

How do clients experience a preordained ending in medium-term psychotherapy? A phenomenological enquiry



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To my husband, sons and dear friends, who have suffered and encouraged me in this long journey whose ending often seemed anything but preordained.

ABSTRACT

This qualitative study explored eight client-participants' experience of a preordained ending in medium-term psychotherapy (average length 12 months) in charitable service settings. The aim was to investigate the experience of ending therapy, in particular when the ending was a 'given'. Interviews were conducted shortly after therapy had ended. Interpretative phenomenological analysis was used, and four domains emerged: Individual Experience, Acceptance, Resistance, and Managing the Ambivalence. Eight sub-themes clustered under these domains. **Individual experience** had one sub-theme: *'ending therapy is a highly individual experience'*. **Acceptance** had two sub-themes: *'a basic human acceptance of preordained endings'*, and *'the transformative impact of therapy endings - and the particular 'carpe diem' of preordained endings'*. **Resistance** had one sub-theme: *'fear of loss, and resistance to finality'*. **Managing the ambivalence** had four sub-themes: *'the painful loss of the relationship can be in part counterbalanced by internalising the therapist'*; *'ending therapy as a transition: looking back and looking forward'*; *'therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities'*; and *'the post-ending therapeutic function of the interview itself'*. Accordingly, against a backdrop of the experience of ending as highly individual, there was often a basic acceptance of the therapy limitation, and the preordained ending in itself had the potential to galvanise psychological change, though counterbalancing this was a resistance to 'finality', linked with fear of loss. Managing the ambivalence around these tendencies was the challenge participants faced. Participants typically experienced ending as a transition, with something of the 'before' being taken into the 'after'; this potentially included the internalising of the therapist. Participants often had a heightened awareness of both their potency and their vulnerability. Importantly, participants valued the research interview itself as an opportunity to process their feelings both in relation to ending, and to their therapy as a whole. The study recommends future research into the possibility of services offering clients a post-ending 'process' session with a third party therapist, as a potential means of deepening, consolidating and validating their experience of ending therapy.

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CHAPTER 1: INTRODUCTION

Endings are intrinsic to our lives. As Heidegger (1962) pointed out, we are the sole species aware of the future; conscious of the fact that everything will pass, until finally our life itself ends. The word 'end' also means 'aim'; which links with the Greek philosophers' emphasis on exploring how best to live our lives, in preparation for death: goals and ends are inextricably connected. How is this reflected in psychotherapy? *'In my end is my beginning'*, wrote T.S.Eliot (1978 [1922]) Might the 'end' of therapy somehow crystallise the purpose?

The pressure or impetus to 'end' therapy may come from different directions, depending on the therapy-setting: at the extremes the end may be chosen or negotiated as the open-ended process evolves, or it may be wholly imposed by external factors. Long-term therapy (and psychoanalysis in particular) tends to be associated with complex decision-making over endings and a protracted lead-up period. Sometimes of course there are forced endings – through one party moving away, becoming pregnant or ill, or dying; these events may have an element of unpredictability and in some cases trauma. In contrast, short-term therapy, usually by definition has a built-in limit, both in terms of time and aims.

My interest and focus is on what seems to be an under-explored middle ground: medium-term therapy (six to eighteen months), where the ending is preordained, by which I mean that there is no option for the client to continue therapy, in this setting, with this therapist, beyond a certain date. Anecdotally, this seems to be a more common context for therapy than the literature would suggest. A straw poll of my fellow students' early training placements revealed nearly half fell into one of the following categories:

- limited time offered by the service (with/without limited extension)
- therapists have limited stint in the placement
- clients naturally 'moving on' (e.g. academic institutions).

Moreover, many funded services historically offering more open-ended contracts are now (through funding cuts) having to impose limits; and EAPs and insurance schemes (a common route into therapy in the US) typically stipulate a maximum number of sessions, amounting to short or medium-term therapy. As O'Donohue and Cucciare, writing from an American point of view, say in their introduction to *'Terminating Therapy: A Clinician's Guide'* (2008), 'termination is not economically neutral... 'termination' typically stops a revenue stream coming from someone (typically a third party payer) to the therapist' (p.xix) – they stress the concern this raises in healthcare economics that therapists may have a financial incentive to over-treat (delay termination) and third parties to under-treat (terminate

prematurely). In the UK the 'third party' may be more likely to be a funded service trying to allot limited resources as best they can.

Although my own clinical work now is a combination of open-ended private practice and short-term (eight sessions) therapy in a GP Practice, I myself had my first placement in a 'medium-term, preordained ending' service: therapists worked for a year, and client sessions – whenever they had started within that year - thus ended at the point the therapist left. My three clients ending at the point I left had very different responses: in summary, two appeared to feel energised, and one more lost (interestingly this third client sought me out some years later, for private therapy). However, I describe these responses through the filter of my observations and limited discussions about ending therapy at the time. It left me wanting to explore in greater depth the lived-experience of such an ending from the point of view of the client: how does it feel to 'have' to end, after a substantial period of therapy, having built – I assumed, drawing from my own experience – a relationship of some standing with a therapist? And I was curious to know what effect an impending ending, not chosen but known about from the start, would have on the client's experience of the work in the lead-up to that end. Would there be a sense of the 'last lap', as in a race – where one observes that an extra surge of energy can be found? Would it be a catalyst for change, as may happen in literature, where there is a shift of tone or perspective? – 'Reader, I married him', begins the final chapter of *Jane Eyre* (Brontë, 2006 [1847]). And what about feelings of loss, anger or helplessness?

My preoccupation with endings is rooted in my particular life experiences: my father died when I was seven, my mother when I was 20. In each case, it was the end of an era, bringing dramatic life changes. More recently, in 2009, my younger sister died at the age of 48. My parents' deaths both came as shocks; there was little or no preparation. The big difference with my sister was that, because she had a terminal cancer diagnosis, there was a specific period of some weeks in which we knew our time with her was limited. This was an immensely intense time for all of us in her close circle: risks were taken; feelings verbalised; 'meanings' explored; journeys, both real and metaphorical, were made; those few weeks were full of both pain and love and were utterly vivid and unforgettable. And this was part of the prompt for my wanting to explore the experience of knowing, quite specifically, that an ending is approaching, as well as the experience of ending itself.

Because three of my birth family of five have died, I feel I have perhaps a greater than average awareness of and interest in mortality. I also, between writing my proposal and finishing the fieldwork of this piece of research, had my own diagnosis of breast cancer, the

word cancer (despite my to-date successful treatment) automatically bringing its connotations of the fragility of life. All in all, I do find myself drawn to existential writing on the subject of mortality. Frommer's (2005) article, 'Living in the Liminal Spaces of Mortality' is one of several quoting the poet Jorge Luis Borges – '*if I could live my life again, in the next I would try to make more mistakes*'; expressing the wish to live less safely, and not lose the 'now'; Borges is a man in touch with his transience. Why is it, Frommer asks, that we so often 'fully experience and value the now only when we become aware that we are about to lose it?' (p.480) He reports that his practice of reading the Obituaries each morning, makes him feel more alive and aware – of his coffee tasting good, of the dog's urine stain on the carpet, or whatever is around him; he offers this as an example of intellectual apprehension of one's transience transformed into 'felt experience'. He refers to the mind struggling with its own mortality, but says that this struggle can be psychologically liberating – that to emotionally grasp one's finiteness catalyses a powerful shift in subjectivity. Yalom (1980) also says that being with the transience of existence can enliven the capacity to savour life, order priorities, tolerate losses and limitations; Aron (2002) explicitly links relational theory and practice to this existential perspective in considering life and love meaningful only in the face of mortality and loss. And Davies (2009) similarly offers the view that love, analytic or other, always blossoms in the shadow of loss, be it a rupture, a wearing out or a death, and that paradoxical as it may seem, this perspective is a fundamentally optimistic one, as human beings must love in order fully to live. Jones (2013), in her beautiful paper "'Now we're out of time": Thoughts on Endings in Poetry and Psychoanalysis', emphasises how the finite-ness of both a poem and analysis (and clinical moments within an analysis) heighten the intensity of the experience, in a way that can have a transformative impact.

I had an assumption, when I embarked on my project, that death and endings were inextricably linked. I found this assumption deserved critical examination. For, in short, while there is something of a death in every ending, all endings other than death offer the experience of retrospect. I have aimed, in this study, to explore this further.

I have also found that the notion of what an ending actually is can become more elusive, even as one concentrates on it. Bulkeley, in her article 'The Enigma of Endings' (2009) writes, 'I discovered that trying to write about 'endings' was easier said than done' (p.303) and it was with some relief I empathised. In Bulkeley's case, she felt paralysed in the 'transitional writing space' of her journal; for me, it has been the transitional space of the British Library, endlessly reading and noting. And it has sometimes felt as if the more I focused on the concept of an ending the more enigmatic it became. Is it a moment of goodbye, or a change of state, or both? I have found references to it as 'margin', 'threshold',

and ‘membrane’; sometimes it can seem simply like a dimensionless division between ‘before’ and ‘after’, but because human beings have the capacity to both imagine and remember, there is a bleeding even across this. Yet in both Bulkeley’s case and my own there is the hope of exploring the purpose and creative potential of what can feel like this difficult-to-grasp entity.

I chose to use interpretative phenomenological analysis as the aim of my study was to give voice to the client; to take the reader deeply into clients’ individual experiences. I anticipated drawing conclusions with not so much generalisability as transferability properties. Thus, notwithstanding this piece of research is qualitative, phenomenological, and idiographic, I hope other studies may build on, confirm and extend its emerging themes and insights, enriching the bigger body of work on endings as a whole.

While this is a small study, I expect it to have wide relevance. All who work in the psychological therapies (as well as practitioners in related health and social fields) have to think about endings, how best to initiate, shape, contribute to or make the most of them; how they relate to the body of work that comes before – and how they impact what comes next. And all who work in these fields also have to consider resources, which are necessarily finite, and it seems increasingly under pressure. Setting limits on psychotherapy, as delivered outside the private practice arena, is very much part of the mental health landscape these days, and my hope is that my work will help shed some light on the effect of such limits, albeit in a particular context.

Although there is a vast body of literature on endings, a huge proportion of it is written from the practitioner’s point of view, and broadly theoretical, albeit drawing on clinical case studies. The psychoanalytic viewpoint dominates heavily, although there is also a substantial quantity of literature on time-limited therapy, where the ending is built-in from the start. Within the much smaller body of empirical literature we will see that few of the research studies have been truly qualitative, let alone phenomenological, nor have many explored client reactions - from the clients’ point of view (as opposed to therapists’ observations of clients) - in depth. Modalities other than psychoanalytic have, in either the theoretical or empirical literature, been under-represented (my own stance is integrative). The issue, important in my study, of whether the therapy ending was negotiated or imposed has had sporadic attention. There are a few studies on ‘forced’ endings, but this word in itself needs investigating, as in my view it takes on a different hue in the context of a ‘preordained’ ending, even though in both cases the client has no choice but to end. It is my observation – from the media, my peers, and my own experience in private practice and working for the

NHS - that therapy is becoming more widespread, dipped into by a greater number of people and perhaps by each person a greater number of times. Not everyone has the means for private therapy, but external resources are inevitably limited, so 'preordained endings' may well be an increasing part of the therapy picture.

CHAPTER 2: CRITICAL LITERATURE REVIEW

Overview

Despite many authors (for example Gelso and Woodhouse, 2002, Davis, 2008) observing that there has been little written about psychotherapy/analysis termination, I found a wealth of literature on the subject. With a few key exceptions, concentrating on unexpected/forced terminations (Limentani, 1982, Glick, 1987, Penn, 1990), including analysts moving their practices (Dewald, 1965, Martinez, 1989), the endings the psychoanalytic literature has focused on are typically negotiated/chosen/decided upon; not imposed on the client. Older, broadly pre-1990s, viewpoints have generally followed the model of termination as a major challenge, sometimes tortuous, theoretically only possible when the complete 'working through' of the negative transference has taken place, and as overall essentially representing 'loss', with grief and mourning a major part of the picture. More recently, there has been a shift towards a more relational perspective, testing some of the aspects of the traditional position; and the realities and practicalities of psychotherapy (as opposed to classical analysis) have made their mark. Ideas have been introduced of 'good enough' terminations, termination involving the end of a personal as well as transference relationship, termination as highly idiosyncratic, termination being less 'absolute', and indeed much questioning of the appropriateness of the word 'termination' itself.

In parallel, and with a more consistently upbeat tone, there is a body of literature on brief-term therapy, where the ending is quite specifically 'built-in' from the start. Key early figures include Malan (1963), influenced by Balint, who used brief, narrow-focal-area psychoanalytic psychotherapy, and Mann (1973), with his 12-session model, though the bulk of the literature has been more recent. The brief-term therapists tend towards the more optimistic view that the limitation of time is a positive tool, and can be an intrinsic part of the curative strategy.

Mander (2000a, 2000b) is one of the relative few who upholds the value of both long-term and brief-term psychodynamic work, referring to the former as 'the rich tapestry of long-term psychotherapy...which reveals its full significance only over time' (2000b, p.315), while writing of the latter, 'the promise of richness and intensity is...rooted in the ancient wisdom of 'carpe diem'' (p.309). As a therapist myself offering both long-term therapy in my private practice and short-term counselling in an NHS context, I can relate to the value of both time-scales.

Early perspectives on endings in psychoanalysis

Many authors start by referencing Freud's dark essay 'Analysis Terminable and Interminable' (1937). However, several, including Schlesinger (2014), also observe that Freud's original words 'endliche' and 'unendliche' have connotations different from and richer than terminable and interminable. Schlesinger refers to Leupold-Löwenthal (1988) who suggests finite/infinite might be substituted, where there is none of the implicit weariness and despair of 'interminable', and the concept of 'infinite' potentially embraces continuation of analysis via self analysis; the idea of the work continuing 'after the ending' is a recurring theme in this thesis. Freud's essay is written on the premise that an analysis could and ideally would be 'completed', this constituting 'the freeing of someone from his neurotic symptoms, inhibitions and abnormalities of character' (p.216). Simultaneously Freud expresses scepticism in relation to endings; his belief that analyzability is potentially always limited by various factors including the death instinct and what befalls the individual later in life (the analysis not necessarily proving a prophylactic). Interestingly, in the same essay - Mander (2000b) points out - Freud describes a case of himself 'imposing' an ending, where he 'resorted to the heroic measure of fixing a time-limit for the analysis', 'a blackmailing device about the value of which there could be only one verdict – it is effective, provided one hits the right time for it' (1937, p.218). Later in his life Freud seemed to question the idea of a 'completed analysis', and I conclude that he seems to have wrestled with both the concept and practicalities of ending. Similarly, Ferenczi (1955 [1927]), often quoted as having published the first article devoted to the process of termination, refers to 'the proper ending of an analysis' being 'when neither the physician nor the patient put an end to it, but when it dies of exhaustion', while further adding, 'the truly cured patient frees himself...slowly but surely' (p.85). His words need to be seen in the context of his own unsatisfactory ending(s) with Freud, as revealed in his diaries published later (1988 [1932]). Neither Freud nor Ferenczi were in a position to acknowledge a context where an ending might be imposed by an external party.

Termination as loss

The model of termination-as-loss pervades much of the psychoanalytic literature. Reich, in her seminal 1950 paper, refers to a flare-up of symptoms when the idea of ending is talked about, reflecting the re-emergence of earlier trauma and unresolved grief. Winnicott (1971a) emphasises the immense dismay at the loss of omnipotence that separation always implies. Shane and Shane (1984) talk about termination as 'an opportunity for experiences with the many meanings of separation and mourning' (p.739). Mander (2000a) says that in ending therapy 'it is inevitable that previous experiences of ending and loss are remembered and emotionally reactivated, which is a chance to compare and contrast situations in terms of

unfinished business, painful memories, regret, remorse and relief' (p.105). Charman and Graham (2004) write, 'the experience of patients (and indeed therapists) during the termination phase is frequently shaped by a past history of painful endings in which the course of events could neither be influenced nor understood' (p.276). Wittenberg (1999) characterises the anxieties around ending as pertaining to infantile, child, adolescent and adult levels of psychic life: on the infantile level this is about being abandoned, starving, left to die, and disintegrating; on the child level it is in addition about feeling lost, unable to cope on one's own, and thrown back into a terrifying state of helplessness; on an adolescent level it includes anxiety around taking on adult responsibilities, and on the adult level ending makes us aware of the passing of time, and being a step nearer to death. Others, such as Coltart (1996) liken therapy ending itself to a death: 'it's not an exaggeration to say...some patients experience the agreement to end as a death sentence' (p.150).

Bergmann, in his much-referenced essay, 'Termination: The Achilles Heel of Psychoanalytic Technique' (1997) stresses the loss of the relationship inherent in ending, saying 'genuine wishes for independence are difficult to foster' (p.163). He continues, 'for many analysands, transference love is the best love relationship that life has offered' (note David Mann's view, which I support, that 'all the features of transference love are features of normal love' (1997,p.8)). In emphasising the unprecedented demands of a psychoanalytic end, Bergmann writes: 'in real life, only death and hostility bring a libidinal relationship to an end' (p.163). Murdin (2000) also talks of the end of therapy being 'contrary to the natural order of any other sort of relationship' (p.25). To some extent I dispute this view. Life offers many examples of libidinal relationships frustrated by 'reality' or circumstances kicking in and tough choices having to be made (affairs where, on being discovered, the spouse gives up the lover, say), and fiction offers many too, (for example, *Brief Encounter* (Lean, 1945)); it is simply not always possible for those who love each other to 'be together'; prior commitments, family loyalty, children, social class, geographical separation, illness or disability may all play parts. I have stressed this point because my research is concentrating on imposed endings.

Grand (2009) illuminates the paradox of termination as repeating the schizoid problem: that is, fear of closeness is confirmed by the knowledge that closeness will inevitably lead to loneliness and loss. 'Analytic loss implicates grief', she says, and 'where else do we embark on closeness knowing that closeness **guarantees** [Grand's emphasis] loss...that grief is an inevitable feature of success?' (p.726). She writes of her patient David, whose 'infant self suffers from the schizoid problem described by Winnicott and Guntrip. He is endangered by contact and he is endangered by the absence of contact' (p.724). Grand reports that she and

David have not ended: 'we seem to be inventing serial termination' (p.725). She is by no means the only psychoanalyst to admit to finding the business of ending problematic.

Analysts' own struggle with termination

Several have taken a reflexive angle on why it might be that psychoanalysts in general have struggled so with termination. Novick (1997) writes about the resistances of analysts, referring to termination as a 'blind spot', and of analysts' 'profound inability to conceive of termination in a way that would lead to scientific and clinical growth' (p.147). He draws attention to the fact that analysts typically do not experience a huge number of terminations, as well as the idea of analysts potentially passing on the unsatisfactory terminations they themselves experienced. Salberg (2009) gives some honest reflections on how the prolonged and messy ending of her own 15-year analysis probably affects her patient terminations. Bergmann (1997) too talks about the danger of a kind of 'Sorcerer's Apprentice' syndrome, whereby having cast the spell, the analyst is then unable to bring the magic he has evoked to an end. Kramer (1990) acknowledges that the model (of analysis) 'in its purest form encourages a perpetual process' (p.26), while Zinkin (1994) suggests -'in order to consider the question of ending analysis, one has to stop being an analyst' (p.18). Schlesinger (2014) writes, 'I have never known a conscientious psychotherapist who did not have trouble with endings', putting it down to separations being 'the most difficult of human experiences' (p.13).

The experience of time in psychotherapy

I suggest that one reason behind the difficulties with ending may be to do with how time is actually experienced in therapy. As therapists we are aware of the 'timelessness' of the unconscious, and that to some extent there is a suspension of the 'everyday' experience of time during a therapy session. In the therapy room, time is explored both backwards (childhood, family legacies, previous sessions) and 'forward', in the sense of hopes, aims and fantasies, as well as in the here and now. Kantrowitz (2015) says, 'analysis is intended to be time-limited, but in a certain way, once begun, time is suspended as the past comes to life and the analysand experiences a younger self' (p.15), while Bass (2009) writes that 'the sense of limits and the sense of timelessness alternate, moving in and out of focus, throughout psychoanalytic work, and are fundamental to the analytic experience' (p.752).

Skolnick (2010) refers to termination having to reckon with two senses of time. He references Bollas (1989) who distinguishes somatic time and object time. Somatic time is rooted in timelessness, provided by the subject mother who by accommodating to the infant's cycle of needs protects the child from the ultimate demands of time. As she

gradually fails the infant's omnipotent desires and becomes an object, so too does she teach the child object time – whereby the child gradually construes a realistic sense of time during the gap between the mother's absence and presence (see also Molnos, 1995).

From this it would seem that potentially different experiences of time being present in therapy may well contribute to some of the struggles and resistances there have been around both implementing and studying its ending. Having said this, the brief-term therapists tend to have a more positive slant on time, while still acknowledging the different kinds of time experienced. James Mann (1973, 1982), a robust proponent of time-limited therapy, argues that not only is the consciousness of time a major influence upon all forms of psychological distress but it also provides the pivotal issue upon which effective therapeutic engagement is dependent. Molnos (1995), writing about brief dynamic psychotherapy, describes the difference between conceiving time as a one-directional, irreversible 'arrow' (a more frightening concept) and the concept of time as a cycle (fundamental states are immanent in time...apparent motions are part of repeating cycles). In Molnos's model, time pressure and the patient's anxiety are used to motivate the patient to work intensively with the therapist.

The developmental perspective on termination

There is a clear sense in the literature of a counter-movement to the 'termination as loss' model, both in the sense of termination as being about more than loss (every ending is also a beginning), and in the sense of loss itself leading to, or creating, gain. This is a position that attracts me, both as a way of framing my own personal losses, and from a wider standpoint of believing in 'mixes' rather than absolutes (I chose an integrative training!).

The Kleinian view is that loss is a developmental step; that mourning is the crucial experience to be tolerated (Klein, 1950). Waddell (2002), a Kleinian child/adolescent specialist writes: 'at the heart of the Oedipal constellation lies the capacity to allow for growth through relinquishment; the sense of separateness, so intrinsic to an adult state of mind, premised on the experience of fear and loss being bearable – painful but not catastrophic' (p.203). Similarly, Charman and Graham (2004), referencing Quintana (1993), put forward the notion of termination as more of a 'weaning process'; a loss, but also an opportunity for development and transformation. In Willock and Curtis's collection of analysts' perspectives on endings (2007), death as a catalyst for new growth is a recurrent theme, reflected in the book's 'phoenix from the ashes' cover picture.

Hoffman (1998) also emphasises the developmental potential inherent in an ending – and perhaps controversially goes further in stressing the **need** for ending, in order for development to take place. He says: ‘to bring analysis to an end can mean owning one’s own experience more completely and taking a greater responsibility for its construction...for many people that developmental achievement cannot be a pre-requisite for termination because termination itself is necessary for it to occur’ (p.259). Jones (2013) makes a similar point, writing, ‘in analysis, termination brings both an absolute loss, disappointment, disillusionment and the opportunity for reparation, expansiveness, for growth, and a recognition that might not occur unless the ending is actual’ (p.613).

In line with Hoffman and Jones, but taking a slightly different angle, Bulkeley (2009), in her article ‘The Enigma of Endings’, first refers to the resistances around saying goodbye or ridding oneself of possessions, with thoughts of creative potential being on a far-off horizon. However, she goes on to draw attention to ‘loss being the shadow side of growth’, and how, often through ‘hard work’, mourning enables us to ‘let go’ little by little, and moreover ‘seems to be the catalyst that affects the transformation’ (p.304). Bulkeley suggests the darkness of mourning is a necessary medium for change and ‘becoming’ – we all evolve from the darkness of the womb (we have to embrace loss in order to be born), and indeed ‘nature continually reminds us of the recurring loss-preceding-growth cycle’ (p.304).

Internalising the therapist, and the capacity to self-reflect

Linked to the idea inherent in mourning, that any significant loss is resolved by internalising the lost love object (Loewald, 1988), another key theme in the literature on endings is the internalising of the analyst/therapist as an aspect of termination (Zinkin, 1994, Tessman, 2003). Also relevant here is Bion’s idea (1962) of the absent breast being a stimulus to ‘thought’: no breast – therefore imagine a breast. As Charman and Graham (2004) point out, the ‘termination as loss’ stance can overlook the processes of consolidation and internalisation which keep the therapy alive in the patient.

Another version of this internalising process leans more towards the capacity to self-reflect or indeed self-analyse – see, for example, Siegel (1982), Shane and Shane (1984), and Bergmann (1997) who specifically believes that successful termination rests on the analysand’s ability to replace the analyst with an internal capacity for self-analysis. But to what degree this internalising of the analyst is a (preferred) pre-requisite or a result of ending is an interesting question (perhaps parallel to the developmental one, see Hoffman above).

Relevant to the idea of 'internal' analysis continuing after the analysis has ended, Jung certainly regarded individuation as an ongoing, indeed never-ending process, which may be why he appears to be quite silent on the question of termination – as Zinkin (1994) points out. Wittenberg (1999) questions the use of the word 'termination', with its implication of finality and irrevocability, emphasising that analysts cherish the hope that analytic work has been established and kept alive internally and that the mind of the patient has been affected in a way that will promote ongoing growth. Reis (2006) also argues that much of the most important work of an analysis is done after termination occurs – using the German '*Nachträglichkeit*', roughly translated as deferred action.

Kupers (1988) writes, perhaps more provocatively, about the members of the 'therapeutic community' (therapy-wise consumers) sharing 'that internalised therapist, much as a clan shares a totem'; and summarises this shared 'world view' as 'always to give the inner life a place of priority in one's conscious ruminations' (p.139).

Acknowledging the end of the relationship itself

Notwithstanding the above, and in line with the more relational and intersubjective orientation that has generally entered into psychoanalysis and psychotherapy in recent decades, there has also been a greater acknowledgement of the more here-and-now 'relational' aspect of therapy endings. Early views concerned themselves almost exclusively with the transference relationship, but more recently there has been increasing recognition of the 'real' or personal relationship as part of the picture too. I have to say here that in my view there is considerable and hard-to-disentangle overlap between the transference and the 'real', but nevertheless, the idea of the personal relationship coming to the fore as therapy ends deserves some focus. Curtis (2002) is one of several to mention an 'equalising' process between client and therapist. Frank (2006) says that missing from the classical approach is the appreciation of the personal relationship ending, while Davies (2009) writes: 'a formulaic answer about the resolution of the transference and a natural movement towards termination may have worked when we understood that transference and that analytic relationship to be based on something old, something distorted and something displaced. It didn't really have to do with the two people involved at all' (p.734).

Mander (2000b) observes a fundamental difference between the endings in brief and longer-term therapy - that it is 'simply much easier to separate from someone after 12 meetings than after a relationship of years' (p.309).

Skolnick (2010) examines termination from a relational model, and believes this model applied to the end of an analysis captures more of the fluidity and texture than the traditional models. He underlines the intersubjectivity within ending when he points out that traditionally the focus has concentrated on the patient's loss of the analyst, but by relational definition it includes the struggles of both parties. He quotes Bass (2001, p.683): 'the trajectory of both lives will not be quite the same for the encounter'.

