and practitioner gender, therapist theoretical orientation and experience level, length of treatment, and preparation for termination (Fortune, Pearlingi & Rochelle, 1992).

Rigidity and Risks in Therapist Response to Client Termination Reactions

As the early literature on termination, and the psychoanalytic orientation in general, focuses on the darker side of client responses to termination, therapists run the
risk of expecting and searching for misery and anger in a client who may instead be feeling pride and relief. Quintana & Holahan (1992) advise that

Counselors should be aware that most clients, particularly those who have experienced significant progress, tend to express positive feelings about ending counseling; counselors may be misled by theoretical articles that emphasize clients’ dysphoric feelings to the exclusion of clients’ positive affective reactions.

(p. 304)

A therapist who is indoctrinated in this view of termination as traumatic may cling to it rigidly, searching for pain, anger, and fear in a client. If a client denies the presence of these emotions, the therapist might interpret the denial as a defense mechanism, believing the emotions are present at a subconscious level. As this process is occurring at the end of therapy, there may be no opportunity for the therapist’s beliefs to be corrected. The rigidity is thus never challenged.

A psychiatrist writing about terminations in inpatient settings, Glenn (1971) explains that when a resident-therapist becomes over-focused on dysphoric reactions, the patient often plays along, as a “sympathetic gift to his troubled therapist: speaking to him about loss and angry feelings so [the therapist] will not feel too bad about going” (p. 439). The patients in one facility Glenn studied often remarked that “the ones suffering most from separation anxiety were the departing doctors” (p. 439). This somewhat cynical view seems idiosyncratic to an inpatient setting, where groups of patients can joke together about the generations of residents they see come and go. It is likely relevant to outpatient treatment as well, however. Through reinforcement, a therapist can inadvertently coach a client into a certain type of reporting, and at termination a client

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may find herself disclosing dysphoric feelings because she knows that is what her therapist values and responds to.

Therapists must be vigilant about this tendency, as fostering a sense of accomplishment and efficacy upon termination may be a key component of consolidating therapeutic change. Expecting a client to be dependent and grieved by the end of treatment may undermine the client’s sense of independence, sending a message of “I don’t think you can handle life outside of therapy.” Furthermore, ignoring significant areas of client affect risks leaving the client feeling misunderstood. If there is healing power in feeling understood (Elliot & Shapiro, 1992), feeling the opposite is likely to be destructive. As Schafer (1973) writes, “Where understanding fails, resentment flourishes” (p. 139). Because treatment is drawing to a close, there may be insufficient time to work through the misunderstanding, and the client may leave the therapist with a range of strong, difficult, and unexpressed feelings. Perhaps a portion of the negative affect associated with termination is due more to being misunderstood than to ending the relationship. This fits with the research described above suggesting a correlation between negative reactions to termination and poor therapy outcome, as the potential for misunderstanding may be greater in unsuccessful relationships.

Misunderstanding and rigidity of beliefs about termination can run in the opposite direction as well. A therapist who believes that clients terminate easily, and that the clinical lore is overstated and melodramatic, may ignore or minimize dysphoric reactions. This therapist may be intent on conducting brief therapy and eager to terminate, perhaps being guided by the research that shows greatest therapeutic gain occurs at the start of therapy (e.g., Garfield [1994] found that 62% of clients felt they had been helped within
13 sessions). Alternatively, some authors have suggested that clinicians who are quick to terminate are restless, sublimating feelings of worthlessness, or avoidant of intimacy (e.g., Hiatt, 1965; Levinson, 1977; Mander, 2003). When rigidity runs in this direction, a similar outcome may result, with the client feeling invalidated and misunderstood.

**Empathic Accuracy**

In a study of terminations forced by student therapists’ academic schedules, Gould (1977) documents some examples of misunderstandings between clients and therapists. His stories are of therapists being surprised by their clients’ reactions, such as the therapist who did not know how attached her client was until the point of termination. More common was the opposite situation: several therapists expected their clients to be anxious and upset when they were told about the time-limited nature of their treatment, and were taken aback when the clients expressed relief to know that “they wouldn’t be coming for the next seven years” (p. 255).

Misunderstanding about a client’s reactions to termination may come from at least two sources: lack of empathy and rigidity. First, a therapist who lacks understanding of the client’s experience in general is likely to misunderstand the client’s experience of termination. Second, a therapist with strong, rigid beliefs about the impact of termination may misread the client’s experience due to expectancy effects. In this case, the therapist’s good general understanding of the client may be clouded by clinical lore, theoretical literature, or his/her own beliefs about termination. This study will explore these two factors and whether they are, in fact, predictors of clients’ satisfaction with the termination experience.
Defining Empathic Accuracy

The “understanding” referred to here is best captured by the construct of empathic accuracy. Empathy, as Rogers (1980) defined it, is the “ability to see completely through the client’s eyes” (p. 85). He further described it as “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view” (p. 85). It is not only taking in what the client says at face value, but it includes “sensing meanings of which [the client] is scarcely aware” (p. 142). Empathic understanding has been defined as “the degree to which the therapist is successful in communicating awareness and understanding of the client’s current experience in language that is attuned to that client” (Lambert & Barley, 2002, p. 22). This definition emphasizes the communication component. It is not enough for the therapist to understand the client’s experience; that understanding must be communicated so that the client feels it.

Another component of empathy is the therapist’s ability to titrate its expression according to what a client can tolerate. As Horvath & Bedi (2002) write,

What is empathic for one client might appear to be intrusive to another.
Consequently it seems that therapists’ ability to place themselves in the client’s position is mediated by sensitivity to the client’s preference and tolerance of expressions of intimate support of this kind....To build a good interpersonal bond, therapists need to be able not only to accept and appreciate the client’s world, but also to individualize the expression of this understanding and support to the client’s relationship stance. (p. 57)
To emphasize these components, this study uses the construct of “empathic accuracy,” which is suggestive of the need to understand the client’s experience and to communicate that understanding accurately.

Since Rogers’ (1957) suggestion that empathy is a necessary tool of therapeutic change, a great deal of research has been conducted to link this construct with successful therapy. It is, in fact, the single most researched variable in psychotherapy process research (Ickes, 1997). Estimates of the correlation vary depending on who is rating therapist empathy and therapy outcome (the client, the therapist, or an objective judge); the highest correlation is found when the client rates both (Lambert & Barley, 2002). In their meta-analysis, Orlinsky, Ronnestad, & Willutzki (2004) found that objective and client ratings of empathy are highly correlated with outcome, but therapist self-ratings are correlated “hardly at all” (p. 350). Furthermore, therapist’s ratings of their own level of empathy are only weakly correlated with client and objective ratings of them (Bohart, Elliott, Greenberg, & Watson, 2002; Caskey, Barker, & Elliott, 1984; Ickes, Marangoni, & Garcia, 1997). Thus, the research supports the theoretical notion described above that what counts the most is the clients’ perception that their therapists understand them (Lambert & Barley, 2002).

Of all therapist attributes, studies have found that empathy and understanding are among the strongest predictors of positive outcome (Lambert & Barley, 2002). In their meta-analysis of empathy studies, Bohart, Elliott, Greenberg and Watson (2002) conclude that there is evidence for empathy playing a causal role in outcome, although the relationship has not yet been conclusively established. These researchers also refer to three qualitative studies that found that when clients feel understood, they feel safer in the
relationship and find it easier to self-disclose. From this one might infer that when in a relationship characterized by high empathic accuracy, a client will feel comfortable correcting a therapist’s misunderstanding or momentary inaccuracy.

Less research has been conducted on the correlation between empathic accuracy and client satisfaction with treatment, which could be quite different from client outcome. One study of 523 patients in individual therapy in veterans’ clinics examined patients’ sense of their therapists’ understanding and therapists’ judgments of their patients’ satisfaction with treatment (Lorr, 1965). A correlation of .30 was found, which is comparable to effect sizes found in studies correlating empathy and outcome (Bohart, Elliott, Greenberg and Watson, 2002).

**Empathic Inaccuracy**

Moments of empathic inaccuracy are inevitable in a therapy relationship, and are not necessarily deleterious. Clients and therapists have fundamentally different perspectives, which may at times lead them to feel out of step with each other. Clients define their problems in terms of their personal experiences and the impact of the problems on their lives; in contrast, therapists define the problems through their theoretical orientation, training, and etiological theories (Scamardo, 2000). Therapists tend to have a broader or deeper conceptualization of client problems (Berkow, 1995; Elliott & Shapiro, 1992). In a 1988 study of 40 clients reporting on almost 400 therapy sessions, it was found that different aspects of the therapy are salient for clients and therapists: clients want to find solutions and to feel better, while therapists tend to be more focused on etiology and insight (Llewelyn et al., 1988). Both perspectives are valid and valuable. Ideally, the therapist and client are pursuing the same general goal, while
using different language and perhaps different roads to get there. Often it is the discrepancy that prompts change and growth; after all, clients often seek therapy in order to gain a new perspective on their problems. This idea is described by Arnkoff (1980):

I suggest that empathy fosters therapy from the client’s point of view by providing the client with conditions for restructuring his or her model of the world….Through demonstrating empathy, the therapist shows that he or she knows the client’s model and accepts it—yet the therapist plainly sees the world from a different model. The therapist simultaneously both knows and knows beyond the client’s perspective. (p. 353)

The difference in perspective can also help the client retain a sense of ego boundaries. An analogy can be made between empathic accuracy in the therapy relationship and attunement between parent and child. Attunement gives a child a secure sense that she is understood and a sense of efficacy; misattunement, however, gives her a chance to experience ego boundaries. She learns that the parent is often, but not always, there for her; that the parent will often, but not always, understand and validate her feelings; and essentially, that the parent is a distinct entity from her. This discord, in the context of a secure attachment, gives the child the opportunity to learn to self-soothe (Stern, 2002). “Good-enough parenting” suggests that the ideal is to be attuned to the child some of the time, but not so much that she never learns how to cope with discord. “Good-enough therapy,” then, may be the condition of a therapist who is empathically accurate some, but not all, of the time, so that the client retains the sense that she can function independently of the therapist.
Thus, a “good-enough therapist” will be empathically accurate much of the time, but not every moment of the therapy hour (Fosha, 2001). A strong therapeutic relationship will allow the client to signal that he is being misunderstood, and the therapist to notice and correct her misattunement. This may take place during the termination process, as a therapist may become temporarily out of step with the client’s feelings about ending therapy. In the context of a strong, empathic relationship, the misstep can be corrected relatively easily; in a relationship with low empathic accuracy, however, the correction will be more difficult, if it occurs at all. The proposed study tests the proposition that empathic accuracy facilitates the termination process in this way.

Current Study

Rationale

As described above, the termination process is theoretically one of the defining moments of the therapeutic process. According to some, it can “make or break” a successful course of therapy. Beyond the dynamic, symbolic importance of the ending of the relationship, it does appear to be critical in that there is little opportunity to repair mistakes made at termination. If a client is dissatisfied or upset with how termination was handled, it is likely that she will have to process and cope with this distress on her own, as she is no longer seeing her therapist. There is some research suggesting a correlation between satisfaction with termination and overall satisfaction with treatment (Marx, 1983). A mishandled termination, then, may lead to disillusionment with therapy in general, which could endanger the gains made or inhibit the client from seeking additional treatment in the future. As the termination process can be of critical importance, research is needed to understand what contributes to making it a success.
This study examines whether clients’ satisfaction with the termination process can be predicted by therapists’ empathy and flexibility in thinking about therapy’s end. It is theorized that these variables—empathy and flexibility—are integral parts of a well-managed termination. A few examples will help illustrate the hypothesis.

Hypothetical client Andrew was seeing Dr. Black for long-term therapy. While they seemed to have a productive working relationship, Andrew often felt misunderstood by Dr. Black, who seemed to think Andrew was more dependent and needy than he felt. Based on difficult terminations Dr. Black had experienced in the past, and on her understanding of endings as traumatic events for clients, she assumed that Andrew would have a difficult time when their relationship drew to a close. She anticipated that some of his presenting symptoms would reemerge, and that he would grieve their parting. She therefore began processing the termination well in advance, and became vigilant for signs that Andrew was struggling.

From Andrew’s perspective, however, there was nothing to mourn and much to celebrate: he had made significant gains in therapy, and he was looking forward to “graduating.” He did not understand his therapist’s digging for painful emotions, and began to wonder whether something was wrong with him because he did not feel grief. He did not want to hurt Dr. Black’s feelings by telling her that he would not miss her, and there did not seem to be enough time left to talk through what was going on, so in the final session he kept quiet and tried to act as she seemed to expect. He left feeling confused, misunderstood, and worried; he also felt relieved to be out of the awkward situation of saying goodbye. He questioned the gains he had made in therapy, and felt ambivalent about seeking therapy again in the future. Dr. Black also felt uneasy, but she
could not figure out what had gone wrong. She surmised that Andrew had been repressing his painful feelings, and she worried that his inhibited grieving would soon manifest itself in new symptoms.

Christine, in contrast, was in brief therapy with Dr. Danforth. She felt that Dr. Danforth understood her better than anyone she had ever known, and she dreaded their termination. Their work had to stop because she was moving out of the state for a new job. Dr. Danforth was enthusiastic about her move, considering it a sign of growth and independence. Eager to reinforce this, he celebrated their termination as a major accomplishment for his client. When she expressed fears about ending therapy, he responded that he knew she was capable of going out on her own, and assured her that her dependency feelings were normal and would abate quickly once she left. Christine began to wonder if he was so enthusiastic because he was glad to be rid of her. This seemed incongruous, however, with the rest of their relationship. Because she felt generally secure that Dr. Danforth understood her and empathized with her, she was able to ask him about it. They explored her fears, and Dr. Danforth saw that although Christine felt ready to move, she was going to miss their sessions tremendously. This was processed sufficiently so that by the time they said goodbye, Christine again felt completely understood by her therapist. She carried the security of that feeling with her into other relationships. For his part, Dr. Danforth incorporated her correction into his thinking about how to handle future terminations.

The first example demonstrates that in some cases, there is no opportunity for the therapist to discover her misreading of the client's termination needs; the second example shows how a therapist can be corrected by the client and brought back into attunement.
with her. Both scenarios point to how a therapist’s rigid expectations about termination can lead him or her into lapses in empathic accuracy. These examples also illustrate how the client’s satisfaction with the termination process can reinforce the gains made throughout the course of therapy, and how dissatisfaction can throw the entire enterprise into question for the client. The variables of empathic accuracy, rigidity, and client satisfaction with termination highlighted in these examples form the basis of the theoretical model underlying the present study.

**Theoretical Model**

This study investigates the impact of therapist empathic accuracy and rigidity of beliefs about termination on client satisfaction with termination. The research and theoretical arguments described above lead to a possible model of the relationship between these variables. Figure 1 depicts one way in which these variables might be related. Therapists who have high empathic accuracy and flexible beliefs about termination will likely be able to determine what their clients need or expect in the termination process; they will respond to those needs and expectations, and the clients will feel satisfied with the termination process. In some cases, as described in the scenario above involving the client Christine, the therapist might misjudge or misunderstand what the client needs. The misunderstanding will presumably lead the client to feel uncomfortable. An attuned therapist might pick up on this discomfort and correct his approach, now accurately understanding the client’s needs and facilitating a satisfying termination. If the therapist does not notice the client’s discomfort, the client may disclose it. This is more likely within the context of a therapeutic relationship characterized by understanding and empathy, as described in the literature review above.
and in the example of Christine. When the client discloses the discomfort, the therapist corrects his approach, leading again to a satisfying termination.

![Diagram](image)

**Figure 1.** Possible model of the relationship between empathic accuracy and client satisfaction.

In contrast, as depicted in Figure 2 and exemplified by Andrew in the scenario above, a therapist with poor empathic accuracy or rigid beliefs about termination will likely misjudge what a client needs or expects in the termination process. Because of the condition of low empathy, the client will not feel safe in disclosing the resulting discomfort, and the therapist will not notice it on her own. Therefore the termination process will continue as before, not meeting the client’s needs, and the client will feel dissatisfied.
Variable in the Current Study

The diagrams above show a complex dynamic that is theorized to take place over the course of the therapeutic relationship. The proposed process is too complex for the exploratory nature of the current study, which tested a much simpler set of variables. The independent variables were the therapist's levels of general empathic accuracy; empathic accuracy specific to the termination situation; and flexibility of beliefs about termination. The dependent variable was the client's level of satisfaction with the termination process. The simplified model is shown in Figure 3.
Level of general empathic accuracy

Level of termination-specific empathic accuracy

Level of rigidity/flexibility in approach to termination

Level of client satisfaction with termination

Figure 3. Model to be tested.

General Empathic Accuracy

As described above, therapist empathy, one of Rogers' core conditions, is strongly related to therapy outcome. It also seems to set the stage for increased client self-disclosure (Bohart, Elliott, Greenberg, & Watson, 2002). When it is absent, it may affect how well the therapist and client can process relationship issues: a study described in Orlinsky, Ronnestad, and Willutzki's (2004) meta-analysis found a negative impact of therapist here-and-now focus in the context of low empathy and genuineness ratings of the therapist. This suggests that processing termination issues in the condition of low empathy would be problematic, or even harmful.
The construct of empathic accuracy includes the therapist’s ability to fully understand the client’s experience and to communicate that understanding accurately and in a way that is appropriate for the individual client. Rogers (1957) emphasized two components of empathy and his other core conditions: first, that the therapist experience empathy, genuineness, and unconditional positive regard, and second, that the therapist communicate these responses to the client. A client-report measure of empathy, therefore, is needed to assess the second component. As described above, this approach to measuring empathy has been found to have the strongest correlation to therapy outcome (Barrett-Lennard, 1962). The empathy scale of the Barrett-Lennard Relationship Inventory (BLRI, 1962) is the most widely used client-rated measure of empathy (Bohart, Elliott, Greenberg, & Watson, 2002), and was used to measure general empathic accuracy in this study.

**Termination-Specific Empathic Accuracy**

Another methodological approach to assessing empathic accuracy is to compare the therapist’s perceptions of the client’s experience with the client’s report of his or her own experience. Ickes (1993) wrote that “the most straightforward way to measure empathic accuracy is to compare the content of a target person’s actual thoughts and feelings with the content of the corresponding inferred thoughts and feelings reported by the perceiver” (p. 591). The degree of congruence between therapist and client ratings is known as predictive empathy. This methodology provides information on the therapist’s global understanding of the client’s view, more than on the therapist’s ability to communicate understanding to the client, and has been used in several studies (Bohart, Elliott, Greenberg, & Watson, 2002). In the current research, predictive empathy was
used to determine how accurately the therapist understands the client’s experience of termination.

For example, therapists tend to assume that clients want or need to process the therapeutic relationship as a part of termination. Lipton (1961) challenges this notion, charging that processing the relationship is the therapist’s need, not the client’s. It is reasonable to assume that some clients do not actually want or need to process the termination, but some do. Further examples are alluded to in the scenarios above: Andrew’s therapist was not attuned to his sense of pride in his therapy gains, and Christine’s therapist missed her anxiety and sadness about their pending separation. This variable of termination-specific empathic accuracy represents the degree to which a therapist detects what a particular client desires with regard to termination. Termination-specific empathic accuracy was measured by parallel forms of a questionnaire about termination-related cognitions, emotions, and behaviors. The therapists were asked to rate how important their clients felt the termination session was, what feelings their clients experienced, and what behaviors (such as tapering sessions, shaking hands at the last session, or evaluating progress) the clients expected and desired. The clients were asked the same questions, and their responses were compared to what the therapists predicted.

**Rigidity of Beliefs about Termination**

There is a wide body of research suggesting that therapists should tailor their interventions to the needs of specific clients (e.g., Brown, Dreis, & Nace, 1999; DeAngelis, 2005; Lazarus, 1992; Prochaska & DiClemente, 1992). A therapist’s approach to termination, then, should be tailored to the client’s needs as well. It is
possible, however, that rigid beliefs and expectations about the termination process may
impede a therapist’s ability to detect and respond to these needs.

Theoretically, a therapist’s general empathic accuracy and termination-specific
empathic accuracy ratings should be highly correlated: a therapist who is empathic in
general is likely to be empathic when it comes to termination. Incongruence between
these two variables might be explained by the level of rigidity of beliefs about
termination. A therapist who is generally empathic may make several errors in judgment
about what a client expects or needs in the termination process because she has rigid
beliefs about the experience of termination, based perhaps on the clinical lore or
theoretical literature. If, for example, she has rigid expectations that a client will
experience anxiety and anger during termination, she might search for these reactions at
the expense of recognizing the pride and relief the client is actually feeling. Thus,
rigidity leads to low termination-specific empathic accuracy, even in the condition of
high general empathic accuracy. This same error can be made, of course, by a therapist
low in general empathic accuracy. In the current study, rigidity was assessed through a
questionnaire in which therapists indicated how strongly they hold specific beliefs about
termination.

Client Satisfaction with Termination

Client satisfaction with termination was the dependent variable in this study. It is
a variable that has received little research attention, although it may be a predictor of
overall satisfaction with treatment (Marx, 1983). Most studies of empathy have used
treatment outcome as the dependent variable, not client satisfaction, and in termination
studies, the focus has usually been on client or therapist’s affective experience of the
process, not on their overall satisfaction with it. Because of the dearth of studies addressing satisfaction, an established measure was not available. For this study, then, a few items with strong face validity were developed to assess this variable.

**Hypotheses and Questions**

The hypotheses and questions of this study were:

**Question 1:** How are the three predictor variables (levels of general empathic accuracy, termination-specific empathic accuracy, and flexibility in approach to termination) related to each other?

**Hypothesis 1:** Level of general empathic accuracy is positively correlated with level of client satisfaction with termination.

**Hypothesis 2:** Level of termination-specific empathic accuracy is positively correlated with level of client satisfaction with termination.

**Hypothesis 3:** Level of flexibility in approach to termination is positively correlated with level of client satisfaction with termination.

**Question 2:** Using the three predictor variables, how can the outcome of client satisfaction be best predicted?

**Method**

In this study, therapist and client dyads were asked to complete questionnaires immediately following their final session. The first questionnaire was a brief general information form (Appendix B). The other four instruments were designed to assess the variables of general empathic accuracy, termination-specific empathic accuracy, therapist rigidity of beliefs about termination, and client satisfaction with termination.
Instruments

Barrett-Lennard Relationship Inventory

The Empathy Scale of the Barrett-Lennard Relationship Inventory (BLRI, 1962) was used to assess the client’s sense of the therapist’s general empathic accuracy (Appendix C). The BLRI was developed under Carl Rogers’ sponsorship to test the relationship between Rogers’ core conditions and therapeutic outcome. It is the most frequently used measure of facilitative conditions from the client’s perspective (Hill & Lambert, 2004). It features five dimensions, one of which is known as the “Empathic Understanding” or the Empathy Scale. This scale, with 16 items, taps “the extent to which one person is conscious of the immediate awareness of another” (Barrett-Lennard, 1962, p. 3). Further describing this quality, Barrett-Lennard writes,

Maximum empathic understanding of B, by A, requires that A be able to discriminate and permit in his awareness all that B gives direct or indirect signs of consciously experiencing when he is with A. This, in turn, requires that A be quite unthreatened and nondefensive in relation to B. To the extent that A identifies with B’s feelings, or unconsciously projects feelings of his own into his perception of B’s experience, or in any other way confuses B’s experiences with experiences that originate in himself, his empathic understanding of B will be reduced. (pp. 3-4)

Barrett-Lennard (1962) used a rating scale ranging from +3 (Yes, I feel strongly that it is true) to −3 (No, I feel strongly that it is not true). He felt that this rating system “reflected how certain the respondent felt about the item statement being correct or incorrect and also how important it was to him that it was true or false” (p. 6). In a later article (1986)
he also noted that this system prevents subjects from settling on a neutral response when they might be reluctant to commit to a positive or negative answer. Other researchers have used this rating scheme when administering the BLRI but converted the responses from $-3...+3$ to $1...6$, in order to eliminate negative scores and increase the ease of statistical analysis; Barrett-Lennard advises against this approach.

When Barrett-Lennard (1962) developed his relationship inventory, he established “quite satisfactory” (p. 11) split-half reliability using the Spearman-Brown formula, with a corrected reliability coefficient of .86 for the Empathic Understanding Scale. Test-retest reliability for this scale over a four-week period was also strong at .89. He validated the content of the items with five client-centered counselors who served as judges of whether the individual items were important indicators of the variables in question. He noted that construct validation was “necessarily indirect” (p. 7), as his was the first attempt to operationalize the theoretical variables of the therapeutic relationship.

In his 1986 article, Barrett-Lennard asserted that the BLRI “may be presumed and treated as valid” (p. 458), citing evidence of content validity and psychometric soundness. He also reviewed studies that have successfully used the BLRI to predict therapy outcome and to assess the quality of other relationships, such as spousal and teacher-student dyads.

A review of rating scales (Ponterotto & Furlong, 1985) found adequate internal consistency reliabilities have been reported across studies (.86 for the empathy scale), and test-retest reliabilities have averaged out to .83 over 2-week to 12-month intervals. However, although the BLRI has been used in many clinical and field settings, it has
undergone many modifications, making cross-study psychometrics difficult to ascertain; this is particularly problematic in determining construct validity.

There are no norms for the BLRI, but Barrett-Lennard (1986) noted that scale scores are usually above zero, although negative scores are not rare. Average scores for the Empathy scale usually fall in between means of the other scales. This suggests that the ceiling effect will not be a significant problem in the present study.

Scoring for the BLRI is a straightforward summing of responses. The reverse-scored items are listed in Appendix C, following the instrument.

**Predictive Empathy Forms**

The predictive empathy forms (Appendix D) were designed for this study to assess the therapist's ability to judge how a client will respond to questions about the termination experience. The client completed a form (PE-C) asking about termination-related cognitions, emotions, and behaviors. The therapist was given the same form, but with questions worded to pertain to the client (PE-T), such as “How important was this last session to your client?” The degree of congruence between the two forms represents the therapist's termination-specific empathic accuracy.

Half of the items in the PE forms were derived from previous research. The first question (“How important was it for you to discuss your reactions to ending counseling with your therapist?”) was taken from Marx and Gelso’s (1987) study, as was the list of termination behaviors (questions 8 and 9, from the Termination Behavior Checklist). The list of emotional reactions (question 5) was adapted from Fortune & Pearlingi’s (1992) study. These lists of behaviors and emotions have been validated by previous research, and so are more sound than lists developed specifically for this study would have been.
For example, Marx and Gelso found one-week test-retest reliability of $r = .88$ ($p<.05$) for their Termination Behavior Checklist data, and correlations between responses of two subject pools were high.

The PE forms include a section in which the client and therapist mark what specific behaviors actually occurred during the termination process (e.g., summarizing the work and setting a date for the final session). This was not included in the final PE score, as discrepancies in this section would not reflect the therapist’s inability to understand the client’s experience, as much as a disagreement about the reality of what transpired. While interesting information, this would not be indicative of empathy. The responses were used in post hoc analyses of termination behaviors.

**Termination Rigidity Scale**

The Termination Rigidity Scale (TRS) was developed for this study. It asks the therapist to indicate strength of agreement or disagreement with specific termination behaviors and conceptualizations. A therapist who answers “absolutely not” to many items about what behaviors should occur during termination, for example, is presumably more rigid in her thinking about termination than a therapist who responds with “maybe, maybe not; it depends.” Items in the first section (questions 1-17) were taken from Marx and Gelso’s (1987) Termination Behavior Checklist, with the modifications made by Quintana and Holahan (1992) so that the items are stated from the therapist’s point of view (e.g., “discussing your plans for the future” was changed to “discussing the client’s plans for the future”).

When scoring the TRS, responses on both ends of the continuum, 1 and 5, were counted as 2; responses 2 and 4 were counted as 1, and the middle response, 3 (“it
depends”), was counted as 0. In this way, a higher score indicates rigidity; a total score of zero would indicate a therapist who is quite flexible in her beliefs about termination processes.

Client Satisfaction Scale

Marx and Gelso (1987) conducted one of the few studies that explored satisfaction with the termination process. They used a single item to assess this variable: participants rated “How satisfied were you with the way your counseling came to an end?” on a 1-5 Likert scale. They found test-retest reliability over 7 days with a pilot sample of 20 clients to be .74 (p<.001); no other psychometrics were reported. Of their sample of 72 former university counseling center clients, the majority reported satisfaction with termination (65% satisfied or very satisfied; 25% neutral; and 10% dissatisfied or very dissatisfied). Satisfaction was uncorrelated with the five variables tested (the therapists’ assessment of how much loss was a theme of counseling and how much processing was done of termination; the clients’ report of their loss history and their closeness to the counselor; and the number of therapy sessions), and no interaction effects were found.

The Client Satisfaction Scale developed for this study included Marx and Gelso’s (1987) question, along with two questions assessing how well the ending went and how resolved the client feels about the therapy. Scoring of this brief measure required no conversion: the higher the total score, the greater the client satisfaction.

A therapist version of the Client Satisfaction Scale was also administered (CSS-T), with questions worded to obtain the therapist’s sense of the client’s experience. The
results were not used to test the formal hypotheses, but were part of post hoc analyses. The data from this instrument was also used to assess selection bias.

Procedure

Several measures were taken to increase the participants’ comfort with the procedure: a letter and informed consent document (Appendix A) aimed to instill confidence and trust in the researcher and the research; the therapist and client mailed their completed instruments separately and had no access to each other’s answers; and the therapist was responsible for asking his/her client to complete the forms.

Participants

Participating therapists were asked to administer the questionnaires to the next consenting clients over 18 years old with whom they terminated. Asking them to recruit the next client they terminate with achieved two goals: it decreased the time between the therapist’s consent to participate and the actual administration, and it decreased selection bias. It countered therapists’ natural tendency to recruit only “successful” clients who terminated easily and with high satisfaction.

Barrett-Lennard (1986) recommends that his relationship inventory be administered after at least three therapy sessions to increase validity. Therapists were therefore asked to recruit clients whom they had seen at least three times. Many studies have shown that the length of the therapeutic relationship is not strongly correlated to clients’ experiences of termination (e.g., Fitzgerald, 1995; Marx & Gelso, 1987) so it did not seem necessary to impose a more stringent criterion.
Power analysis indicated that with an effect size of .30 and with alpha set at .05, 30 dyads were needed to reach power of .81. The final data set used in the regression analysis was 34 dyads.

Recruitment

A diverse group of therapist participants was sought, with a range of degrees, orientations, and years of experience represented. As explained above, clients were recruited by their therapists. All participating therapists were contacted by phone, email, or in person. In June, 2005, a phone call to every therapist in the Missoula phone book was attempted, including a few therapists beyond the Missoula area (e.g., Hamilton and Thompson Falls), yielding contacts with about 110 individuals. Groups such as the Clinical Psychology Center and Counseling and Psychological Services at UM were also contacted. About 50 therapists did not respond to the initial phone call. Sixty-six individual therapists agreed to participate; many individuals and groups were given more than one packet, so that about 110 packets were disseminated between June and December, 2005.

Several follow-up strategies were employed throughout the fall. Reminder postcards were mailed or hand-delivered to about 35 therapists in October. Therapists at the Clinical Psychology Center received reminder emails. Close to the end of the fall semester, a box of doughnuts was delivered to the University counseling center’s therapists, to thank them for their help and remind them to continue giving the questionnaires to their terminating clients. Finally, members of this dissertation committee encouraged colleagues to fill out the questionnaires.
Administration

When therapists agreed to participate, they were mailed a packet including:

- a letter to the therapist, explaining the study and how to administer the questionnaires to the client;
- a letter to the client, explaining the study;
- two informed consent forms for the therapist, and an information sheet for the client;
- a set of questionnaires for the therapist (General Information form, Predictive Empathy-Therapist, Client Satisfaction Scale-Therapist, and Termination Rigidity Scale);
- a set of questionnaires for the client (General Information form, Barrett-Lennard Relationship Inventory-Empathy Scale, Client Satisfaction Scale, and Predictive Empathy-Client);
- a $5 thank-you gift for the client; and
- two stamped return envelopes.

The therapists were asked to hand the client packet to their patients at the final session. Both parties were asked to complete and return their packets within two days of the final session. Complete instructions are listed in Appendix A.

Confidentiality

Client data in this study was completely anonymous. Therapist-client dyads were linked by coding printed on the questionnaires (e.g., client packet 001 was matched with therapist packet 001), and this coding was linked to the mailing list. The key linking the questionnaires to the mailing list was used to generate the reminder postcard mailing list.
and to identify packets coming from the same therapist. The key was maintained separately from the data, and the completed instruments were reviewed without knowledge of the participant’s name. Because recruitment was based in the small community of Missoula, identifying information about the therapist (ethnicity, age, and sexual orientation) was not solicited.

Results

Description of Sample

Of the approximately 220 packets disseminated to 110 therapists, 90 packets were returned (a return rate of about 41%). Of these, 89 were usable; one packet had two pages of data missing and was therefore omitted. There were 38 cases in which both therapists and clients returned questionnaires, yielding matched pairs, and 13 unmatched packets (nine returned from therapists and four from clients). Of the matched pairs, there were 34 individual therapists represented. Seven therapists sent in more than one packet. Not all of these were matched with client packets, so only four packet sets had to be randomly selected for elimination to ensure that each therapist was represented only once. This yielded a data set of 34 matched sets to be used in the analyses.

Sample Demographics

Forty-two clients and 47 therapists returned questionnaires, with 34 pairs of matched questionnaires with each therapist represented only once. Demographic information about the larger set of respondents is included in Appendix G. The data presented in this section refer to the smaller sample of 34.

Of the 34 clients in this sample, 19 (55.9%) were female, and 30 (88.2%) were Caucasian. The average age was 35 (SD = 13.2), with ages ranging from 18 to 64. On
average, the clients had had 3 therapists in their lifetimes (SD = 2.9), with a range from one to 15.

Of the 34 therapists in this sample, 24 (70.6%) were female. The sample was heterogeneous in terms of degrees and professional affiliation, as the figures below show.