Moving away from the 'gold-standard' ending

As a broad generalisation, over time the literature reflects a move towards taking a more open and fluid attitude towards endings. Early works often stressed 'conclusions' about termination, or indications of 'readiness' for ending, typically listing required achievements or states. Thus there was an implied notional 'ideal'. Firestein's (1978) seminal study ends up with 13 questions about termination pretty neatly and definitively 'answered' (although later, in 1982, he noted the 'extreme variation' in endings). Hoffer's (1950) criteria for ending include 'an increase in the degree of awareness of unconscious processes' and 'a reduction in repetition-compulsion', while one of Rickman's seven criteria (1950), 'heterosexual genital satisfaction', is very jarring to the contemporary ear. Kramer (1986) writes of 'cues' to ending therapy, including the patient relating more to the therapist as an equal, seeming to have internalised the therapist, and having generally less to talk about. Mander (2000b) says that 'spotting the moment' when it is possible for both participants to let go and say goodbye is 'surely one of the most important therapeutic skills' (p.305). Wittenberg (1999) has talked about the last session 'ideally' coming about as 'part of a natural ending', 'a planned response to the patient's decreased need for therapy' (p 342). These criteria and ideals seem to me to need the qualification of 'assuming there is no fixed ending'; however, they do perhaps have some relevance to **all** endings, in suggesting or predicting what might make an ending, chosen or imposed, satisfactory – although this word itself begs more investigation.

But in any case, more prevalent now is a more 'open' view of endings: of endings never being perfect, but perhaps being 'good enough' (Murdin, 2000), along with a recognition of no 'one size fits all'. Kramer (1990) argues against the 'perfectionist, lofty goals' of the past, while Mitchell suggested in 1993 that terms like 'completed analysis' were outdated, also positing that the weight of what an 'idealised' imaginary completed analysis might look like can negatively impact both patient and analyst as they work towards an ending that best reflects their own goals. Watchel (2002) echoes this when he calls for a genuine respecting of the patient's point of view in termination and that the end should be a time for pride as well

as humility, rather than 'guilt-tripping' patients about what has been left undone or unaddressed.

Gabbard (2009) writes that he was struck by how his clinical experience with terminations was dramatically at odds with what he had been 'taught to expect'. He proposes that idealised versions of termination in the past need to make room for 'good enough' terminations and refers to his 'growing awareness that the ending of an analysis is a highly idiosyncratic clinical phenomenon' (p.577). In Kantrowitz's book, Gabbard (2015) points out that there is a host of papers on the theory and technique of how the end of analysis is 'supposed' to occur, but goes on to say, 'what is immediately apparent is that analysis terminates in so many different ways that there is considerable irony that a 'standard' approach to termination permeates the literature on the subject' (p.xiv). Kantrowitz herself starts from the perspective of 'myths' that have created expectations about how analyses should end, setting unrealistic goals and encouraging fantasies of completion that can 'adversely affect attunement to the individual analysand' (p.1).

In practice, and pertinent to my research question, the luxury of being able to 'consider' when to stop therapy is not always there. Watchel (2002), in comparing three therapy modalities' approaches to ending - psychoanalytic, experiential and cognitive-behavioural, starts off by pointing out that clinical considerations for termination are rarely the only ones; he stresses, for example, the 'bottom line' aspect of medical insurance cover, but, like Kupers (1988) also notes that therapy is not necessarily a once-and-for-all event. Kupers in fact talks of therapy being typically consumed periodically, 'in pieces' (p.117). Cummings (2008) champions his model of 'focused, intermittent psychotherapy throughout the life cycle' whereby 'interruption replaces termination' (p.99). In any case, any brief therapy tends to hold the possibility of leading to longer-term work, or being returned to for further stints (Mander, 2000b). I address brief therapy more specifically below.

A more positive view of endings

As part of the upswing against the 'termination as loss' model, increasingly there are references in the literature to endings as including positives as well as negatives, some authors (such as Molnos, 1995) suggesting the 'blend' of these itself having a potentially therapeutic effect, if the ambivalence can be borne.

Research by Fortune et al (1992) found positive reactions at the end of therapy (pride, independence, accomplishment) were stronger than negative reactions (which they found weak or absent). Charman and Graham (2004) draw attention to the mix of feelings likely to

be present: pleasure and pride in work done, and developments achieved, alternating with doubt and anxiety about future challenges; and gratitude balanced against profound sadness over leaving a valued relationship.

In general, therapists working within brief-therapy or time-limited models focus more on the positive features of endings. For example Gelso and Woodhouse (2002), like Fortune et al above, say positive experiences in brief therapy tend to outweigh negative, and that these positive feelings include feeling 'healthy', 'proud' and 'calm'. Quintana (1993) in response to the move towards short-term therapy at the time, recommended the 'termination as loss' metaphor be updated to 'termination as transformation' (p.426).

Time-limited therapy

As well as often taking a more positive slant on ending, a crucial aspect of time-limited therapy is often the actual use of the time limit (the impending ending) in the work, and a recognition of the energy that having this 'end' in sight can prompt. Dewald (1965) noted, writing about forced terminations, 'in some patients the announcement of termination played a major dynamic role in the treatment relationship' (p.118). On a more microcosmic level, Wiggins (1983) has talked about the power of the final minutes of a session.

James Mann (1973,1982), a key early figure, describes his 12-session model, in which 'the time limit directly influences the progress and process of the treatment because...of its enduring role in giving meaning to the past, present and future affective life of each person' (1982, p.2). He continues, 'any kind of psychological treatment is part of the experience of time insofar as the patient works towards facing up to his past so that he can gain some mastery over the present and be freer for shaping his future' (p.4). Mann claims his treatment structure 'mobilises all of the patient's contradictory feelings about time' – that 12 weeks both has a brevity about it, but also 'feels' like a long time; and that his plan 'arouses an optimistic sense of urgency', though is also 'tempered by a sense of pessimism and pre-determined disappointment' (p.10), echoing the persistent theme of contrasts and polarities inherent in endings. I would agree – drawing from my NHS eight-week work – that such a time period can both seem like a long time and a little, but would argue pessimism and pre-determined disappointment are by no means inevitably part of the picture. Pertinent to Mann's model is 'Parkinson's Law of Psychotherapy' (Applebaum,1975) whereby patients shrink the time necessary to perform a task or expand it when more time is available. While this may have a slightly trite ring, it may relate to the idea of narrowing the focus of the work when time is limited (see Malan, 1963, – and many others since).

Elton Wilson (1996) writes of 'the arousal of strong emotions emanating from previous relationship patterns' that a clearly fixed ending date is likely to accelerate, her use of the word 'arousal' reflecting the energy that brief-term therapy with its highly visible ending, has the potential to stir. Murdin (2000), too, implies an increase in libidinal tension as the ending approaches when she talks about it 'allowing the climax and discovering whether it is equivalent to a loss of one's own good things to the other, or whether there is a renewable source that the individual keeps and develops after the end.'(p.38)

A number of authors in addition to those mentioned above also support the idea that the prospect of termination itself deepens/accelerates/intensifies the work. Rank (1945,1952) felt that the clash of wills inherent in setting a time limit contained huge therapeutic potential. (As an aside, although he is stressing the positives of predetermined ending, Rank with his 'clash of wills' seems to be echoing Mann (above) and others in his belief that clients will inevitably show strong resistance to the idea of a time limit; a notion that seems to me to have roots in therapist arrogance and the erroneous assumption clients will always 'want more therapy', if at all possible. This research will test this belief, particularly prevalent in the older psychoanalytic literature). Taft (1962), writing in a social work context and seemingly influenced by Rank also stressed the value of limited time. She writes that child counselling at the time was typically 'open-ended' and a potential 'blind alley' for children to endlessly play out the transference with their case worker. She argues for the use of limited time, saying 'time represents more vividly than any other category the necessity of accepting limitation as well as the inability to do so, and symbolises therefore the whole problem of living' (p.12). Her view is that as living beings we are geared up to movement and growth...achieving something new, the next stage; hence we do not like a goal that can never be reached nor yet a goal that is final, beyond which we cannot go. We have the double fear of the static and the endlessly moving. Perhaps reflecting this latter fear, Mander (2000b) suggests there may be an element of relief about built-in ending – possibly from the practitioner's point of view too, in that it is safe to say a time-limited therapist 'will not have to suffer the protracted indecisiveness of their long term colleagues in relation to setting an ending' (p.303).

Reviewing the various points made above, it could be hypothesised that the separation inherent in ending has both rewarding and painful elements, and thus places on the client the demand to tolerate emotional ambivalence. Molnos (1995), in her book about brief dynamic psychotherapy, writes, 'the healing emotional experience consists in discovering each of us and our relationships become stronger once we stop splitting the positive from the negative...for the sake of psychic health, opposite feelings have to be kept together in

struggle and in harmony.’ (p.66). I would argue that this is potentially true of any endings, not just brief-term ones.

Theoretical versus empirical perspective

Much of the literature, particularly the psychoanalytic literature, is written from a theoretical standpoint, albeit based on clinical impressions and sometimes using specific clinical vignettes (for example, Curtis, 2002, Grand, 2009, Salberg, 2009). Some of the literature seems to lie somewhere between theory and case study, notably when analysts write about moving their practices (Dewald, 1965, Weiss, 1972, Beatrice, 1983 and Martinez, 1989); even Firestein’s study (1978), presented as more formal case study research, has the flavour of a personal ‘story’. Gelso and Woodhouse (2002, p.345) stress the paucity of empirical research on termination (almost ‘non-existent’ before the 1980s), hypothesising that the ‘likely culprit’ is ‘the great complexity of termination’, as well as the subject itself being ‘emotionally conflictual’ for the researcher (and therefore, they imply, challenging to investigate). Gelso and Woodhouse do, however, note a ‘gradual accretion’ of a small body of research, which they selectively review. Key empirical studies cited by Gelso and Woodhouse include: Marx and Gelso (1987) and Quintana and Holahan (1992); both these were quantitative studies about what typically transpired during termination phase of relatively brief therapy (average 10 sessions in former, median 12 in latter), both conducted at university counselling centres, the former measuring the clients’ point of view and the latter the therapists’ observations on their clients. The categories (used in both the studies above) of ‘termination components’ which participants were invited to record the occurrence of, can seem to lack subtlety, for example: ‘assessed extent to which goals were attained’ (ticked by 72% of clients; 91% of counsellors); ‘counsellor and client related like equals’ (ticked by 49% of clients, 33% of counsellors) etc. There is the slight sense that the move away from the theoretical and psychoanalytic viewpoint of termination as a ‘difficult and perilous period darkened by inevitable loss and mourning’ (Fortune et al, 1992, p.171), where endings are somewhat tortuous and elusive, has sometimes resulted in an almost too light and superficial summary of the process. In my study I am aiming for depth and insight, without the heaviness of assumed morbidity.

Therapists’ or clients’ point of view?

As we have seen, much of the theoretical literature in relation to endings inevitably puts the therapist’s point of view – either implicitly or explicitly. Kramer (1990), a respecter of Rogers’ client-centred perspective, observes that ‘satisfactory terminations’ have traditionally been assessed more by therapists than by patients. Moreover, there is a growing body of theoretical work focusing specifically on the effect on therapists of endings with

clients/patients (Weddington and Cavenar,1979, Goodyear,1981, Voirst,1982, Murdin , 2000). Empirically too, more studies seem to have been done with, or via, therapists than with clients themselves (for example, Gould,1978, Martinez,1986, Boyer and Hoffman,1993). Firestein's (1978) original study of eight client endings was based mainly on interviews with the analysts and supervisors, while research by Fortune (1987, 1992) explored reactions of both social workers and clients (at termination), but only from the social workers' point of view. Walsh (2003) lists, in detail, both positive and negative reactions of clients in relation to endings across service settings, noting (interestingly) that 'clients' reactions do not have to be positive to be beneficial' (p.153); but again these client reactions are observed from the point of view of the practitioner. More recent small case studies include Valdivia (2010) who writes of battling through to a 'good enough' ending with a traumatised nine-year-old boy, reflecting that she could have introduced the 'fixed' end date more sensitively, but concluding that the impending ending did play a pivotal role in developing her capacity to understand what the child had experienced in the past. Again, and understandably, this study rested on the therapist's observations of the client's reactions.

But – in line with Bion's view that patients may be our best teachers - what of the views of clients themselves about termination, fixed or otherwise? There is a small body of work here - to which I shall be adding mine. Again, much of this is psychoanalytically biased, with patients often being trainee analysts; there is also a quantitative bias, and typically a substantial gap between the ending and the researching of it. Craige (2002), for example, researched 121 analytic candidate clients in the 'post termination' phase (median of two years post ending), predominantly using questionnaires, although 20 participants were interviewed in more depth. Roe et al (2006) investigated the feelings about terminating of 84 clients in psychodynamically-oriented private practice psychotherapy (mean of just over two years in therapy). The research was conducted an average of nearly 18 months post terminating, with clients having had a say in when the ending took place, and indeed with this very choice emerging as a feature of satisfaction. Again this research was not primarily qualitative: Roe et al developed a 'Feelings toward Terminating Therapy Scale', whereby clients were asked which of a list of emotions they felt; they found that positive feelings (e.g. pride, satisfaction) tended to outweigh negative (e.g. fear, embarrassment). Open-ended responses highlighted loss of the meaningful relationship with the therapist as the 'factor contributing most often to negative feelings', perhaps endorsing the relational aspect of ending as being the core loss. But it is the tick-box aspect of this kind of study (albeit with some open-ended response provision) that has contributed to my desire to do something more deeply qualitative and phenomenological.

Kantrowitz (2015) reports in depth on a study of 82 former analysands, based on telephone interviews of one or two hours with each. Again, the majority of the endings were over (some well over) five years prior to the interview, so I would argue that this is capturing a more considered 'looking back' than the immediate experience of actually ending (the focus of my study). The size of Kantrowitz's sample also necessarily lends a quantitative slant to some of the findings. The mix of reasons for ending included: illness, death, moves, and feeling confident enough for self-analytic work, but in no case had the ending been preordained as in my study. Kantrowitz found confirmation of her hypothesis that endings had specificity rather than uniformity and her book explores this variety, with some of her analysands describing experiences of great emotional depth and profound connection, and others highlighting feelings of disappointment and betrayal. Overall Kantrowitz challenges the assumption that analyses inevitably end with grief.

Particularly pertinent to my study of medium-term therapy endings, Etherington and Bridges (2011), with a humanistic person-centred orientation, conducted a narrative case study on 'endings and six-session reviews', focusing on the experience of six clients in a service offering counselling to people with a history of abuse. Participants were asked to tell the stories of the whole of their counselling, but the paper concentrates on the endings. Like Roe (2006), Etherington and Bridges note the scarcity of research on endings from the client's perspective. In their discussion they underline the ambivalence clients feel about endings, and how this is worked with in the therapy. Etherington and Bridges stress the importance of clients 'having a say' in when they are to end (note that these clients all had a history of abuse), which of course raises a contrast with my study, where the participants experience a preordained ending. However, the authors report – somewhat frustratedly – that, since conducting the study, funding cuts have meant the service is now offering a maximum of 18 sessions, significantly reducing client choice in the matter of ending; this supports my anecdotal impression that preordained endings are increasingly the norm in funded agencies.

Forced endings

A few pieces of research look specifically at 'forced' endings, described by Gelso and Woodhouse (2002) as being 'when factors outside the therapy influence termination, such as the therapist's move to a new training setting' (p.360) which by this definition would seem to encompass preordained endings, although the word 'forced' has a more brutal ring. A number of these studies are in the context of psychotherapy/psychology trainees, whose clients have to end (or at least be referred on) when their therapist's training internship finishes. There is a predominantly negative leaning to these findings, for example the

(superficially unsurprising) idea is put forward that forced terminations tend to be harder for the client than natural terminations (Saad,1983, Goldthwaite,1985, Fortune et al,1992), with, for example, Saad finding that clients may experience increased levels of anger, mourning and mood disturbance. Zuckerman and Mitchell (2004) draw attention to ‘premature dropping out’ as a potential result of the forced termination process (21% in their sample). Schlesinger (2014) refers to the training clinic situation where a forced ending may first be heard about on the grapevine but in any case ‘generally comes as a shock to patients’ (p.25), with common initial reactions including flight, withdrawal, denial, resignation and apathy.

However, buried in the more negative findings around ‘forced’ endings are some positive snippets, for example Gould (1978) found that clients whose therapists informed them they would be leaving at the end of the school year appeared to be ‘relieved’ to know there would be a time limit, and did not appear to have difficulty in investing in the therapeutic work. Gould’s work was done in the context (strange now, in our age of greater transparency) of some supervisors believing that clients should not be informed early-on about the imposed ending, since awareness of a time limit might lead to failure to engage with the therapy. Zuckerman and Mitchell (2004) note that most clients in their study were in fact transferred on to another therapist, while from the more open-ended responses it emerged that 21% of their sample of 52 interns felt the forced termination served to create a stronger sense of urgency and motivation to address therapeutic goals. Again, we lack the clients’ own perspective here.

Empirical work – summary observations

In general the empirical studies emphasise the mix of loss and gain in endings, with an overall more sanguine tone than is present in much of the psychoanalytic literature, perhaps partly in line with much of the research having centred on shorter-term therapy. One key issue brought out is the time given to the ending process itself: Marx and Gelso (1987) and Quintana and Holahan (1992) both indicate the value of time being devoted to termination; the latter study quotes 69% of clients rating discussing – in their therapy - their own reactions to terminating ‘important’ or ‘very important’. Gelso and Woodhouse (2002) encapsulate what actually transpires during this time as: the work being summarised, including to what extent goals have been accomplished; the client sharing with the therapist their likes and (to a lesser extent) dislikes about the counselling; and plans for the client’s future being discussed, including the conflicts and problems that remain unresolved. Gelso and Woodhouse report ‘the counsellor typically invites the client to return if and when the client feels the need’ (p.348) – which raises another key issue, that of the ‘open door’, and/or

onward referral. Given that none of my participants was going immediately into further therapy, this will be returned to – in the context of my study - in the Discussion chapter. Finally, Gelso and Woodhouse echo Gabbard (2009) and Kantrowitz (2015) when they stress the fallacy of the idea that the ending process is the same for everyone.

My stance

I went through a gamut of emotions in reading the background literature to my research, including feeling overwhelmed at times, and thinking my reading would ‘never end’; eventually I had to set my own limit and decide it was ‘enough’ – experiencing both a loss and a gain as I did so.

Several individual psychoanalytic authors, particularly those offering deeply authentic clinical case studies, I found nourishing and impactful, but I also had more negative feelings in relation to the pervading psychoanalytic view of endings as loss-focused and prolonged. The suggestion by Novick (1997) that analysts themselves have a problem with ending rang very true, and I contemplated an incompatibility between protracted analyses and the attachment perspective (I adhere to), whereby it is the creation of a secure base that allows for healthy separation (Ainsworth and Bell, 1970, Holmes, 1997). As a mother currently in the process of seeing my children leave home, I am aware of the necessity to ‘let go’, and the joy, along with some poignancy, of seeing my offspring reach independence. In reviewing the literature I found myself welcoming the more positive voices in relation to endings, with their emphasis on the development potential, and the significance of internalising the therapist.

The brief-term therapist writers to some extent seemed like a breath of fresh air, with their optimism around time limitation as itself having therapeutic value, and this also appealed to the practical, realistic side of me that recognises not everyone has the time or money for long-term therapy. However, where there were notes of evangelism and the implication that brief-term therapy is the automatic answer for all, I felt resistant. Equally, the more quantitative empirical studies around endings felt unsatisfactory, potentially reducing a complex experience to shallow summary words and phrases.

Overall, the writers who emphasised the dangers of generalising about ‘endings’ made sense to me, based on my own experience with clients; yet I was also aware that in relation to my research, it was both the individual experiences, and some common themes that I hoped to uncover.

CHAPTER 3: RESEARCH OBJECTIVES AND METHODOLOGY

1. INTRODUCTION AND OBJECTIVES

My central question is: **how do clients experience a preordained ending of medium-term therapy?** To recapitulate: by 'preordained ending' I mean limited in terms of the length of time the service offers, or limited by the therapist's/client's restricted time in one place; in other words, where the limit is imposed but in some sense arbitrary – neither determined by choice/readiness of the individual, nor built-in as part of the theory of the therapy itself. I define 'medium-term' as therapy duration of six to 18 months.

A complete 'epoché' of the researcher's feelings and orientation is neither possible nor desirable, but I have to some extent tried to bracket my interest in seeking out the 'optimistic' in relation to endings, which is probably borne out of my own experiences of endings and loss and a basic desire to believe in silver linings. In reviewing the literature I notice I have felt drawn towards reading about the positive aspects of ending; I find it comforting and affirming that endings can have a catalytic power; that a loss can be turned into a gain; sometimes it makes me question to what extent I have truly faced up to the darker, sadder sides of my own losses. But the IPA methodology I chose does not invite hypotheses, and I was keen to set out with as open a mind as possible.

2. RESEARCH DESIGN

Approach

As Giorgi (2012) points out, the subject matter of human experience and relationship has very different characteristics from the object – things and processes - of natural sciences, and a body of methodologies have emerged that take account of this. My objectives called for a qualitative approach, as it is people's 'grasp of their world' that I am interested in (Ashworth, 2008, p.4). Moreover, my research approach is a constructionist one; essential to the constructionism view (drawing from Mead, 1934, and Kelly, 1955) is the idea that the individual does not just 'perceive' their lifeworld, but is a 'constructor' of it, a sense-maker.

In line with Smith (2008), I see qualitative research as taking the raw data from participants, and performing certain transformations on it: essentially clarifying the psychological meaning by lifting it out of the potentially confusing empirical medley, and overall rendering the implicit explicit. While the data from participants is in one sense the 'absolute source' of material, in

reality the whole process of collecting it is intersubjective, and inevitably affected by the researcher themselves; awareness of this needs to be woven into the analysis and interpretation.

Within qualitative research, I chose **interpretative phenomenological analysis** as the obvious and ideal method for my study since it is consistent with the epistemological position of my research question: my interest is in the 'authentic experiential structure', as opposed to 'objective reality' (Giorgi and Giorgi, 2008, p.48). The currency of IPA is 'the meanings particular experiences, events, states hold for participants' (p.53), which is what I wished to explore in relation to clients and their endings. Studies in the past have concentrated more on 'reports' of endings than on the 'lived experience' of endings or indeed the meanings clients make of them. IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being, and assumes a chain of connection between people's talk, and their thinking and emotional state (Smith and Eatough, 2007). At the same time, as Smith and Eatough point out, the method allows that this chain of connection is not at all straightforward. People struggle to express their thoughts and feelings, and may well defend against self-disclosure for various reasons. The researcher has to interpret the person's mental and emotional state from their words (and, I would argue, the whole experience of the interview). In practice, this interpretation involves moving between building up rich experiential descriptions, grounded in the participants' words, and developing an alternative, more interrogative account. There is also a recognition that any analytic account will necessarily be partial, not the whole account; more could always be milked from the data.

IPA aims to reach as close an understanding as possible of the first-person perspective from a second-person position. Thus there is effectively a two-stage interpretation process: the participants are trying to make sense of their world, and the researcher is trying to make sense of the participants trying to make sense of their world: the 'double hermeneutic'. IPA explicitly views the research exercise as a dynamic process with an active role for the researcher in that process; access to the participant's personal world depends on and is complicated by the researcher's own conceptions – indeed, these are required in order to make sense of that other personal world, through a process of interpretative activity (Smith and Osborn, 2008).

IPA has its roots in phenomenology and hermeneutics (the study of interpretation). Phenomenology, a philosophy initiated by Husserl (1927), involves the careful examination of human experience, with a particular interest in the **essential** qualities of that experience. Husserl argued we should 'go back to the things themselves' – the experiential content of

consciousness, reasoning that nothing could be spoken about or witnessed if it did not come through someone's consciousness. Giorgi and Giorgi (2008) make the point that consciousness here is not limited to awareness but includes the unconscious and pre-conscious processes – thus, in my view, bringing in the question of 'interpretation' that may bypass an individual's conscious meaning-making, of which more below. But Husserl was striving to reduce experience back to its core; bracketing off culture, context and so on, in order to get to universal essences.

To some degree in contrast, although he was a student of Husserl, Heidegger (1962) thought that that contextual factors are critical in how we make sense of experience; our observations are always made from a position of our own. For Heidegger the proper model for seeking meaning is through interpretation, and thus he links phenomenology with hermeneutics (Moran, 2000). Heidegger's 'Dasein' refers to the experience of being that is peculiar to humans, which involves our being 'thrown' into the world, and having an inevitable and inextricable involvement with it; person and world are mutually-constitutive (Shaw, 2011).

IPA takes these concepts of an individual's interpreting his experience to make meaning, and an individual being inevitably engaged with 'other' (world/people) and offers us access to the experience of another through a process of intersubjective meaning-making. For me, the emphasis on intersubjectivity as inherent to the research method I have chosen also links with Halling's idea (2008) of the 'deepest awareness of another being simultaneously personal and objective' (p.20).

I think it useful to focus briefly here on the 'interpretative' aspect of IPA. (I note Hefferon and Gil-Rodriguez in their article on the rise in popularity of IPA (2011) are at pains to emphasise 'IPA is primarily an interpretative approach', lamenting what they see as some tendency towards 'primarily descriptive' IPA (p.756).) Schleiermacher, an early hermeneutic theorist, is one important source from whom IPA draws, and his words seem to have a particular relevance to my own stance on interpretation. Schleiermacher (1998) talked about grammatical and psychological interpretation, the former understood via the totality of language, the latter referring to the individuality of the speaker. Smith et al (2009) point out that for Schleiermacher, interpretation is a craft, involving the combination of a range of skills including intuition. Schleiermacher believes that the aim of the interpretative process is to understand the writer as well as the text, and on the basis of a detailed, comprehensive and holistic analysis, he actually says one can end up with 'an understanding of the utterer better than he understands himself' (Schleiermacher, 1998, p.266). Smith et al (2009) stress that

this should not be viewed as a licence to claim our analyses are more ‘true’ than the claims of our research participants, but feel ‘it does allow us to see how our analyses might offer meaningful insights which exceed and subsume the **explicit** [their emphasis] claims of our participants’ (p.23). ‘Claims’ seems to me a slightly odd, almost combative, word here, but I take Smith et al as endorsing the idea of looking beyond the simple face value of people’s words, as indeed we do in practising psychotherapy. Heidegger’s view of interpretation is also interesting, complex as it is. In the latter part of ‘Being and Time’ he discusses interpretation explicitly, stressing any new stimulus will interact with the reader/analyst’s ‘fore-structure’ (prior experiences, assumptions, pre-conceptions). However, he then seems to indicate (Smith et al, 2009, p.25) that understanding can work to make sense of the fore-structures in terms of the things themselves; in other words, having engaged with a text (or interviewee’s words), I may be in a better position to know what my fore-structures were. This, Smith points out, helps us to see a more enlivened form of bracketing as both a cyclical process and something which can only be partially achieved, which to me rings true. I had a sense of this in conducting my interviews and analysis after immersing myself in the current literature on endings: I found themes emerging from the data starting to chime with and even make sense of some of the vast body of reading I had done – this being part of my ‘fore-structure’, but to some extent previously only semi-processed.

Other possible methodologies I briefly considered

Narrative case study

The narrative case study approach has much in common with IPA, including beginning from a ‘curious, not knowing’ position (Anderson and Gerhart, 2007), acknowledging researcher reflexivity in the gathering and interpreting of the data (Simons, 2009), as well as overall seeking out how people make meanings of their experiences. Both methodologies share the conviction that human science research can articulate valuable knowledge through ordinary language, and both pay close attention to the expressions of research participants (Wertz, 2011). Given that I ended up writing my findings within a chronological framework, to some extent reflecting participants’ own narratives in the interviews, I considered the narrative enquiry method perhaps more in retrospect than when designing my project. However, overall I felt that, in comparison to IPA, this approach puts more emphasis on the **nature** of ‘the story’ and in particular ‘how’ the participants’ stories are constructed, which was not of itself my focus of interest. (The chronological aspect of participants’ narratives was, I felt, more led by the very subject matter of ‘endings’, rather than idiosyncratic story-construction.) Moreover, narrative case study research typically seems to involve an extended dialogical process with participants, clarifying and checking the interpretation of their narratives; this,

involving as it would a more prolonged relationship with me, with its own 'ending', I felt would add a complex and superfluous extra layer to this study.

Grounded theory

I rejected another qualitative method, grounded theory, while acknowledging there is much in common between Charmaz's constructivist grounded theory (2014) and IPA. As Charmaz (2011, p.293) says, both phenomenologists and constructivist grounded theorists aim 'to understand experience and its meanings as their research participants do', and both look for tacit meanings and actions'. But overall it was not my aim either to test hypotheses nor to construct a tidy theory of preordained endings, I wished more to explore the lived experience, and from this draw out insights, be these convergences across participants or individual-specific. I generally found, in the literature, attempts to find theoretical neatness unconvincing. Having said this, I have ended up presenting what could be loosely termed a 'model', in the interest of showing some relationship between the key themes in the context of a broader framework.

Sample

I had a sample of eight participants, each interviewed individually. There is much discussion in the literature about sample sizes for IPA, with a fairly pervading sense of 'less is more' (Reid et al, 2005). 'Greater depth is always preferable to a broader, shallower and simply descriptive analysis of many individuals', write Hefferon and Gil-Rodriguez (2011, p756). Smith et al (2009), while highlighting the fact that sample size is contextual and must be considered on a study-by-study basis, do suggest (p.51) between four and ten data points for a professional doctorate. I had several reasons for tending towards the upper end of this. I myself have over 25 years' experience as a qualitative researcher; IPA analysis is considerably more detailed than what I would typically do on an interview/transcript, but I am familiar with facing large amounts of data, and dealing with it methodically and thoroughly. While accepting the nature of the 'individual' experience is key to IPA, an important part of the analysis is to look for convergences, and work towards domains across cases (Smith, 2008); I knew from experience that a sample of eight is sufficient for themes and patterns to emerge where both commonalities and differences can usefully be explored. Also, I hoped this sample would yield a mix of demographics (gender, age, socioeconomic group), and levels of psychological disturbance; as indeed it did; this I regard as a fortunate and enriching factor.

In drawing up the list of criteria in terms of client-participants' experience of therapy ending, I was balancing the recognition that a relatively homogenous sample is optimal for IPA alongside the practicalities of finding participants, and not pointlessly narrowing the field:

- All to have experienced a preordained ending of therapy, known about in advance
- Therapy duration of six to 18 months
- Not to be going straight in to further therapy
- Psychotherapy modality to be integrative/humanistic/psychodynamic, where the therapeutic relationship is openly a focus (I excluded structured approaches such as CBT)
- Therapist could be trainee or qualified
- Therapist not to be personally known to me

Sourcing the participants

I approached several services and agencies offering medium-term therapy, including the NHS psychological services of my local borough, who at the time offered up to a year of psychodynamic psychotherapy. The service itself was, in principle, very ready to help. However, the challenge of getting my research proposal through the official application process proved too arduous and longwinded, and I abandoned this route. I also found a university counselling service willing to put up my invitation to participate, but in the event this bore no fruit. Another agency, offering up to 18 months therapy for women, initially showed willing but subsequently lost its funding and was then in the process of phasing out.

My two successful sources were both London-based charitable services, offering low-cost, subsidised psychotherapy. One was the Metanoia Counselling and Psychotherapy Service (attached to the institute where I had trained); here trainee therapists are given placements of a year, and the clients they are working with thus have to finish with them when the placement is up; it is possible for clients to be offered another therapist at this point, but none of my participants was, nor did they inquire about this. At my second source, the practice is, currently, to offer up to a year of therapy. The therapists here are qualified. The director of each of the services, having had an explanation of my research via email and telephone conversations, agreed to take my 'invitation to participate' and my noticeboard flyer (see Appendix 5). They informed their therapists that the former was available for giving to clients, and pinned the latter up in the client waiting area. I made amendments to the flyer along the way, mainly reducing its words, and adjusting closing dates. In the event, seven of the eight participants came via their therapist giving them the invitation; one came directly via having seen the noticeboard flyer.

Most participants were given my invitation by their therapist two to four weeks before ending, typically with the comment along the lines of – you might be interested in this; one therapist spoke of ‘closure’. One therapist first mentioned the research verbally, and then gave her client the invitation when she said she was interested. Another therapist had given his client the invitation along with ‘other questionnaires’.

Table (i) below summarises participants’ factual data. In the Findings chapter **Table (iv)** gives a more detailed background to each participant.

Table (i) - Summary of participant demographics and therapy experience

Gender of participants	5 female, 3 male	
Age of participants	20s (2); 30s (2), 40s (1), 50s (1), 60s (1), 70s (1)	Median age: 41.5
Ethnic origin of participants	6 white Caucasian (including one Antipodean, one Southern European); 2 mixed race (Afro-Caribbean/white)	
Marital/family status	3 single, 3 cohabiting or partnered, 2 divorced	3 had children
Length of therapy (*includes extension)	17m*, 14m*, 14m*, 13m*, 12m, 10m*, 10m, 8m	Mean: 12.25 months
Gender of therapists	6 female, 2 male	
Status of therapists	5 trained; 3 trainees	
Modality of therapists	Most participants were unsure. One reported ‘integrative’, one ‘person-centred’, and one ‘relational’. One therapist was TA (though participant unaware)	
Previous therapy?	7 had had therapy previously, generally several bouts and over a period of some years	
Currently taking medication?	2 on anti-depressants; 2 using Diazepam	

In terms of their routes to the service, half the participants had self-referred, either finding the service online, or being aware of its existence – from friends or acquaintances. The other half had come via a mention by a professional. Important factors included location, transport, and low cost.

Data collection

My requirement was for rich data: I wanted to grant participants the opportunity to tell their stories, to speak freely and reflectively, develop their ideas and consider the question of meaning. Thus I used semi-structured, in-depth interviews of approximately 1½ hours; a

couple were a little longer. My interview guide (see Appendix 8) contained certain topic areas I hoped to cover, but the interviews were largely participant-led, in terms of how and in what order these were approached. Four of the interviews were conducted in participants' own homes, and three took place at Metanoia (as a member, I can book a room). The other interview was eventually conducted over the telephone as the participant consistently felt too anxious to leave her house and meet me at Metanoia, but was also disinclined to be interviewed in her home. (See more on this participant in **My reflexive journey** below).

I offered participants token payment of £20 to cover their expenses, and some brief feedback on this is included under **Ethical considerations** below. All interviews were recorded (participants agreeing to this was a criterion of eligibility).

I stipulated all interviews should be conducted within three months of the therapy ending; in practice, seven were within a month, and five of these within 16 days, of the ending (see Appendix 9 for detail). I think this is significant, as the data I gathered constitutes thoughts and perceptions of a very recent ending. This contrasts with many studies on endings which have involved 'looking back' from a much later vantage point, where participants have had longer to reflect on the ending. My study offers the value of immediacy, with memories of the lead-up and final session still fresh in mind; it is a 'snapshot in time': an analysis of fairly immediate thoughts and feelings.

I was aware of the need for these interviews to be quite different from a qualitative market research depth interview (of which I have conducted hundreds), albeit with some basic similarities (putting participant at ease; active listening; avoiding closed/leading/manipulative questions, etc). But I aimed to reach into a depth of experience and meaning-making not usually necessary or appropriate to do in a market research session – indeed, nearer the level of a psychotherapy session, and I feel I achieved this. However, there was also the issue of trying to maintain the boundary between research and therapy (McLeod, 1999, p.98); certainly at times I had a sense of the 'subtle overlap' Finlay (2016, p.6) refers to, between relational-centred research and therapy practice. That, in the event, participants found the interview therapeutic is, as we shall see, an important finding in itself.

In September 2011 I conducted a pilot interview, helpful in many ways, including pointing to refining my criteria of 'preordained' and me 'not personally knowing the participant's therapist'.

The interviews themselves I conducted between April 2012 and December 2013.

Data analysis

As Smith et al point out (2009, p.79), IPA analysis is more about analytic **focus** than a single rigidly prescribed method: there is the idea of a 'healthy flexibility' in relation to analytic development. However, there are some characteristic common **processes** - for example, moving from the phenomenological to the interpretative and from the particular to the shared - and **principles**, namely a commitment to understanding a person's experience, and the meaning it has for them.

I had an early taste of IPA analysis in a workshop run by one of Jonathan Smith's team at Birkbeck, and this fed into my approach. We experienced analysing part of an interview, moving from the descriptive to the interpretative, and it was interesting to observe both the commonalities and the individual differences emerging in the interpretation stage, as researchers brought their own lenses to bear on the material (see also Storey, 2007, for her discussion on 'stretching' data in pursuing interpretations).

Immediately after each interview I wrote my own top-of-head impressions, observations and feelings, including a pen-portrait of the participant, to capture something of the flavour of the session while it was still very fresh. I then transcribed the interviews myself, verbatim, and including tones of voice, prosodic features, and body language recalled; I printed the transcripts in landscape orientation with wide margins. Although I am a fan of the computer for finished written work, with its speedy ability to alter and perfect text, in analysing raw data I like to hand write; my brain seems to work in a freer and more exploratory way, appropriate for this stage in proceedings, and I am quite simply used to it, after many years of analysing in this way.

In my mind, across the whole analysis process, was the hermeneutic circle where the part is interpreted in relation to the whole and the whole is interpreted in relation to the part.

I also allowed myself a degree of flexibility in how I conducted my analysis, changing tack at a couple of points (see below), mindful of Smith and Osborn's recognition that 'there is no single definitive way to do IPA' and 'you may find yourself adapting the method to your own particular way of working and the particular topic you are investigating' (2008, p.55).

The actual analysis and Findings write-up ended up with five key stages, detailed below.

- **Stage 1:** line-by-line **exploratory comments** on each transcript. Using three different coloured pens, I focused on the material as if with three different hats on,

and wrote comments accordingly: black pen for **descriptive comments**, comments with a phenomenological 'face-value' focus, staying close to the participant's explicit meaning, clarifying 'content'; red pen for **linguistic** comments, focused on exploring the participant's specific use of language; and blue pen for **conceptual comments**, abstracting a little from the content, and engaging at a more interrogative and interpretative level ('Interpretative coding should refer back to the core experiential accounts...but need not be entirely constrained by them', Shaw, 2011). (See example pages of this stage in Appendix 3)

- **Stage 2: emergent themes.** I had been planning to go through the transcripts writing emergent themes in the other margin, but having engaged with the transcripts at a granular level, I had a strong sense of a natural, chronological framework around the subject of the lived experience of a preordained ending: broadly - how participants felt about it in advance, their experience of the lead-up to it, their experience of the final session, reflections later, the effect of the interview, and so on. (To some degree this also reflected the narratives of the interviews: albeit with gentle prompts from me, participants tended towards telling their story chronologically). In addition there were a few 'overall' themes such as the individual background of each participant; their relationship with the therapist; etc. On the basis of this I decided to start collating the data from the transcripts under these theme headings across participants, and drawing out the emergent themes **within** each heading as I went Accordingly (see Appendix 2), my next step was to draw up A3 analysis charts, one for each key 'experience theme' (broadly chronological), with
 - columns for each of the eight participants
 - a further column for the emergent themes within each experience theme
 - a final (tenth) column for jotting down thoughts – as I had them - around 'higher level' themes (these would become the basis for the sub-themes feeding into the domains, see Stage 3 below)

I went through each transcript transferring, summarising and sometimes developing my three-colour comments, as well as referencing quotes, under each of the eight participants' own columns. In the ninth column I started to pull out emergent themes, referencing different participants, and sometimes linking or contrasting the different participants. There was some fluidity in the process as I added in the occasional new 'experience theme', on an A3 sheet, (checking back over previously analysed transcripts) as I went, while also 'unpacking' the emergent themes, when new nuances appeared. I have typed up two examples of these charts in Appendix 1, recognising that the raw A3 handwritten version would not be suitable to include, but wanting to show this important stage of the audit trail. It was from these charts, I

initially wrote the Findings Chapter, referring back to the transcripts to extract the exact quotes (from the line references).

- **Stage 3: sub-themes.** To some extent Stage 2 and Stage 3 overlapped, as the process of writing up of the body of the first draft of the Findings Chapter itself had an analytic aspect. But, broadly, the next stage was to stand back, and do a mental overview across all the (chronological) experience themes and the emergent themes within them, and in particular reflecting on the notes I had made in the tenth column, around higher level themes; this is something I have some familiarity with, for a higher level analysis. It involves elevating beyond the detail, and I would describe the process as a mix of 'sieving', to separate out the bigger summary findings, and 'taking a step further' – perhaps into more obviously psychological and philosophical realms. A number of sub-themes emerged, to some extent cutting across the 'chronological experience' themes, and the emergent themes within these, but drawing certain proportions of input from each. These sub-themes I then interrogated and honed; this involved some splitting and some merging of themes, as well as dropping a couple (in the interest of focus and wordcount).
- **Stage 4: domains.** The final eight sub-themes I drew up I then took a further step back from, already having a sense of some of them clustering. Four domains emerged, overarching the eight sub-themes.
- **Stage 5: re-structuring the Findings Chapter.** In the interest of greater transparency – in terms of showing how each sub-theme was derived – I re-wrote the Findings Chapter using the sub-themes (under their domains) as headings, in line with IPA convention. The original analysis headings appear as sub-headings under each of the themes, wherever they are relevant.

Quality /Trustworthiness

Among the plethora of literature on assessing quality/validity/trustworthiness in qualitative research, I was drawn to keeping certain key concepts in mind. Kvale (1996, p.27) invokes the notion of 'craftsmanship' in terms of validating qualitative research, whereby emphasis is 'moved from inspection at the end of the production line to quality control throughout the stages of knowledge production'. Relevant here too is Elliot et al's (1999) framework of seven guidelines in relation to publishability of qualitative research, which include situating the sample, grounding in examples, accomplishing general vs. specific research tasks, and resonating with readers. Most helpful perhaps were Yardley's (2000) four broad principles, outlined by Smith (2009, chapter 11), as applied to IPA. I address these here in relation to my project:

(i) Sensitivity to context

This can be taken in a number of ways, including **sensitivity to the existing literature**, **sensitivity to the interactional nature of the data collection**, and **sensitivity to the data itself**.

- I read very widely round the subject of endings; I was aware that while I thought I had found a 'gap' for my research to focus on, endings have been researched and contemplated by many distinguished figures in our field; my aim was to embed my findings in this context.
- There were certain sensitivities within the interview process which I felt to be important to keep in mind: my participants knew I was a psychotherapist; I was aware this might affect their accounts, for example in how they presented their therapeutic relationship. I did my best to encourage frankness here.
- Sensitivity to the raw material being worked with has included using a substantial number of verbatim quotes, to ensure the participants' voices are heard 'directly' and allow the reader their own chance to check the interpretations.

(ii) Commitment and rigour

I feel that commitment and rigour are qualities I inherently have in my work and in anything I undertake; with an IPA project I aimed to put this characteristic stance to good effect. As mentioned, early on I did a pilot interview, following which I tightened my recruitment criteria. Later I had to exclude some potential participants who did not meet my exact criteria, for example any who were even faintly considering going back into therapy immediately. In terms of the analysis, I used a research partner (a fellow student, also conducting an IPA study): as well as being in a constant process of mutually interrogating our doctoral research work we specifically analysed one of each other's interviews, using the same three exploratory modes described in 'Stage 1' above. I also had the opportunity to discuss in detail a passage of transcript from one of my interviews with my student cohort (and tutor), giving me twelve fresh views on it against which to compare my own. What I learned from others' input was threefold: firstly it was reassuring to have many of my own perceptions and interpretations confirmed; secondly there were some extra and different observations which enriched the picture as a whole, and for which I was grateful (I recognise that any analysis is inherently partial (Smith et al, 2009)); but thirdly, I was reminded of the limitations of a transcript as a representation of an interview, and that my own experience of interviewing the participant face to face,

with a sense of their physical presence, nature of pauses, and so on, gave me a substantial additional base to draw from.

I decided against checking data (interpreted 'meaning') with participants themselves (having found support here from the IPA experts, including Jonathan Smith himself). Although it may appear to offer validity of a sort, I felt that in this case particularly, participants' analysis of what they said/meant in retrospect would bring its own problems and complications, not least because their feelings about their ending might well change over time – and it could have been a year or more later that I would have been returning to them. Overall, I wanted to preserve the focus being on the ending from the point of view of 'immediately afterwards'.

(iii) Transparency and coherence.

For me transparency begins with **reflexivity**, something many others (for example, Elliott et al, 1999) have placed key emphasis on. At all stages I tried to reflect on my own stance; I recognised that a complete bracketing off of bias, of personal hopes, expectations, and areas of special interest, was of course not possible, nor, with a constructionist approach, desirable, but that what was crucial was to be as aware of these elements as possible. As a therapist, reflexivity is ingrained in my practice and indeed my life. I made notes as I went in a research diary, believing the act of reflective writing (Bolton, 2005) both clarifies and deepens insights. Other concrete examples of transparency include detailing the recruitment procedure (above) and showing an audit trail of the analysis process in my Appendices. For coherence I have at all stages endeavoured to put myself in the shoes of the reader; I have overall aimed for clarity and flow; where inconsistencies, ambiguities and contradictions have existed in the data (Smith, 2009, p.182) I have tried to make sense of them through interrogation and analysis.

(iv) Impact and importance.

Ultimately, says Yardley (p.183), the test of real validity is whether it 'tells the reader something interesting, important or useful'. This is an aspiration of my project throughout.

Ethical considerations

I obtained ethical approval for my project from Metanoia's Research Ethics Committee (see Appendix 7). The main ethical concern in relation to this research centred around the fact that the subject of their therapy ending had the potential be an emotional one for some participants. My bearing this in mind during all parts of the process, from recruitment,

through interviewing, to writing up, itself constituted part of the ethical sensitivity of the project. There was a question around the extent to which clients would wish to share something of their actual therapeutic journey with me, the interviewer; describing and exploring their experience of ending would necessarily involve some reference to the issues they went to therapy for. I made it clear that the degree of openness they chose here was entirely up to them, while hoping that my personal manner, as well as my reassurances on confidentiality and anonymity, would create a context in which participants felt safe and comfortable to express themselves to an extent they did not find adversely disturbing, or later regret. As well as asking them about their experience of the interview at its end (McLeod, 1999), I gave them my contact details and an informal invitation to re-contact me should the interview have opened up anything difficult to cope with, or should they feel they wished to add anything. In the event, none contacted me further in relation to this. I also told participants that eventually I hoped my research thesis would be published, and asked if they would be interested to be told about this when it happened. All said they would be.

Participants were of course told, from the initial point of contact, that they had the right to withdraw at any point, prior to finished publication. They were assured of anonymity and confidentiality, such that transcripts and notes were all anonymised and audio files stored on a password-protected PC.

As mentioned, I excluded any participants who had had therapy with a therapist known personally to me.

I offered participants £20 to cover expenses. As well as recognising that they might have had travel expenses, and had certainly given up their time for the interview, I also had the idea this might broaden my potential sample to include some who might not otherwise have considered volunteering; I wanted if possible to avoid a very specific sample of clients who had a particular issue with ending, which they wanted to discuss in the interview. My sense is that in the event the expenses payment did not make a great deal of difference to my sample (the self-selected sample is examined in the Discussion chapter), although all were appreciative to some degree. Two participants said they had forgotten about it until the moment of payment; three had planned to give it to charity; most said they would have happily done the interview regardless of expenses; one said it felt 'symbolic', that what he was giving me was obviously 'of worth', in the same way paying even a small amount for therapy conferred on it a value; and one other (also a man) said it had made a small but significant difference to his volunteering, that this overt 'exchange' of giving and receiving

had made him feel more 'comfortable' (interestingly he also talked about his own therapy as a 'deal' and had kept the receipts of his payment for it).

3. MY REFLEXIVE JOURNEY

Recruiting participants had its frustrations and joys. I was lucky in having a participant volunteer early on, which gave me a basic belief in my flyer having the potential to 'work'. But, having spread my bread on the water, I had to wait a long time for a second participant and at this point I was eager not to lose momentum. In fact during much of the doctoral research process, as well as my life in general, I have carried anxiety about losing momentum, which I think reflects my sense that atrophy can quite easily creep in, if allowed to, and means I am a (slightly neurotically) high energy person overall. With my recruitment, a lull tended to propel me into trying new avenues, most of which were fruitless, but it gave me a feeling of continuation. When a participant contacted me, usually by email, sometimes by telephone, I felt a little leap akin to when a new therapy client does – but stronger, as participants are harder overall to come by! In each case I felt enormous gratitude to both the participant and their unknown therapist who had acted as a conduit (sometimes I was able to thank them), and a general sense of 'connectedness', that my invitational words had somehow resonated with someone enough to prompt them to respond.

Some of the interviews took place in home, some at Metanoia. In participants' homes I had more sense of privilege, and role of guest, being invited in, offered tea, shown photographs. I also gained a richer picture of the individual, seeing how and where they lived. These interviews felt a little less 'interview' like, more conversational, with phones, doorbells, flatmates, pets etc., occasionally interrupting. These are the interviews I now recall with particular clarity, because of all the additional, unique cues. The interviews at Metanoia were inevitably closer to a therapy session, taking place in a room used for therapy, comfortable but neutral, with little to distract. As an established member of Metanoia I had more of a sense of host, and thus power, although I obviously did my best to put participants at ease and express my gratitude to them. But differences between how forthcoming participants were was, I felt, down to them as people rather than interview context.

The one interview I did by telephone I had some doubts about including, but eventually decided this participant (Bianca) represented something quite important, which might even prompt future research. Bianca had a history of unstable mental health (including a spell as an in-patient), and was on medication relating to her diagnosis of emotional dysregulation

disorder. Her condition led her to postpone our interview, scheduled to take place at Metanoia, several times, as it transpired she suffered acute anxiety about leaving her home, along with deciding what to wear, etc., yet she still seemed keen to do the interview (and it seemed important for her that she should see it through). I realised that I had not considered diagnoses, medication, or in-patient history as possible exclusions for my research, maybe something of an omission. A preordained psychotherapy ending for someone likely to need ongoing if not constant support will clearly have a particular impact – and so it proved. But I was aware of the ‘exception that might prove the rule’, and was also loath to waste the data; I offer the argument that the presence of Bianca in my sample served to underline the relative robustness of most of the other participants, even the more vulnerable among them; and that having the contrast of someone receiving ongoing care from mental health services with those that might fall into Freud’s ‘ordinarily unhappy’ category, was valuable.

I am used to deadlines; my working life, before training to be a psychotherapist and counselling psychologist, has been mainly project-based, working to strict commercial or organisational schedules. I have found the lack of specific deadline on this thesis challenging – and the irony of writing about preordained endings without one myself did not escape me. I have made my own deadlines along the way, but life has intervened and the deadlines, because they were not set in stone, moved. My psychiatric health placement, clinical dissertation and then clinical viva took precedence during 2012 and 2013, the latter also being the year of my breast cancer diagnosis and lengthy treatment. My doctoral research seemed sometimes like an old but distant friend, something peripheral yet treasured, which I knew I could pick up from where I left off. This feeling was stronger when I was listening back to the recordings; my participants were back in the room with me. At other times, particularly once the transcripts were finished, sitting in a huge lifeless pile in a box file, I felt anxiety, that my doctoral research was slipping into the background, retreating from me, and becoming amorphous, hard to get a purchase on, and potentially overwhelming to re-visit. At the end of 2014 I planned to devote the first three months of 2015 to the analysis and writing up, but we were suddenly facing another serious illness in the family. With many months of uncertainty, another possible ending was in the picture, and it drew attention to my sense of the relationship between endings and brinks: at times you peep over the brink to ‘see’ the other side, at other times you actually go over the brink - and into the ending experience. Those of my participants who had been given an extension had, in a small way, done each of these.

CHAPTER 4: FINDINGS

1. OVERVIEW

As mentioned in the Methodology, I conducted my original analysis within a broadly chronological framework, as chronology seemed to have a particular significance in researching endings, and moreover these headings largely followed the narratives of the interviews.

However, as my interpretation moved to a higher level, the key sub-themes and domains emerging from the analysis (see **Table (ii)**) cut across the chronological headings. Thus, after introducing the participants, this Findings chapter is structured by theme, in keeping with IPA, with **Table (iii)** showing a summary of where the themes drew from my original analysis headings.

Domains and sub-themes

Eight sub-themes emerged, clustered beneath four domains – see **Table (ii)**. Neither the sub-themes nor the domains are entirely discrete.

The sub-theme of **'ending therapy is a highly individual experience'** can itself be thought of as a domain: **'An Individual Experience'**. The next domain, **'Acceptance'**, embraces two sub-themes, **'a basic human acceptance of preordained endings'** and **'the transformative impact of therapy endings - and the particular 'carpe diem' of preordained endings'**. The third domain, **'Resistance'**, again has one sub-theme, embracing two linked concepts (see more on this, later) - **'fear of loss, and resistance to finality'**. The fourth domain, **'Managing the Ambivalence'**, includes four sub-themes: **'the painful loss of the therapist can be in part counterbalanced by internalising the therapist'**; **'therapy ending as a transition: looking back and looking forward'**; **'therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities'**, and **'the post-ending therapeutic function of the interview itself'**.

Table (ii) – The eight sub-themes within the four domains

Domains	Sub-themes
1.An Individual Experience	(a) Ending therapy is a highly individual experience
2.Acceptance	(b) A basic human acceptance of preordained endings (c) The transformative impact of therapy endings - and the particular 'carpe diem' of preordained endings
3.Resistance	(d) Fear of loss, and resistance to finality
4.Managing the Ambivalence	(e) The painful loss of the therapist can be in part counterbalanced by internalising the therapist (f) Therapy ending as a transition: looking back and looking forward (g) Therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities (h) The post-ending therapeutic function of the interview itself

In the Discussion chapter the domains and themes are presented as a model, and further explored and contextualised.

	AN INDIVIDUAL EXPERIENCE	ACCEPTANCE		RESISTANCE	MANAGING THE AMBIVALENCE			
	(a) <u>Ending therapy is a highly individual experience</u>	(b) <u>A basic human acceptance of preordained endings</u>	(c) <u>The transformative impact of therapy endings – and the particular ‘carpe diem’ of preordained endings</u>	(d) <u>Fear of loss, and resistance to finality</u>	(e) <u>The painful loss of the therapist can be in part counterbalanced by internalising the therapist</u>	(f) <u>Therapy ending as a transition: looking back and looking forward</u>	(g) <u>Therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities</u>	(h) <u>The post-ending therapeutic function of the interview itself</u>
‘What ‘effect’ did ending have?’	*	*	*			*		
‘Participants’ experience of endings in general’	*							
‘Post-ending contact with the therapist?’	*			*	*		*	
‘How has it been, since ending?’	*	*	*	*	*		*	
‘Participating in the research’	*		*	*		*	*	*

* indicates the theme having drawn from the original analysis heading

2. INTRODUCING THE PARTICIPANTS

Backgrounds

Table (iv) gives some idiographic background to each participant. Participants (and their therapists) have pseudonyms throughout.