![Figure 4. Degrees held by therapist respondents.](image)

![Figure 5. Professional affiliations of therapist respondents.](image)

Therapists in this sample had been in the profession for an average of 15 years (SD = 10.72, maximum of 40 years), and the majority (58.8%, n = 20) estimated that they
had conducted over 100 terminations. The distribution of termination experience was curvilinear, with the next largest group (17.6%, n = 6) indicating that they had conducted between one and ten terminations.

Therapists were asked about their theoretical orientation only with regard to the current course of therapy. As the charts below show, eclectic/integrative and cognitive/behavioral orientations were the dominant approaches overall, but during the termination session therapists frequently switched to client-centered and interpersonal approaches.
Figure 6. Primary theoretical orientation of therapy with terminating client.

Figure 7. Theoretical orientation of final session.
According to the therapists’ reports, the average length of treatment was one year (M = 12.6 months, SD = 11.67). The majority of terminations (55.9% of 34 therapist responses) had not been time-limited treatments from the start of therapy. The most frequently cited reason for terminating (35.3% of both therapist and client responses) was extra-therapy circumstances, specifically the therapist or client moving. Symptom improvement and goal achievement were also common reasons for termination; taken together, they accounted for 50% of therapist responses and 47.1% of client responses. Most respondents reported reaching the decision to terminate together, while very few indicated that a third party forced the decision.

Table 1

Mean Responses to Question of Who Made the Decision to Terminate (Therapist N = 34; Client N = 34)

<table>
<thead>
<tr>
<th>Decision to Terminate</th>
<th>Therapist Mean</th>
<th>Client Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>The therapist did</td>
<td>1.71</td>
<td>1.50</td>
</tr>
<tr>
<td>The client did</td>
<td>1.94</td>
<td>1.97</td>
</tr>
<tr>
<td>We decided together</td>
<td>2.26</td>
<td>2.15</td>
</tr>
<tr>
<td>A third party did (e.g., insurance company would not cover additional sessions)</td>
<td>1.29</td>
<td>1.26</td>
</tr>
</tbody>
</table>

Note. Respondents rated each possibility on a Likert scale with a range of 1 (not true), 2 (somewhat true), and 3 (very true).

Sample Representativeness

This study relied on therapists to return a cold call soliciting participation; to remember to recruit a client several months, perhaps, after receiving the packet; and to
interrupt the flow of the often very intense and private termination process with a research study unrelated to either the client or therapist. Given these factors, sample bias is unavoidable. One way to assess the existence of bias in the sample is to examine responses to a question on the therapist general information questionnaire, "Was this the first client to terminate since you received this questionnaire packet? If no, why?". Of the sample of 34 questionnaire sets, 19 (55.9%) therapists indicated that it was not. Eight of these responses were from therapists who had already given the first packet to another client, and were completing their second or third packet. The charts below show the breakdown in responses to this question.

![Pie chart showing the breakdown of responses to the question.](image)

**Figure 8.** Was this the first client to terminate since you received this questionnaire packet?
Figure 9. If no, please explain why the first client to terminate is not participating.

Descriptive Statistics for Primary Variables

Distribution charts for each of the four instruments are included in Appendix H, and Appendix I shows means and frequencies for each item of the questionnaire packet. The data in Appendix I includes all questionnaires that were received; the data reported in this section reflect only the 34 matched questionnaires that were used in the final analyses, unless otherwise specified.

Barrett-Lennard Relationship Inventory

The 16-item Empathy Scale of the Barrett-Lennard Relationship Inventory (BLRI, 1962), used to measure the client’s report of the therapist’s general empathic accuracy, has a possible score range of −48 to +48. Using the entire sample of 42 clients, this instrument yielded a mean of +30.83 (SD = 18.14). In the sample of 34 clients used in the final analyses, the mean was +32.24 (SD = 9.63). The scores ranged from a minimum of +6 to a maximum of +48. While the sample is clearly skewed toward high empathy, it appears that there is sufficient variability in scores to rule out a ceiling effect.
BLRI scores were correlated with responses to the question, “Overall, how empathic was your therapist during therapy?”, as would be expected (Pearson’s r = .562, p < .001). This lends some support to the construct validity of the total BLRI scores.

**Predictive Empathy Forms**

The variable of the therapist’s termination-specific empathic accuracy was assessed by calculating the discrepancy between the therapist and client answers on individual items of parallel forms of a Predictive Empathy (PE) measure. For example, if a client responded to the first question (“Compared with other sessions, how important would you say this last session was?”) with a 4, “somewhat,” and the therapist predicted that her client would respond with a 7, “very,” the item was given a score of 3. In scoring the PE, no distinction was made between overrating and underrating clients’ reactions. The sum of discrepancies on 41 individual items produced the therapist’s PE score. Thus, a lower score indicated higher predictive empathy. A higher score indicated a greater gap in the therapist’s understanding of how the client responded to the termination.

The possible range of PE scores was 0 to 264. For the 34 cases in which both therapists and clients returned questionnaires, there was a PE mean of 58.4 (SD = 17.46). This signifies that, on average, therapists over- or underestimated their clients’ reactions by a total of 58 points, across all items on the PE. The range of scores was 81, with a minimum score of 30 and maximum of 111. The distribution of responses falls in the shape of a normal curve.
Termination Rigidity Scale

The 26-item Termination Rigidity Scale (TRS) has a possible score range of 0 to 52. The mean score was 20.09 (SD = 5.53). The range of scores was 21, with a minimum score of 11 and maximum of 32. The distribution of scores was rather even, with the exception of a higher cluster of scores in the 19-21 range.

Two methods were used to assess the reliability of the TRS scores. First, Cronbach’s alpha was calculated to determine internal consistency, and at .80 (N = 46) was acceptable. No items stood out for deletion to increase the alpha. Second, seven therapists completed the TRS twice, providing a small sample of convenience for a test-retest reliability check. The correlation between their scores was .751 (p = .052). Thus, it appears that the reliability of these data is acceptable.

Client Satisfaction Scale

The 3-item Client Satisfaction Scale (CSS) has a possible score range of 3 to 21. The CSS yielded a mean of 19.03 (SD = 2.4). The range of scores was 8, with a minimum score of 13 and maximum of 21. The distribution of scores was strongly skewed in the positive direction.

Again, Cronbach’s alpha was calculated to determine the degree of internal consistency. All questionnaires, including the therapists’ rating of their clients’ satisfaction, were included in this calculation. The alpha showed strong reliability at .84 (N = 85), and none of the three items stood out for deletion.
Hypotheses and Questions

Question 1

How are the three predictor variables (levels of general empathic accuracy, termination-specific empathic accuracy, and flexibility in approach to termination) related to each other?

This question was addressed by calculating Pearson correlations for the predictor variables. No significant relationships were found, with the exception of the negative correlation between the BLRI and TRS.

Table 2

Intercorrelations between Predictor Variable Scores

<table>
<thead>
<tr>
<th></th>
<th>BLRI</th>
<th>PE</th>
<th>TRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLRI</td>
<td>--</td>
<td>-.178</td>
<td>-.360*</td>
</tr>
<tr>
<td></td>
<td>Pearson Correlation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Significance (2-tailed)</td>
<td>.314</td>
<td>.036</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>PE</td>
<td>Pearson Correlation</td>
<td></td>
<td>-.026</td>
</tr>
<tr>
<td></td>
<td>Significance (2-tailed)</td>
<td></td>
<td>.882</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>TRS</td>
<td>Pearson Correlation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Significance (2-tailed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).

Hypotheses 1-3

Hypotheses 1-3 predicted that the BLRI, PE, and TRS scores would be predictive of CSS scores, when regressed separately. The hypotheses were tested with a review of scatterplots and separate regressions. None of the scatterplots revealed significant linear or curvilinear relationships, and none of the regressions found the variables to be predictive.
Table 3

**Summary of Separate Regression Analyses for Variables Predicting Client Satisfaction with Termination (N = 34)**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Adj R Square</th>
<th>SE of the Estimate</th>
<th>B</th>
<th>SE B</th>
<th>Beta</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLRI</td>
<td>.026</td>
<td>2.374</td>
<td>.059</td>
<td>.043</td>
<td>.235</td>
</tr>
<tr>
<td>PE</td>
<td>.008</td>
<td>2.396</td>
<td>-.027</td>
<td>.024</td>
<td>-.194</td>
</tr>
<tr>
<td>TRS</td>
<td>-.001</td>
<td>2.407</td>
<td>-.074</td>
<td>.076</td>
<td>-.171</td>
</tr>
</tbody>
</table>

**Question 2**

*Using the three predictor variables, how can the outcome of client satisfaction be best predicted?*

This question was examined with multiple linear regression analysis. The analysis was planned to be stepwise, due to the exploratory nature of the research. However, given the low correlations between variables, no variables would be entered in the stepwise regression equation; the analysis was therefore changed to hierarchical. When the three predictor variables were entered into a regression analysis simultaneously, no significant predictive relationships were found.
Table 4

Summary of Simultaneous Regression Analyses for Variables Predicting Client Satisfaction with Termination (N = 34)

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>SE B</th>
<th>beta</th>
<th>Semi-partial correlations</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLRI</td>
<td>.041</td>
<td>.048</td>
<td>.163</td>
<td>.149</td>
</tr>
<tr>
<td>PE</td>
<td>-.023</td>
<td>.024</td>
<td>-.168</td>
<td>-.165</td>
</tr>
<tr>
<td>TRS</td>
<td>-.051</td>
<td>.082</td>
<td>-.117</td>
<td>-.108</td>
</tr>
</tbody>
</table>

Exploratory Findings

The instruments used to generate scores for the predictor variables contained a great deal of information about the termination process. An exploration of this data yielded some interesting findings and compelling questions that may guide future research. All of the findings reported here must be interpreted with their post hoc nature in mind. All should be viewed as exploratory.

Reactions to Termination

Data from the clients’ Predictive Empathy forms show that affective reactions to termination were generally positive, with mean ratings showing that the most endorsed experiences were a sense of accomplishment and increased closeness with the therapist. The least endorsed experiences were doubt about progress, guilt, and anger.
Table 5

Client responses to “Which of these have you experienced while ending therapy?”, with each item rated on a Likert scale, where 1 = not at all and 7 = very much (N = 42)

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>sense of accomplishment</td>
<td>5.19</td>
<td>1.4</td>
</tr>
<tr>
<td>our relationship became closer</td>
<td>4.29</td>
<td>1.6</td>
</tr>
<tr>
<td>ambivalence (mixed feelings)</td>
<td>3.91</td>
<td>1.9</td>
</tr>
<tr>
<td>increased energy/motivation for activities outside of therapy</td>
<td>3.91</td>
<td>1.9</td>
</tr>
<tr>
<td>pride</td>
<td>3.88</td>
<td>1.9</td>
</tr>
<tr>
<td>desire for more sessions</td>
<td>3.86</td>
<td>2.1</td>
</tr>
<tr>
<td>we began to relate more as equals</td>
<td>3.83</td>
<td>1.6</td>
</tr>
<tr>
<td>reluctance to end</td>
<td>3.80</td>
<td>2.0</td>
</tr>
<tr>
<td>sadness</td>
<td>3.59</td>
<td>2.1</td>
</tr>
<tr>
<td>anxiety</td>
<td>3.05</td>
<td>1.9</td>
</tr>
<tr>
<td>disappointment</td>
<td>2.93</td>
<td>2.0</td>
</tr>
<tr>
<td>relief</td>
<td>2.80</td>
<td>1.8</td>
</tr>
<tr>
<td>reexperiencing previous losses</td>
<td>2.48</td>
<td>1.6</td>
</tr>
<tr>
<td>doubt about progress</td>
<td>2.02</td>
<td>1.1</td>
</tr>
<tr>
<td>guilt</td>
<td>1.63</td>
<td>1.2</td>
</tr>
<tr>
<td>anger</td>
<td>1.60</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Asked about the client’s satisfaction with overall therapy success and with termination, therapists and clients gave high ratings, with therapists only slightly underestimating clients’ scores (Client: therapy success $M = 6.18$, $SD = .896$, $N = 42$; CSS $M = 18.14$, $SD = 3.295$, $N = 42$; Therapist: therapy success $M = 5.39$, $SD = 1.010$, $N = 47$; CSS $M = 16.36$, $SD = 2.480$, $N = 47$). Figure 10 shows mean ratings, with the Client Satisfaction Scale scores converted to yield data proportionate to the single item score of therapy success. For both clients and therapists, there was a strong correlation between satisfaction with therapy and satisfaction with termination (Clients: Pearson’s $r = .557$, $p = .01$; Therapists: Pearson’s $r = .515$, $p = .01$).
Figure 10. Client and therapist satisfaction with therapy and termination. Clients and therapists gave high responses on a 7-point scale to the question, "Overall, how successful do you feel this therapy was?" Satisfaction with termination scores are from the CSS, a three-item measure, divided by three to yield comparable ratings. Therapist CSS scores reflect the therapists' assessment of how the client felt about termination, not the therapists' own satisfaction with the termination.

The client questionnaire ended with an open-ended question about the impact of the termination process. A review of the responses reinforces the strong positive flavor of the quantitative findings. The most common theme, expressed by eight of the 35 who wrote comments, was appreciation for the availability of additional contact: as one wrote, "I felt like a baby bird leaving the nest, going into the world on unsteady wings."
Therapist said I could always return to the nest.” The other most common statements concerned feeling pride or increased self-esteem and feeling ready to end. Many clients wrote warmly about their therapists, said that the ending was therapeutic and touching, and expressed sadness at the ending. Five stated that they desired more sessions, and four wrote that they had not expected to end when they did. A few described negative feelings such as fear, anger, and discomfort. Three noted that the ending was not particularly different from other sessions. The excerpts below (transcribed with punctuation altered to increase readability) are typical responses, emphasizing the themes of mixed feelings and desire for continued contact.

Ending therapy sort of clarified things. It made me feel like I had “gotten better” or I guess made progress; it felt like a success. It was a bit sprung on because I was sort of hesitant to fully let go, saying things like, “Ohh...sometime next semester...” But my counselor was like, “Dude, it’s the end—you’ve grown, now go out and use it,” which is scary and good, but in the end I know I can always go back if I need to.

For the final session, it was not planned out to be the final, it was just found that I had achieved the goals I wished to and had a really good sense of myself and where I want to go in the future. I was really happy that my counselor left open the opportunity to come back if I feel it would be necessary. It lets me know that if something happens in the future she is there for me. It was a great experience!

It was kinda sad. I enjoyed the sessions and feel like I made great progress
She provided an appropriate amount of closure, while encouraging me to stay in touch. She gave me a plant that she had been rooting for me—this was very thoughtful & touching because I will think of her as I care for the plant. Overall, I'm very sad to be ending my therapy with her. It took me a long time to truly open up to her, but once I did, I felt like I could trust her completely. This has been my most positive experience with therapy, and I will never forget how she helped me to grow as a person mentally and emotionally. She is a wonderful person & therapist and I will miss her tremendously.

Termination Behaviors

On the Predictive Empathy forms, clients were asked to rate the extent to which they wanted specific termination-related behaviors to occur, and then to indicate the actual occurrence of these behaviors. On average, clients most wanted to: thank their therapists, be invited to return if needed, discuss plans for the future, hear the therapists’ feelings about termination, assess goal attainment, hug or shake hands with their therapists, and summarize the work. They indicated that they did not want to: hear the therapist talk more about him/herself, ask the therapist about how therapy works, ask the therapist personal questions, or give a gift to the therapist.

Twelve of the items on the PE forms were repeated on the TRS, allowing a comparison between therapists’ beliefs about what ought to occur in terminations and what clients wanted. There was rough agreement between therapists and clients, such that therapists endorsed summarizing the work and assessing goal attainment as important to every termination, and ranked talking more about themselves as a behavior that should not occur. The only area of clear disagreement was in hugging or shaking
hands: clients generally indicated that they wanted this to occur, while therapists were more hesitant, particularly indicating that hugging probably should not occur.

Errors of Omission and Commission

The PE-Client form asked both what behaviors the client wanted to occur and what behaviors actually occurred. Responses showed strong agreement between these two questions. The most frequent termination behaviors that occurred were: thanking the therapist, discussing plans for the future, summarizing the work, being invited to return, hearing the therapist’s feelings about termination, assessing goal attainment, and discussing the client’s feelings about termination. The least frequent behaviors were: asking the therapist personal questions, giving the therapist a gift, hearing the therapist talk more about him/herself, and asking questions about how therapy works. These actual behaviors overlap with the desired behaviors listed above.

Thus, at the group level, there was strong agreement between which behaviors were desired and which occurred. At the individual level, responses on these two questions were compared to determine the extent to which therapists met client expectations for termination. Specifically, clients rated a list of possible behaviors, such as “thanking the counselor” and “summarizing the work,” on a 1-7 Likert scale, where 1 represented “did not want this to happen at all” and 7 represented “wanted this to happen very much.” On a separate list of the same behaviors, clients indicated whether the behavior had actually occurred. When a client gave a behavior a rating of 5, 6 or 7 and then indicated the behavior did not occur, one point was given. Likewise, when a client rated a behavior 1, 2 or 3 and indicated that the behavior did occur, one point was given. If a client gave a rating of 4, no points were given. Thus, each client had a score of total
errors, representing the number of times there was a mismatch between his/her desires and what occurred. While the word "error" is rather strong for a situation in which a client's hopes for terminations are not met, "errors of omission" and "errors of commission" are convenient ways of describing these discrepancies. The former is used to refer to situations in which the client wanted something to occur but it did not; the latter describes situations in which the client did not want something to occur that did, in actuality, happen.