Table (iv) Introducing the participants

Name	Background	Psychological orientation
Pamela	40s, single. Episode of physical and mental assault in hospital during a termination a few years ago. Father left when young; lack of family support/secure base.	PTSD symptoms – including anxiety and panic attacks; lack of agency; hypervigilance; agoraphobia. Abandonment issues; insecure attachment pattern; manic episodes.
Philip	50s, divorced. At 19 discovered his father was not his biological father, but had to keep the secret.	Depression/lack of motivation. Existentially struggling to find vitality, meaning, agency. Others have controlled his life since birth. Identity issues.
Andrea	30s, single. When eight, lost sister in accident, followed by parents' split. Alcoholic father.	Traumatic past – major influence. Survivor's guilt. Avoidant attachment pattern. Has perhaps found strategies to dull /avoid pain.
Evelyn	20s, mother of two. Insecure family base – her father had a second family and eventually left.	Trust issues, including difficulty in trusting herself. Abandonment anxiety. History of not being allowed/able to process emotions.
Jason	20s, single, wheelchair-bound. Seeking work, post graduating. While at	Intense attachments - and potential feelings of loss and abandonment. Easily stressed;

	university, beloved grandmother died, and parents divorced.	struggles to self-soothe. Tension between wish to be independent vs inevitable dependency on services.
Hilda	70s, long-since divorced. Lives in (hated) sheltered accommodation. Artistic; animal lover. History of childhood neglect, and domestic abuse in marriage. Years on fringes of mental health services. Lack of support system.	Traumas in past have had major impact. Issues with abandonment and lack of agency. Fearful, anxious, angry. Paranoid-schizoid position – distinct good vs bad division. Identity issues.
Bianca	30s, single. Diagnosis of Emotional Dysregulation Disorder; currently on medication. Small inheritance now facilitating leaving home.	History of impulsive behaviours and addiction. Disorganised attachment pattern. Anxiety and depression. Angry at limitations of mental health resources.
Marcus	60s, girlfriend encouraged his coming to therapy for anger-management; works part-time. Brief reference to childhood neglect. Ex-alcohol/ drug misuse.	Anger issues – apparent phlegmatism interspersed with uncontrolled rages. Ambivalent attachment pattern.

3. DOMAIN (1): AN INDIVIDUAL EXPERIENCE.

Sub-theme (a): Ending therapy is a highly individual experience

Overview of the domain

The sub-theme here represented a domain in itself, importantly underpinning all the other themes. That ending therapy is a highly individual experience may seem an unsurprising finding, but it is a crucial starting point, underlining the psychological uniqueness of human

beings. Each participant brought their own history, issues and patterns to their experience of ending therapy. Ending had the potential to echo previous endings, which were individually varied, whatever more general points might be made. To what extent habitual attitudes and behaviour presided, and to what extent a participant could see themselves as able to make new and different choices was influenced by many factors, including basic resilience; where a participant was on their psychological journey; how deeply ingrained their defences were; and therapist factors. In addition, there was individual variation in how reflective and articulate participants were, and how open they chose to be with me. Having said this, many of the subsequent seven sub-themes start to emerge under this first sub-theme, for which there is considerably more text than for the subsequent themes; as is typical of qualitative themes, there is overlap and interweaving between them.

Entering therapy

In talking about therapy ending, it seemed necessary and important for participants to talk about their original reasons for seeking therapy, the therapeutic relationship and the work of the therapy itself. Participants' keenness to speak at relative length about this is a finding in itself (see Discussion); the wealth of material they brought in this respect can only relatively briefly be covered here.

Reasons for seeking therapy were probably typical of any group of clients in a charitable service offering medium-term therapy, and included: depression; anxiety; continuing effects of distant and recent traumas, as well as full-blown PTSD; bereavement; relationship problems/endings; self-esteem issues; problems in regulating emotions; other unresolved issues from childhood; and specific life crises (for example, joblessness; a move to new sheltered accommodation). Frequently a mix of reasons was given, but of course, and crucially, each participant's story was their own. In a couple of cases it was other people's encouragement or insistence that brought them to therapy.

"It was an ultimatum, actually – the children's dad said either you go counselling, or we split up...and he says he'll go his way and I'll go my way...and that was why I came...but in the first few weeks I realised that I had deeper issues that I never even knew I had before going into therapy..." (Evelyn)

Note how Evelyn talks initially in abstract terms – 'go counselling', seemingly seeing it simply as a route to saving her relationship, only subsequently discovering the reality of therapy revealing 'deeper issues' of which she had been unaware.

Evelyn's degree of surprise about what therapy actually entailed probably links with her being the only participant not to have experienced therapy before, underlining another element of difference within the sample. Most participants had had more than one bout of therapy, and individual experiences had varied greatly. Jason had had found his university counsellor enormously helpful (and it offered another example of an imposed ending, one which he had found very emotional and which we covered in the research interview). He had felt he needed further help, both to deal with historical trauma and his present difficulties, so had asked to be referred on:

"I kind of was very much aware that it wasn't a good time to stop...which led me to seek further support... I'm dealing with the job hunt, I'm dealing with living in temporary accommodation... [...] [My grandmother] died in October of 2008, so literally a month after I began at university...it literally blew the top off everything for about six or seven weeks or so, and of course it's still going on now, in a sense, even though it's four and a half years down the line...still finding a way to deal with it and move along with it...that was very much an issue that still needed addressing."

Jason resorts to almost business-like language at the end, perhaps in an attempt to bring order to the chaotic threads of past and present.

Other participants had had more negative experiences with therapy; a couple had felt frustrated with the limitations of what they had been offered, either from the NHS or their workplace.

"We [XX company] have this service called Help Direct and they will offer you services, whether it's therapy or anything, which gave me a couple of sessions with a therapist then...she did the tapping...um...method, where you tap and she regresses you...and goes back to certain points, and makes you re-live it... [...] that was only a couple of sessions...unfortunately XX weren't prepared to offer me any more with her." (Pamela)

Pamela's words (the repeated 'a couple of sessions', and 'weren't prepared') all underline the position of the service user, not so much choosing, but being the recipient of a limited offer. Hilda also reported a poor previous experience, and in the next quote, by apparently saying she is not angry, in fact suggests the opposite.

*“The previous people were psychologists...[...] she was falling asleep once or twice, she would be listening to me...[...] and I actually said to her one day – I got quite – I didn’t get angry with **her**, but I thought – what am I sitting here talking to, and I said – ‘are you bored with me?’...”*

Her anger is also betrayed by her referring the psychologist as something inanimate (‘what’, rather than ‘who’, am I sitting here talking to?).

Some had not felt ready or able to engage with therapy. Bianca spoke of CBT as requiring too much of her.

[I: Had you had any therapy previously?] *“Yes, I had, but I hadn’t really engaged with it very well – CBT, a very lovely lady as well, but...CBT, you have to practise it, if you do practise it, it can be a very useful tool, but...it’s here and now, looking at your emotions logically, and seeing if there’s any substance in what you can do about them...um...I realised that – my thinking processes and emotions are so deregulated it is very difficult to practise these techniques...”*

For Andrea, the adolescent counselling she had been sent to seemed to have been more help to her mother than to help her.

“As a child, as an adolescent...my mum...at the time I didn’t really understand it, because I’d go in there and draw pictures, and – for me, it was time off school, kind of thing. I didn’t really understand what was going on – but mum did say to me at the time that it did help, and it helped her gain insight into what was going on in my mind...”

Philip had had private analytic therapy (among other bouts), which had left him with ambivalent feelings, interestingly around the difficulties of ending it (the therapist had discouraged ending), linked with his resentment of the continued steep cost.

Two had had experience of group therapy; one had been extremely attached to his group therapist; something he measured his feelings towards his subsequent therapist against.

These varied experiences of previous therapy had significance in inevitably giving rise to different hopes and expectations. For some, there were high hopes that **this** therapy would be better than previous offers. For Evelyn, it had a particular value as ‘first ever therapy’. For

some of the others, the therapy (and its ending) that they were being interviewed about had less emotional investment, in that it was essentially one of several stints in their lives, which perhaps inevitably reduced the drama of its ending. Although a criterion of the research was that participants were not intending to enter therapy again in the immediate future, all expected to have, or were open to having, more therapy at some point.

Length of therapy: expectations and attitudes

In terms of presenting the time period, 'preordained' did not equate to cut-and-dried, reflecting the fact that in the context of clinical care, even in time-limited psychotherapy services, a 'case-by-case' element could and did enter the picture. Again this links with the 'individuality' of experience.

Factors counteracting exactness in the question of time included: participants themselves expecting they would need or want to come for a short period only (and later extending this); the suggestion from the therapist that 'we start with a trial period, and then review'; therapists adding extra sessions on to the end, in lieu of sessions missed; therapists applying for a (fixed) extension; therapists not necessarily being upfront about exactly when their placement was ending; and participants perhaps simply not taking in the 'maximum time offered' information. Having said this, participants were all aware that there would be a time limit.

Participants had differing recollections of the degree to which they were aware (early on) of the precise endpoint, and what they felt about this. Maybe this reflects the fact that psychotherapy, perhaps more than other therapies or services, is a step into the unknown, with the state of 'ending' (at the beginning) lacking clarity, but it also reflects the different psychological orientations of the participants.

Participants did, of course, all have the option – implied or spelt out – of finishing their therapy earlier, and in this sense the endings I was researching were not so much prescribed as representing the maximum possible. Philip started therapy in November and originally anticipated having therapy for a period of three or four months. In the event he ended when his therapist's placement finished, in the following September. His account suggests that he initially he may not have wanted to think he needed a longer period of therapy, and hints at the eventual decision to 'go the full distance' being subtly influenced by his realising that his therapist would otherwise have a small window left in which to take on a new client. Did Philip not want to see taking the maximum time for himself as entirely related

to his own needs? Yet he also, in the second quote, indicates a sense of achievement, in having stayed the course.

“Originally I didn’t think we’d probably go the full distance [...] I’d sort of pitched it as – I’ll give it three or four months...and – perhaps that’s because I’d already done some, had some previous therapy, um...I don’t know – it’s not that I didn’t want to invest in it, I suppose, perhaps I thought that that might be an optimum at the time. Actually it proved that actually I wanted to keep going... [...] he [therapist] was fairly flexible...[...] and that was obviously very helpful, that he was in a position to do that. I mean I guess from his point of view, the further we do go along, the less straightforward it is for him to take on another client...but that was never, there was never any pressure from that point of view...”

“At the beginning I’d considered we might finish in the late spring possibly...but we wanted to continue, I wanted to continue...[...] And I think we did meet about 35 times, which seemed like a reasonable...um... whichever way you cut it...”

It transpired it was exactly 35 sessions, Philip had kept the receipts in an envelope. This seemed like tangible proof of a substantial time period; in his case possibly something of a substitute for actual work done (see later). When asked about the aspect of ‘having’ to end, Philip referred to accepting it as ‘part of the deal’, with a ring of both resignation and possibly anger about it. The ‘transactional’ meaning of ‘deal’ had perhaps particular relevance to Philip, with his emphasis on receipts for the money he had paid (low fee as it was), and linking with his previous resentment over the money paid to his analytical therapist who had resisted Philip’s attempts to end.

Evelyn gave a confused account of what she expected in terms of the length of therapy, perhaps mirroring her confused state when she started. It was made clear that a year was the maximum, but that some people had a shorter period of therapy. In some ways it seemed the length of a year was almost frightening, and yet once the therapy started it also seemed to go fast.

“She said it would be... a year’s the maximum...so I knew I’d be there for the year...but wasn’t too clear if it was going to be the shorter or the long period...um...but I did know about the year’s length.”

[I: What did you feel about that year’s length?]

“I did seem like a really long time...a year; it did feel like a really long time. However, when I was going every week to the sessions, it didn’t feel like...didn’t feel like a year, it felt shorter...it went very quickly.”

Andrea was asked by her therapist how long she envisaged coming for therapy – prompted in part by having to fill in a form which possibly had some expectation of a ‘four-to-six months’ answer. Andrea herself would have liked a more open-ended approach – and perhaps reacted negatively to the idea of being driven by box-ticking.

“She kind of initially asked me – I think she was asked by Metanoia, and she had to write it on a form – and she said, how long do you think you’ll be coming...like, ‘four to six months’ or something, and I said to her – to be completely honest I don’t know but I think it will be longer than that. [...] I knew myself, from past experience, that it wasn’t going to be over in five minutes.[...] I didn’t feel comfortable putting a time on it because I really didn’t know how it was going to feel for me.”

Andrea’s therapy in fact lasted eight months. But it came as something of a shock to her to be given only around four to six weeks notice of her therapist ending her placement (two of these weeks with the therapist on holiday). Although Andrea’s vulnerability comes across in the quote above, at this point it seemed that her avoidant attachment pattern kicked in, and she smoothed over any possible feelings of rejection, resentment or anxiety by deciding it was the right time to end anyway.

“It was a surprise...and initially I was like – OK, fine..it’s OK...like, I wasn’t too bothered...[...] She told me how many sessions I had left, [...] she told me right, we’re finishing up on this day, that means you’ve got this amount of sessions left, dah dah dah...and she had two weeks holiday in between, which was fine... I guess if I wanted to make alternative arrangements, I could within that time period as well... I – er – thought it over for a little while, and then I thought – no, you know, I think I feel OK.”

Later Andrea reflects on the difficulty of ‘making alternative arrangements’ – that is, starting with somebody new, and although she starts in the third person, she ends up speaking for herself.

“I can imagine it [the enforced ending] could be difficult for some people, because if you’re still, if you’re in the middle of something – if it was – say- three or four months ago, I would have been like (pained) ah, what do I do now? I’m right in the middle of

*some really heavy stuff here, I **don't** want to...do I want to have to go through and explain all of this to someone new? I know they'll have my notes, etcetera, etcetera, but do I really want to have to go through that again? [...] that would have been very difficult, and I think I would really have struggled.[...], getting comfortable with someone else and opening yourself up to them.”*

For Pamela it had been made clear that the therapy period was ‘up to a year’. After her several small bouts of therapy of different kinds, with little continuity, this seemed a wonderfully extensive period, and her first reaction was relief and gratitude. (Her use of the word ‘qualify’ again underlines the service context.)

*“If [X service] hadn't taken me on, I don't know where I'd be right now...[...] and so when they said – yes, I qualify for a **year**...I thought, oh, thank God!”*

To Jason, again the length of time seemed generous, compared with his expectations. In his case, however, he was not clear about the period until after the therapy had started.

“In one of our sessions, I just remember mentioning to him – how long is this going to happen? Six to ten sessions? And he said something like – oh no, you get about a year or so....so it was actually quite a pleasant surprise that it was actually going to be quite – a bit more long term than that.”

Bianca's therapist, like Pamela's, made it very clear from the start that the offer was for up to a year of therapy, with an initial trial period of six weeks. Bianca was used to a system of prescribed and limited services, and recalled accepting this news without much consideration, citing its charity context.

“She was very clear about the ending [...] I didn't think anything of it – because, you know it's a charity and – you know – she was doing pro bono work so I didn't really question... [...] and she said – we'll start with an initial six weeks and see how we get along.”

Later we shall see Bianca was less sanguine about the ending. Certainly participants' attitudes to the prescribed limit on therapy were apt to fluctuate, with different feelings emerging as the end actually approached.

Marcus's experience was complicated by having a male therapist first, whose placement ended after about five months, then the female one with whom he had recently finished. He knew in both cases that the period was limited.

"I knew it was kind of time-limited [...] I mean I knew exactly how long it was going to last...when I started I first saw a guy, then a woman...and both of them I was very aware of the date when it was going to finish...or near enough."

His language here has a paradoxical element – he knew 'exactly' how long, and was 'very aware of the date', yet he refers to it being 'kind of' time-limited, and adds 'or near enough'. In the event the goalpost of the second ending moved, as the therapist stayed on another two months. His response to this is explored in the following section.

The concept of an imposed ending was potentially further complicated and blurred by the question of extension. In the event, five participants had some kind of extension. In each case this did have an absolute limit, and was always proposed by the therapist, gratitude from the client typically following. Again this fits with the 'charitable service' model, where beneficiaries receive what is offered rather than making proactive requests. And again, extensions played a different role for different individuals.

Pamela's extension was one of the more obviously 'needed'. She became very anxious as the end of her official 'year' approached; her therapist clearly had her own view that Pamela was not ready to end, and applied for – and was granted - an extension. *"I couldn't have been any more happier that she'd said that!"* Pamela said, admitting also to a later fantasy of a further extension, but this was never an option.

"...I was hoping that they might turn around and change their mind...[...] but Jane was very assertive of that, from when she said it to me. It was – Pamela, as much as I'd like to, unfortunately [X Service] won't extend it any further...this is it. There was no glossing it up."

The 'service' emerges as a third entity, ultimately calling the shots, with therapist possibly hiding behind its authority.

Three participants had an extension based on making up for missed sessions, with possibly a backdrop of other factors. Jason had not been able to travel due to snow and illness; it also seemed that his therapist had felt Christmas a bad time for Jason to end, so he had

been given five extra sessions in the new year. Hilda was also given an extension (of two months), based partly on sessions missed through her having had a chest infection – for which she was extremely grateful.

“She said, well as you’ve been ill and couldn’t come for a couple of weeks... she asked them for an extension, and I thought – ‘oh blessed, lovely!’”

In Bianca’s case it seemed her therapist used the two month extension as something of a bargaining chip, offered in return for regular attendance – with good results (see Sub-theme (c) below).

Marcus had ended up with an extension almost inadvertently. His therapist’s leaving date changed - from July to September. A man with anger issues, he had mixed feelings about this, feeling both aggrieved that his expectation was being altered – yet also pleased the therapy was continuing.

“I can remember feeling slightly annoyed... I mean, I knew it was going to end at a certain time...and then...it wasn’t. I mean I didn’t say that to her... [...] and also, you know, I was ambivalent...I was quite - I was glad that it was going on as well.”

Participants’ reflections on their therapy and the therapeutic relationship

In a study of the ending of therapy, it seems pertinent to write a little about participants’ reflections on the therapy itself. Each individual of course had their own problems and startpoints, and their own perceived gains and challenges. There is room here only to give a flavour of the variety of experiences, and some commonalities.

All participants felt that they had benefited from their therapy. A mix of gains were mentioned, including: support, empathy, insight, helpful strategies, breaking patterns, becoming less anxious, being more in touch with feelings, resolving difficult relationships, learning to trust and ‘integrating different parts of myself’. As individuals, some participants were more reflective than others, and/or more able to articulate what their therapy had been about.

Of course there is a distinction we in the profession struggle with (particularly in ‘outcome’ measurement), between longer-term gains, that may not even be evident at ending, and gains recognised in the moment. Participants were not in a position, so soon after ending, to judge or make distinctions here.

Notwithstanding the small sample, I observed a tentative correlation between having **longer** medium-term therapy (a year plus) and the feeling that therapy had had more impact overall.

Philip on the one hand appreciated the focused attention of therapy and its reassuring rhythm.

“It’s comforting to know that once a week you can come down and unburden your thoughts for an hour...or best part of an hour...with somebody who you have confidence in, empathetic and so on.”

However, he also reflected on his pattern of donkey-like stubbornness (passive aggression?) that had constantly put the brakes on moving forward, while simultaneously recognising the value of the challenge of therapy.

“I’m sure he [therapist] felt that I could have been going further and faster and I think he’s probably right! I have been dragging my heels...I know that (wry laugh) [...] I probably used to sort of...um...bit like the donkey that doesn’t like to be ...beaten forward... (smiling)...and um..but I mean I recognise that...unless you’re a bit challenged in coming to have some therapy, I suppose there’s not a lot of point really.”

Marcus, who had come with anger issues, also appreciated the regular weekly frame of therapy.

“It was good...knowing that time was there... in the week, I’d probably think – oh well, I can bring that up, when I have the session.”

And therapy had helped Marcus in offering some illumination on his anger. His therapist had “talked about something called ‘fragile process’ [...] that – I’ll go off – I’ll kind of magnify events out of context sometimes...”. He started to experience what he described as ‘controlled’ anger, in contrast to his more typical uncontrolled rages.

“She [therapist] said – and I’d agree with her – that that was quite a good expression of anger, because it didn’t flip over...but it made the points it needed to make, in an angry way, but I didn’t rage...”

There had been regulation' learning for Pamela too. Often feeling *“at war with myself”*, she had discovered to self-soothe.

“I’m getting a hold on everything – or most of it, like I can soothe myself now, without pulling out my hair or...sometimes I would hit myself you know...all these things that I used to do were part of the anxiety...”

For Pamela, self-acceptance had also been important. She said, in relation to her termination, *“forgiving myself was one of my biggest things”*. In addition, connecting her issues to childhood had also been enlightening.

“It was like learning to walk and talk and think again, from the very beginning, because I’d been in such a mindset from an early age, and it turns out my anxiety came from my childhood; I just didn’t realise it.”

Pamela emphasises the revelatory aspect with the polysyndeton at the beginning of the quote. The intensity of the sessions had the potential to exhaust her, as she describes here:

“Most of my sessions with Jane I ended in tears! [...]...oh my gosh, who knew it could be so a) very cathartic and very therapeutic, but also emotionally draining...and I would have to come home and get an hour or two kip before I would be of any use to anyone and myself.”

For Andrea there had been more obvious resistance to the painful aspects of therapy.

“There was a period of time when I almost didn’t want to go back...because I was really struggling with what I was dealing with, and I knew it was going to be hard, I would sit there bawling my eyes out, and would even sit in silence sometimes...[...] and I was like – I’ve had enough of this, I don’t want to deal with this any more...this goes in the ‘too hard’ basket, and Gillian’s going to make me deal with it, and I don’t want to deal with it any more...”

But it seems that Andrea did persevere, and had gradually gained some insight into her emotions.

“I had no idea I was angry - no idea at all. All I thought I was feeling was – I was sad because I missed my sister [who died]...[...] no idea that I was like – how dare you leave me?”

An important aspect of therapy for Jason had been to ‘normalise’ his problems (of difficulties in finding a partner, job-hunting, uncertainty over accommodation) – such that he could see these were problems common to many young people, and not just linked to his disability.

Evelyn echoed Pamela’s self-acceptance to some extent, feeling a ‘weight was lifted off her shoulders’ when she could release herself of blame:

*“Before, I used to blame myself, and say – oh, it’s my fault that my mum wasn’t nice to me when I was younger...it was my fault, with me and the children’s dad...I realised that it wasn’t me to blame **totally**, so...[...] .it was a breakthrough.”*

Bianca and Hilda, perhaps the most vulnerable participants, seemed to have needed essential ‘holding’ as much as anything, and were less inclined to talk about particular insights.

The therapeutic relationship was, unsurprisingly, central to all participants, and is explored more in Sub-theme (e) later, but again the **individuality** of the relationships comes through and is relevant to touch on here.

Pamela, semi-alienated from her mother, was deeply attached to her therapist, almost idolising her as the most wonderful wise healer, in whom she had complete faith.

Hilda, for whom loneliness was a key theme, spoke of her therapist as *“like the best friend you’ve ever had”*, highlighting her empathy, and delighting in their apparent interests in common – spirituality, and the arts – which her therapist encouraged her pursuing.

*“She knew that I wanted to dance, and sing and write poetry...and she was **so** encouraging [...]... a very good listener...very empathetic, she had **huge** empathy...I don’t know – it was just a great encouragement”*

Evelyn on the other hand was keen to stress the difference between therapist and friend:

“I didn’t see her as a friend, because she’s not my friend, she’s there to work, and I’m there to work, like...I’m there to get something, to gain something...”

Philip spoke more wistfully in relation to the therapeutic boundary that distinguished his therapist from someone you could invite out to supper.

“The nature of it is that it’s not a personal relationship is it, in that...well..er...[...] you know, much as you might like somebody, you...it’s not really part of the deal that you say – would you like to come out for a meal next week?! That’s just not part of the deal really. And you have to understand that.”

He uses the second person as if to try to help himself accept the implicit agreement (for all, not just him) – and the word ‘deal’ perhaps similarly.

Marcus expressed mixed feelings in relation to his therapist. A man prone to anger, as mentioned, he sometimes felt aggravated by her, but seemed to manage to let his feelings ‘pass’:

*“I **could** have got angry with her, because sometimes I felt she was being silly [small laugh]...[...] it was quite regular, I’d think – OK, fair enough, if you want to say that, that’s fine...”*

[I: Did you feel you were holding your anger in?]

“I was quite happy to...to sit with it. Because it was only one line of thought perhaps...that I felt it was...inappropriate or something. [...] I mean...I just let it pass...”

Other comments of Marcus’s were more wholeheartedly admiring and appreciative. Here he observes how well his therapist listened and remembered, and was present for him.

“With Paula, that technique of ‘listening’ that therapists have...and she did it very well...and remembering things I’d said from the previous sessions...[...] it’s just amazing – she just – she seemed...she always seemed to be there for me.”

Andrea, we saw earlier, found therapy very hard at first, and sometimes felt angry with her therapist for ‘making her deal with it’, but also gave credit to the non-judgemental “*place of comfort*” her therapist created, which allowed her to open up in a way that was perhaps at odds with her nature.

Jason said he had ‘invested’ a great deal in his relationship with his therapist, the businesslike language, as before, masking a deep attachment, as he also spoke longingly of the possibility of seeing him again (see Sub-theme (e)).

Bianca, who came from a place of basic dissatisfaction with services and help available to her, had had a negative reaction to her therapist at first.

“Actually it was quite frightening because she did have such a demeanour that...er...did exude authority and at the beginning I thought – oh, is this going to work?...”

The therapist’s clear boundary-setting had initially grated on Bianca, although - with her emotional dysregulation - turned out to be an acknowledged important part of the therapy. Boundaries were something Bianca had lacked in her childhood.

“I have to say, Judith was fantastic...it took a while, but she had all the qualities of a good therapist...very clear boundaries...whilst also caring...it’s interesting because I think of her as ...almost like – maybe – a parent figure...something I didn’t have, you know...who cared, with very clear boundaries, about what was right and what was, you know, wrong...[pause]. That was very helpful.”

The lead-up to ending

Again there were individual differences in terms of the lead-up to the ending, as well as some clear commonalities, discussed later, under the other domains.

Andrea had taken up Spanish lessons two weeks before her therapy was due to end; she considered both were ‘me time’, and rationalised that she would not easily have time to do both therapy and Spanish. Thus the end of the former overlapped with the beginning of the latter, blurring the sense of ending and perhaps helping to numb Andrea’s feelings around it.

“(seemingly confident) I think I’ll be fine – I have a very busy life, and I’ve also started Spanish lessons now, on a Monday, so it was like – it would be two nights of my week [if she did therapy as well]...so it frees up some more time for me [...] that works really well, those both things, those tie in well together...”

Her extreme emphasis on being 'fine', it 'working really well' and 'tying in well' somehow suggest an almost unbelievable tidiness, again raising the question of how much Andrea is in touch with any sense of sadness at the loss – a theme pertinent to her history.

Bianca's account of the lead-up also suggests a denial at work, with an ignoring of the ending at the time leading to something of a crash later, in line with her characteristic poor ability to regulate.

[I: How did you feel about that session, when she referred to time being up soon?]
*"I didn't really feel very much to be honest – because I knew, from the beginning...**Now** I feel it (resigned, slightly bitter laugh) – now, when I need it, I feel it. Like everything else in life...you know...you don't think it's going to be as bad. [...] but at the time I didn't think about it...until actually the very end."*

Typical of Marcus was making conflicting observations, and he offered another example when he said that on the one hand the approaching ending meant that *"everything got compacted, if you like"*, but on the other that *"it did seem endless in a way..."*. Evelyn spoke more dramatically (note her word 'explodes'), but also paradoxically, of knowing about the end from the start, yet still experiencing it as a shock.

"It's sudden, it is very sudden. Because even though you know it's going to end...and you've known from the beginning that we're on a time limit [...] it's like dripping, dripping, and it just like explodes at the end, you just end it."

"You just finish. It was very sharp and like the ending's ...very sharp...like a cut-off point, even though it was gradually over the weeks, she's like building up to say – you know, this is the end."

Evelyn's word 'cut-off' may be a clue here, reflecting her own cut-off-ness in terms of facing the end, a strategy to deal with her fear of it, perhaps.

For Philip the ending of therapy was a moving goalpost, with him considering ending in advance of having to end (something that others, such as Pamela, Evelyn and Hilda would not have dreamt of doing), but finally finding himself going with the dictated ending of his therapist's placement finishing. As in his past, he ultimately found himself contemplating rather than making choices.

A number of participants openly dreaded the loss of therapy, as the ending approached, although as we shall see later, this was often mixed with other, more positive feelings. Pamela perhaps had the clearest concept of a 'countdown', the final strait calling to mind a death toll.

“So when she told me April would be my last one, it was like...dreading...counting down the weeks...[...] I'd be like – oh God, I can't give this up! I need it [laughs] because whenever things went wrong I always knew that come Monday morning I had someone to discuss it with, and talk it out; to make sense of it all...[...] And once the new year came in, I knew, it was like a death toll...it was just like ...BOOM! ...BOOM! And I just kept thinking – oh my God, I don't think I can do this.”

Hilda was clearly dismayed about the loss of her therapist, but in contrast to Pamela seemed to have blanked her feelings during the approach to ending, concentrating instead on being effusively grateful for the extension she was given. In the interview it was hard for her to revisit this time.

Some felt pressure to divulge or disclose, with the end in view (see Sub-theme (c)), while others had a greater sense of the ending coming at an appropriate time for the work – see Sub-theme (b). Andrea spoke with brisk certainty of having dealt with what she needed to. *“If I felt there was still more stuff to be dealt with, I wouldn't be finishing.”* This does belie the fact that Andrea **had** to end with her therapist. It seemed part of Andrea's pattern to take the 'in control' position, regardless.

All participants' therapists had introduced the subject of ending, and invited some sort of discussion and exploration around it, as it approached, although how much discussion there had been varied according to individual participants. Marcus and Jason were both reluctant to give it much focus. In these quotes, Jason supports his therapist's intention, but sounds fearful, while for Marcus there is the hint of a tussle as to who could control the agenda.

“Ivan first broached it as an idea – ‘Jason, I just need to remind you that we're coming up to the end I would like to give you some time to think about the issues you'd like to address and how we're going to approach the ending’...[...] so, he didn't ‘spring it on me’ [...] I suppose the first time he mentioned the ending was about seven from the end, and then after we discussed it initially I just kept it in the back of my mind... ‘OK’...a kind of faintly unpleasant realisation of something you already knew...[...] you know this was coming, you don't really want to discuss it....” (Jason)

“I think she was quite eager to talk about it [ending], because she’d bring it up, now and again, at the beginning of a session...but I was much more in the here and now.”

(Marcus)

Bianca’s therapist, perhaps mindful of Bianca’s emotional dysregulation, had clearly flagged the impending ending. Bianca perhaps tried to counterbalance her own sense of powerlessness (in having no choice but to end) by observing and praising her therapist’s competence. *“I have to say [...] she did her job very well there...telling me that time was going to be up very soon.”*

Emotional response to ending and the final session

Again I will concentrate here on highlighting some of the individual differences between participants in terms of their emotional response to ending and the final session, while the commonalities they share will be given more focus under the later domains.

One difference was the degree of open-ness in relation to expressing feelings of sadness and loss (which it was my strong impression all felt, to some extent); but some were expressive, others more oblique. Loss is explored later, under Sub-themes (d) and (e), but here I will give an indication of the different expressions of it, from different individuals.

Evelyn openly drew a parallel with death – albeit apologetically, as if shocked by her own words: *“This is really bad to explain it this way, but it’s like someone **dying** suddenly...”*

Pamela also expressed the loss of her therapist as akin to a death, and found the complete severing of contact painful. She was quickly drawn into her familiar abyss of abandonment.

“I was going to lose this person...and it felt like a death. It felt like...I think the last weekend I felt like I was grieving....because I’m never going to see her again. Ever. And it’s just ...it was the hardest thing ever, to think about. And that was one of my problems – is that I don’t like change. [...] And now that Jane’s gone, I feel abandoned.”

In general the men were less direct in expressing sadness. Philip downplayed his sense of loss - although it still came across. Initially he said, *“I have felt a bit of a sense of loss at times...”* then later, *“it’s something that’s been very helpful and in that sense I’ll miss it, but I’m sure I’ll see it from the perspective...it’s not like being hit by a car, I knew it was coming and it’s come, and you deal with it.”* Somehow the dramatic image of ‘hit by a **car**’ **actually**

ends up suggesting a presence of impact, rather than the lack of it. Marcus, the other middle-aged male participant, described a poignant sense of finality, yet also struggled to actually convey his own emotions, and his account remained essentially detached: *“You know...it ended...and it was...sad...and...I sort of thought, I remember on the day, I thought – I’ll never come here again. [...], this is the last time I’ll be here.”*

Anger and resentment at the imposed ending had their place in some cases. The ending of Bianca’s 14 months of therapy has to be seen in this context of her viewing herself as needing significant support from mental health services, support which in reality was patchy. She paid tribute to her therapist being very clear about the prescribed ending, saying she therefore ‘couldn’t be angry’ with her or the charity, yet her words convey a frustration and resentment with the system as a whole. *“I couldn’t be angry with somebody who was very clear...[...] but I do think more money should be put into mental health services...”* Bianca acknowledges *“the loss is there **now**. Sometimes you don’t feel the loss of something until, you know, you understand you really needed it”*, but overall struggles to sit with her feelings, and it may simply be easier for her to talk more generally of the shortcomings of the health service. We will see, under Sub-theme (e), that Bianca had particular frustration with there being a set period before she could contact her therapist again; she pays lipservice to boundaries - but emotionally rails against them. Later she again conveys a veneer of rational understanding covering more childish foot-stamping, and the sense of having been left in limbo. *“I wish she might have mentioned other things...getting more help...maybe putting a plan together in terms of what I would do, if I needed to have further support...[...] Maybe she was trying to not baby me any more...[...] With the problems I have, I don’t think...I think it’s a lifelong thing, you know.”*

Pamela, we have seen, felt enormous sadness about her therapy ending, but she also mentioned resentment – while quickly stalling herself with a rationalisation. *“In the same breath I was resentful that it had to come to an end – and why couldn’t I continue to see Jane? But I suppose they have to offer the service to everybody...unfortunately...”*

In Evelyn’s words there is possibly the echo of the rage she felt with her father, who had another family while she was growing up. *“You don’t get to see that person again – even though they’re there...”*

Andrea revealed her sense of vulnerability around the asymmetry of the therapeutic relationship. *“I’ve opened myself up....you don’t really know much about them, but they know a lot about you, so you feel that you’ve become very close to them...but I obviously don’t*

know anything about Gillian really, because [...] – it's a one-way street." Her final words here again have an angry ring about them.

Experiences of the final session were also individual, as well as having commonalities, drawn out under the other domains. Some participants gave gifts, meaningful in different ways according to the individual. For example, Pamela was keen to leave her therapist with a positive reminder of herself as a client. She thought carefully about her therapist and the characteristics of the gift:

"I was going to take her flowers, then I thought – no, flowers die...I want something that's going to have a little bit more longevity, so, because of her 'new age' kind of thing, [...] I bought her a Feng Shui bamboo plant, which is supposed to bring good luck and keep evil spirits away and stuff, [...]...it will continuously live on and on... [...] So every time she sees the plant she'll think – 'I done good, that's one that I helped; I know that as long as my plant's alive, she'll manage' (laughs) sort of thing."

Pamela also seemed to be giving herself a boost, with the metaphor of the hardy, long-living plant. For Marcus, his gift-giving was partly about crossing a boundary – he knew presents were, strictly speaking, against the rules, but took refuge in an almost playful mode, saying – *"rules are meant to be broken sometimes, they're not cast in stone, you know – and anyway, I mean clients are slightly mad or supposed to be!"* Bianca gave her therapist a card, both wanting to thank her, and gaining from the setting out of 'meaningful' words.

"I thought about [...] buying her a card and writing something meaningful down, to thank her for all the help she'd given me. [...] I just bought a card that was plain [...] ...it was more important for me to write the sentiments [...] something along the lines of – thank you very much for your support...you know, this journey has been very hard, you have been extremely helpful towards the end, thank you so much from me...[...] .for leading me, putting the effort in..."

In keeping with Bianca's anger towards the service for the limited offer, her expression of gratitude seems moderate rather than wholehearted (*"putting the effort in"*, etc). The distraction function of a card may also have been important to Bianca, who took an almost blasé attitude towards the ending on the day, only later mourning her loss.

Physical contact featured for some, in the final session, again representing different meanings for different individuals. Final session hugs, it seems, had a number of functions,

including participants' expressing gratitude and emotional attachment, having a desire to assert themselves, or wanting to 'mark' the ending, Therapists too may use a hug to acknowledge a relationship beyond one of service provider and user. While Pamela said she *"couldn't help herself"*, in going for a hug, Evelyn, keen to mark the session, 'asked' for a hug, to some degree in compensation for the absence of any other 'celebration'; the hug she received gave the ending some solidity at least. *"It felt like a solid 'this is the end' [...] it was like a nice ending..."* In Bianca's case the therapist initiated the hug – welcomed by Bianca as a sign of personal caring, beyond the 'service' ring fence. *"[The hug was] very nice, you know...I mean I genuinely think she did care."* Andrea on the other hand had thought about hugging her therapist, but – in keeping with her avoidant attachment pattern – felt unconfident about the reception she would receive (feared rejection?), and held back; this she had also done with her previous therapist. She ended up disappointed, expressing her frustration by emphasising the imbalance (previously described as a *"one-way street"*) of the therapist-client relationship, and focusing more on the assumed reticence of the other rather than her own. *"The funny thing is it was the same with my last counsellor – again, I felt like, oh it's my last session, I want to give her a hug, but she wasn't forthcoming either, so I'm like – I guess for them it's a professional relationship, so maybe if you give your client a hug, maybe it feels too personal for them."* We return to hugs and their meanings under Sub-themes (c), (d) and (g).

'Holding in' emotions was a feature of final sessions for some – sometimes in parallel with expressing some (see Sub-theme (g)), sometimes in place of it. Hilda, who had never cried in her sessions, put a lot of store by 'containing herself', perhaps partly reflecting her war-generation upbringing, but also her psychic fragility – giving her the sense that crying with a witness might trigger total collapse?

"When I said goodbye to her – I'd learned to contain myself...so there were no tears in that room...it was only when I got home.....[...]...there were several times when I was talking to her previously I could have just cracked up...but I've sort of learned to contain myself....[...] I'm not meant to cry. I mean I had lessons – when I was very young, stop snivelling, and all that kind of thing..."

Jason had been grateful for the end-of-therapy form-filling, as he too was keen to hold himself together and not become too emotional in the session – *"I didn't want too much sentiment [...] I kind of had to keep my responses fairly short."* While Jason felt relief at the paperwork muting his emotions by diverting attention to something practical, Evelyn felt disappointment at form-filling replacing the sense of celebration she would have liked

“We had to fill in the piece of paper that we had in the first assessment session [...] We had to go over that paper again...[...] filling out a little bit of paper, it wasn't anything...significant.”

Her repetition of ‘that piece of paper’, ‘that paper’, ‘a little bit of paper’ stresses its (resented) insignificance for Evelyn, while her referring to ‘we had to...’ underlines the demands of the third entity – the service, possibly detracting from a hoped-for greater intimacy between her and her therapist?

What ‘effect’ did ending have?

This piece of research specifically focused on clients whose endings were preordained. Perhaps unsurprisingly, most participants – prior to the interview - had not given much conscious thought to what effect ‘having to end’ was actually having. The ending was a given, and there was little evidence of any hypothetical comparison with a more ‘chosen’ ending. In this sense, the individual participants were notably similar. Moreover, the ‘imposed’ aspect of the ending did not seem to have been discussed or processed much in the sessions, and this may reflect the service context, where everyone has a comparable deal, and this norm invites no special attention.

We will explore, under Sub-themes (b), (c), (f) and (g), some of the attitudes and responses to the ‘imposed’ aspect of the end, once participants were invited to focus on it, and here will just highlight a couple of differences between individuals. For Hilda, having to end was almost entirely unwelcome, although accepted as in line with her previous experiences as a largely passive recipient of services. Evelyn, on the other hand, while she had some nervousness about ending, had more fear of ‘unending’, and the dependence that continuing counselling represented: *“If you didn't have the time limit, and you keep going on and on and on, then you'd be dependent on your counsellor.”* Others laid greater stress on a future orientation, in Philip's case starting to ‘put into practice’ some of his learnings, and in Andrea's being *“almost little bit excited to see how I can cope on my own”*. Jason admitted some fear, but for him he was comparing this ending with a previous (also imposed) one where he felt more scared. *“Whereas now I'm probably a bit less emotionally scared, after finishing with Ivan...when I was finishing with Margaret [previous therapist] everything was just up in the air. It was just scary. Things are not quite so scary now...because I'm slowly building up connections, slowly finding my way...”* The comparison held a degree of comfort for him, in underlining his progress.

Participants' experience of endings in general

Sometimes, although frankly not as often as I had expected, during their interviews, participants spontaneously brought up other endings, as points of parallel or comparison; in other instances participants were prompted by me to consider other endings and losses in their lives. Endings are a huge and ongoing issue in life, and there was not time in these interviews to do more than scratch the surface of any parallels between therapy-ending and other endings. It also seemed to be the case that there had been relatively little time given, during therapy, to processing the therapy-ending in relation to other endings in participants' pasts, which may reflect the overall 'limited time' nature of the therapy.

However, and particularly with encouragement, individual participants did bring up other endings in their lives that included: the death of someone close, abandonment, divorce, a pregnancy termination, job endings, end of school or university, moving home, and previous therapy endings. These endings had sometimes triggered wider endings – for example, when Andrea's sister died, her parents then split up, and it was the end of life as she knew it in almost every respect; when Philip's stepfather died, it was not only a death, but the potential 'sealing over' of the secret of the identity of his biological father, since no-one else alive was aware of it.

Endings were difficult for Jason (*"I'm not good with endings, I don't like endings"*), He talked of the 'void', post university – when he had to finish his previous therapy as well as move away from all that had become familiar to him during his studies.

"One of the big things that was going on when I was finishing with Margaret [previous therapist] was just a complete void, I suppose, in terms of not knowing where I was going to be living, not knowing anything about future job opportunities, and just having to go back to London with virtually no connections [...] a very scary time."

Moreover Jason had experienced some painful deaths in his family, including that of his much loved grandmother, four years earlier – *"I suppose I have to come to terms with the fact that my nan's death will always have the ending I don't like...and that's, that's what it is...[...] it just hurts...so I try not to think about it too much"*. He reflected this 'trying not to think about it too much' in keeping the ending of his therapy *"in the back"* of his mind, rather than the front.

In Hilda's interview, she found herself talking emotionally about seeing her dead father in his coffin, as a child of 11, and being told it would be inappropriate to kiss him; perhaps the

complications around the appropriateness of hugs with her therapist (who was sometimes receptive, sometimes not) linked back to this.

Marcus was prone to find endings difficult, upsetting, and prompting - his word - self pity: *“I think it just feeds into my negativity...and I feel abandoned.”* He recalled feeling ‘quite shocked’ when told his NHS therapy was going to end, on a previous occasion. In relation to leaving jobs, he said - *“I’m not good at saying goodbye to the people...I’d avoid it...where I am now, I will leave it, eventually, in the next few years – but I think I’ll just slip away...”*.

However, he also spoke of the grief of losing a previous therapist. *“Relationships have ended and I’ve grieved them. I have actually grieved this therapist I was in love with...that was a big grieve...you know, I was kind of stunned.”* Perhaps for him therapy had presented an opportunity to grieve, rather than deny, a loss. Although conversely there was an element of relief in the end of this current bout of therapy being less intensely painful than the previous one.

Bianca stressed that, with her fragile mental state, the ‘lack of predictability’ inherent in ending was hard for. Ending therapy came at the same time as she was planning to move house, away from her arguing parents, and it seemed like too much change for comfort.

Andrea, with her traumatic history, also found the prospect of change challenging, but in her case her vulnerability was overlaid by her characteristic robust veneer:

“I can find change difficult, that was one of the things I’d been working on in my counselling...trying to look at things as a new opportunity...because sometimes I find it difficult when you’re then thrust into the unknown...[...] because – well I don’t know what’s around the corner...and I’m quite a positive person, so try to focus on being really positive and going, ‘you know, it’s going to be fine, don’t worry about it, it’ll all come together’ sort of thing.”

In fact Andrea’s working life was characterised by constant short job contracts, which in some way suited her avoidant attachment style (*“I’m used to endings as such”*), also demonstrated by her showing little overt emotion in ending her therapy.

Pamela’s fear of abandonment betrayed a more ambivalent, clinging attachment pattern - played out in her relationships with men.

“No, they [endings] are not easy...because of the whole abandonment issue, I have a great – what’s the word...allergy! to it...I’ve gone out with all my boyfriends twice – or maybe three times... I keep coming back, because it’s a habit, and better the devil you know...”

Evelyn said, of the end of her therapy, it *“just felt like **another** relationship ending”* – calling up her father’s leaving ‘very suddenly’ to live with his ‘other’ family, although she was quick to add that she felt this ending was *“totally different – because my dad left for selfish reasons; I’ve come to achieve something...”* However, her then mentioning her emotional realisation as the session ended – *“oh my gosh, I’m not going to see Elisabeth again”*, suggests there is more of a parallel in the endings than she may have been aware of.

Post-ending contact with the therapist?

The subject of participants’ possible or fantasy future contact with their therapist is given greater inspection under Sub-themes (d) and (e), but it is worth mentioning that again, there were clear individual differences here.

Three participants had specific plans to make contact, perhaps using these as lifelines to hang on to, in the face of feeling shaky around ending. Jason’s therapist, Ivan, had given him his email address while cautioning against its over-use, and Jason had given the business of re-contact much thought. He clearly wanted to demonstrate to Ivan that he could be controlled and respectful by **not** using it – until Christmas, three months away.

“If I leave it that long [till Christmas] then he’ll understand I wasn’t champing at the bit to contact him...particularly as he’s made the effort to say – ‘Jason, I don’t want you to use it straight away’”

For Jason, future contact was also linked with a hope around his own progress.

“I’d love to be able to tell him – I’ve got a new partner, or I’ve got a job, you know...or I’m living at this new house...those are the three particular events that I’d like to maybe tell him about in the future...”

For Bianca, the challenging issue of boundaries came into it, she having *“made a promise that I wouldn’t contact her”* for three months. She did, however, plan to contact her after this, and like Jason, wished to be able to tell her therapist that she was doing better. In Bianca’s case her words – and tone - are possibly tinged with the anger of the abandoned.

“(slightly shrill) I hope to say I’m feeling better! I don’t want to say actually I’m feeling really crap (little laugh) [...] you know, it’s natural, you want to turn round and say – actually I’m doing OK”.

Hilda also had plans to contact her therapist. She had rationalised it was reasonable to ask – *“If I get in touch with you – **now and again**, to speak with you, would that be all right?”* That her therapist had said yes was *“a great relief”*. Hilda planned to telephone her therapist ‘at the weekend’, barely two weeks after ending, and was counting down the days. As with Jason, the sense of having a lifeline in place seemed important, but Hilda was finding it harder than Jason to hold off using it.

Other participants were living more in the realm of fantasy contact with their therapist. . Pamela had had to send in some forms after her last session, and puzzled by ‘client code’ had texted her therapist for clarification. She suspected the rules might dictate that her therapist could not answer her, but still she hoped... *“A little bit of me wants to have that little contact...for her to ask me how I’m doing...but [...] she’s most probably got certain protocols [...] she might be thinking this is my way of reaching out to her so she might not answer...”* She shows some emotional maturity in seeing different parts of herself (*“a little bit of me”*) and in putting herself in her therapist’s shoes

Philip expressed a hope that he and his therapist would exchange *“a few friendly words”* if they bumped into each other. Marcus echoes this, when he talked about imagining he and his therapist might *“exchange little smiles”*, should they ever find themselves on the tube together. His fantasy suggests the intimacy of a shared secret.

Andrea said on the one hand that she understood *“our time period together was for a set reason, and I can’t overstep that”*, while at the same time also saying, *“I’m sure if I was desperate or wanted to speak to her about something, I’m sure she would be open to that...”*, suggesting a somewhat confused hope of a safety net.

How has it been, since ending?

Most participants had had only a short period post ending their therapy, before their interview. But again, individual experiences of this period had varied.

Jason, Bianca, Hilda and Pamela had all to some extent struggled with their sense of loss. Jason spoke almost as if of a romantic break-up, that he hoped the loss he felt sharply now

would “*semi-fade into the background*” as time passed. For Bianca it was worse than she had expected, and she was in a state of some anxiety, saying “*well, shit, you know, I wish it hadn’t ended so quickly*” and that she could do with having her therapist back. Hilda had felt bereft: “*it really hit me...you know, I’d felt I’d lost...almost a chum...*”, and she had only just resisted picking up the phone to her therapist.

Pamela had had one ‘bad week’ where she felt herself “*regressing back to my old way of thinking, and habits and thoughts*”; she had gone on a manic shopping splurge, but had redeemed the situation, returning the goods and finding she could forgive herself this ‘blip’. She was also doing her best to see the positives of ending.

Andrea, in contrast, was concentrating on the practical benefit of having an evening freed up, and doing Spanish lessons instead.

When asked about possible future therapy, all could envisage having it at some point. However, Philip talked of wanting to absorb this therapy experience first. Evelyn felt she would have nothing much to say now, but also feared dependency on therapy. Bianca currently had too much else going on in her life, but would certainly be looking into having therapy again in the future. And others (see Sub-theme (b)) wanted to focus more specifically on acceptance of, and some inherent positives in, the ending of (this) therapy.

Participating in the research

Participants identified a number of reasons for volunteering, explored more thoroughly under Sub-theme (h) (and to some extent Sub-themes (c) and (d)), but worth just mentioning here, to give a flavour of their variety.

One reason for participating, emphasised by Pamela, Evelyn and Philip, was that the interview provided a transitional step in ending therapy – both via the similarity between the interview and a session, and via the perceived connection (through our shared profession) between me and their therapist. Another (linked) reason, mentioned by several including Jason and Evelyn, was that the interview offered a chance to process the ending. For a couple of participants – including Evelyn again - the interview also represented ‘taking a step’, giving themselves an awareness of their own agency. Andrea, Marcus and Hilda were among those who emphasised their wish to give help, perhaps each had reasons for wanting an inversion of the client-therapist power hierarchy; volunteering effectively gave them the upper hand, having something of value to offer. Andrea also referred to the fact that she had conducted research and needed participants herself in the past, so she identified with my

position. She said she was *“more than happy to help out [...] And – it’s no big deal for me”*. Evelyn had also done ‘experiments’ and knew what it was like to need participants, which had added to her motivation to volunteer. Hilda and Marcus were more tentative, perhaps seeking reassurance from me: *“It may help [you]; I don’t know about that side of things”* (Hilda), and *“I thought – oh, I’ll do that. It could be...helpful to me...and maybe to you...”* (Marcus). Marcus’s comment embraces the idea of reciprocation, which links with the notion Pamela had of wanting to ‘give something back’, having received something of worth herself through her therapy.

Overall, Andrea and Bianca had the most detached and matter-of-fact responses to questions around their choosing to participate, and indeed to questions around the ending of the interview itself. Their two interviews were shortest. Bianca felt that identifying her feelings at the end of the interview was ‘hard’ – *“I’m not feeling...not feeling too engaged with it [...] not fully connected”*. She was perhaps distracted by her anxiety, her discovering that the period post-ending therapy was more challenging than she expected, and her wondering what could come next.

Andrea on the other hand stated that she felt no different at the end of the interview from the beginning; it was as she expected. This echoed an earlier comment she had made about not enjoying her therapist asking her how she was feeling, often being unable to go beyond simple ‘I don’t like it’ answers. The attempt to ‘open up’ the experience of ending may at some level have felt a little threatening to Andrea, despite her apparent keenness to participate.

4. DOMAIN (2): ACCEPTANCE

Overview of the domain

All participants expressed some degree of acceptance of the preordained ending, and moreover some acknowledgement of the power of an enforced ending to bring about change. The domain has two sub-themes beneath it: one is to do with a purer ‘acceptance’ of a known-about-in-advance ending, and the other to do with the potentially galvanising aspect that awareness of limited time can have. In both cases there is an allowing or welcoming of the ending – as opposed to a resisting of it (which we explore in Domain (3), later). As we shall see, both ‘accepting’ **and** ‘resisting’ can co-exist.

Sub-theme (b): A basic human acceptance of preordained endings

Overview

Preordained endings in therapy need to be seen in the context of preordained endings in life. As humans, we constantly experience entities (childhoods, courses, holidays, meals, exams, books...) that have, to some degree, a set duration, and at some point come to an end. While participants in the research only occasionally verbalised their specific recognition of this broader point, the analysis does reveal - to a greater or lesser extent, among the different individuals – a basic acceptance of the ending of therapy, in line with this wider experience of preordained endings as deeply familiar. In addition, an acknowledged fear of ‘never-ending’ therapy - possibly linked with everlasting dependency, meant a set ending was to some extent reassuring. Moreover, in the context of a charitable service there is an expectation of limit.

Entering therapy

Pertinent to Sub-theme (b) here is the fact that all but one of the participants had had therapy before, and in the majority of cases this had been for a limited time. For Pamela there had been an offer of short-term counselling through work. Jason had had to finish his university counselling because he graduated.

“I finished my previous therapy at XX university [...], and that obviously had to finish because of the official finishing of my degree.”

So the notion of a limit was often familiar. The fact that all were open to having further therapy at some point (although not immediately, as was a criterion of participating) also paints a picture of some acceptance of ‘therapy in bouts’.

Length of therapy: expectations and attitudes

Important here is the recognition of the ‘service’ setting, and the general sense of acceptance of what is offered in such a context. Charitable service (subsidised) therapy differs from private therapy in its fundamental basis: the client is being offered or given something by a provider, rather than making a purchase. There is a question of eligibility, and this research suggests clients tended to be grateful when it was confirmed they had it. Perhaps not surprisingly, there was therefore some expectation, and acceptance, that the service offer had limits. Participants in this study had an awareness that private therapy would cost considerably more than the £5 to £10 per session they had typically been asked to contribute.

Moreover, for some participants the length of time on offer seemed munificent. For Pamela, after her several somewhat disjointed bouts of therapy, a period of ‘up to a year’ seemed comfortingly extensive, To Jason, again the length of time seemed generous, compared with his expectations. In his case, however, he was not clear about the period until after the therapy had started – when news that he would ‘get about a year’ came as a ‘pleasant surprise’.

The lead-up to ending

Relevant to Sub-theme (b) here is the sense some participants had of it being ‘the right time to end’ – albeit that the ending was imposed. Several spoke of perceiving the time of ending as appropriate or fitting, (even while in some cases simultaneously talking about dreading ending and feeling pressurised). Perhaps too, there is an element of the work fitting the time: if time is limited, the work may take on a shape that fits the space allotted. The link with Sub-theme (c), the galvanising effect of ending, may play a part here too – in making the ending feel, to an extent, ‘right’.

Evelyn reflected that in some ways an ‘endpoint’ had been reached – with no more material forthcoming. *“I needed to end...[...] everything that I came to achieve, was achieved...and there was a point where I actually came to a session and I had not really anything to say...”* However, especially given Evelyn’s contrasting sentiments expressed under Sub-theme (a) above, the therapist in me does question – might Evelyn be shutting down, as a defence against feeling abandoned?

Philip seemed to feel that the end was timely, in his case he linked it with the idea of independence, and the need to move forward with the learnings from therapy (a link here with Sub-theme (c)). *“It’s something that needs to be brought to an end at some point. And I felt that it might be for the best to see how I would fare under my own steam anyway [...] and try and carry some of that benefit forward.”*

Jason also spoke of the need to reach independence from therapy, and that now was ‘the right time’ to end, although in his case there is more of a sense of him trying to persuade himself of a positive slant to the ending, and a warding off of self-pity. He seems to be highlighting the distinction between want and need. It was *“...not necessarily that I **wanted** to finish, but that now is the right time. You can’t go on forever with counselling [...] eventually you have to stand on your own two feet [...] Whilst my emotional being didn’t necessarily see it as a positive, when I thought about it consciously I was determined not to sit and...cry into*

my milk.” There is something poignant about a wheelchair-bound young man referring to standing on his own two feet, while both this phrase and the reference to crying into milk suggest regression, and the challenge of growing up.