As mentioned above, these errors are generally few; overall, there is a strong relationship between how much the client wanted something to occur and how often it did occur. Figure 11 shows this relationship.

Figure 11. The relationship between how much clients wanted a behavior to occur and how much it actually occurred.
On average, each client indicated 3.6 errors, of 19 possible behaviors. A large majority of mistakes were errors of omission (123 errors of omission versus 32 errors of commission; see Appendix J for errors on individual items). For example, six clients wanted to hug or shake hands with their therapists but did not; none experienced this physical contact without wanting it. Similarly, only one client indicated that the therapist had talked more about him/herself when the client did not want him/her to do so.

The most common error, reported by 15 of 43 clients, was on the item, “Your counselor expressing how s/he feels about you.” Ten clients indicated that they wanted this but that it had not occurred, and five indicated that they did not want it but that it did occur. The second most common error, reported by twelve clients, was on the item, “You stating things about your counseling that you liked and disliked.” Eleven indicated this was an error of omission, while only one indicated it was an error of commission. Other items with high error rates were the therapist expressing reactions to the termination, the client expressing feelings for the therapist, and the therapist suggesting other sources of help. The items with the lowest error rates were behaviors that were entirely within the clients’ control: the client expressing reactions to the termination, giving a gift to the therapist, and thanking the therapist.

The number of errors of omission on each of the 19 items and the average of how much clients wanted the behavior to occur were compared to ascertain whether behaviors that were more important to clients were less likely to be missed. There was no correlation between these two variables (Pearson’s r = .041, p = .86). Thus, very important behaviors such as thanking the counselor and being invited to return were just
as likely to be missed as less important behaviors such as giving the counselor a gift or asking the counselor personal questions.

The number of errors made in individual cases was compared to the measures of client satisfaction, general empathy, and therapist rigidity. As would be expected, there was a negative correlation between errors and CSS (Pearson’s $r = -0.364$, $p = 0.018$); in other words, the clients who were most satisfied with the termination process experienced the lowest discrepancy between how they wanted the termination to go and how it actually went. Similarly, there was a negative correlation between errors and the BLRI, such that clients who felt their therapists were empathic reported fewer errors of omission and commission (Pearson’s $r = -0.376$, $p = 0.014$). In contrast, there was no significant correlation between the level of therapist rigidity and the number of errors of omission and commission (Pearson’s $r = 0.174$, $p = 0.297$), although the relationship is in the expected direction (i.e., more errors, higher rigidity).

**Therapist Accuracy in Prediction**

Looking at the 41 individual PE items across the 34 matched questionnaires, it is possible to determine which questions yielded the greatest predictive accuracy—in other words, on which questions therapists most accurately estimated their clients’ experiences of termination. The complete list of PE items, along with the total sum of discrepancy points across therapists, is provided in Appendix K. The items with the lowest discrepancies, where therapists were most accurate in predicting their clients’ feelings, assessed the extent to which the clients felt anger, guilt, sadness, and doubt about progress, and how easy or difficult the client found the termination process. Therapists had the most trouble accurately predicting the extent to which their clients wanted them
to share their feelings about termination and about the client. They also had difficulty predicting whether the clients felt a growing sense of equality with the therapist, and the extent to which their clients disclosed their reactions to the termination process. In summary, therapists tended to be fully aware of their clients’ salient emotional reactions, but were likely to misinterpret issues of disclosure.

**Therapist Beliefs about Termination**

The Therapist Rigidity Scale assessed, in part, the extent to which therapists believe certain statements about the termination process. Responses showed quite moderate beliefs overall. On a Likert scale of 1 (False) – 3 (It depends) – 5 (True), the strongest agreement was with the statement, “Terminations are easier when the decision to end is mutual” (M = 4.21, SD = .88). The greatest disagreement was to the item, “The termination process almost always causes old symptoms to resurface” (M = 2.60, SD = .90). Other response means fell between 2.8 and 3.4, showing that on average, therapists did not endorse beliefs strongly in the true or false direction.

**Empathy’s Relationship with Disclosure**

A key assumption of the model underlying this study is the finding cited by Bohart, Elliott, Greenberg and Watson (2002) that clients find it easier to self-disclose in relationships characterized by high empathy. This supposition was tested with the current data set in two ways. First, responses to the question, “How much did you tell your therapist about your reactions to ending therapy?” were found to be positively correlated with responses to the question, “Overall, how empathic was your therapist during therapy?” (Pearson’s r = .673, p < .01). Second, the question about how much was disclosed was positively correlated with the BLRI score (Pearson’s r = .516, p =
These correlations lend support to the idea that clients were more likely to disclose reactions to termination in conditions of high empathy.

The Role of Therapist Experience

Contradictory results have been found in the literature when assessing the impact of therapist experience on clients' reactions to termination (Fortune, Pearlingi & Rochelle, 1992). The variable of therapist experience (as measured in years) generated inconsistent results in this study, as well. A significant positive correlation was found between experience and BLRI scores (Pearson’s r = .377, p = .028), suggesting that experienced therapists were perceived as being more empathic. Correlations between experience and PE, TRS, and CSS scores were not significant (PE: Pearson’s r = -.092, p = .604; TRS: Pearson’s r = -.245, p = .162; CSS: Pearson’s r = -.111, p = .533).

The Role of Treatment Length

Previous research has also found contradictory results when correlating the length of treatment with clients’ experiences of terminations (Fortune, Pearlingi & Rochelle, 1992). In this study, treatment length appeared to be an important variable. Correlations between treatment length and the scores on the BLRI, PE, CSS, and TRS were examined. Calculations used the therapist’s estimate of the number of months of treatment. This is not an exact measure of treatment length, as it does not account for the frequency of sessions over the course of a month. It is, therefore, only a rough estimate of the time span during which the therapist and client worked together. Post hoc analyses showed that treatment length was significantly correlated with clients’ rating of their therapists’ empathy, with predictive empathy scores, and with clients’ satisfaction with the termination process (BLRI: Pearson’s r = .368, p = .025; PE: Pearson’s r = -.366, p = .029).
The only variable that was not significantly correlated with treatment length was the TRS score (Pearson’s $r = -0.31$, $p = 0.841$), which makes sense, as therapist rigidity is theoretically independent of a specific relationship.

**Discussion**

**Comparison to Previous Research**

This study assessed the extent to which clients’ satisfaction with the termination process could be predicted by therapists’ empathy and flexibility in thinking about therapy’s end. It also added to the small body of empirical data on client’s experiences with termination.

The results of this study reinforce the finding of the more recent research on termination (e.g., Fortune, Pearlingi & Rochelle, 1992; Marx and Gelso, 1987) that the process of ending therapy is usually not the traumatic struggle suggested by the traditional literature. Clients in this study were generally very satisfied with the termination process, and most often reported positive emotions such as a sense of accomplishment and increased closeness with the therapist. This is a particularly noteworthy finding given the high number of “forced” terminations that came about because therapists were moving away or because a clinic policy required ending.

This study also reflects previous research’s finding of the positive correlation between successful treatment and successful terminations (e.g., Fitzgerald, 1995; Fortune, Pearlingi & Rochelle, 1992; Marx, 1983). This raises the possibility that terminations that go poorly may be due more directly to unsuccessful therapy than to clients’ attachments and difficulties with saying goodbye, as has been suggested in some of the earlier termination literature. Thus, as described above, a client’s stance of “I am not
really losing anything of value” (Gould, 1977, p. 240) may be a realistic response to the ending of an unsuccessful process, not a defense against the pain of termination. Fitzgerald’s (1995) finding that successful treatment is the most powerful predictor of a smooth and productive termination makes intuitive sense: in successful therapeutic relationships, every part of treatment, including the termination process, will be smoother and more productive than in unsuccessful relationships. Thus, perhaps termination should be seen as a continuation of the therapy process, more than as a discrete phase with significant differences in process factors.

This current study extended previous research in several important ways. First, the current study drew from a broader range of populations than previous studies have, yielding a sample diverse in length of therapy, setting, and therapist experience level. Previous studies have drawn from homogeneous populations, such as short-term clients at a university counseling center or long-term clients in a private practice. This study included therapists conducting their first termination and therapists who had been in practice 40 years, and it assessed the endings of therapy relationships that had lasted between three and 325 sessions. Participants were from private and group practices and community and university clinics. Therapists were from several theoretical and professional orientations. Thus, this sample captured the wide range of ways contemporary psychotherapy is being conducted. This diversity increased the external validity of the study, and thus is a significant reinforcement to the existing research’s findings of positive client experiences of termination.

Second, the research to date has focused on clients’ reports of their termination experiences, or therapists’ speculations on their clients’ experiences. This study gathered
data from therapist and client dyads, which yielded rich data about the accuracy of therapists’ perceptions. It appears, happily, that therapists are generally accurate in perceiving their clients’ experiences and levels of satisfaction with termination. They were most successful at assessing their clients’ anger, guilt, sadness, and doubt about progress, and how easy or difficult the termination process was overall. Of all the areas examined, therapists were least accurate in assessing how much their clients wanted them to disclose their feelings about termination and about the clients themselves.

Third, quantitative studies on termination have relied on relatively straightforward questions with high face validity. This study compared clients’ expectations for termination to their reports of what actually transpired, a more subtle approach that lent robustness to the findings of high satisfaction, as it appeared that client expectations for termination were met more often than not. Further, qualitative analysis of clients’ responses to an open-ended question about their termination experience provided additional validation of the positive tone at therapy’s end. Clients described feeling pride, readiness to end, and comfort in knowing that they could return for further therapy if needed.

**Primary Findings**

The present study hypothesized that variables of therapist empathy and flexibility in thinking about termination would predict clients’ satisfaction with therapy’s end. The lack of significant findings has several possible explanations, not mutually exclusive. First, the variables included in this study simply may not be important predictors of satisfaction with termination. Second, the variables in the model may be important, but other variables, such as treatment length or client personality, may have greater influence.
on client satisfaction with termination. Third, the model may accurately represent
predictors of satisfaction with termination, but there may have been problems with the
subject pool. Fourth, the model may seek to address a problem that does not really exist.
That is, the sample may not be biased, but may accurately represent very high satisfaction
levels in the population of clients. Rigidity and lack of empathy may not be creating
difficult terminations, because these problems may not exist in significant numbers.
Fifth, the model may be accurate, but the instruments used to measure the variables may
lack sensitivity. As each of these possibilities raises interesting questions about the
process of termination, they will each be discussed in depth.

Accuracy of the Model

It is possible that a therapist’s empathy and flexibility in thinking about
termination do not affect the process of ending therapy. The premise of the proposed
model was that an empathic therapist will be able to judge accurately what the client
wants or expects during termination, or will have established a safe enough relationship
with the client that the client will feel comfortable correcting misjudgments or asking
directly for want she wants. Perhaps, however, “what the client wants or expects” does
not actually enter into the equation. It is likely that many clients, with little prior
experience with terminations, have no expectations for the termination process and are
willing to follow the therapists’ lead. The qualitative data in this study suggest that what
really matters to clients is the amount of warmth and positive regard they feel from the
therapist, more than the therapist’s accurate judgments about client expectations for
specific behaviors such as hugging goodbye or assessing goal attainment.
Alternatively, clients may have some mild desires and expectations around these behaviors, but those feelings may be overshadowed by more salient reactions. For example, one client wrote of his therapist pulling away at termination: “Today, no hug at all, didn’t even walk me to the lobby. Seemed rather abrupt.” Of 42 clients, this client showed the highest level of discrepancy between desired and actual behaviors. For example, he wanted very much (7 on a 1-7 Likert scale) to share his feelings about termination, to assess goal attainment, and to hear the therapist’s feelings about ending the work, yet none of these occurred. Nevertheless, he was highly satisfied with his termination process, and gave his experience of termination a 2 on a 1 (easy) to 7 (difficult) scale. Clearly, something else influenced this client’s satisfaction with termination more than whether his expectations were met. This raises the possibility of the second explanation, that other powerful variables play into clients’ satisfaction with termination.

Role of Alternative Variables

The variables tested in this study may be important but inadequate to explain the wide variety of termination experiences. Other variables, such as client personality and overall progress in therapy, may also be highly influential in satisfaction with termination.

Post hoc analyses showed that length of treatment and therapist experience level were related to client satisfaction. Length of treatment may be particularly relevant if the therapy was ended before goals were accomplished. For example, the client who had the lowest satisfaction with termination of all the matched questionnaires indicated that her therapy ended because she was moving, and that she was very concerned about unmet
therapy goals: “[Ending is] scary because I trust myself so little. How will I remember to incorporate all I learned into my daily life?” In this case, the premature termination left this client feeling dissatisfied.

Personality factors, unmeasured in this study, could have a strong impact on the process of termination. Some clients may be dissatisfied and uncomfortable with termination regardless of the therapist’s empathy. For example, a client with strong abandonment fears may have such an intense reaction to ending therapy that no amount of empathic accuracy will lead to satisfaction. Alternatively, a highly independent client, who never became attached to the therapist, may be quite undisturbed by a clumsily managed termination. This could be the case with the client described in the previous section, who was quite satisfied with the termination overall even though he had wanted it to go quite differently.

The model tested in this study assumed that conditions of high empathic accuracy increase the client’s likelihood of speaking up when she feels she has been misunderstood (Bohart, Elliott, Greenberg and Watson, 2002). Post hoc analyses showed a correlation between empathy and disclosure, but it was not ascertained whether this was the case in situations of misunderstanding, when disclosure is more difficult. A lack of assertiveness skills may limit the client’s willingness to voice discomfort at the perceived misunderstanding. Alternatively, a client who has not attached to the therapist or who has a low investment in therapy may not be sufficiently involved in the process to even experience discomfort; such a client would not be bothered enough to attempt a correction.
The construct of a therapist’s empathic accuracy may be reciprocal, not just a trait held by the therapist. Some clients are easier to read than others. Studies of “readable” clients have found that they tend to share attributes with “ideal” clients (Ickes, 1997), who may be more likely to feel satisfied with how their therapists manage termination. Colvin (1993) found that people whose personalities were most accurately judged by friends tended to be extraverted, agreeable, emotionally stable, and conscientious. He further suggested that people whose traits are difficult to judge appear to lack a consistent personality structure and behave inconsistently. In a study of “perceivers” making judgments of videotaped dyads having discussions, Hancock and Ickes (1996) found that 44% of the variance in perceivers’ empathic accuracy scores was accounted for by the “readability” of the targets. They suggested that the less readable targets tended to allow the other member of the dyad to take the initiative in the discussion and to suppress their true feelings in favor of socially desirable expression.

This suggests several factors that may have influenced the results of the present study. It reinforces the link between empathy and level of disclosure, in that more readable targets are likely to disclose more. It also raises the issue of assertiveness again, as less readable targets seem to be less assertive, according to Hancock and Ickes (1996), or at least less likely to communicate openly about themselves. Further, as they appear to be more influenced by social desirability, they may be less likely to respond honestly to evaluative questionnaires such as those used in the current study. Thus, an unassertive client who is difficult for the therapist to read and who does not communicate openly about her needs or expectations for termination may also not communicate her dissatisfaction with the process in a post hoc questionnaire. In this way, extraneous
factors of assertiveness and willingness to disclose will obscure the role of the therapist’s empathy in determining client satisfaction.

Sample Issues

It is possible that the proposed model is accurate but that selection factors interfered with obtaining a representative sample of clients for the study. Specifically, the study’s recruitment procedures may have filtered out clients who had particularly difficult terminations. Therapists may have been unwilling to ask dissatisfied clients to participate in the study, or may have been unable to, in cases in which clients failed to attend the final session. Furthermore, dissatisfied clients may have been less willing to return their questionnaires.

The small sample size may also have compromised results. For example, a therapist’s rigid beliefs about terminations may, by chance, coincide with what the client wants or needs in ending the therapy. Alternatively, a disengaged client may not have strong desires for termination, so will be pleased with the ending regardless of what transpires. It is possible, then, for an unempathic, rigid therapist to manage the termination in such a way that the client is highly satisfied. A larger subject pool would decrease the influence of these sorts of patterns.

The Model May Address a Non-existent Problem

A fourth possibility is that rigidity, low empathy, and client dissatisfaction with termination are not the problems this study assumed they were. Perhaps the current sample did not overrepresent successful terminations, but accurately drew from the population of people highly satisfied with termination.
One key assumption of this study was that some therapists hold rigid beliefs about clients’ experiences of termination. This assumption was not upheld in this study. Therapists endorsed very moderate beliefs about termination, generally responding with “it depends” to questions about how terminations should be run and how clients tend to respond to the process. This suggests that therapists are less influenced by the rather rigid early termination literature than was expected. Their beliefs are probably more based on the range of client reactions that they have observed during their careers or other types of training influences.

**Measurement Sensitivity**

A fifth possible explanation for the lack of significant results is that the instruments may have been insufficiently sensitive. The Client Satisfaction Scale, in particular, is not nuanced or subtle. It contains only three items, each with high face validity. The scores on this scale were positively skewed, with very little variability. The insensitivity of this measure could provide a partial explanation for the surprising responses of the client described above, who reported what sounds like a painful termination, with unmet expectations and a withdrawing therapist, yet endorsed high satisfaction with his therapy’s closure on the CSS. Further, the items on the CSS may not have construct validity. For example, the second client described above, who had the lowest CSS score of the matched questionnaire sets, responded with a 3 to the question, “How resolved or settled do you feel about this therapy?” (on a Likert scale of 1, unresolved, to 7, resolved). This low rating makes sense, considering that she was moving out of town before “finishing” therapy and attaining her therapy goals. This lack
of therapy completion is not what the CSS was intended to evaluate, and is an example of
the possible low construct validity of the measure.

Finally, clients who have strong affection for their therapists may be unwilling to
give them low ratings, even when appropriate. They may be particularly vulnerable to an
end-of-therapy bias (Barrett-Lennard, 1962). This may explain the positive correlation
between length of treatment and scores on the CSS and BLRI: as clients spend more time
with their therapists, their attachment and affection grows so that they are reluctant to
seem critical of them (especially after receiving warm, positive feedback from their
therapists during the final session). Measures with lower face validity might circumvent
this problem.

Additional Findings

Regardless of the lack of support for the proposed model, this study generated a
great deal of information with clinical applicability. With the possibility of comparing
client and therapist perceptions of the same termination, it yielded a wealth of descriptive
information about what factors are important in the termination process. Disparities
between therapists and clients were analyzed post hoc, from three angles: differences
between what clients wanted and therapists’ beliefs about what should occur during
termination; differences between what clients wanted and what actually transpired; and
differences between what clients felt and what their therapists thought they felt. Overall,
there is a great deal of concordance between the views of therapists and clients. Areas of
frequent discrepancies, however, are useful for pointing out what can be “blind spots” for
therapists.
Of all the possible termination behaviors assessed in this study, clients most wanted to thank their therapists. Therapists might keep this need in mind, and resist the urge to deflect the gratitude with statements to the effect of, “Oh, but you did all the work,” as clients may experience this as invalidating. Therapists should also consider that clients probably want to hug or shake hands at the end of therapy. This was an item strongly endorsed by clients, but one on which therapists frequently underestimated their clients’ desires. Thus, it was also a behavior which clients frequently desired but which did not occur. Regardless of the therapeutic issues surrounding physical contact with specific clients upon termination, therapists should know that it is something about which their clients likely have strong feelings.

In general, clients’ expectations for the termination process were met. This finding, of course, raises the issue of cognitive dissonance, as clients’ post hoc report of what they wanted to occur will inevitably be influenced by what actually happened. Nevertheless, a look at the areas of discordance—where clients wanted a behavior to occur but it did not, or where clients did not want a behavior to occur but it did—yields information that can be useful to a therapist wishing to improve how terminations are conducted. Discrepancies fell in areas that therapists have some control over, and suggest that therapists should attend carefully to clients’ desires to discuss specific issues: the therapist’s feelings about the client and the termination, what the client liked and disliked about therapy, and where the client can go for additional help.

This study also examined differences between what clients felt about termination and what their therapists thought they felt. The resulting data show where therapists may commonly misread their clients’ reactions to termination. Again, therapists were least
accurate in predicting how much their clients wanted them to share their feelings about termination and the client.

Clients' interest in their therapists' feelings for them was an issue that arose repeatedly in the qualitative data gathered from clients. Specifically, several wrote of the pride they felt while listening to their therapists' opinions of them. The quantitative data, however, suggest that clients did not hear how their therapists thought of them as much as they wanted. There are many possible reasons for therapists' failure to meet their clients' desires for disclosure. The data suggest that the therapists simply did not know how much their clients wanted them to disclose their feelings. Moving beyond the data into speculation, it may be that some therapists thought their feelings were apparent and did not require verbalizing; others may have been uncomfortable with giving direct evaluative feedback. Some of that discomfort may be because the therapist held a negative view of the client. Perhaps some therapists were relieved to terminate, or felt frustrated by the lack of progress and so were reluctant to disclose their feelings. Further, some therapists may not make such disclosures as a function of their theoretical orientation. An interpersonal process-oriented therapist, for example, is much more likely to disclose personal reactions than a traditionally blank-slate psychoanalytic therapist. Alternatively, the explanation may lie with the client: perhaps clients are less likely to ask directly for disclosure than for other termination behaviors.

The qualitative data included the common sentiment that, although clients felt ready to terminate, they also felt grateful for invitations to return for additional sessions if needed. Some may conceptualize this as an incomplete termination, in service of avoiding the painful feelings of truly ending the relationship with the therapist. Whether
it is a defense or not, the clients in this sample obviously derived a great deal of comfort from it.

In summary, at the end of a successful course of therapy, clients are likely to be experiencing a mix of emotions, including pride for their progress and sadness about ending an important relationship. They are likely to want to express gratitude to the therapist; to hear the therapist’s thoughts about their work and the therapist’s feelings about them as people; and to be invited to return in the future.

Limitations

Many of this study’s limitations, particularly pertaining to the viability of the proposed model, were reviewed above. Methodological concerns were alluded to but are explored here in greater depth. Overall, the strategy of gathering data from both therapists and clients generated very rich data, but with some cost in sample representativeness.

It was hoped that the questionnaire methodology would result in greater sample representation and more honest responses than would interviews or observer ratings. The chosen format does have limitations, however. As discussed above in the section on Sample Representativeness, sample bias was unavoidable, and may have arisen at several points in the procedure. Clients who were particularly distressed by the termination may have been less likely to return questionnaires. At least six times, therapists did not ask their clients to participate either because it seemed inappropriate or the client did not attend the final session. About fifty therapists did not respond to phone calls soliciting their participation, perhaps yielding a sample that overrepresented therapists who feel good about their terminations, or are comfortable with a researcher gathering data on this
very private process. Of the therapists who agreed to participate, only about 40% actually did so, creating more room for sampling bias.

The instruments asked therapists and clients to think deeply about complex issues. Clients were asked to consider the ending of a very meaningful relationship in terms of their expectations and disappointments. Therapists were asked to enter the mind of their clients, to discern how their clients may have been disappointed in them. It may have been quite difficult for both parties to be honest and clear about their experiences. Furthermore, therapists may have unconsciously made changes in how they managed the terminations because of their involvement in the study. The instruments had strong face validity, which may have increased the therapists’ self-consciousness as they processed the therapy’s end.

Thus, while this study’s methodology provided a new depth of quantitative data, this richness may have come with a cost. That was expected, as the study was exploratory in nature, and intended to be a starting point for investigating this important treatment issue.

**Directions for Future Study**

Exploratory studies such as this one help point the direction for further research. A first step is to validate the findings from the post hoc analyses, particularly the correlations between the extent to which client expectations were met and their BLRI, TRS, and CSS scores. Further questions provoked by the current study include:

- How much are client expectations for terminations actually met? The present study found that they usually are; the methodology of assessing this, however, is subject to cognitive dissonance. A better approach would be to
assess client expectations prior to the final session, and then establish what actually occurred afterwards.

- What is the role of the invitation to return, which was so important to clients? Does it function as a defense against painful feelings of loss, thus preventing full processing of the relationship’s end? Or does it helpfully contribute to a sense of security? Further, does it function in a similar way for the therapist, who faces these losses on a frequent basis? How do terminations compare for clients who know they can return, versus those who are separated from their therapists by circumstances such as geography? Presumably most therapists offer their future availability to clients, when neither is moving away; when the therapist does not make the offer, what is the reasoning? How does that decision influence the client?

- How does therapists’ disclosure during the termination process (e.g., what the therapist thinks about the client’s progress, and how the therapist feels about the client) affect the client? What are the reasons for disclosing reactions to the client only during termination, versus throughout the course of therapy?

- Why did the predictive empathy scores not correlate with the BLRI? Which approach to measuring empathy is more valid? Triangulating with observer ratings might help establish validity of the different assessment approaches. Would the PE scores be more valid if the instructions were, “Answer these questions as if you were your client. Record the answers you think your client would give”? Perhaps, on the other hand, the PE measure is
a more accurate way to assess empathic accuracy, whereas the BLRI's strong face validity compromises its construct validity. That is, the BLRI may be capturing another construct, such as general liking of the therapist, more than true empathy.

Summary

Regression and correlation analyses failed to support the research hypotheses and questions about the relationships among the outcome variable of client satisfaction with termination and predictor variables of general empathic accuracy, termination-specific empathic accuracy, and therapist rigidity of beliefs about termination. While the proposed model was not supported, post hoc analysis of the rich data generated a number of questions and considerations for therapists conducting terminations. In general, terminations were positive experiences for the clients in this study, and their views on the process were largely reflected and understood by their therapists. Therapist “blind spots” tended to be in areas of mutual expression of feelings: they tended to be inaccurate in estimating the extent to which clients were eager to express gratitude and to hear their therapists’ feelings and thoughts about them. It may be that the therapists’ expressions of support and liking for clients contribute more to client satisfaction with the process than the variables of empathy and flexibility.
References


Dear Therapist:

Thank you for agreeing to participate in this study on therapy terminations. I am conducting my dissertation research on the relationship between client and counselor at the time of therapy’s closure, and am grateful to you for your willingness to help.

In this packet you will find questionnaires for you to complete and questionnaires for your clients, along with separate return envelopes and a thank-you gift for your client. You’ll notice that both sets of instruments are marked with a letter code. This code is how I will match returned packets from you and your clients. Your data will be read without knowledge of your identity. Please do not put your name on the packet.

Any consenting client who is at least 18 years old and who has seen you for at least three sessions is eligible to participate.

Instructions

1. Invite your client to participate, in advance if possible.
2. Give the instruments to your client at the final session.
3. Emphasize to your client that you will have no access to his/her questionnaires, and that his/her responses are completely anonymous.
4. Ask your client to fill out the questionnaires in a private location on the day of the final session, and mail them within two days.
5. You should fill out the questionnaires and return them within two days of the final session.

Please contact me if you have any questions about the research procedures.

Thank you again for your help,

Alison Cobb, M.A.
Principal Investigator
Psychology Department
The University of Montana
Missoula, MT 59812
(406) 243-2367
Dear Client:

Thank you for agreeing to participate in this study on therapy terminations. I am conducting my dissertation research on the relationship between client and counselor at the time of therapy’s closure, and am grateful to you for your willingness to help.

Your participation in this study is completely voluntary. Your therapist will not know whether you participate or not. The enclosed token of my appreciation is yours to keep, whether or not you participate.

Attached are some questionnaires for you to complete, and a return envelope. You are to send your packet back to me directly; your therapist will not see your responses. All information you provide will be strictly anonymous. Please do not put your name on the packet.

Please fill out these questionnaires on the day of your final session, and mail the packet back to me within two days.

Feel free to contact me if you have any questions about the research procedures.

Thank you again for your help,

Alison Cobb, M.A.
Principal Investigator
Psychology Department
The University of Montana
Missoula, MT 59812
(406)243-2387
Purpose
The purpose of this research study is to examine therapist and client perspectives on the final phase of therapy.

Procedures
This study requires participation from both the therapist and client. The client completes the packet of questionnaires on the day of the final therapy session, and mails the packet back within two days. The questionnaires will take approximately 45 minutes to complete.

Risks/Discomforts
The questionnaires are not expected to create any discomfort. Because the questions address relationship issues, there is a possibility that positive or negative emotions may be aroused.

Benefits
This study is not designed to lead to specific benefits for the participants. It may, however, help you in thinking about and processing the final sessions of your therapy.

Compensation for Injury
Although we do not foresee any risk in taking part in this study, the following liability statement is required in all University of Montana consent forms. In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University’s Claims representative or University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)

Confidentiality
All information you provide will be strictly anonymous. Please do not put your name on the questionnaire. Only research staff will have access to the data. Your therapist will not see your responses.

Voluntary Participation/Withdrawal
Your decision to take part in this research study is entirely voluntary. You may withdraw from the study at any time without penalty. Your therapist will not know whether you participated or not. If you decide not to participate, it will not affect your therapy or services you may seek in the future. The gift enclosed in the packet is yours to keep, regardless of whether or not you participate.

Questions
If you have any questions about the research, contact the experimenter or her faculty supervisor at the phone numbers above. If you have any questions regarding your rights as a research participant, you may contact the chair of the Institutional Review Board, Sheila Holland, through the Research Office at the University of Montana at 243-6670.
THERA PIST INFORMATION AND CONSENT

TITLE: Therapy Termination Study

INVESTIGATORS: Alison Cobb, M.A., Clinical Psychology Graduate Student; (406)243-2367
Jennifer Waltz, Ph.D., Faculty Supervisor; (406)243-5750
The University of Montana, Missoula, MT 59812

Purpose
The purpose of this research study is to examine therapist and client perspectives on the final phase of therapy.

Procedures
This study requires participation from both the therapist and client. The researcher solicits participation from the therapist, and the therapist invites the client to participate. The therapist completes and returns the packet of questionnaires within two days of the final therapy session. Each packet will take approximately 45 minutes to complete.

Risks/Discomforts
The questionnaires are not expected to create any discomfort. Because the questions address relationship issues, there is a possibility that positive or negative emotions may be aroused.

Benefits
This study is not designed to lead to specific benefits for the participants. It may, however, help you in thinking about and processing the final sessions of this therapy.

Compensation for Injury
Although we do not foresee any risk in taking part in this study, the following liability statement is required in all University of Montana consent forms. In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University’s Claims representative or University Legal Counsel. (Reviewed by University Legal Counsel, July 6, 1993)

Confidentiality
All information you provide will be strictly confidential. Please do not put your name on the questionnaire. Your consent form and the key linking your packet to the mailing list will be stored separately from your questionnaire, in a locked file cabinet. Completed questionnaires will be reviewed without knowledge of your identity. Only research staff will have access to the data. Your clients will remain completely anonymous to the researchers, with no way to determine their identities.

Voluntary Participation/Withdrawal
Your decision to take part in this research study is entirely voluntary. You may withdraw from the study at any time without penalty.

Questions
If you have any questions about the research, contact the experimenter or her faculty supervisor at the phone numbers above. If you have any questions regarding your rights as a research participant, you may contact the chair of the Institutional Review Board, Sheila Hefford, through the Research Office at the University of Montana at 243-6670.

Participant’s Consent
I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team. I voluntarily agree to take part in this study. I understand I will keep a copy of this consent form.

Printed Name of Participant ___________________________ Participant’s Signature ___________________________ Date _____________

Experimenter’s Signature ___________________________
Appendix B
General Information - Client

1. What is your gender? ______ male ______ female

2. What is your age? ______

3. What is your race/ethnicity?
   ______ American Indian/Alaska Native ______ Hispanic
   ______ Asian/Pacific Islander ______ White, non-Hispanic
   ______ Black, non-Hispanic ______ other: _____________________________

4. In your lifetime, how many different therapists or counselors have you seen for treatment? ______

5. How long have you been in this therapy? ______ # sessions over ______ # years, ______ # months

6. In general, how frequently have you met with your therapist?
   ______ more than once a week ______ monthly
   ______ once a week ______ other: _____________________________
   ______ every 2 weeks

7. Why is your therapy ending? (If more than one reason, rank them in order of importance, with 1 being most important)
   ______ financial concerns ______ client dissatisfaction with therapy
   ______ time concerns ______ treatment requirements/court mandated
   ______ improvement in symptoms ______ third party concerns (e.g., insurance limitations, clinic policy)
   ______ goals achieved ______ circumstances not related to therapy (e.g., moving out of town); describe: _____________________________
   ______ other: _____________________________

8. Who made the decision to end the therapy? Circle a number for each option:

<table>
<thead>
<tr>
<th>not true</th>
<th>somewhat true</th>
<th>very true</th>
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9. When did you and your therapist first start talking about termination? (X one)
   ______ first session
   ______ early in therapy
   ______ middle of therapy
   ______ last few sessions
   ______ final session
   ______ did not talk about it
   ______ other: _____________________________

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10. At what point was termination a focus of discussion, with significant session time devoted to it? (X all that apply)
   - first session
   - early in therapy
   - middle of therapy
   - last few sessions
   - final session
   - did not talk about it
   - other: ______________________________

11. Overall, how successful do you feel your therapy was? (Circle one number)

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12. Overall, how close did you feel to your therapist during therapy? (Circle one number)

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13. Overall, how empathic was your therapist during therapy? (Circle one number)

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General Information - Therapist

1. What is your gender? _____male _____female

2. What is the highest degree you have completed?
   ____BA/BS  ____PsyD
   ____MA/MS  ____MD
   ____PhD  ____other: _____________________________

3. What is your professional affiliation?
   ____Social Worker  ____Psychologist
   ____Counselor  ____Psychiatrist
   ____Marriage & Family Therapist  ____other: _____________________________
   ____Student, studying to be a ____________

4. How many years have you worked as a therapist? ______years

5. About how many termination sessions have you conducted? ______

6. What was your primary approach to your work with this client? (X one)
   ____psychodynamic  ____eclectic/integrative...list prominent influence(s): _____________________________
   ____cognitive/behavioral  ____emotion focused/experiential
   ____client-centered  ____gestalt
   ____interpersonal  ____other: _____________________________

7. What orientation best characterizes the final session with this client? (X one)
   ____psychodynamic  ____eclectic/integrative...list prominent influence(s): _____________________________
   ____cognitive/behavioral  ____emotion focused/experiential
   ____client-centered  ____gestalt
   ____interpersonal  ____other: _____________________________

8. How long has this client been in therapy with you? ______sessions over ______years, ______months

9. In general, how frequently have you met with this client?
   _____more than once a week
   _____once a week
   _____every 2 weeks
   _____monthly
   _____other: _____________________________

10. Why is this therapy ending? (If more than one reason, rank them in order of importance, with 1 being most important)
    _____financial concerns  _____client dissatisfaction with therapy
    _____time concerns  _____treatment requirement/court mandate met
    _____improvement in symptoms  _____third party concerns (e.g., insurance limitations, clinic policy)
    _____goals achieved  _____circumstances not related to therapy (e.g., moving out of town); describe: _____________________________
    _____lack of client progress  _____________________________
    _____other: _____________________________

11. Was this treatment time-limited from the start? _____yes _____no

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12. Who made the decision to end the therapy? Circle a number for each option:

<table>
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<tr>
<th>not true</th>
<th>somewhat true</th>
<th>very true</th>
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13. When did you and your client first start talking about termination? (X one)

- first session
- early in therapy
- middle of therapy
- did not talk about it
- other: __________________________
- last few sessions

14. At what point was termination a focus of discussion, with significant session time devoted to it? (X all that apply)

- first session
- early in therapy
- middle of therapy
- did not talk about it
- other: __________________________
- last few sessions

15. Overall, how successful do you feel this therapy was? (Circle one number)

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16. Overall, how close did you feel to your client during therapy? (Circle one number)

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17. Overall, how empathic did you feel with your client during therapy? (Circle one number)

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18. Was this client the first to terminate since you received this questionnaire packet?  yes  no

If no, please explain why the first client to terminate is not participating. This information is needed to help assess selection bias.