Emotional response to ending, and the final session

Relief was one feature, among the different emotional responses to ending. For Philip for example, with his pattern of hesitancy and vacillation, the ‘certainty’ of ending itself had a reassurance about it, and an element of relief, that the endless cycle of discussing what the week had thrown up was stopping. Here he uses the dramatic simile of ‘radioactivity’ to highlight the potentially interminable aspect of therapeutic material.

“When it came to the end, it felt about right really. If you’ve been doing something for 35 weeks...I could quite easily turn up here next Friday at 2 o’clock, and start talking again...[...] the material generates itself, doesn’t it! Based on whatever’s there, like radioactivity... [...]...even just that week’s worth of reflections and experiences.”

Later he used the metaphor of ongoing therapy being akin to continually eating, without ever allowing time ‘to absorb’ the nutrition. Philip conveyed the impression that therapy had been hard for him, and he had at times resisted the pressure to engage, which may represent another side of the relief that it was now ending. For him it seems that long-term open-ended therapy might have felt threatening in a number of ways, and that there were advantages to him in his therapy ending, albeit that there was the hint of a ‘cop out’ about it.

What ‘effect’ did ending have?

‘Having to end’ therapy seemed to be overlaid with a larger existential acknowledgement – a philosophical acceptance of endings.

“It’s my experience for things to terminate. [...] Things come to an end.” (Marcus)

For Pamela, recognising that ‘everything has a beginning, a middle and an end’ was therapeutic in terms of her past traumas. The idea of a ‘conclusion’ (via the concluding of therapy) brought insight and relief.

“Everything, I realised, has to come to an end. And I realised I held on to things too much – whether it was [...] the trauma of the assault, [...] the death of my gran...I never dealt with anything, it never came to a conclusion [...] so I had to learn that everything has a beginning, a middle and an end...”

And fear of the interminable was talked about by several participants. Loss may be feared, but 'endlessness' is too. The point was made that 'everlasting' therapy is a frightening prospect, possibly both from the angle of anything infinite, and more specifically in relation to the idea of dependence on therapy for ever. Evelyn felt that open-ended therapy would have meant she would "*never resolve anything*", but would be "*going every week just for the sake of it somehow*". She summarised: "*If you didn't have the time limit, and you keep going on and on and on, then you'd be dependent on your counsellor.*"

Pamela talked of the bringing of different parts of herself together, saying that without the therapy ending "*I don't think I would have done that integrating process ...because I was quite comfortable, the way I was, with her [therapist], I think I could have gone on...indefinitely, not having to integrate...*"

How has it been, since ending?

Aspects of participants' experience since ending, that reflect Sub-theme (b), include the fact, as mentioned above, that all participants could see themselves having more therapy at some point – but (as was a criterion of participating), none had immediate plans to seek it. Philip talked of wanting to absorb this therapy experience first; Evelyn both felt she would have nothing much to say now, but also feared dependency on therapy; Bianca currently had too much else going on in her life, but would certainly be looking into having therapy again in the future. Jason gave the sense of being drained by the emotional impact of ending, but also envisaged an immediate re-entry into therapy as possibly "*re-hashing the same old things – when actually I need to find my way to deal with them myself.*" Pamela on the one hand stated that she would have private therapy if she could afford it, but mused – "*would it stop me getting on with my life?*" Again we see evidence of the theme of there being a measure of human acceptance in – and welcome of - a preordained ending.

Sub-theme (c): *The transformative impact of therapy ending – and the particular 'carpe diem' of preordained endings*

Overview

This is the second sub-theme within the domain of 'Acceptance', and underlines the more 'active' aspect of the domain. Endings both constitute and prompt change – and there can be a welcome aspect to this. In this study there was for some a 'now or never' galvanising of

the work, the 'enforced' aspect of the ending playing a particular role here. For some the impact of ending energised their hopes and objectives for the future. Ending therapy also seemed to be associated with a shift in the relationship, at parting. Many participants described a degree of boundary crossing during their final session, more often initiated by the participant themselves (gifts, hugs, etc), and often this was linked with the desire to exercise their own agency – again reflecting the energy and 'carpe diem' of this sub-theme.

Length of therapy: expectations and attitudes

An example relevant to Sub-theme (c) that fits in here is Bianca's extension story. True to her mental health condition of emotional dysregulation disorder, Bianca's attendance had initially been sporadic – her health and boyfriend abroad both playing a part. Her therapist had given the extension with the stipulation that Bianca now must attend, inviting a new level of commitment to the process.

*“[the extension] – It was because I'd missed a few sessions [...], but she did say – you do now **have to attend**”*

[I: How did you feel about that?]

“[firmly] That she was justified, she was justified. And generous. [...] Maybe I wasn't totally engaged in the process at that time...I think perhaps it was at the beginning...and I was in two minds...and sometimes I didn't want to do it!”

With the end firmly in sight, and the time now clearly limited, Bianca had from then on engaged in a far more focused way.

The lead-up to ending

The lead-up to a preordained ending can produce a shift of gear in the work. Sometimes participants talked of a 'pressure', to cover ground, to 'divulge'. Therapists also sometimes also experimented and 'pushed', as time became short.

Evelyn and Pamela, both of whom had strong attachments to their therapists, and regarded their sessions as a place of sanctuary and release, appeared to have a strong sense of wanting to 'disclose all' – before it was too late. Evelyn talked of the 'rush' to get things out, as the year's end neared. *“I felt like somehow I had to get everything out, because I had a time limit of 'when'... I kept thinking about - oh, the end's coming soon, I do need to say everything, like get all my issues out”*. Pamela too felt the time limit imposed pressure – to *“get sorted...before the D Day.”* In Philip's case it was his therapist who seemed to want to

underline the 'now or never' aspect of ending therapy – his words have a brusque ring, although Philip acknowledges this is his own interpretation.

“He gave me the opportunity, [...] Anything you haven’t brought up already, now’s the time to get it off your chest really, because we ain’t going to be here in a couple of weeks’ time; that’s not what he said, but that’s how I interpreted it...”

Pamela felt her therapist had been more 'proactive' in the final sessions, introducing a new exercise using stones, for example. Philip's therapist had also 'pushed' him in the last few sessions - in his case, a little beyond his comfort zone. *“In a couple of those sessions [...] we did go to one or two uncomfortable places...[...].he got me playing my mother in a conversation [...] with me saying what I wanted to say, and then saying what I thought she would say, or think...”* Philip admitted feeling discomfort, yet also acknowledged usefulness in this more challenging approach.

Emotional response to ending and the final session

Relevant to Sub-theme (c) here is the boundary-crossing that often seemed to be a feature of participants' final session. We saw (under Sub-theme (a)) that some participants brought gifts, in all cases aware that strictly speaking this was against – or at least bending - the rules. Hence the action could be seen as a manifestation of agency or risk-taking - potentially linked with therapeutic movement.

Marcus was the one male participant to give a present. He chose a novel about a psychiatrist and patient, which itself had a focus on an ending - where the psychiatrist, in love with the patient, decides against telling her – *“he didn’t want to concretise it, by making it something out there in the world”*. Marcus himself had been deeply and painfully in love with a previous (group) therapist, and never told her; an issue that felt unresolved, although he had learned to live with it – and perhaps enjoyed indulging, slightly tragically, in it. His relationship with this current therapist seemed to have been much less intense – which had both 'second best' and 'relief' aspects. But of key relevance here is that Marcus clearly knew he was crossing a boundary with his gift, and although slightly anxious also betrayed some glee in flexing his own agency in breaking the rule.

“I was a bit nervous; she said she didn’t want presents, but I thought – I’ll give her a present anyway. [...] Well, I said something – I’ll bring you a present, and she said we’re not supposed to take presents (small laugh) – but I did anyway.”

As mentioned under Sub-theme (a), Pamela gave her therapist a bamboo plant (representing both thanks, and hope for her own future sturdiness) and a card, with substantial message, expressing her deep gratitude.

“On the lines that, if it hadn’t been for her I don’t know where I would have been, she helped put Humpty Dumpty back together again...um...I thanked her for making me believe in myself...[...] I just basically thanked her for every single point...it took up one page and a bit! [...] I was very very very very grateful.”

She used the end as an opportunity to both think through and convey her appreciation of the work – and her words (‘every single...’, ‘it took up one page and a bit’, the repeated ‘very’) all emphasise her strength of feeling. She also noted the service *“try to deter you from forming an attachment to your counsellor”*, and *“try to keep you at a distance”*, but she felt that giving card and present was *“what I wanted to do, so that’s what I was going to do”*. Again there is a positive energy in the note of defiance and asserting of agency; the resistance to being just a meek rule-follower; the desire to be seen as an individual, not just another service user.

Hugs also had their place in potentially indicating a ‘transforming’ of the usual, in most cases initiated by the participants themselves. Pamela, despite knowing it was frowned on to ‘form an attachment’ to one’s therapist, said she *“couldn’t help herself”*, - and went for a hug – which was freely given. Evelyn also seemed to have felt good about asserting herself with the hug, breaking out from her usual more passive pattern.

“I actually asked her – can I have a cuddle (laughs)...so I actually asked her for a hug, and said thank you for everything, that you’ve helped me...”

[I: Do you think she would have hugged you if you hadn’t asked?]

“No – she wouldn’t of! But I felt like I needed a hug – to say ‘thank you for everything, I’ve gained so much from there’, and it’s like a ‘goodbye’...but I approached [initiated – sic] a hug...whereas that was the only thing different in the session - apart from writing the paper -, so for me I ended it how I wanted to end it, by giving the hug [...] it made me feel good actually, when I gave the hug”.

Her repeated, *“I actually asked her”* carries a note of pride, and It seems as if Evelyn was also making a decisive move to counteract her disappointment in the ordinariness of the paperwork having dominated the final session – with some success.

The hug that Marcus initiated with his therapist was possibly in the shadow of unfinished business with his previous therapist. Like the giving of the book, there is also a hint of rebelliousness and ‘turning the tables’ in Marcus’s hugging his therapist.

“I wanted to give her a hug, at the end [...] I think I probably said, can I give you a hug...[...] It was slightly awkward [...] but I felt if I hadn’t it would have been a pity.”

[I: You’d have been disappointed?]

*“Mm....it was a bit like the other therapist...[...]...I gave her a book as well...um (pause)...but I didn’t give **her** a hug.”*

What ‘effect’ did ending have?

Many participants, notwithstanding their feelings of sadness and loss (see later), saw some positive aspect in the enforced ‘change’ inherent in ending – with its implication of new era, new beginning. Pamela acknowledged the particular learning for her, inherent in having to end. She reflected on her past pattern of ‘holding on’ (to people, to her traumatic narratives) being potentially beneficially loosened by having to ‘let go’ of therapy.

“It never ends if you keep on holding on to it. [...] I had a hard time accepting the fact it [therapy] was all over, but I had to – and I was like, Pam, you can’t hold on to this, this is one of the things that you do – badly! So – let it go.”

Other participants also commented, in different ways, on the pressure of the approaching ending actually accelerating the work, or prompting change that might not otherwise have taken place.

“It did mean that I had to kind of explore...everything. Everything got compacted, if you like.” (Marcus)

“Everything that I came to achieve, was achieved a little bit earlier...” (Evelyn)

Several looked forward to using learned strategies or new attitudes or behaviours in the future. Pamela looked back on *“getting very comfortable and not necessarily putting the tools that I was being given to use”*, but now wanted *“to go out and put it into practice.”* Philip also spoke of *“carrying things forward”* and (*“hopefully”*) *“putting into practice some of the things that I’ve been telling myself I would put into practice.”*

Andrea too said she could *“kind of start putting into place the things that Gillian was teaching me...and guiding me with..”* An example she gave was her therapist’s suggestion she deal

with her 'Peter Pan' father in less of a berating parent-to-child manner, and more as adult-to-adult.

How has it been, since ending?

As we saw under Sub-theme (a), there had been a mix of experiences in the short period post ending, but these included some decisively positive ones. Evelyn had made a new friend (*"not a professional, but she has a psychology degree"*) to whom she was opening up – having before therapy never shared her problems with anyone. Pamela, in the spirit of wanting to 'give something back', was considering volunteering at the trauma unit call centre at work

Participating in the research

For some participants the decision to put themselves forward for the research itself represented a bold step, possibly a new 'trying out' of the learnings from therapy. Evelyn was quite nervous and unsure what to expect of the interview. She talked about volunteering being *"an experience for me as well"*, and wondering what lay in store, then saying to herself more bravely – *"d'you know what, I'm not going to think about it, just [...] on the day I'll just – you know – see what's it's about"*. Philip's courage came to the fore more during the interview, when he somewhat suddenly brought a lot of his own material in towards the end, having just gone to a significant funeral that potentially sealed the secret of his biological paternity. His revealing this to me was unplanned, and turned out to be cathartic for him.

5. DOMAIN (3): RESISTANCE

Sub-theme (d): *Fear of loss, and resistance to finality*

Overview of the domain

Again there is a single sub-theme here, representing this important domain of 'Resistance', a paradoxical force in opposition to the 'Acceptance' domain above. There appeared to be two key, but linked, strands to this 'resistance' in the lead-up to a known ending: fear of loss, manifest in a resistance to finality. Fear of loss was openly expressed by some, more buried in others. In parallel, participants demonstrated a resistance to finality, evident in various actions and attitudes, such as plans for, or fantasies of, future contact; leaving their therapist with a gift; internalising their therapist's voice, and indeed opting to participate in the

research. Initially I toyed with treating ‘fear of loss’ and ‘resistance to finality’ as two distinct themes, but concluded that in the context of preordained endings they are inextricably linked, the latter frequently – if not invariably - being an attempt to cope with the former.

Length of therapy: expectations and attitudes

I had anticipated greater precision around both the presentation of, and reactions to, the time period of therapy offered than in fact I found. Although participants were all aware that there would be a time limit, many did not seem to have taken in the ‘maximum time offered’ information. The vagueness from some participants, when asked what they had felt about the limited period, could, I would argue, reflect some ‘resistance to finality’ even at this outset stage; a kind of wilful blindness to the ending being in the picture. Some other (though possibly linked) factors counteracting exactness in the question of time, included: participants themselves expecting initially they would need or want to come for a short period only and the suggestion from the therapist of a ‘trial period’, followed by a review; the addition of extra sessions in place of missed sessions and applications for extensions also blurred matters, while a couple of therapists were less than clear about exactly when their placement was ending. (There is some sense that therapists themselves may have some resistance to facing finality.)

The lead-up to ending

Again the slightly indistinct memories that some participants had of the lead-up period links with this theme of resistance or defence, in the face of impending loss. For some, in the lead-up, the ending seemed to come in and out of focus, perhaps like climbing a mountain peak, often shrouded in cloud but occasionally more visible.

Having said this, several participants openly referred to their dread of the loss inherent in ending therapy (as has already been mentioned under Sub-theme (a)). Pamela, we saw, likened the countdown to a death toll. Jason was another who expressed dread as the end approached, recognising both the unique-ness of the therapist-client relationship and his characteristic investment in relationships generally - *“ending something is never particularly easy for me...I dreaded the final session with Ivan, because I knew that – this is ‘it’ now...”* We also saw under Sub-theme (a) how Jason and Marcus resisted actually focusing on the ending – Jason keeping it *“in the back of my mind...you don’t really want to discuss it”* and Marcus wanting to be much more *“in the here and now”*, despite his therapist’s efforts to bring up the subject.

Evelyn had seen a fellow client on the bus, also upset about her ending, which seemed to have allowed her to acknowledge her own sadness as the end approached – previously somewhat denied, and again demonstrating a degree of defence in the face of impending loss. .

Emotional response to ending and the final session

Under other sub-themes (Sub-theme (a), above, and (e) and (g) – see later) I have documented the acute feelings of loss some participants felt, around ending their therapy. These feelings have relevance here to Sub-theme (d) specifically when interplaying with resistance and defence. We saw under Sub-theme (a) how Andrea diminished her feelings of loss by blurring the ending of therapy with the taking up of Spanish lessons. Evelyn's fear of loss, on the other hand, veered towards a fantasy idea (I would suggest longing) of not completely 'ending', but having three-monthly review sessions built in over the coming year.

The giving of gifts also potentially ties in with this Sub-theme of fear of loss and resisting finality too. Gifts, along with other functions, could represent a continued connection with the therapist, a 'leaving a part of themselves', so that the separation is not so absolute. But in Hilda's case, although she had a store of many beautiful cards, she feared writing one in this instance, *"because it felt too much like an ending"*, so she gave her therapist an unaccompanied bunch of red and yellow tulips. Again we see the fear of acknowledging finality.

Post-ending contact with the therapist?

Despite the not infrequent references to 'never seeing x again', there was in many cases a lack of absoluteness about further contact between participant and therapist – whether this was a stated or agreed 'loophole' of possible contact after a period of time, or fantasy contact. Again we see evidence of participants not wanting to accept the finality of separation and loss.

Seven participants had an email address or mobile number for their therapist. Three had actual plans to contact their therapist – after a certain period of time. We saw, under Sub-theme (a) that Jason had thought carefully about re-contacting Ivan, not immediately but certainly he had plans to do so, One of the functions of Ivan's email address seemed to be as an emergency lifeline; a sense that the loss of Ivan had not been total.

"It's helped me – because if I really really desperately needed some – I could perhaps – whatever...But at the moment I don't need to." (Jason)

Bianca's therapist had said that contact should not be made for at least three months, perhaps recognising that Bianca had boundary challenges. Bianca, who had *"made a promise that I wouldn't contact her"* during this period, did plan to contact her after it, and talked of hoping (fantasising?) that she might then have private therapy with her, although cost was a possible obstacle.

Hilda also had plans to contact her therapist – in her case, very soon - and even waiting this short period was hard for Hilda.

"I would have liked to phone her half a dozen times, but I haven't...yet...but at least I know that I can. [...] We're almost up to the weekend, so I might give her a call on Saturday..."

Hilda, prompted by me in the research interview, said she would like to say what she had not been able to say at the ending itself: *"I felt so sad, when I left you and came back home"*. In Hilda's case the prospect of loss and finality had been too frightening, and she had shut down her emotions – until she got home, when she wept. We noted that she was unable to write a card, feeling this 'felt too much like an ending'. In contrast, Hilda's therapist had given her a butterfly-emerging-from-its-chrysalis card, with words Hilda found particularly precious - including: *'it has been a joy and blessing for me to know and work with you', 'may you learn more and more the peace of living in the present moment', and 'you will always have a special corner in my heart'*. Hilda felt deeply touched to be written to in this way, and despite being thirty years older than her therapist, the mother-transference is clearly present in this next quote:

*"You're not addressed in terms like that every day...I mean if you're a close family, you probably might be...you would be encouraged by your mother...[...] She [therapist] gave me a sense of worth, because I can feel sort of (sighs, struggles to find words) ...not physically weak, but partially **missing**."*

The word 'missing' here may well reflect Hilda's current missing of her therapist, again a direct expression eludes her, as she defends against her sense of loss.

Andrea used her characteristic matter-of-fact language in relation to her ending: *"It was a little bit sad...as if, like – oh, I may never see Gillian again....you know?"* One might guess

that she diminishes her sense of loss with ‘a little bit’ sad, and the finality of parting with the word ‘may’.

Pamela, Philip and Marcus, we saw under Sub-theme (a), were playing more with the idea of fantasy contact with their therapist. Philip, for example, talked somewhat wistfully of the unacceptable possibility of suggesting ‘a meal out’ with his therapist. Like more specific planned contact, fantasies too can have the function of smudging the sense of finality and loss.

How has it been, since ending?

As we saw under Sub-theme (a), for some participants the ‘ending’ of therapy did not really hit them until after the event, evidence of their resistance to thinking about it in advance (despite therapists often trying to focus their clients on it), linked with the fear of its loss. (This may well be true for many preordained endings in life). Jason, Bianca, Hilda and Pamela all struggled, post ending. Pamela found deleting the alert on her phone particularly painful: *“Because that was like the final thing. Deleting the reminder.[...] all the Mondays: Jane! Jane! Jane! (laughs, sadly) – and I look at my calendar, and it’s no more Jane.”*

Another relevant point here, in relation to the period ‘post ending’ (short as it was, for most) is that for participants, having the research interview ‘booked in’ itself diminished or delayed the sense of finality about their therapy ending that they might otherwise have been forced to face (see also the next section, below).

Participating in the research

All participants knew of the possibility of the research, and most had already made their decision to volunteer, before they ended therapy. Thus participating in the research inevitably had its own role in lessening the ‘finality’ of therapy ending, and its concomitant loss. Pamela actually said – *“It wasn’t ‘ending’ – I had you to look forward to...”*. Philip perceived the interview as a helpful stepping stone to ending – likening it to the rehabilitation drug methadone! In his case our interview was at Metanoia, the site of his therapy. *“I thought it was a good way of weaning myself off coming here really...to come here again, and have a different conversation really.”* The word ‘weaning’ conjures up the needs of a child, as well as suggesting Philip’s desire to blunt his sense of loss,

Inevitably, I was, for most, associated with their therapist. Some had not really taken in the fact that I did not know their therapist, but in any case, I was perceived as being in the same

field. In this quote Hilda links me with her therapist Hannah, the ‘somebody who understands’ that she was losing.

“To be honest you were...um...some sort of connection with Hannah ... I felt [...] here’s somebody who’s almost attached to the same line of business...I mean [...] you’re like an extension of somebody who understands.”

Again this offers support for the theme of ‘resistance to finality’. Moreover in several cases it transpired that the interview was actually taking place at the same time as the participant’s weekly therapy session; obviously this was a time participants were potentially free, but it also may reflect this desire for an ending not to be absolute.

There was further substantiation for the theme at the end of the research interview itself, with Evelyn saying – *“my first one...I might do a couple more...”*, and Philip echoing this with his parting, semi-joke comment of, *“can I come back for another interview?”*

Marcus said he felt sad as our interview came to a close, feeling that it was a further, and perhaps unusually final, experience of ending.

“Normally when I have an interview like this, and it is with therapists, it’s either been an assessment, leading to something else, or it’s – you know what I mean...So...I have been talking...personally, on this deep level [...] So this is another ending.”

He was one of several participants who asked about when/where the research might eventually be published – again blurring the finality of our parting.

6. DOMAIN (4): MANAGING THE AMBIVALENCE

Overview of the domain

Crucially, therapy-ending challenged each individual to manage their ambivalent feelings around accepting/welcoming the ending, and resisting/fearing it, these feelings being present to differing degrees. The following four sub-themes represent aspects of the experience of managing ambivalence.

Sub-theme (e): *The painful loss of the relationship can be in part counterbalanced by internalising the therapist.*

Overview

The lived experience of ending involves a lived experience of loss. In this study what participants particularly focused on was the loss of the relationship with the therapist. How participants dealt with this sense of loss differed according to their psychological make-up and their attachment models. Some felt abandoned; some detached emotionally before the end; some were almost ashamed of their grief and saved expressing it until they were alone. Yet also present is the idea that a relationship is never truly lost, as something of it is internalised and continues to exist beyond the face-to-face contact itself.

Participants' reflections on their therapy and the therapeutic relationship

Highly relevant to this sub-theme is the fact that for all participants the relationship with their therapist had been central to their therapy (and for me, as a practitioner who believes in the centrality of the therapeutic relationship to the therapeutic work, this was an affirming finding). In talking about their therapy endings, it was the end and loss of this contact that typically dominated. Participants often used the present tense (see Hilda's quote below) in speaking of their therapists, reflecting some continued (or hoped-for continued?) presence, pertinent to this sub-theme.

All participants, by virtue of the criteria of the research, had taken the maximum time offered with their therapist, so might be expected to have valued them/their relationship with them. Indeed, participants typically spoke very favourably of their therapists, as has already been alluded to under Sub-theme (a). Hilda particularly appreciated her therapist's warmth, which offered a stark contrast to the 'cold psychologists' she had seen previously.

"She gave me such a lot of warmth...and this is something I haven't had a lot of...I say that in fact, not in self-pity. Um...and she exudes a lot of warmth and caring, that woman..."

Note that she refers quite impersonally to 'that woman', perhaps in an attempt to mute her sharp sense of loss. Evelyn said of her therapist, *"I really liked Elisabeth...I felt like I could talk about **everything**"* and spoke of her as *"a lovely person"*. Philip, normally given to ambivalence and indecisiveness, nevertheless finally asserted, in relation to his therapist – *"I*

have a high regard for him, there's no two ways about it." Bianca, given to criticism in many respects, had great appreciation for the caring her therapist showed her.

She was very - very caring...She often said, I care about you – even when you're being like this and that...totally the opposite of the person... [her friend's psychoanalyst]"

Bianca grew to trust her over time, and value her forthright approach

"She voiced opinion – she was great! [...] it worked very well for me. I am quite a forthright person...I think it was a very good match, because ...you know...she challenged my thinking."

Andrea spoke appreciatively of how her therapist made her feel comfortable enough to open up.

"I felt really comfortable with her, and she's a lovely lady...and I really opened up to her, and probably even told her things that – I'm not embarrassed to say, but I don't know...I can't think of the word, but probably – I told her some really open, personal things about myself that I guess – I'm not ashamed of myself, but I really opened myself up to her, because I felt comfortable enough to do it as well, and I knew there was no judgement."

Andrea's words betray someone struggling with shame, so the sense of Gillian being non-judgemental was clearly of great value to her. Marcus found he could accept things his therapist said because he felt she was essentially on his side, despite it sometimes seeming like going over old ground. He plays with the word 'love' here (although he had actually been 'in love' with a previous therapist, and not with this one).

"There was a kind of...there was 'a' love, you know...um...I mean she seemed quite grounded...and...um...er (sighs)...I mean there was a love sometimes...because sometimes she was saying stuff that...either I already knew, or – you know, I didn't take issue with, I didn't rage about them, where I might have raged with my girlfriend about them..."

[I: It felt more acceptable in the therapy?]

"Well, yes...I felt that she was more on my side."

In general, negative feelings were noticeable by their absence, in participants' accounts of their relationships with their therapists. Some were entirely uncritical, and voiced only positive – and as we have seen, in some cases, adoring - regard; there might be a number of reasons at work here, including the genuinely far greater sense of the positives, the brevity of the interview, the fact that they knew I was a therapist, and so on. It was not my place to actively probe for darker feelings in this research, and using the participant-led IPA methodology I had chosen, much as I might have liked to. Here Marcus gives a rare example of a more critical take – in this case on the asymmetry in the relationship.

“I mean she did say, early on, that the whole thing is in the relationship...”

[I: What did you make of that?]

“Well I found that...(sniffs)...well I found that quite difficult really; I didn't really know what she meant...[...] she's there and I'm here...she's doing all the listening...”

Emotional response to ending, and the final session

As we saw in Sub-themes (a) and (d), loss and sadness played a major part in ending therapy. The loss participants spoke of typically centred on their therapist, the loss of the weekly intimacy, and the thought of not seeing them again.

For Hilda, this sense of loss was acute. In this quote, she uses my name, perhaps because I represent a thread of connection to her therapist. *“I would have carried on [if allowed to], without a doubt, Clare...I came home...um...and I just sat there weeping...[...] I just felt **lost** again.”* In the final five words there is also the ring of familiar abandonment, for Hilda.

Jason expressed his sadness in the second person, perhaps to distance himself slightly, as (like Hilda) his loss is keen. He repeats 'long', which underlines his sense of the length (and substantiality?) of their time together, but this word also connects with the idea of yearning.

“It was emotionally very sad because you just think – well, that's it now, after a year and a bit...and [...] it was quite long term...so you feel like – well, you've let someone into your life for a long...and suddenly they're not there. It was quite ...(haltingly)...[...] a sad thing...”