- I already gave the packet to the first client.
- The first client did not come to last session.
- The first client declined to participate.
- I forgot to give the packet to the first client.
- I did not feel it was appropriate to ask that client to participate.
- other: __________________________

Please describe further:
Appendix C
Below are listed various ways that one person might feel or behave in relation to another person. Please consider each numbered statement with reference to your present relationship with your therapist, mentally adding his or her name in the space provided. For example, if your therapist's name was John, you would read statement #1 as, “John wants to understand how I see things.”

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Circle a plus number (+3, +2, or +1) for each “yes” answer, and minus numbers (-1, -2, or -3) to stand for “no” answers. Here is the exact meaning of each answer number:

| +3  | Yes (!), I feel strongly that it is true. |
| +2  | Yes, I feel it is true. |
| +1  | (Yes) I feel that it is probably true, or more true than untrue. |
| -1  | (No) I feel that it is probably untrue, or more untrue than true. |
| -2  | No, I feel it is not true. |
| -3  | No (!), I feel strongly that it is not true. |

1. ________ wants to understand how I see things. 
2. ________ may understand my words but does not see the way I feel. 
3. ________ nearly always knows exactly what I mean. 
4. ________ looks at what I do from his/her own point of view. 
5. ________ usually senses or realizes what I am feeling. 
6. ________’s own attitudes toward things I do or say prevent him/her from understanding. 
7. Sometimes ________ thinks that I feel a certain way, because that’s the way he/she feels. 
8. ________ realizes what I mean even when I have difficulty saying it. 
9. ________ usually understands the whole of what I mean. 
10. ________ just takes no notice of some things I think or feel. 
11. ________ appreciates exactly how the things I experience feel to me. 
12. At times ________ thinks that I feel a lot more strongly about a particular thing than I do. 
13. ________ does not realize how sensitive I am about some things we discuss. 
14. ________ understands me. 
15. ________’s response to me is usually so fixed and automatic that I don’t really get through to him/her. 
16. When I am hurt or upset, ________ can recognize my feelings exactly, without becoming upset too.

Form OS-64, Godfrey T. Barrett-Lennard, Ph.D.

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BLRI-E Scoring

negatively scored items:

2
4
6
7
10
12
13
15
This questionnaire is about the final phase of therapy, as you and your therapist ended your work together, and about your last therapy session. Please read the questions carefully.

1. How important was it for you to discuss your reactions to ending counseling with your therapist? (Circle one number)
   
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2. How important was this last session to you?
   
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3. Overall, how important to you was the process of ending therapy?
   
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4. Did you think ahead about this session more than about previous sessions?
   
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5. Which of these have you experienced while ending therapy? (Check one box for each item.)
   
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<td>a) ambivalence (mixed feelings)</td>
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<td>b) anger</td>
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<td>c) anxiety</td>
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<td>d) desire for more sessions</td>
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<td>e) disappointment</td>
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<td>f) doubt about progress</td>
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<td>g) guilt</td>
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<td>h) increased energy/motivation for activities outside of therapy</td>
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<td>i) pride</td>
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<td>j) reexperiencing previous losses</td>
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<td>k) relief</td>
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<td>l) reluctance to end</td>
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<td>m) sadness</td>
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<td>n) sense of accomplishment</td>
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<td>o) our relationship became closer</td>
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<td>p) we began to relate more as equals</td>
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<td>q) other (describe)</td>
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6. Rate how you experienced the process of ending therapy:
   
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<tr>
<td>easy</td>
<td>difficult</td>
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</table>
7. How much did you tell your therapist about your reactions to ending therapy?

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<tbody>
<tr>
<td>I expressed nothing</td>
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<tr>
<td>I expressed some reactions, but not all</td>
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<tr>
<td>I expressed everything</td>
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8. What behaviors did you want or not want to occur during the process of ending therapy? (mark each item)

<table>
<thead>
<tr>
<th>Behavior Description</th>
<th>1</th>
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<tbody>
<tr>
<td>a) You thanking the counselor</td>
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<td>b) Summarizing the work</td>
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<td>c) Assessing how much goals have been attained</td>
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<td>d) Discussing your plans for the future</td>
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<td>e) Counselor sharing his/her feelings about ending the work</td>
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<td>f) Setting a date for the final session</td>
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<td>g) You sharing your feelings about ending therapy with the counselor</td>
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<td>h) Counselor inviting you to return if you feel the need</td>
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<td>i) You and counselor hugging or shaking hands</td>
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<td>j) You stating things about your counseling that you liked and disliked</td>
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<td>k) You feeling like you and your counselor were relating more like equals than you had at earlier times</td>
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<td>l) Counselor suggesting other types of help or other places to get help</td>
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<td>m) You asking counselor personal questions about him/her</td>
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<td>n) Counselor talking more about him/herself</td>
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<tr>
<td>o) Tapering off the frequency of sessions</td>
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<tr>
<td>p) You asking counselor questions about how counseling works</td>
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<tr>
<td>q) You expressing how you feel about your counselor</td>
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<td>r) Your counselor expressing how she feels about you</td>
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<td>s) You giving a gift to the counselor</td>
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<tr>
<td>t) Other:</td>
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</table>

103
9. **What behaviors actually occurred during the process of ending therapy?** (X all that apply)

   a) You thanking the counselor _____
   b) Summarizing the work _____
   c) Assessing how much goals have been attained _____
   d) Discussing your plans for the future _____
   e) Counselor sharing his/her feeling about ending the work _____
   f) Setting a date for the final session _____
   g) You sharing your feelings about ending therapy with the counselor _____
   h) Counselor inviting you to return if you feel the need _____
   i) You and counselor hugging or shaking hands _____
   j) You stating things about your counseling that you liked and disliked _____
   k) You feeling like you and your counselor were relating more like equals than you had at earlier times _____
   l) Counselor suggesting other types of help or other places to get help _____
   m) You asking counselor personal questions about him/her _____
   n) Counselor talking more about him/herself _____
   o) Tapering off the frequency of sessions _____
   p) You asking counselor questions about how counseling works _____
   q) You expressing how you feel about your counselor _____
   r) Your counselor expressing how s/he feels about you _____
   s) You giving a gift to the counselor _____
   t) Other: ______________________________

10. Use the space below to describe what this ending process and the final session were like for you. Include whatever was memorable or important for you, and what had an impact on you. Write about your feelings and your thoughts, but please do not include any personal information that would identify you.
This questionnaire is about the final phase of therapy, as you and your client ended your work together, and about your last therapy session. It asks you to estimate your client's reaction to termination. Please read the questions carefully.

1. How important was it for your client to discuss his/her reactions to ending counseling with you? (Circle one number)
   - not at all
   - somewhat
   - very

2. How important was this last session to your client?
   - not at all
   - somewhat
   - very

3. Overall, how important to your client was the process of ending therapy?
   - not at all
   - somewhat
   - very

4. Did your client think ahead about this session more than about previous sessions?
   - not at all
   - somewhat
   - very

5. Which of these has your client experienced while ending therapy? (X one box for each item.)
   - ambivalence (mixed feelings)
   - anger
   - anxiety
   - desire for more sessions
   - disappointment
   - doubt about progress
   - guilt
   - increased energy/motivation for activities outside of therapy
   - pride
   - reexperiencing previous losses
   - relief
   - reluctance to end
   - sadness
   - sense of accomplishment
   - our relationship became closer
   - we began to relate more as equals
   - other (describe)

6. Rate how your client experienced the process of ending therapy:
   - easy
   - difficult
7. How much did your client tell you about his/her reactions to ending therapy?

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<tr>
<th>1</th>
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<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client expressed nothing</td>
<td>Client expressed some reactions, but not all</td>
<td>Client expressed everything</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

8. What behaviors did your client **want or not want** to occur during the process of ending therapy? (mark **each** item)

<table>
<thead>
<tr>
<th></th>
<th>did not want this to happen at all</th>
<th>wanted this to happen very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Thanking you</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>b) Summarizing the work</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>c) Assessing how much goals have been attained</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>d) Discussing your client's plans for the future</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>e) You sharing your feelings about ending the work</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>f) Setting a date for the final session</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>g) Your client sharing feelings about ending therapy with you</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>h) You inviting your client to return if s/he feels the need</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>i) You and your client hugging or shaking hands</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>j) Your client stating things about counseling that s/he liked and disliked</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>k) Your client feeling like you and s/he were relating more like equals than you had at earlier times</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>l) You suggesting other types of help or other places to get help</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>m) Your client asking you personal questions about yourself</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>n) You talking more about yourself</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>o) Tapering off the frequency of sessions</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>p) Your client asking questions about how counseling works</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>q) Your client expressing how s/he feels about you</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>r) You expressing how you feel about your client</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>s) Your client giving you a gift</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
<tr>
<td>t) Other:</td>
<td>1 2 3 4</td>
<td>5 6 7</td>
</tr>
</tbody>
</table>
9. What behaviors actually occurred during the process of ending therapy? (X all that apply)

   a) Thanking you_____ k) Your client feeling like you and s/he were relating more like equals than you had at earlier times_____
   b) Summarizing the work_____ l) You suggesting other types of help or other places to get help_____
   c) Assessing how much goals have been attained_____ m) Your client asking you personal questions about yourself_____
   d) Discussing your client’s plans for the future_____ n) You talking more about yourself_____
   e) You sharing your feelings about ending the work_____ o) Tapering off the frequency of the sessions_____
   f) Setting a date for the final session_____ p) Your client asking questions about how counseling works_____
   g) Your client sharing feelings about ending therapy with you_____ q) Your client expressing how s/he feels about you_____
   h) You inviting your client to return if s/he feels the need_____
   i) You and your client hugging or shaking hands_____ r) You expressing how you feel about your client_____
   j) Your client stating things about counseling that s/he liked and disliked_____ s) Your client giving you a gift_____ 
   t) Other: ______________________________
Appendix E
Mark each item with 1, 2, 3, 4 or 5 to reflect how much you believe each behavior should be part of the termination process:

<table>
<thead>
<tr>
<th>Item</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tapering off the frequency of sessions</td>
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<tr>
<td>2. Marking the ending as a significant event in the counseling</td>
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<tr>
<td>3. Using the ending to process the client's previous experiences with loss</td>
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<tr>
<td>4. Summarizing the work</td>
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<tr>
<td>5. Establishing a date for the final session well in advance</td>
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<tr>
<td>6. Assessing how much goals have been attained</td>
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<tr>
<td>7. Asking the client what things about counseling s/he liked</td>
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<td>8. Asking the client what things about counseling s/he disliked</td>
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<tr>
<td>9. You sharing feelings about the therapy with the client</td>
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<tr>
<td>10. You and the client hugging</td>
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<tr>
<td>11. You and the client shaking hands</td>
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<tr>
<td>12. You talking more about yourself</td>
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<tr>
<td>13. Discussing the client's plans for the future</td>
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<tr>
<td>14. Inviting the client to return if s/he feels the need</td>
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<tr>
<td>15. Discussing future contact with the client</td>
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<tr>
<td>16. You suggesting other types of help for the client</td>
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<tr>
<td>17. Discussing future counseling with the client</td>
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<td>18. Giving the client an opportunity to express feelings about ending</td>
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<td>19. Other:</td>
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Mark each item with 1, 2, 3, 4 or 5, to reflect whether you believe each statement to be true or false:

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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>20. The termination process almost always causes old symptoms to resurface</td>
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<tr>
<td>21. Clients respond more strongly to termination than to most other parts of therapy</td>
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<td>22. Termination evokes grief related to previous losses in the client's life</td>
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<td>23. Joy and pride are more common reactions to termination than fear and sadness</td>
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<tr>
<td>24. Terminations are easier when the decision to end is mutual</td>
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<tr>
<td>25. Clients in long-term therapy have more difficulty terminating</td>
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<td>26. The client is in a better position than the therapist to decide when to terminate</td>
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</table>
1. How satisfied were you with the way your counseling came to an end?

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</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>somewhat</td>
<td>very</td>
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2. How well did the ending go?

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<td></td>
<td>poorly</td>
<td>moderately</td>
<td>well</td>
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3. How resolved or settled do you feel about this therapy?

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<tr>
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<td>unresolved/unsettled</td>
<td>resolved/settled</td>
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CSS-T

1. **How satisfied was your client with the way counseling came to an end?**

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<tbody>
<tr>
<td>not at all</td>
<td>somewhat</td>
<td>very</td>
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2. **How well did the ending go for your client?**

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<td>poorly</td>
<td>moderately</td>
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3. **How resolved or settled does your client feel about this therapy?**

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</thead>
<tbody>
<tr>
<td>unresolved/unsettled</td>
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<td></td>
<td>resolved/settled</td>
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</table>
Appendix G
Demographics of All Respondents

Of the 42 clients who returned questionnaires, 23 (54.8%) were female, and 38 (90.5%) were Caucasian. The average age was 35.9 (SD = 13.2), with ages ranging from 18 to 64. On average, the clients had had 3 therapists in their lifetimes (SD = 2.7), with a range from one to 15.

Of the 47 therapists who returned questionnaires, 31 (66%) were female. The sample was heterogeneous in terms of degrees and professional affiliation, as the figures below show.

![Pie chart showing degrees held by therapist respondents.]

**Figure 4.** Degrees held by therapist respondents.

![Pie chart showing professional affiliations of therapist respondents.]

**Figure 5.** Professional affiliations of therapist respondents.
Therapists in this sample had been in the profession for an average of 14 years (SD = 10.13, maximum of 40 years), and the majority (58.7%, N = 27) estimated that they had conducted over 100 terminations. The distribution of termination experience was curvilinear, with the next largest group (19.6%, N = 9) indicating that they had conducted between one and ten terminations.

Information about the therapists’ theoretical orientation was only collected regarding the current course of therapy. As the charts below show, cognitive/behavioral and eclectic/integrative orientations were the dominant approaches overall, but during the termination session therapists frequently switched to a client-centered approach.
Figure 6. Primary theoretical orientation of therapy with terminating client.

Figure 7. Theoretical orientation of final session.
The average length of treatment was one year ($M = 11.67$ months, $SD = 10.53$). The majority of terminations (61.7% of 47 therapist responses) had not been time-limited treatments from the start of therapy. The most frequently cited reason for terminating was extra-therapy circumstances (42.6% of 47 therapist responses, and 38.1% of 42 client responses). The majority of these circumstances were the therapist or client moving; in two cases, respondents indicated that the therapist was ending a practicum. Symptom improvement and goal achievement were also common reasons for termination; taken together, they were endorsed as frequently as extra-therapy circumstances. Most respondents reported reaching the decision to terminate together, while very few indicated that a third party forced the decision.

Table 1

Mean Responses to Question of Who Made the Decision to Terminate (Therapist N = 47; Client N = 42)

<table>
<thead>
<tr>
<th></th>
<th>Therapist Mean</th>
<th>Client Mean</th>
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</thead>
<tbody>
<tr>
<td>The therapist did</td>
<td>1.81</td>
<td>1.57</td>
</tr>
<tr>
<td>The client did</td>
<td>1.89</td>
<td>1.90</td>
</tr>
<tr>
<td>We decided together</td>
<td>2.09</td>
<td>2.14</td>
</tr>
<tr>
<td>A third party did (e.g., insurance company would not cover additional sessions)</td>
<td>1.26</td>
<td>1.24</td>
</tr>
</tbody>
</table>

*Note.* Respondents rated *each possibility* on a Likert scale with a range of 1 (not true), 2 (somewhat true), and 3 (very true).
Appendix H
Distributions of Scores: All Questionnaires

BLRI

STD. DEV = 10.59
MEAN = 30.8
N = 42.00

TRS

STD. DEV = 5.33
MEAN = 20.2
N = 45.00

CSS

STD. DEV = 3.30
MEAN = 18.1
N = 42.00

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Distributions of Scores: Matched Questionnaires

**BLRI**  
Range: -48 -- +48  
Std. Dev = 9.63  
Mean = 32.2  
N = 34.00

**PE**  
Range: 0 -- 264  
Std. Dev = 17.46  
Mean = 58.4  
N = 34.00

**TRS**  
Range: 0 -- 52  
Std. Dev = 5.53  
Mean = 20.1  
N = 34.00

**CSS**  
Range: 3 -- 21  
Std. Dev = 2.41  
Mean = 10.0  
N = 34.00
Frequencies and Means for All Respondents

General Information – Client

1. What is your gender? 19 male, 23 female
2. What is your age? X = 35.93
3. What is your race/ethnicity?
   - 1 American Indian/Alaska Native
   - 0 Asian/Pacific Islander
   - 0 Black, non-Hispanic
   - 1 Hispanic
   - 38 White, non-Hispanic
   - 2 other
4. In your lifetime, how many different therapists or counselors have you seen for treatment? X = 3.29
5. How long have you been in this therapy? X = 25.93 sessions
6. In general, how frequently have you met with your therapist?
   - 2 more than once a week
   - 1 monthly
   - 23 once a week
   - 3 other
   - 12 every 2 weeks
7. Why is your therapy ending? (If more than one reason, rank them in order of importance, with 1 being most important)

<table>
<thead>
<tr>
<th>Reason</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>financial concerns</td>
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<td>3</td>
<td>1</td>
</tr>
<tr>
<td>time concerns</td>
<td>7</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>improvement in symptoms</td>
<td>9</td>
<td>7</td>
<td></td>
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<tr>
<td>goals achieved</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>lack of client progress</td>
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<tr>
<td>client dissatisfaction with therapy</td>
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<tr>
<td>treatment requirement/court mandate met</td>
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<tr>
<td>third party concerns (e.g., insurance limitations, clinic policy)</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>circumstances not related to therapy (e.g., moving out of town)</td>
<td>16</td>
<td>1</td>
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</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>
8. Who made the decision to end the therapy? Circle a number for each option:

<table>
<thead>
<tr>
<th>Option</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Very True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X = 1.57</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>X = 1.90</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>X = 2.14</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>X = 1.24</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>X = 2.43</td>
<td>3</td>
</tr>
</tbody>
</table>

122
9. When did you and your therapist first start talking about termination? (X one)
   6 first session
   4 early in therapy
   6 middle of therapy
   15 last few sessions
   5 final session
   0 did not talk about it
   6 other

10. At what point was termination a focus of discussion, with significant session time devoted to it? (X all that apply)
   4 first session
   0 early in therapy
   4 middle of therapy
   18 last few sessions
   21 final session
   4 did not talk about it
   0 other

11. Overall, how successful do you feel your therapy was? (Circle one number)
    1 2 3 4 5 6 7
    not at all  somewhat X = 6.18 very

12. Overall, how close did you feel to your therapist during therapy? (Circle one number)
    1 2 3 4 5 6 7
    not at all  somewhat X = 5.69 very

13. Overall, how empathic was your therapist during therapy? (Circle one number)
    1 2 3 4 5 6 7
    not at all  somewhat X = 6.36 very

123

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General Information – Therapist

1. What is your gender? 16 male, 31 female
2. What is the highest degree you have completed?
   - 6 BA/BS
   - 19 MA/MS
   - 18 PhD
   - 0 PsyD
   - 0 MD
   - 4 other

3. What is your professional affiliation?
   - 0 Social Worker
   - 13 Counselor
   - 17 Psychologist
   - 0 Psychiatrist
   - 1 Marriage & Family Therapist
   - 0 other
   - 16 Student

4. How many years have you worked as a therapist? X = 14

5. About how many termination sessions have you conducted?
   - 1-10 9
   - 11-20 4
   - 21-50 3
   - 50-100 3
   - over 100 27

6. What was your primary approach to your work with this client? (X one)
   - 1 psychodynamic
   - 17 cognitive/behavioral
   - 6 client-centered
   - 2 interpersonal
   - 13 eclectic/integrative
   - 3 emotion focused/experiential
   - 0 gestalt
   - 1 other

7. What orientation best characterizes the final session with this client? (X one)
   - 0 psychodynamic
   - 13 cognitive/behavioral
   - 14 client-centered
   - 8 interpersonal
   - 6 eclectic/integrative
   - 5 emotion focused/experiential
   - 0 gestalt
   - 1 other

8. How long has this client been in therapy with you? X = 25.93 sessions over 11.67 months

9. In general, how frequently have you met with this client?
   - 3 more than once a week
   - 23 once a week
   - 13 every 2 weeks
   - 1 monthly
   - 4 other
10. Why is this therapy ending? (If more than one reason, rank them in order of importance, with 1 being most important)

<table>
<thead>
<tr>
<th>Reason</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>financial concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>time concerns</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>improvement in symptoms</td>
<td>12</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>goals achieved</td>
<td>8</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>lack of client progress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>client dissatisfaction with therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment requirement/court mandate met</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>third party concerns (e.g., insurance limitations, clinic policy)</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>circumstances not related to therapy (e.g., moving out of town)</td>
<td>20</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Was this treatment time-limited from the start? 18 yes, 29 no

12. Who made the decision to end the therapy? Circle a number for each option:

<table>
<thead>
<tr>
<th>Not true</th>
<th>Somewhat true</th>
<th>Very true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X = 1.81</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>X = 1.89</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>X = 2.09</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>X = 1.26</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>X = 3.00</td>
<td>2</td>
</tr>
</tbody>
</table>

13. When did you and your client first start talking about termination? (X one)

| 9 first session |
| 4 early in therapy |
| middle of therapy |
| 15 last few sessions |
| 4 final session |
| did not talk about it |
| 3 other |

14. At what point was termination a focus of discussion, with significant session time devoted to it? (X all that apply)

| 1 first session |
| 2 early in therapy |
| 7 middle of therapy |
| 24 last few sessions |
| 19 final session |
| did not talk about it |
| 1 other |
15. Overall, how successful do you feel this therapy was? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>somewhat</td>
<td>X = 5.39</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Overall, how close did you feel to your client during therapy? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>somewhat</td>
<td>X = 5.12</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Overall, how empathic did you feel with your client during therapy? (Circle one number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all</td>
<td>somewhat</td>
<td>X = 5.69</td>
<td>very</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

18. Was this client the first to terminate since you received this questionnaire packet? 20 yes, 27 no

If no, please explain why the first client to terminate is not participating. This information is needed to help assess selection bias.

- 10 I already gave the packet to the first client.
- 3 The first client did not come to last session.
- 0 The first client declined to participate.
- 11 I forgot to give the packet to the first client.
- 3 I did not feel it was appropriate to ask that client to participate.
This questionnaire is about the final phase of therapy, as you and your therapist ended your work together, and about your last therapy session. Please read the questions carefully.

1. How important was it for you to discuss your reactions to ending counseling with your therapist? (Circle one number)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>somewhat</td>
<td>X = 4.64</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How important was this last session to you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>somewhat</td>
<td>X = 5.73</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Overall, how important to you was the process of ending therapy?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>somewhat</td>
<td>X = 5.31</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Did you think ahead about this session more than about previous sessions?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>X = 3.59</td>
<td>somewhat</td>
<td>very</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Which of these have you experienced while ending therapy? (X one box for each item.)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) ambivalence (mixed feelings)</td>
<td>3.91</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) anger</td>
<td>1.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) anxiety</td>
<td>3.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) desire for more sessions</td>
<td>3.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) disappointment</td>
<td>2.93</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) doubt about progress</td>
<td>2.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) guilt</td>
<td>1.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) increased energy/motivation for activities outside of therapy</td>
<td>3.91</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) pride</td>
<td>3.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j) reexperiencing previous losses</td>
<td>2.48</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k) relief</td>
<td>2.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l) reluctance to end</td>
<td>3.80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m) sadness</td>
<td>3.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n) sense of accomplishment</td>
<td>5.19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o) our relationship became closer</td>
<td>4.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p) we began to relate more as equals</td>
<td>3.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Rate how you experienced the process of ending therapy:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>easy</td>
<td>X = 3.23</td>
<td>difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. How much did you tell your therapist about your reactions to ending therapy?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>X = 4.60</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>I expressed nothing</td>
<td>I expressed some reactions, but not all</td>
<td>I expressed everything</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. What behaviors did you want or not want to occur during the process of ending therapy? (mark each item)

<table>
<thead>
<tr>
<th>did not want this to happen at all</th>
<th>wanted this to happen very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) You thanking the counselor</td>
<td>6.20</td>
</tr>
<tr>
<td>b) Summarizing the work</td>
<td>5.40</td>
</tr>
<tr>
<td>c) Assessing how much goals have been attained</td>
<td>5.52</td>
</tr>
<tr>
<td>d) Discussing your plans for the future</td>
<td>5.80</td>
</tr>
<tr>
<td>e) Counselor sharing his/her feelings about ending the work</td>
<td>5.68</td>
</tr>
<tr>
<td>f) Setting a date for the final session</td>
<td>4.52</td>
</tr>
<tr>
<td>g) You sharing your feelings about ending therapy with the counselor</td>
<td>4.75</td>
</tr>
<tr>
<td>h) Counselor inviting you to return if you feel the need</td>
<td>6.05</td>
</tr>
<tr>
<td>i) You and counselor hugging or shaking hands</td>
<td>5.43</td>
</tr>
<tr>
<td>j) You stating things about your counseling that you liked and disliked</td>
<td>4.39</td>
</tr>
<tr>
<td>k) You feeling like you and your counselor were relating more like equals than you had at earlier times</td>
<td>4.38</td>
</tr>
<tr>
<td>l) Counselor suggesting other types of help or other places to get help</td>
<td>4.36</td>
</tr>
<tr>
<td>m) You asking counselor personal questions about him/her</td>
<td>3.02</td>
</tr>
<tr>
<td>n) Counselor talking more about him/herself</td>
<td>3.42</td>
</tr>
<tr>
<td>o) Tapering off the frequency of sessions</td>
<td>3.74</td>
</tr>
<tr>
<td>p) You asking counselor questions about how counseling works</td>
<td>3.02</td>
</tr>
<tr>
<td>q) You expressing how you feel about your counselor</td>
<td>4.84</td>
</tr>
<tr>
<td>r) Your counselor expressing how s/he feels about you</td>
<td>4.86</td>
</tr>
<tr>
<td>s) You giving a gift to the counselor</td>
<td>2.88</td>
</tr>
</tbody>
</table>
9. What behaviors **actually** occurred during the process of ending therapy? (X all that apply)

a) You thanking the counselor 41
b) Summarizing the work 36
c) Assessing how much goals have been attained 34
d) Discussing your plans for the future 39
e) Counselor sharing his/her feeling about ending the work 33
f) Setting a date for the final session 26
g) You sharing your feelings about ending therapy with the counselor 32
h) Counselor inviting you to return if you feel the need 33
i) You and counselor hugging or shaking hands 29
j) You stating things about your counseling that you liked and disliked 18
k) You feeling like you and your counselor were relating more like equals than you had at earlier times 16
l) Counselor suggesting other types of help or other places to get help 20
m) You asking counselor personal questions about him/her 8
n) Counselor talking more about him/herself 7
o) Tapering off the frequency of sessions 16
p) You asking counselor questions about how counseling works 6
q) You expressing how you feel about your counselor 26
r) Your counselor expressing how s/he feels about you 28
s) You giving a gift to the counselor 7

10. Use the space below to describe what this ending process and the final session were like for you. Include whatever was memorable or important for you, and what had an impact on you. Write about your feelings and your thoughts, but please do not include any personal information that would identify you.

*(identifying information has been deleted to preserve confidentiality)*

**Matched**

- She prepared a ritual that was very lovely. ... We talked about where I'd come from, from both our perspectives, & what the future might be like for me in terms of this process. I might have liked to hear more of how she felt/thought about me, but that might've been unprofessional to have done. She was supportive & positive, as always. I felt light & happy, & positive about not just the ending, but the whole process, no longer questioning its effectiveness
- A peer used CPC. My use was my own recipe. I saw that it was good.
- She provided an appropriate amount of closure, while encouraging me to stay in touch. ... Overall, I'm very sad to be ending my therapy with her. It took me a long time to truly open up to her, but once I did, I felt like I could trust her completely. This has been my most positive experience with therapy, and I will never forget how she helped me to grow as a person mentally and emotionally. She is a wonderful person & therapist and I will miss her tremendously.
- It was the right time to end therapy. It was a decision I made & my counselor supported. We did not specifically plan for this to be the final session & had previously talked about having one more session. Therefore, I felt a little unprepared when it ended, but I'm satisfied overall with the work that we did. I felt sad when it ended & cried unexpectedly and I guess I was a little angry that it had not been a more structured ending. But, overall, it was the right time for me and I’m thankful for my therapist's help & understanding.

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• I think this therapy was too informal/superficial to get deeply into things. There were only 4 sessions and that's just not enough time for a bond/comfortableness to be formed. It would be nice if the University had more counselors available so therapy could continue longer. It was just too quick & knowing that from the beginning kept me from really opening up & feeling heard/understood.

• I felt that counseling helped me to feel more confident in myself and to have a renewed motivation and to relax.

• When I started, I wasn't sure what I thought of him. He is a student! and although I often thought he and I weren't clicking I thought something is better than nothing—it can always get better—I hope he is learning something. He never came across like a student. Very professional and confident. I think one of the most important things he taught me was to speak to my "other" what I really feel—communicate expectations. I appreciated the suggestions he shared w/me like "Think of nothing but this one object'/focus or unfocus/relaxation techniques. And the use of "You may be right" in conflict. I have been reluctant to admit that I will miss therapy but I am eager to try to deal on my own. Scary because I trust myself so little. How will I remember to incorporate all I learned into my daily life? -If I lose touch w/some coping tactics/realities—can I maintain some others?

• The ending session was due to a move. Since moving is stressful inherently, some (most) of the last session was a discussion of the week. The ending process was used as a model for endings in other parts of my life. Much time was spent in the ending months to set up contacts where I was moving. I felt uncomfortable at the end of session expressing gratitude, not because it was not heartfelt, but because it made me have to think of the session as between 2 people rather than me and a therapist who needs no affirmation from me.

• The process of ending w/my therapist was very therapeutic and healing. I think we made tons of progress over a short period (during the last few months of therapy). My therapist shared how I affected her & the impact that I had on her. This felt really good. We wrote letters to one another—regrets & appreciations—and I think it was helpful for both of us. We both cried, expressed our care for one another & I believe genuinely learned from each other.

• I feel this question is moderately inapplicable to me as my counselor served as guidance for improvements made on my own (the most effective strategy I feel), thus, when I recovered sufficiently, I became more & more independent. By the final session, it was more of a "touch base & wrap up" kind of thing. There was no need for future help or guidance. No strategies or plans. However, the invitation to return if need be was extended. Our sessions were so infrequent at the end that there was no real feeling of abruptness. This closing strategy was the most effective for me.

• My final session was a bit rushed, not through any fault of the therapist, but because of circumstances beyond the control of either of us. My moving date was a bit up in the air, & we managed to squeeze in 2 sessions in one week, which was very unusual. I don't feel as if I had a satisfying sense of closure because I left therapy due to a move out of town, but not because I wanted it to end. However, I do feel like I've gained some of the insights necessary to work on—and in—my own head in my new place. I liked the therapist's style. We connected well & he appreciated my sense of humor. I felt like he got a kick out of my irreverence & respected my intelligence. Overall, I felt like we related as equals even though he was much older than I. To be honest, however, I don't think the final session was much more memorable than any other.
I appreciated the review of where I'd come from. Outside of therapy, I thought about the things I accomplished, and what other things I'd want to (eventually) approach in therapy, but not with this therapist. I felt I'd reached the goals with this counselor I could/would (plus, I was moving). I thought about (and discussed w/my therapist) what changes I'd made and how far I'd come and she told me the same—it was a good final session & I felt ready to be "on my own"—with the possibility of phone sessions if needed.

My counselor received a job elsewhere or the sessions would not have ended. He was a tremendous help—very understanding of my situation & will be missed extremely. I wish him well but wish he were staying here.

I thought my therapist was very thorough in concluding sessions.

I believe it ended when it needed to. I feel that I have acquired the necessary processing tools for handling future crisis.