Later he speaks of returning home after his final session, and wishing it had been summer, which he thinks might have made him feel 'more alive'; perhaps a meaningful loss always has the echo of death about it.

Evelyn, in describing her feelings, emphasised the length of time, and the committed regularity of therapy, and how this created a bond, which then had to be severed. *“She [therapist] asked me why do I feel so emotional, and it was just literally, when you meet someone, and you spend your whole year with them, and every week, seeing that person, same time, same place, you do sort of like...‘bond’ in a way...and then it’s like the ‘broken’ bond...”* A later comment seems to draw attention to the uniqueness of the counselling relationship – which goes from such regular intimacy to total non-contact. *“It was just very emotional...and there’s nothing that can prepare you to end a relationship, with counselling...”*

Post-ending contact with the therapist?

We saw, under Sub-theme (d), how both planned and fantasy future contact with their therapist could play a part in diminishing participants’ sense of finality and loss.

But of more specific relevance to Sub-theme (e) here is the notion of the internalised therapist, in particular as a vehicle for coping with the loss of the concrete weekly interaction. We have noted that participants had a tendency to revert to the present tense in talking of their therapists, itself a sign of their continued internalised presence.

Most participants did seem to feel that that some element of their therapist ‘lived on’ with them – in some specific or more abstract sense. For Jason this was mixed with his sense of loss – he spoke of his therapist occupying his mind as ‘unavoidable’, said that *“you can’t suddenly discard them”*; and – almost hopefully – that *“maybe in six or seven months time I won’t be thinking of him to such a degree...”*. Hilda spoke with a measure of wistfulness – *“she does live on a bit, because I know she was sitting there, listening to me, in depth, and you don’t get that every day”*.

For others their therapist’s continued presence was more of a clear positive. Evelyn said she could ‘still feel’ her therapist’s warmth. Bianca said she could recall her therapist’s laugh, and indeed still carried in her mind her therapist’s ‘whole demeanour’; she *“had a very clear aura about her”*.

Pamela and Andrea gave the impression of having actually internalised the voice of their therapists.

“Sometimes I hear her voice – when I’m thinking about things or processing things [...] and I’m like – oh, that’s what Jane would say.” (Pamela)

Pamela went on to say that when certain obstacles presented themselves, she would ask – what would Jane say? She had in fact gone on a dysfunctional shopping spree soon after her therapy ended, and admitted - *“unfortunately, when I went crazy shopping on Saturday I didn’t want to hear what Jane had to say!”*

Andrea had dealings with her father approaching, and envisaged consciously calling up the encouragement and support her therapist had given her. *“I think I will hear her going – ‘come on, remember how I told you to deal with...’ well, not ‘told you’, but ‘advised you’ [...] Maybe, if I’m starting to wobble a little bit, maybe feel her going (gentle tone), ‘come on, you worked through this, you can do it’ [...] Which is kind of nice – a little bit of reassurance.”*

How has it been, since ending?

A small relevant point here pertains to the decision all participants had made, not to seek further therapy at this point (a criterion of participating). One reason, not specifically alluded to, but could be assumed, is to do with many participants underlining the hardest part of ending being the loss of the therapist him/herself. Starting again immediately with a new person might not be the obvious antedote to this. Rather, the loss requires a period of absorption, with (ideally) the loss object gradually becoming internalised.

Sub-theme (f): *Ending therapy as a transition: looking back and looking forward*

Overview

Endings divide ‘before’ and ‘after’, appropriately symbolised by Janus, the two-faced god of transitions. Typical of participants’ endings was a standing back and reviewing their period of therapy. Many compared ‘then and now’, either formally or informally, and in most but not all cases this was bound up with a sense of achievement and movement. Linked with this was a re-orientation towards the future; an ending is a beginning, and participants expressed both their hopes and fears in relation to this. There is also a quality of ‘no-man’s-land’ about a transition, an ‘in between’ state where boundaries may dissolve; where the old rules no longer apply, but the new ones have not yet been set up.

Participants' reflections on their therapy and the therapeutic relationship

Participants, as mentioned, were eager to take the opportunity in the research interview to speak about their therapy. Processing their therapeutic experience (with me) indeed emerged as a key element of the interview (see Sub-theme (h)). But, earlier on, in the therapy itself, it was also the case that the ending of therapy had prompted a certain amount of reflecting on what had gone on in the therapy, of observing changes, and weighing up gains. Often this had been done with their therapist. We have noted (in Sub-theme (a)) that all participants felt that they had benefited from their therapy, with individuals highlighting different (though overlapping) elements of positive movement; some also talked about the more difficult, challenging aspects of their therapy. These findings are also evidence of Sub-theme (f) here, especially the 'looking back' element of the transition.

The lead-up to ending

It was a common feature in the lead-up to ending, for a certain amount of 'taking stock' and 'summing up' to take place, as well as some thinking about the future.

Several participants reported their therapist, in the last few sessions, encouraging them to think about the work and what they had achieved. In some cases this was more formal, in some cases less. Andrea was pleased when her therapist suggested that they should summarise her progress, as she felt positive about it. But she also seemed to need her therapist to confirm her own view. *"She was like – shall we go over and talk about what you've achieved...[...] it was interesting as well for me to get her view on how she'd seen my progress, because I felt personally that I'd made really **good** progress, and quicker than I expected to."*

Jason's therapist encouraged a recap on strategies Jason could usefully employ in coping with stress (such as - living in the moment, putting things in perspective), and also proposed a view of therapy as a kind of 'springboard' into the future. Philip talked of himself and his therapist 'taking stock' and 'wrapping up', but in characteristic fashion Philip did not highlight any specifics. In Pamela's case her therapist more specifically encouraged her to write down the 'pros and cons' of where she was – what she had achieved, and what she still suffered. Her long list of what she had achieved included: *"I am not afraid of saying how I feel any more", "I can soothe myself and stop myself panicking", and "I have a better relationship with my mum and family"*. The 'cons' side was shorter, but included the poignant, *"I still feel alone and unloved", and "I still have issues about abandonment and rejection"*.

Evelyn's therapist had also initiated an evaluation, this time a chart drawn up together, with the emphasis on causes of anxiety and how Evelyn's response to these had changed over time: *"We had to draw, on a piece of paper ..[...] like if it causes fear, anxiety ...[...] if it was a past or a present fear...and then with that she said 'before' this is how I'd I have seen it, and 'now' this is how it all is...and it sort of wrapped up everything in one. So it gave me like a point where I'd started and like now – this is the end."* Although Evelyn presents this positively, there is a ring to 'wrapped up' that suggests an easy and neat finish on the therapist's part, but a possible 'short-changed' feeling on Evelyn's, an echo of which is also present in Evelyn's later referring to this *"paperwork"* being *"a little reminder, sort of"*.

'Looking ahead' was also an aspect of the lead-up to ending. Some participants had clear and in some cases precious memories of their therapist expressing confidence that they would be 'all right' in the future, post therapy. Jason was particularly touched when his therapist, Ivan, told him he was actually an inspiration to him (an able-bodied man). Ivan had said – *"Jason, you understand that I see **you** as an inspiration...you're an amazing person, you're so positive, you're so 'get up and go' – you are an inspiration to me and so many others'."* Jason had felt that *"to have that come from a counsellor, that was quite something"*. His counsellor had also said he had *"every faith that you'll be able to cope...sometimes I feel that I'm letting people go and they shouldn't stop their counselling, that's not a feeling I have with you – I have the feeling that you can go on and be successful in whatever you do"*. This significantly helped strengthen Jason's belief in his own ultimate ability to be independent and flourish.

Pamela, too, related her therapist saying she had faith in Pamela coping – *"she said that she was positive I was going to be OK"*, although she wept in our interview as she said it, suggesting that, in the face of losing her therapist, her own faith in herself was shaky.

Emotional response to ending and the final session

The final session had the status of a transition which sometimes involved now-or-never boundary-crossing and meaningful words, but sometimes felt flat, superficial, or disappointing – perhaps in keeping with it being a period of neither 'before' nor yet 'after'.

We have seen that boundary-crossing featured for some, particularly in relation to gift-giving and hugs. Gifts and cards could also specifically relate to 'taking stock' – as well as sometimes looking forward. Cards to therapists typically referred to the achievements of therapy, and participants' gratitude for their therapist's support and facilitation. Pamela's card message, for example, as noted previously, included referring to her therapist as having

“helped put Humpty Dumpty back together again”. A participant’s card or gift could be viewed – among other roles it might have - as both a thank you for the past, and a tangible ‘extension’, or part of themselves, for their therapist to take into the future.

Some participants’ therapists reflected in this last session on what it had been like to work with their client, words which were often treasured (see Jason, above). Philip, for example, described himself as *“very appreciative”* of his therapist’s final-session words, recalled with uncharacteristic clarity: *“he said we’d been on a long journey, and he said it had been an honour to work with me.”*

On the other hand, the final session could have a sense of ‘no-man’s-land’; almost a numbness. Despite being ‘a session’, in some respects like any other, realistically, with the end nigh, there was no space to bring in new material. In some cases official paperwork was an inescapable focus, which although it often pertained to be measuring feelings and states etc. was potentially both reductive and distracting. Hilda’s therapist had given her a very touching card, but Hilda felt that their actual interchange in the last session had a - possibly deliberate - surface-only quality about it. *“I think we were talking pretty superficially... maybe that’s what she wanted...”* Hilda’s words sound wistful, as if she might have had ‘wanted’ something different. Evelyn struggled to reconcile the ‘ordinariness’ of the session set against its significance, as the last. *“It was just an ordinary session, yes [...] – just an ordinary session...but this time you have to say bye at the end...and you’re not going to see that person again.”* Andrea, having just mentioned her sense of exposure as a client - *“you open yourself up a lot....become very vulnerable”* – then described her parting in language that might be used for a brief social encounter, the word ‘act’ perhaps giving away the brave face she put on: *“Oh, just act normal! [I said] ‘take care’ – ‘it was really nice to meet you’...and she wished me all the best...”*

Thus participants had differing experiences of the professional distance starting to dissolve in the transition, and a merging of client-therapist to person-to-person relationship. Some felt an intimacy, but others felt the loss of a deeper level of connectedness as ‘social’ rules and language moved in to replace the focused therapeutic work of them being helped to connect with the disowned parts of themselves. Jason’s words capture some of this: *“I don’t suppose we talked about **much**, to be honest, we just sort of went back through some stuff...in a sense that session wasn’t so much ‘client and counsellor’ it was just – ‘Jason, I wish you well’, and that’s...you know...that was it. We didn’t discuss anything **new**, because that would have....(pause) there were a lot of silences in that last session”*.

What 'effect' did ending have?

The effect of ending, we have seen, stimulated two-directional looking – towards both past and future. In terms of the future specifically, several participants, talked with a mix of anxiety and excitement about the prospect of going forward without therapy, with its implicit sense of independence. Andrea felt *“it’s almost like I’ve been let out of school”*, with no teachers to turn back to; *“I’m almost a little bit excited to see how I can cope on my own.”* Philip spoke about it being time to see how he would *“fare under his own steam”*, and even Hilda, who was in some ways devastated by the loss of her therapy, said: *“The thought that did enter my head was – now you’re going to have to stand on your feet again, and sort your problems out as they come along.”*

Evelyn clearly looks in both directions in this quote:

“A whole year...2012, I’ve done this; now I can move into 2013 with my new, not new self, but everything I’ve gained to move on...so a year is good I think [...] because you have to get on with life....”

In ‘with my new, not new self’, she wrestles with the idea of something constant from the past taken into the future, versus something different and changed.

These feelings and comments in relation to taking stock and looking forward are also relevant under Sub-theme (g) below.

Participating in the research

As well as the whole ‘looking back’ over their period of therapy that typically went on in the research interview (see Sub-theme (h) for more detail), of specific relevance here is the interest several participants, including Marcus, took in the ‘when and where’ questions around the publication of my research – further evidence of a future-focus at this ‘endpoint’ of their therapy.

Sub-theme (g): *Therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities*

Overview

Overlapping with the previous theme of looking both back and forward is the effect ending therapy had on participants in terms of their coming face-to-face with both their strengths and their vulnerabilities. An enforced therapy ending constitutes a pressure: for participants a sense of capability or resilience was often experienced alongside a fear of coping alone; some felt armed with learning and insight, but simultaneously aware of their own frailties, perhaps fed by past memories. To what degree this intrinsic tension could be tolerated was part of the 'testing' aspect of ending.

Participants' reflections on their therapy and the therapeutic relationship

In reflecting on their therapy in the research interview, as we saw under Sub-theme (a), several participants identified new or increased strengths, which represents one aspect of this Sub-theme (g). Courage, resilience and increased agency were examples of these. Pamela had learned to voice her needs - to change the pattern of her family Christmas in this instance: *"If it wasn't for her [therapist], I most probably wouldn't have had the courage to say – I'm not doing Christmas this year everybody [...]...because I had to try and change the cycle of what was happening all the time."* Evelyn echoes this greater sense of her own agency in this quote: *"I found my voice...and that came more near the end of the session [sessions], I more found my voice then, I was more able to stick up for myself and everything...[...] actually that was my main thing that Elisabeth said at the end of the session like – now you've got your voice, use it...something to carry on."* Even Hilda, one of the more vulnerable participants, observed some positive self-development: *"This has grown a bit, this kind of effort from me has grown...so that part of me feels more at peace with myself. [...] She [therapist] pulled something out of me."*

The lead-up to ending

As we have seen under other sub-themes, the lead-up to the end prompted many reflections, many relating to participants' sense of themselves, their past and their future – and both their stronger and frailer qualities. The end of therapy typically represented increased independence – which could bring a sense of strength or vulnerability or in many cases both. Pamela related her therapist saying she had faith in her coping, and that *"I basically have to learn to rely on myself...[...] Part of me was wanting to believe her"*, crying as she spoke; but she also reported more confident moments, when she felt she could go it

alone. *“I did start to feel a lot stronger, and there were times when I felt – I don’t need therapy, I can do this! I can do this on my own.”* We saw under Sub-theme (f) that Andrea felt *“almost a little bit excited to see how I can cope on my own”*. Under Sub-theme (b) we heard Philip say *“it might be for the best to see how I would fare under my own steam”* while Jason gave a more overtly mixed picture, expressing anxiety about how he could cope, but taking comfort and strength from his therapist’s referring to him as ‘an inspiration’.

Emotional response to ending and the final session

Again this Sub-theme, the power of ending to amplify both strengths and vulnerabilities, can be traced in the mix of emotions and behaviours at this time. Some participants spoke more openly of vulnerability-highlighting emotions, their anxiety and sense of imminent loss – others (and there is a male bias here) appeared more defended, although betrayed their sense of vulnerability in other ways. But participants’ strengths were demonstrated too – for example in the boundary-crossing behaviours of the final session.

Hilda, we saw under Sub-theme (e), had acute feelings of loss as her therapy ended, alongside which was a sense of her own weakness and dependency: *“I’m asking myself – for God’s sake, am I going to need to talk to somebody for the rest of my life?”* Pamela talked of losing *“my Monday crutch”*, and said, *“now that Jane’s gone – I feel abandoned”*. Several participants held back on expressing sadness in the final session, suggestive of a fear of tipping too far into a vulnerable place. Evelyn revealed some of her paradoxical thoughts and feelings as she described, despite having cried many times before in her therapy, making great efforts not to cry at the point of parting. She seemed to fear the avalanche of emotion that a few tears might trigger; in this sense, it felt unsafe to cry in the session: *“I thought it would be too much, all my crying would be too much...”* However, *“afterwards, oh yeah I was crying, I was crying – and I cried all the way home [...] A good couple of hours crying actually...”* Simultaneously she seemed to want to buttress her own determined line of thought that it was a good time to end, the work had been done. *“I thought it felt a bit silly, that I’ll be crying over finishing the counselling, even though I know I’ve come to a point where I’ve actually got everything **from** there...”*

In Pamela’s case she held tears back in the belief that ending on a positive note would be an affirmation of the work, and that crying might seem like letting her therapist down. Projecting this potential anxiety onto her therapist may also have been easier than owning her own doubts about being ready to be let go. *“I didn’t want to be melancholy...I didn’t want to make the transition even worse...I didn’t want her to remember me as being this miserable person*

[...] *I wanted her to think – ‘she’s going to be OK’*”. Although Pamela’s frailty is visible here, her caring for another and her determination are also present.

Jason referred to his previous therapy ending (at university – another prescribed ending) as *“everything was just up in the air; it was just scary”*, but saw himself as stronger now – *“whereas now, I’m probably a bit less emotionally scared, after finishing with Ivan [...] because I’m slowly building up connections, slowly finding my way...”*. He has an anxiety about ending, but simultaneously a sense of being in a stronger place than when he had to end therapy before.

We saw under Sub-theme (c) how boundaries might be crossed in the ‘carpe diem’ of an impending end, and this has relevance for this Sub-theme (g) too, demonstrating participants’ decision-making and resolve. Physical contact was one boundary - five participants ended up having a hug with their therapist, in most cases initiated more by the participants themselves. Marcus sensed awkwardness, but was determined, and *“felt if I hadn’t [given a hug] it would have been a pity”*, while Evelyn *“wanted to end it by giving the hug”* which *“made me feel good actually...like a solid ‘this is the end’”*. Gifts, in all three cases given with some awareness of breaking protocol, seemed potentially to represent another aspect of manifesting agency – of putting a priority on authentic expression over ‘rules’.

Post-ending contact with the therapist?

Fantasy post-ending contact with their therapist also had the potential for participants to tap into both strengths and weaknesses. For Andrea, for all her robust exterior, there was a sense of needing a possible safety net, when she said, *“I’m sure if I was desperate or wanted to speak to her about something, I’m sure she would be open to that...”* Pamela talked with maturity of knowing that her fantasy of contact was likely to remain a fantasy, and that it was Jane’s internalised voice she needed to hold on to. We saw earlier that several, including Jason, were enjoying imagining telling their therapist about positive steps forward, in itself suggesting some visualisation of progress – rather than the reverse.

How has it been, since ending?

The limited standpoint most had meant that it was sometimes hard for participants to assess to what degree they felt more aware of their stronger aspects or their more vulnerable ones, since their ending. Pamela, we saw, had had one ‘bad week’ where she had gone on a ‘shopping splurge’, as part of the aftermath of holding her emotions in during the final session, which left her feeling *“disappointed in myself, falling at the first hurdle...”*. However,

following this episode, Pamela focused on helping a friend move house, and the next day returned all the clothes to the shop, rationalising she should not be too hard on herself (something that had been a pattern in the past), should instead view it as a ‘blip’ and move on. Both her vulnerabilities and strengths come out in her account.

Evelyn, as we saw under Sub-theme (c), wished there had been a ‘review’ session in prospect, post-ending, but had also made a new friend, to whom she was opening up – having never been used to sharing her problems with anyone. Again we see a mix of vulnerability and strength here.

Participating in the research

Participating in the research could be seen as both an obscuring (or even denial) of ending (in that it prolonged an experience closely linked to therapy) and thus perhaps something of an antidote to feeling vulnerable, but also a demonstration of strength, in representing a proactive move, possibly embracing self-worth. Pamela, as we saw in Sub-theme (c), specifically said that she wanted to give something back (by doing the interview), and for Evelyn volunteering had been a moderately daunting step into the unknown.

Bianca was more anxious than she had expected, post ending, - “*well, shit, you know, I wish it hadn’t ended so quickly*” – but she was also finally moving out of her argumentative parents’ home which she knew was a positive step; in addition, for her, even organising herself to participate in the research had been something of an achievement. So the picture was again a mixed one.

Sub-theme (h): *The post-ending therapeutic function of the interview itself*

Overview

A key theme, and relevant to the managing of ambivalence was the significance of the role of the research interview itself. Most participants described the interview as very valuable in helping them make sense of their therapy ending. Crucial seemed to be the space an interested ‘third party’ intrinsically opened in terms of processing; but also the specific perception of me, the therapist-researcher, as both connected to, and outside, participants’ relationships with their therapists – a kind of transitional object, helpful in the moving from one state to another.

Participants' reflections on their therapy and the therapeutic relationship

These reflections came up naturally in the interviews, and were not discouraged by me. There are two angles on this, firstly an ending is an ending 'of something' therefore this entity deserves some definition/exploration before the end can be focused upon, or regarded as meaningful; but secondly, it became clear that the interview itself offered participants a means of actually processing the therapeutic experience, as well as its ending.

Participants were aware that I was a therapist, and to some extent saw me as a conduit or link to their own therapist, the loss of whom was in some cases very significant. Also, I was aware of having a particular curiosity in participants' relationships with their therapists, thinking of my own clients and the accounts they might give of me, and our work together.

Participating in the research

It emerged that participating in the research was of key significance in relation to what was being researched – that is, the therapy ending. Importantly, it meant the final session of therapy was not so final: there was the interview to come – constituting at the very least a 'follow-up', and in some cases perceived as something of an extension of the actual therapy. Some therapists, from what the participants reported, may have felt the chance for their clients to have extra exploration of their feelings around the ending of therapy might be useful. However, no participant reported being given strong encouragement to participate; they had merely been told of the option.

For all participants who had been clients at MCPS, the fact that I had trained at Metanoia and offered them the option of being interviewed there, added to the sense of interconnection between their therapy and the interview. Hilda, we have seen, openly spoke of me as, in her mind, having "*some sort of connection with Hannah*" by virtue of being "*...almost attached to the same line of business...*". Philip at one point mused, in relation to his therapist, "*if he wants to contact me (slight laugh) and say he'd like to interview me for his PhD, I'd be happy!*", also suggesting an implicit link between his therapist and me. Sometimes, as mentioned previously, our research interview was scheduled for the same time as they had had therapy, which potentially it made more graphic the notion of it as either a continuation of the therapy, or possibly 'filling the space' therapy had left. Pamela was open about viewing the interview as a little 'extension' (her word); Evelyn saw it as "*like doing a little session*", and Philip spoke of using it as "*a good way of weaning myself off*" coming to therapy.

Some anticipated the interview as offering the opportunity to process either aspects of their therapy or the ending itself. Jason, while saying it was pleasing and relieving not to need 'prepared answers', nevertheless welcomed the idea of reflecting on his counselling with someone outside the process. *"It was a final stop on that counselling process – to have done some of my own personal reflection on what my sessions were like with Ivan, **without** Ivan there...if that makes sense."*

Like Jason, who felt that although his mother was aware he was finishing therapy, she *"wouldn't have wanted to go into a major discussion about it"*, Evelyn similarly felt that nobody she knew would be especially interested in her feelings about ending therapy, and liked the idea of reviewing them with someone who was. *"I was sitting, thinking [when saw the flyer] - we're going to be ending very soon, maybe it would be nice to have an 'overview' of the ending? I think this would be a nice experience, to 'overview' with someone else [...] Because I don't think my friend would be interested in it! In hearing about the ending! (small laugh)"*

Bianca's words are less straightforward, but she seems to be echoing the two above. *"I just thought – why not? (pause). I thought the topic was interesting...and it's like...feeling very pertinent to me right now."*

As the research interview came to an end, six of the eight participants openly volunteered that the interview had been valuable, often very valuable, in helping them process their feelings around ending, and in some cases around their experience of therapy more generally.

Pamela said that the interview had been *"my little bit of therapy (laughs)"* and had helped her *"with the trauma of having no more therapy any more"*. She echoed other participants in emphasising other people not being interested in her feelings about ending her therapy; it had therefore been therapeutic to have this opportunity to explore them. *"It's been very beneficial...very cathartic...um, I see it as an extension of therapy, because nobody else wanted to talk to me about it; no-one has sat down and said to me – I know your therapy's finished...how are you feeling? [...] No-one cares really."*

She pointed out that feelings in the approach to ending were not the same as the feelings after the ending, and it was this that made the interview especially helpful. *"Because you don't know how you're going to feel until after it's ended. So, talking about the end in the run up to it is neither here nor there – it's not until **after** it's ended ...then you can talk about it. So*

– *it's been very therapeutic for me [...] to be able to speak about it, to you.*” Moreover, the interview had offered a testing ground for Pamela to talk about the trauma (of her hospital abuse) that she had originally brought to therapy, with an outsider, a new person. *“I realise I can talk about it now without it affecting me, to a point...that's the whole thing she [therapist] said you need to do”.*

Jason likewise talked of it having been helpful to talk to me about his grandmother's death – *“I always wanted to get to the point of talking about my nan without...falling to pieces”.*

Marcus felt that reviewing his time in therapy had been *“a good thing to do”*; that it had made him *“think about what I actually did when I was there”* and that he'd gained by *“actually 'verbalising' it, to someone else”.*

Evelyn likened the interview to a 'final chapter', a time of 'overview', the chance to change perspective from experiencing to thinking about the experience. *“It's like talking about it and stuff has actually helped a lot, because I've actually been able to ...**think** about the ending and stuff...because before this I'd never actually thought – actually it was a really sharp ending...”* She seemed more ready to end now, than at the time – *“Now I've been able to overview everything, over the whole programme of doing the counselling... and I feel like I could leave...”* Philip also seemed to feel the interview had helped the actual ending process. *“I suppose it's helped a gradual feeling of winding things up, and I've put it into that context really...”* For Hilda there was a sense of having had her therapist with her – both in talking about her, and in the transference whereby I seemed to be a representation of her. *“Well – about Hannah – it's like bringing her into the room, because (smiling but slightly shaky) she's very vibrant and full of life – and that's **good**. [...] Because you are somebody I feel able to talk to...”* I have to question to what degree Hilda had accepted, let alone processed, her ending with Hannah, given her intention to call her within days. It was also the case that my interview with her ended up the longest; Hilda struggled to accept endings.

CHAPTER 5: DISCUSSION

1. INTRODUCTION

In this chapter, after some introductory reflections, I discuss the domains and sub-themes identified in the findings in more detail and in relation to the existing literature. I then consider the challenges and limitations of my study and indications for further research, finishing with my conclusion and contribution to the field, and some final reflexive thoughts.

Therapy-ending: different from death?

Therapy by its nature is not just an ‘in the present’ experience of sessions, but ‘works’ between sessions, and beyond them, ideally facilitating ongoing and lasting psychological change. I came to the conclusion that while in all endings there is something of a death (I am reminded of ‘la petite morte’, the French idiom for orgasm), death itself is unique, the only ending about which there is no (reliable) retrospective account. And while several authors, as mentioned, liken ending therapy/psychoanalysis to death (‘a death sentence’ (Coltart, 1996, p.150), ‘a small death’, (Field, 2007, p.260)), I found considerable support for my conclusion that death is distinctly different from therapy ending. Hoffman (1998), for example, takes issue with equating termination with death, pointing out that death ‘places a limit on any chance to revise the meaning of our experience by reinterpreting earlier experiences in the light of later ones’ (p.246). Similarly, Skolnick (2010) questions the ‘shibboleth of classical theory’ of likening the end of an analysis to death, saying that although it can awaken issues of death and permanent loss ‘it is not a death, either an actual one or of primitive drives and wishes...neither of us has actually died for the other, either internally or externally’ (p.232). Jones (2013) writes, ‘with many endings, goodbye is the beginning of something new. And then there is death, the real end. Termination is not the same as death [...] the ending is not absolute in the sense that both partners continue to exist in the other’s mind and both can continue to reflect on and learn from the experience together after parting’ (p.616).

How important is the ending of therapy?

For the majority of my participants (a self-selected sample, of course) ending therapy was a major issue, although not for all of them, underlining the individuality of the experience (see Sub-theme (a)). O’Donohue and Cucciare (2008) raise the question of ‘professional narcissism – we think relating to us is so important and meaningful that ending this must be

a difficult, emotional process' (p.xvi). They also point out that different therapeutic orientations have very different perspectives on termination, which to my mind relates to the crucial issue of how an ending typically comes about within these orientations.