Felt good about process & success; good therapist, would recommend him highly; good listener. ... seems to really care & fight for our rights; knowledgeable & caring; felt he was honest with me & kept me on honest track!

Ending wasn't really discussed until I showed up for last session.

Terminating was very hard for me—I felt very attached—saying goodbye was a tremendous loss. At the same time, my therapist & I had been working on my being [ready] to let go for some time—and when the therapy ended—I was ready to take this step. I feel that my therapy was very successful—although I miss her I wouldn't change the process—including the terminating process.

it's kind of hard to describe it gave a good sense of closer for me. & helped me to move on with my life with tools to help me have more selfconfidence. [sic]

Other than the thought that it would be the last session and I would probably not see or speak with him any more, there were no feelings about it other than a little emptiness inside that happens whenever I'm with someone for the last time. How I might feel beyond that never gets explored. unless prodded out of me. This may be part of my difficulties but I'm not sure. To date I do not know what my diagnosis is. I never wanted to know because I'd end up ruminating about it until it made me crazy trying to understand its terms. ....God bless and good day. P.S. Thank you for the 5.00. Helped me stay in tobacco towards the end of the month. --Anonymous Client.

Felt ready to end sessions & know that I can call again if I need to.

The ending was difficult because I felt a strong desire to continue meeting. I felt safe, understood, and gently pushed. I was and am concerned I may not feel so comfortable as I move on to another therapist. The process of ending was kind and honest on both our parts. I felt that we took time to acknowledge the end and this was important to me. I left with a new set of tools & resources, grateful for our several sessions. ...Thanks for lunch. ($5)

I feel that my counselor and I handled termination very well and I feel that the entire process was successful and beneficial. I liked to hear good things from my counselor and I appreciated hearing a little bit about what she is doing in her life.

Ending therapy sort of clarified things. It made me feel like I had "gotten better" or I guess made progress; it felt like a success. It was a bit sprung on because I was sort of hesitant to fully let go saying things like "Ohh... sometime next semester..." But my counselor was like dude it's the end you've grown now go out and use it which is scary and good but in the end I know I can always go back if I need to.
• I thought that my experience in counseling was really great. I felt like I had a place to go to talk to a person with an unbiased opinion. For the final session, it was not planned out to be the final it was just found that I had achieved the goals I wished to and had a really good sense of myself and where I want to go in the future. I was really happy that my counselor left open the opportunity to come back if I feel it would be necessary. It lets me know that if something happens in the future she is there for me. It was a great experience!

• I feel fortunate to be in a “good place” at this time. Last time therapy ended, I wasn’t. We’ve discovered some things about me that have left me vulnerable and led to bad situations. Now I realize these attitudes I can avoid some of these problems. The final session was no different from others, except for the last few minutes, when we briefly talked about how far we’ve come and the counselor asked for some feedback. The counselor sort of pulled away from last week’s end-of-session hug. Today, no hug at all, didn’t even walk me to the lobby. Seemed rather abrupt.

• Going into this session I was not expecting it to be the last session, however at this point in tx. things were going well and my life was doing good, so I felt it okay that this would be the last session knowing I could always come back if needed.

• The end to my therapy sessions were externally imposed. Thus in the final session I wanted to recap the topics covered in therapy. I also wanted to consider future goals/plan of action for best dealing with my struggle. I felt that these 2 objectives were met (recap & planning), yet I felt/desire more sessions as there are many remaining issues for me to work through.

• It was kinda sad. I enjoyed the sessions and feel like I made great progress

• The ending process for me was very pleasant and very meaningful. I learned so much about myself during my therapy and Blessed to have such a good therapist and so glad that programs are out there for people on low incomes. Thanks So Much!

• I really wish that counseling wouldn't have to end. The short-term counseling policy of CAPS only allowed 9 sessions. My counselor and I clicked, and therefore I'm a bit reluctant to have it come to an end. Counseling as a whole was a positive experience. I was surprised at the last session when my counselor reserved a portion of time to discuss her own view of me and my future. It was a self-esteem boost for me to hear someone I respect talk about their views on my strengths. It was nice to hear her express her own reluctance to end counseling. I wish I would have told her more about what a great job she did and how much I appreciated her help.

• I could tell that our relationship means something to her, & we felt a mutual like and appreciation for each other.

**Unmatched**

• Scary, fear of the unknown. Don’t know whos going to replace him. I go to the shrink for depression. It seems they keep changing every year. That adds to my depression. I feel like Im starting over every time they change. Very frustrating. [sic]

• It was really similar to all of our other sessions.

• I felt like a baby bird leaving the nest, going into the world on unsteady wings. Therapist said I could always return to the nest. It was important to have closure and know that therapy wasn’t going to be a never ending process. Its important to keep the focus of the therapy on teaching the individual skills to care for themselves post-therapy rather than becoming reliant on the therapy itself.
This questionnaire is about the final phase of therapy, as you and your client ended your work together, and about your last therapy session. It asks you to estimate your client’s reaction to termination. Please read the questions carefully.

1. How important was it for your client to discuss his/her reactions to ending counseling with you? (Circle one number)
   
   ![Questionnaire](image)

2. How important was this last session to your client?
   
   ![Questionnaire](image)

3. Overall, how important to your client was the process of ending therapy?
   
   ![Questionnaire](image)

4. Did your client think ahead about this session more than about previous sessions?
   
   ![Questionnaire](image)

5. Which of these has your client experienced while ending therapy? (X one box for each item.)

   ![Questionnaire](image)

6. Rate how your client experienced the process of ending therapy:

   ![Questionnaire](image)
7. How much did your client tell you about his/her reactions to ending therapy?

<table>
<thead>
<tr>
<th>1 2 3 4 5 6 7</th>
<th>Client expressed nothing</th>
<th>X = 3.85 Client expressed some reactions, but not all</th>
<th>Client expressed everything</th>
</tr>
</thead>
</table>

8. What behaviors did your client want or not want to occur during the process of ending therapy? (mark each item)

<table>
<thead>
<tr>
<th>1 2 3 4</th>
<th>did not want this to happen at all</th>
<th>X =</th>
<th>wanted this to happen very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Thanking you</td>
<td></td>
<td>5.13</td>
<td></td>
</tr>
<tr>
<td>b) Summarizing the work</td>
<td></td>
<td>4.65</td>
<td></td>
</tr>
<tr>
<td>c) Assessing how much goals have been attained</td>
<td></td>
<td>4.51</td>
<td></td>
</tr>
<tr>
<td>d) Discussing your client’s plans for the future</td>
<td></td>
<td>5.07</td>
<td></td>
</tr>
<tr>
<td>e) You sharing your feelings about ending the work</td>
<td></td>
<td>4.41</td>
<td></td>
</tr>
<tr>
<td>f) Setting a date for the final session</td>
<td></td>
<td>4.33</td>
<td></td>
</tr>
<tr>
<td>g) Your client sharing feelings about ending therapy with you</td>
<td></td>
<td>4.30</td>
<td></td>
</tr>
<tr>
<td>h) You inviting your client to return if s/he feels the need</td>
<td></td>
<td>5.38</td>
<td></td>
</tr>
<tr>
<td>i) You and your client hugging or shaking hands</td>
<td></td>
<td>4.11</td>
<td></td>
</tr>
<tr>
<td>j) Your client stating things about counseling that s/he liked and disliked</td>
<td></td>
<td>4.04</td>
<td></td>
</tr>
<tr>
<td>k) Your client feeling like you and s/he were relating more like equals than you had at earlier times</td>
<td></td>
<td>3.67</td>
<td></td>
</tr>
<tr>
<td>l) You suggesting other types of help or other places to get help</td>
<td></td>
<td>3.71</td>
<td></td>
</tr>
<tr>
<td>m) Your client asking you personal questions about yourself</td>
<td></td>
<td>2.63</td>
<td></td>
</tr>
<tr>
<td>n) You talking more about yourself</td>
<td></td>
<td>2.89</td>
<td></td>
</tr>
<tr>
<td>o) Tapering off the frequency of sessions</td>
<td></td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>p) Your client asking questions about how counseling works</td>
<td></td>
<td>2.26</td>
<td></td>
</tr>
<tr>
<td>q) Your client expressing how s/he feels about you</td>
<td></td>
<td>3.59</td>
<td></td>
</tr>
<tr>
<td>r) You expressing how you feel about your client</td>
<td></td>
<td>4.41</td>
<td></td>
</tr>
<tr>
<td>s) Your client giving you a gift</td>
<td></td>
<td>1.74</td>
<td></td>
</tr>
</tbody>
</table>
9. What behaviors actually occurred during the process of ending therapy? (X all that apply)

a) Thanking you 39  
b) Summarizing the work 43  
c) Assessing how much goals have been attained 40  
d) Discussing your client's plans for the future 42  
e) You sharing your feelings about ending the work 35  
f) Setting a date for the final session 32  
g) Your client sharing feelings about ending therapy with you 30  
h) You inviting your client to return if s/he feels the need 34  
i) You and your client hugging or shaking hands 25  
j) Your client stating things about counseling that s/he liked and disliked 19  
k) Your client feeling like you and s/he were relating more like equals than you had at earlier times 8  
l) You suggesting other types of help or other places to get help 23  
m) Your client asking you personal questions about yourself 6  
n) You talking more about yourself 8  
o) Tapering off the frequency of the sessions 17  
p) Your client asking questions about how counseling works 7  
q) Your client expressing how s/he feels about you 21  
r) You expressing how you feel about your client 27  
s) Your client giving you a gift 4
TRS

Mark each item with 1, 2, 3, 4 or 5 to reflect how much you believe each behavior should be part of the termination process:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolutely not; this should not happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absolutely; this should happen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X =

1. Tapering off the frequency of sessions 3.28
2. Marking the ending as a significant event in the counseling 4.06
3. Using the ending to process the client's previous experiences with loss 3.32
4. Summarizing the work 4.60
5. Establishing a date for the final session well in advance 3.79
6. Assessing how much goals have been attained 4.40
7. Asking the client what things about counseling s/he liked 3.70
8. Asking the client what things about counseling s/he disliked 3.77
9. You sharing feelings about the therapy with the client 3.78
10. You and the client hugging 2.72
11. You and the client shaking hands 3.17
12. You talking more about yourself 2.43
13. Discussing the client's plans for the future 4.36
14. Inviting the client to return if s/he feels the need 4.15
15. Discussing future contact with the client 3.60
16. You suggesting other types of help for the client 3.57
17. Discussing future counseling with the client 3.38
18. Giving the client an opportunity to express feelings about ending 4.64

Mark each item with 1, 2, 3, 4 or 5, to reflect whether you believe each statement to be true or false.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>False</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It depends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>True</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. The termination process almost always causes old symptoms to resurface. 2.60
20. Clients respond more strongly to termination than to most other parts of therapy. 2.87
21. Termination evokes grief related to previous losses in the client's life. 3.11
22. Joy and pride are more common reactions to termination than fear and sadness. 3.45
23. Terminations are easier when the decision to end is mutual. 4.21
24. Clients in long-term therapy have more difficulty terminating. 3.43
25. The client is in a better position than the therapist to decide when to terminate. 3.00

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### CSS

1. How satisfied were you with the way your counseling came to an end?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 6.12</td>
<td>very</td>
</tr>
<tr>
<td>somewhat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How well did the ending go?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>poorly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 6.29</td>
<td>well</td>
</tr>
<tr>
<td>moderately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How resolved or settled do you feel about this therapy?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>unresolved/unsettled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 5.74</td>
<td>resolved/settled</td>
</tr>
</tbody>
</table>

### CSS-T

1. How satisfied was your client with the way counseling came to an end?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 5.47</td>
<td>very</td>
</tr>
<tr>
<td>somewhat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. How well did the ending go for your client?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>poorly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 5.68</td>
<td>well</td>
</tr>
<tr>
<td>moderately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How resolved or settled does your client feel about this therapy?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>unresolved/unsettled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X = 5.21</td>
<td>resolved/settled</td>
</tr>
</tbody>
</table>

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Appendix J
Termination Behaviors
Client Responses to PE-C #8 & 9

What behaviors did you want or not want to occur during termination?
What behaviors actually occurred during termination?

<table>
<thead>
<tr>
<th>Behavior</th>
<th>mean wanting to occur</th>
<th>freq actually occurred</th>
<th>sum errors</th>
<th>wanted, did not occur</th>
<th>% of total errors</th>
<th>didn’t want, did occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>You thanking the counselor</td>
<td>6.37</td>
<td>41</td>
<td>3</td>
<td>2</td>
<td>67</td>
<td>1</td>
</tr>
<tr>
<td>Counselor inviting you to return if you feel the need</td>
<td>6.16</td>
<td>33</td>
<td>9</td>
<td>8</td>
<td>89</td>
<td>1</td>
</tr>
<tr>
<td>Discussing your plans for the future</td>
<td>5.88</td>
<td>37</td>
<td>7</td>
<td>5</td>
<td>71</td>
<td>2</td>
</tr>
<tr>
<td>Counselor sharing his/her feelings about ending the work</td>
<td>5.72</td>
<td>32</td>
<td>11</td>
<td>9</td>
<td>80</td>
<td>2</td>
</tr>
<tr>
<td>Assessing how much goals have been attained</td>
<td>5.60</td>
<td>32</td>
<td>8</td>
<td>7</td>
<td>88</td>
<td>1</td>
</tr>
<tr>
<td>You and counselor hugging or shaking hands</td>
<td>5.53</td>
<td>29</td>
<td>6</td>
<td>6</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Summarizing the work</td>
<td>5.45</td>
<td>34</td>
<td>5</td>
<td>4</td>
<td>80</td>
<td>1</td>
</tr>
<tr>
<td>You expressing how you feel about your counselor</td>
<td>4.86</td>
<td>25</td>
<td>11</td>
<td>9</td>
<td>82</td>
<td>2</td>
</tr>
<tr>
<td>Your counselor expressing how s/he feels about you</td>
<td>4.86</td>
<td>26</td>
<td>15</td>
<td>10</td>
<td>64</td>
<td>5</td>
</tr>
<tr>
<td>You sharing your feelings about ending therapy with the counselor</td>
<td>4.84</td>
<td>32</td>
<td>4</td>
<td>3</td>
<td>75</td>
<td>1</td>
</tr>
<tr>
<td>Setting a date for the final session</td>
<td>4.60</td>
<td>25</td>
<td>10</td>
<td>7</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>You feeling like you and your counselor were relating more like equals than you had at earlier times</td>
<td>4.48</td>
<td>17</td>
<td>8</td>
<td>8</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>You stating things about your counseling that you liked and disliked</td>
<td>4.40</td>
<td>18</td>
<td>12</td>
<td>11</td>
<td>92</td>
<td>1</td>
</tr>
<tr>
<td>Counselor suggesting other types of help or other places to get help</td>
<td>4.26</td>
<td>19</td>
<td>11</td>
<td>7</td>
<td>60</td>
<td>4</td>
</tr>
<tr>
<td>Tapering off the frequency of sessions</td>
<td>3.83</td>
<td>16</td>
<td>10</td>
<td>7</td>
<td>70</td>
<td>3</td>
</tr>
<tr>
<td>Counselor talking more about him/herself</td>
<td>3.24</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>75</td>
<td>1</td>
</tr>
<tr>
<td>You asking counselor questions about how counseling works</td>
<td>3.15</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>88</td>
<td>1</td>
</tr>
<tr>
<td>You asking counselor personal questions about him/her</td>
<td>2.91</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>67</td>
<td>3</td>
</tr>
<tr>
<td>You giving a gift to the counselor</td>
<td>2.80</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>

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Appendix K
Therapist Prediction Errors on PE

Rate how your client experienced the process of ending therapy. 33 total discrepancy points

Overall, how important to your client was the process of ending therapy? 39

How important was this last session to your client? 48

How important was it for your client to discuss his/her reactions to ending counseling with you? 52

Did your client think ahead about this session more than about previous sessions? 55

Which of these has your client experienced while ending therapy?

25 anger
32 guilt
34 doubt about progress
34 sadness
37 sense of accomplishment
38 reexperiencing previous losses
39 reluctance to end
40 desire for more sessions
42 disappointment
46 ambivalence (mixed feelings)
47 relief
48 pride
49 increased energy/motivation for activities outside of therapy
49 our relationship became closer
50 anxiety
58 we began to relate more as equals

What behaviors did your client want or not want to occur during the process of ending therapy?

38 You inviting your client to return if s/he feels the need
41 Your client stating things about counseling that s/he liked and disliked
43 Your client sharing feelings about ending therapy with you
44 Summarizing the work
44 Your client asking you personal questions about yourself
44 Your client giving you a gift
47 Discussing your client's plans for the future
48 You talking more about yourself
48 Thanking you
48 You suggesting other types of help or other places to get help
49 Tapering off the frequency of sessions
49 Assessing how much goals have been attained
50 Your client asking questions about how counseling works
54 You and your client hugging or shaking hands
56 Your client feeling like you and s/he were relating more like equals than you had at earlier times
57 Your client expressing how s/he feels about you
57 Setting a date for the final session
62 You expressing how you feel about your client
68 You sharing your feelings about ending the work