The ending of therapy in relation to other lived endings

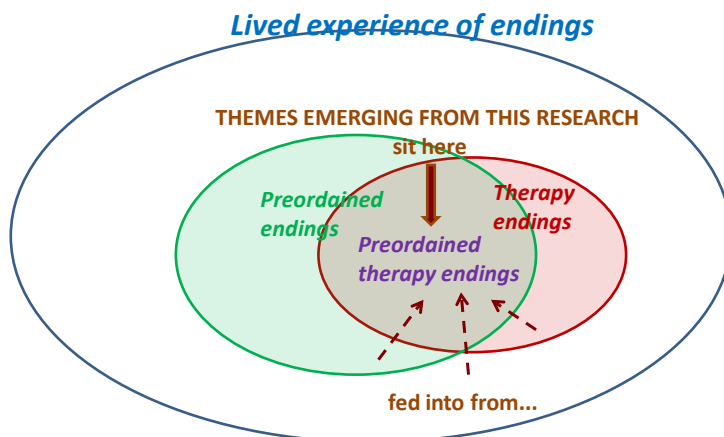
I think both I and my supervisor were surprised that participants did not talk more of their therapy ending consciously bringing up other endings and other losses, although individual stories of loss were clearly alluded to, and had their bearing. But in the interviews it tended to be me who prompted thoughts around this, and overall it was a less rich area than I expected. I have reflected on why this might be. Partly it may relate to Sub-theme (b), that - notwithstanding feelings of loss and potentially pain – there is a basic acceptance of endings, particularly in relation to preordained endings (as opposed to traumatic and unexpected ones). The kind of therapy itself may typically have been more solution-focused than an approach directly using the therapeutic relationship as a means of exploring and processing previous experiences. Maybe, too, ending therapy may have had the potential to call up earlier losses more in retrospect than 'in the moment'; a second interview further down the line could have explored this possibility.

2. EXPLORATION OF THE SUB-THEMES AND DOMAINS EMERGING FROM THE FINDINGS

Placing the themes in the context of the lived experience of endings

Ending psychotherapy is one of many, many experiences of endings. Some endings are preordained, and this includes the therapy-ending experiences I have researched here, while recognising that much of the therapy-ending literature focuses on 'non-preordained' endings. The themes that emerged obviously pertain to preordained therapy endings specifically, but inevitably draw from the universe of the lived experience of endings of all kinds, of preordained endings generally and of therapy endings generally. **Figure (i)** illustrates this context.

Figure (i)
How the themes emerging from this research sit within the lived experience of endings as a whole



Spinelli (2003) writes of two inter-related avenues of inquiry within phenomenology: *ontological* inquiry, which focuses upon the intrinsic, universal features of existence, and *ontic* inquiry, which is more about the specific, individual ways each of us is in the world. The themes of my research reflect something of both these levels of inquiry. I have perhaps reversed the traditional view of the ontological as backdrop for the ontic in proposing that Sub-theme 1 – the individuality of the experience of ending therapy – is the ‘setting’ against which the further themes, drawing more general conclusions about the human experience of preordained therapy endings, need to be positioned. This is in keeping with IPA as moving from the particular and granular to a higher, more interpretative level.

Discussion of the domains and sub-themes

The domains and sub-themes can be represented as a model, where the broad polarities of ‘acceptance’ and ‘resistance’ are key - see **Figure (ii)** below. A differing mix of these two tendencies was present in every participant’s experience of a preordained therapy ending; and each individual had the challenge of dealing with their conflictual feelings.

Figure (ii)
 Model of the four domains in relation to the experience a preordained ending of therapy

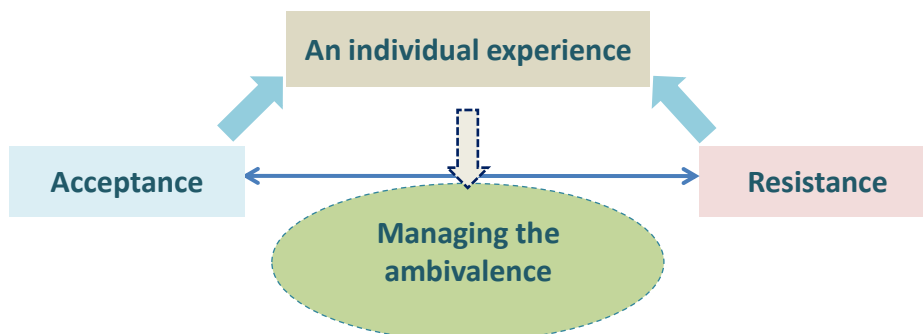
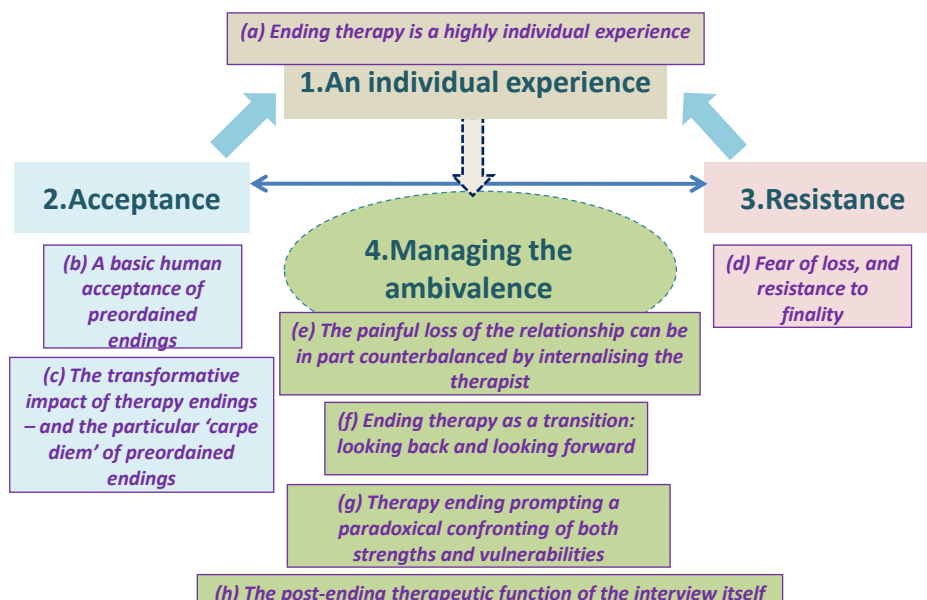


Figure (iii) shows how the eight sub-themes map onto the domain model.

Figure (iii)
 The eight sub-themes mapped onto the four domains in relation to the experience of a preordained ending of therapy



Each domain, with its sub-themes, will now be explored further, in relation to the literature.

DOMAIN (1): AN INDIVIDUAL EXPERIENCE

Sub-theme (a): Ending therapy is a highly individual experience

We noted in the literature review that Gelso and Woodhouse (2002) stressed ‘nothing could be further from the truth’ than the idea of the ending process in psychotherapy being the same for everyone. Craige (2002), in a psychoanalytic context, says that mourning the loss of the analyst will have distinctly personal meanings for each patient. Kantrowitz (2015) echoes this, as well as conclusions by Salberg (2010) and Schelsinger (2014), when she emphasises that generalisations interfere with our appreciation of both the complexity and specificity of the experience of ending therapy, and when she says, ‘termination has a power and meaning that is always deeply personal’ (p.103). O’Donohue and Cucciare (2008) write that termination is inherently complex, not a simply unitary phenomenon, and include in their list of variables that can affect it: the success of the therapy, the nature of the problem addressed in therapy, the diagnostic status of the client, and the personal characteristics (including attachment styles) of client and therapist. Frank (2009) also upholds the idea of specificity when he argues for a ‘case by case’ basis for termination, underlining it as ‘an opportunity to develop a unique ending that has the most appropriate meaning for the members of the analytic pair’ (p.151).

The eight participants in this research demonstrate how an individual’s psychological orientation and history clearly have a bearing on their experience of a preordained ending of therapy. Specifically coming to the fore in parting with their therapist is each participant’s characteristic fundamental relation to ‘the other’.

At a basic level, Pamela, Jason and Hilda all dreaded the end of their therapy intensely, it playing right into their fear (and experience) of abandonment. These interviews were longer than the others: in other words, I found myself drawn into a parallel process, as they ‘resisted being abandoned’ by me. Andrea on the other hand had an outwardly robust attitude to ending therapy, reflecting her need to be (or see herself) in control, following her fragmented and traumatic childhood. Taking the view that it was ‘the right time to end’ could be interpreted as defending herself against potential vulnerability by ‘choosing’ what was inevitable. Andrea’s interview was also the shortest – she ran out of things to say after 80 minutes, thus dictating the end herself, and mirroring her avoidant attachment pattern. There were very differing stances towards the preordained time limit too: Pamela was grateful the time offered seemed so extensive; Andrea seemed to resent the one-size-fits-all implication; while Philip envisaged ending earlier and in the event extended to fit with his therapist’s placement, partially – he implied – to suit the therapist; he seemed uncomfortable with his own needs taking centre-stage. The experience of loss when therapy ended, and how they

spoke of it, again differed markedly between participants, reflecting their different inner worlds and survival strategies. Hilda clutched at straws (the interview with me, a planned future phone call with her therapist), but felt back in her well-defended loneliness, which included not having been able to communicate the extent of her sadness to her therapist. Pamela referred to grieving, and her fear of change. Marcus's tone remained emotionally detached, while Jason seemed to have more access to his feelings of loss, but kept control by speaking in the second person. Bianca, lacking a sense of agency, was angry that something had been taken away. Other emotions around ending also linked with individual psychology – Philip's relief (at there being a certain 'end') probably reflected his own uncertain decision-making; Evelyn's disappointment in the lack of celebration in the final session may echo her childhood experience of disillusionment with her largely-absent father. For Andrea the disappointment was in the lack of hug; closeness continued to elude her. Participants' expectations or fantasies of future contact were also very varied, some prioritising the 'lifeline, if I need it' role, others envisaging pleasing their therapists with news of their achievements. And some participants appeared to be coping better than others. Bianca felt worse than she expected; Pamela, post a manic shopping splurge, had returned the goods and stabilised; Evelyn had consolidated a new and valuable friendship.

The individuality of the ending experience is to a greater or lesser extent woven in to all the other domains and sub-themes.

It is also worth highlighting the issue of my participants making sense of their ending experience 'for me', for the purposes of my research. This is potentially relevant to all research where participants are aware of the researcher, but what I am drawing attention to specifically here is the inevitable transference present in the interviews. Each participant had their own response both to me as an individual, and my doctoral study: Hilda and Andrea were keen to identify (Andrea with conducting research, Hilda with some general sense of intellectual endeavour); Philip sought reassurance that he had been helpful, thus turning the focus on my needs; Jason asked about publication, with its implication of future contact, and so on. Thus in addition to the 'individuality' of the experience of ending therapy, there was the individuality (for both of us) of the experience of the interview itself.

DOMAIN (2): ACCEPTANCE

The theme of 'acceptance' included a degree of surrendering to what was a 'given', sometimes with an element of relief, as well as some recognition of the galvanising potential for change that ending brings.

Sub-theme (b): A basic human acceptance of preordained endings

When participants were told of the preordained time period of the therapy offered there was little, if any, negativity: it tended to seem either generous in comparison to other therapy periods, or stretching hazily into the future, or both. The fact of its 'preordained-ness' had rarely been given any conscious thought prior to the interview. This is less likely to be the case in brief-term therapy when a specific, relatively small number of sessions is mentioned (I have experience of this in my NHS work) so the lack of negative reaction may link with medium-term (low-cost) therapy appearing relatively munificent. However, I think overall the lack of initial negative reaction has its roots in the more general theme of there being, for human beings, some philosophical acceptance of endings, and particularly where an ending is known about in advance. Wittenberg (1999), writing about child psychotherapy endings, supports this when she reports there is 'less fury' from children whose ending is planned from the start than from those whose therapists (for a variety of reasons) 'leave'; she suggests this is because 'it would seem the reality of the situation is consciously and unconsciously to some extent worked at throughout the therapy' (p.349). I note here that unexpected endings are likely to be a different ballgame, but these endings were not the focus of my research.

So, although there was a plethora of emotions and responses involved in participants' experiences of ending, the theme of fundamentally 'accepting' the fact of the ending does run through these findings. One factor in acceptance might be the familiarity of endings (endings, like them or not, are constantly lived through). Another aspect of acceptance may relate to the security of the 'therapeutic frame' (Casement, 1985); the freedom within therapy (for unfettered psychological exploration) necessarily requires containment, and time is an element of this – possibly encircling, as well as during, sessions.

Moreover, the findings revealed, even within feelings of loss and insecurity, an element of **relief** in therapy having to end. This relief underlined a measure of fear expressed by some participants of 'never-ending' therapy (the 'interminable' of Freud's essay (1937) - for all that 'unendliche' may have better translations). In Gould's study (1978), as mentioned, participants who were told their therapist would be leaving at the end of the year 'appeared relieved' that they would not be in therapy indefinitely, and furthermore did then stay for the duration, implying a satisfaction with there being a preordained ending.

The Kleinian view of loss as a developmental step (Klein, 1950) is relevant here too – and rings true in terms of participants recognising that letting go of the old is part and parcel of moving on to the new, and sometimes expressing dread in relation to the alternative -

continued dependency (and implicit un-wellness). Etherington and Bridges (2011) report a participant saying, *“knowing there was an end was important, not because I wanted the end, but because I think you have to move on”* (p.15). Evelyn felt deeply sad about ending, yet offered the view that without the time limit *“you keep going on and on and on, then you’d be dependent on your counsellor”*. Pamela talked of accepting the ending of therapy as a valuable chance to loosen her pattern of ‘holding on’, and start accepting endings generally.

Even without a specific fear of ongoing dependency, it may be difficult to have no built-in ending to therapy: Bass (2010, p.279) refers to a patient, John, who although he feels he no longer ‘actually needs therapy per se’, is also ‘not sure he doesn’t want it’, and thus asks – ‘how do you end a relationship when you are continuing to get something useful from it?’ In my research, Philip, characteristically indecisive, likened therapeutic material to ‘radioactivity’ in its everlastingness; knowing the material would never dry up, he appreciated the external hand dictating the finishing line. A preordained ending may play (at least on one level) a helpful part in such cases.

A final point here addresses the relative lack of the anger that might have been expected in relation to a preordained ending of therapy. Mann (1973), while evangelical about his twelve-session model, also refers to patients’ ‘inevitable disappointment with their therapists’ in relation to being time-limited. Why did this not seem to feature in my study? Along with the reasons given above, relating to familiarity, relief, and a recognition of developmental potential around endings, there is also in my research the presence of the service, as distinct from the therapist. It was always this ‘third’ that was seen to be dictating the time limit (and in fact the main expression of anger was Bianca’s, against mental health services in general). Participants typically conveyed a sense of themselves and their therapists being in the same boat, both having to conform to the rules. An example of this related to final paperwork, also spoken about by a participant in Etherington and Bridges’ study (2011, p17): *“it was bureaucracy really, because as far as my relationship with Nina was concerned we both knew what was happening, and the paperwork wasn’t necessary for either of us, but it was for the funding”*. Having the ‘third’ of the service setting the policy not only potentially diverted more negative emotions, but also sometimes offered a ‘bonding’ compensation - via mutual recognition of both client and therapist being subjected to institutional rules.

Sub-theme (c): The transformative impact of therapy endings – and the particular ‘carpe diem’ of preordained endings

Therapy ending as an initiator of change is another aspect of the acceptance, or embracing, of ending. Clearly ending therapy is itself a change (something that was happening is now

not) and any one change intrinsically has the potential for a ripple effect. But more than this, therapy is in the business of change: clients come with a stated desire for change (whatever questions there are around how authentic a wish this is). The change an ending introduces may re-connect people with that possibility. Quintana (1993), who tends to look at the positive potential in ending, advocates revising the 'termination as loss' model (with its stress on 'termination as crisis') to 'termination as transformation' (with an emphasis instead on the 'termination as development' component), indicating clear belief in the power of endings to effect change.

As mentioned, time-limited therapy advocates (for example Taft, 1962, Mann, 1973) take the view that the limitation of time is a positive tool; that intrapsychic development is sharpened by the knowledge that the therapy is not going to last forever. Elton Wilson (1996) writes, 'the existential reality of an agreed time limit is a powerful force for change' (p.8). Field (2007), referring to her pregnancy necessarily bringing therapy to an end for her clients, writes, 'with a clear ending in sight, a certain kind of urgency has prompted several clients to move into a deeper mode of working' (p.172). It could be argued that an imposed ending offers a practice version of making good use of what life we have, in the face of mortality, and as such it is not surprising that ending therapy might have the power to stimulate re-orientation, decision-making, new ways of being. In Etherington and Bridges' study (2011) one of their participants who had been abused as a child felt mobilised to go to the police, by her impending ending: "*we had this deadline looming and I knew that if I was going to do that I had to do it before ...[we ended][...]I wanted to make the most of it.*" (p.15). A preordained ending, in not 'waiting' for a client's readiness but dictating the end, may have particular clout, and indeed there was evidence for this in my findings. For Evelyn, volunteering to do the research interview was itself an atypical, courageous step. Pamela talked of an 'integrating process' that she felt would not have happened if she had not been ending, while Andrea and Philip expressed a new sense of agency associated with becoming independent. Winnicott's idea (1971b), discussed by Reis (2010, p.221), has relevance here – of termination as an opportunity for the patient, by relegating the analyst to limbo, to discover his or her own inventiveness. Skolnick's angle (2010) is slightly different but related; with his 'open-door' model of patients returning episodically, he notes that the periods away from treatment can often serve to consolidate the gains of therapy. He writes: 'potentials for changing, hinted at but never realised during the therapy per se, blossom and flourish when the patient is away from the therapeutic arena' (p.232). Perhaps clients themselves have an inkling of this, consciously or unconsciously, as the ending approaches.

One 'change' a therapy ending may bring about relates to the actual experience of, and handling of, endings. Elton Wilson (1996, p.92) refers to an end date stimulating emotions emanating from previous relationship patterns, these transference reactions indicating clients' survival strategies – which can then be confronted and explored. Pamela, in my study, although deeply upset and anxious about her ending was also able to see how 'letting go' of therapy offered itself as a new and more mature experience for her. Valdivia (2010), with her disturbed nine-year-old patient, also indicates the importance of the transference, the impending ending offering an opportunity for her to understand the traumatic endings the boy had experienced in the past, and for them to work through a new kind of ending.

Another perspective on 'change' within a therapy ending is the change in the relationship. Several of my participants brought gifts or initiated hugs, typically well aware of this as boundary-crossing or at least boundary-testing, but often enjoying their own agency.

DOMAIN 3: RESISTANCE

The tendency in opposition to 'Acceptance', and forming the third domain, is 'Resistance'. Resistance has its origin in fear, and a key fear in ending is of loss. Resisting finality emerges as a way of coping with this fear of loss. Thus participants' fear of loss and resistance to finality are closely linked. This theme embraces participants' attempts at blurring or fudging a real 'end' (planning future contact, etc), as well as the defensively held-back expressions of emotions of some participants, who might be said to be resisting truly experiencing the loss inherent in ending.

Sub-theme (d): Fear of loss, and resistance to finality

Loss of the therapist is explored below (Sub-theme (e)) in more detail, but in my study the **fear** of loss to some extent dominates over the actual experience of loss and separation, which so much of the psychoanalytic literature has concentrated on; a key reason being that my research was conducted so very soon after the therapy ending, with the interview itself almost 'extending' the therapy. To me, Sub-theme (d) has highlighted the difference between fear of loss (and the resistance that partners it), and the actual experience of mourning a loss, a phase my participants had only just, if at all, entered.

Thus the prospect of change (in an ending) can have galvanising, developmental aspects (Sub-theme (c)), while simultaneously prompting fear, specifically fear of loss. Some participants (Pamela, Evelyn and Jason, for example) clearly exhibited both these polarisations (see 'Managing the ambivalence' below), and in fact overcoming fear can itself be a strengthener in the more robust. But there were participants for whom fear of loss and

resistance to finality was paramount, which raises the whole issue of individual client vulnerability, and how this might interact with a preordained ending. Wittenberg (1999) notes a difference in the response to a time limit according to how disturbed a (child) patient is: she suggests the less disturbed are potentially able to make the most of the time available and invest in 'getting on with the task in depth', while for the more disturbed 'putting inner restrictions' and being unable to use the therapeutic offer fully may be the result (p.349). This was reflected in the more vulnerable in my sample, Hilda and Bianca, both of whom had had psychiatric treatment and neither of whom felt ready to end – or indeed felt it likely they would ever reach a point of not needing support. Quintana and Holahan's research (1992) may have relevance here: they found that clients in 'successful therapy' (as assessed by counsellors) often had a sense of graduation and accomplishment, giving their endings a rosier feel, while it was clients in 'unsuccessful therapy' who were 'most likely to have strong and intense reactions to ending therapy' (Quintana, 1993, p.430). While this begs a whole question around what is successful and unsuccessful therapy, Quintana (1993) does point out that these differences may be particularly salient in time-limited therapy (the case for the majority of the 1992 research sample) 'which does not have the luxury of continuing therapy until positive change occurs'. In other words, a preordained ending may be harder on some clients than others.

Resistance to finality has an existential perspective too. It may be our fear of death that feeds into this, in many everyday 'ending' experiences. Note the parting words of 'see you', '*au revoir*', '*arrivederci*', '*Auf Wiedersehen*', which all imply future meeting, and blunt the notion of an 'end'. Freud (1915) affirmed that the unconscious does not believe in the possibility of its own death, which Yalom (1980) interprets as the reality of our transience not taking root in our unconscious as it cannot be imagined, since we are always present when trying to envision it.

Related to this is a basic human resistance to, or lack of tolerance for, absolutes and a tendency towards messiness, caveats, compromise and exceptions. Five of my participants we have seen were offered extensions, even within a framework of prescribed limits. And there are a number of participants' thoughts and behaviours that could be interpreted as them either resisting finality per se or wanting to blur it. Andrea took up Spanish classes before her therapy end-date, the overlapping of the two (both perceived as 'me-time') somehow smudging a defined sense of 'end'. Most of the participants had their therapist's contact details; there was a spectrum of intentions in terms of using them, with three having definite plans to do so. Fantasy future contact also played a part (possible bumping into each other; or in Philip's case, the idea his therapist might request his involvement 'for his

PhD'). Moreover, internalising their therapists' voice and leaving their therapists with gifts (see also Sub-themes (c) and (e)) might also have constituted elements of counteracting finality. All participants could envisage having therapy again in the future, although there was a recognition among this group that it would not be with the same therapist.

Volunteering for the research interview could also be seen as part of a resistance to finality; as Pamela said, *"It wasn't 'ending' – I had you to look forward to"*. And even at the end of the interview, comments relating to a desire to do more interviews indicated further human reluctance to accept an end.

Although not the focus of this research, there was some indication that therapists themselves had their own resistances and difficulties with ending; to start with, these therapists had chosen to put the idea of participating in my research in front of their clients (a possible handing over of the baton?); moreover, in participants' accounts, there sometimes appeared to be 'mention' of ending by the therapist, without any real 'processing' following on, although this is more an observation of mine than a judgement of the participants themselves.

In the literature we saw how analysts themselves (for example Bergmann, 1997, Salberg, 2009), have traditionally had difficulty with bringing endings about at all, also suggesting a resistance to finality, and behind this a fear of loss. Over time, with the general discarding of the idea of a perfect end to an analysis, there is a greater acceptance of endings as 'good enough' and - importantly - 'for now', with its implication of future meeting. Attempts to nail criteria for ending (Rickman, 1950, Hoffer, 1950, Firestein, 1978) have given way to more fluid notions. One is of the 'open door': Craige (2009) proposes a model of the patient returning on an 'as needed' basis, or for a planned follow-up; Skolnick (2010) says the end 'may or may not be the final separation' (p.232), and, like Craige, leaves the door open for future contact; while Schlesinger (2014) writes, 'to a therapist there is no such thing as an ex-patient' (p.237). Some (including Kupers, 1988, and Cummings, 2001) have stressed the reality of, or preference for, therapy being experienced in bouts, while overall there is a general recognition among analysts that 'analysis cannot but remain incomplete' (Ferraro and Garella, 2009, p160). In service settings, it is often the case that clients having to end are re-referred on (Zuckerman and Mitchell, 2004), again diluting the conclusiveness of endings. All these attitudes and practices potentially feed into the notion that resisting finality is a way of coping with fear of loss.

DOMAIN 4: MANAGING THE AMBIVALENCE

We have seen how the experience of a preordained ending incorporated elements of both acceptance and resistance, and how the balance differed among individual participants. But for all, the preordained ending of therapy presented the challenge of managing ambivalence. Grappling with opposing ‘forces’ tests us, as human beings: how do we integrate conflicting feelings? To return to Molnos (1995), it is a hallmark of psychic health to keep together opposite feelings ‘in struggle and in harmony’ (p.66). The sub-themes within this domain illustrate aspects of participants’ experience of managing their ambivalence.

Sub-theme (e): The painful loss of the relationship can be in part counterbalanced by internalising the therapist.

The older literature, most of it psychoanalytic, emphasises ending involving ‘the working through of the transference’. More recently, with the greater relational perspective, the ending of the real or personal relationship with the therapist has come to the fore. I see transference and ‘real’ relationships as inextricably linked, with patterns of relating inevitably deriving from historical experience, but in any case, in my study, from the participants’ point of view, the loss of the relationship with their therapist emerges as the **key** loss in relation to ending.

I noted earlier that the loss of the intimacy inherent in the therapeutic relationship can be viewed as unprecedented (Bergmann, 1997, Murdin, 2000), clients not necessarily having experienced relationships of this calibre outside therapy. Butler (2003) writes of the way loss prompts irrevocable changes within **ourselves**, which Frommer (2005) interprets as the loss of crucial ties that constitute our being potentially meaning we no longer know ourselves as we were. These deep fears around our own identity may be underlying the idea of ‘missing’ someone, which is the language that participants themselves tend to use (Hilda in fact does say she herself feels ‘partially missing’). Bass (2010) refers to a specific patient, Tom, who said at the end of his therapy that he would not miss the conversations, “*I think I tired of them some time ago*”, but added, “*I’ll miss you. The person you are. It is not easy to find someone intelligent, thoughtful, caring...It is just the fact of talking to you that it is hard to give up*” (p.280). Bulkeley (2009) in talking about the (not easy) ending of her own analysis, says ‘it was the relationship between us that sustained me’ (p.307). More quantitatively, in Craige’s study (2002) candidates experienced ‘loss of the unique analytic relationship’ more strongly than ‘a general sense of loss’; and we saw that in Roe et al’s research (2006), ‘loss of the meaningful relationship with the therapist’ was the factor contributing most often to negative feelings towards terminating.

Several participants in my study felt the loss of the therapeutic relationship keenly, movingly communicating their sadness, sometimes even a sense of grieving. It was the contrast of the previous weekly intimacy with the prospective absence of this that hit so hard. Some did in fact draw parallels with death, observing that 'never meeting again' was the likely reality. Evelyn spoke of a bond being 'broken' and there being nothing that could have prepared her for it. Some participants described having held back on expressing grief in their final session, partly, it seemed, not wanting to burden their therapist. Marcus said he felt 'abandoned', with its clear ring of transference. One participant, Andrea, superficially appeared more matter-of-fact about the end of the relationship, seemingly reflecting her more avoidant attachment style.

Four participants gave their therapist a gift or card, an act relevant to several of the sub-themes, but one simple aspect of it seems to be to mark the meaningfulness of the relationship and the gratitude participants felt as a result.

I think it worth noting here that in my study no participant reported being invited to re-contact either the service or the therapist at a later date, whereas in much of the literature there are many examples of less absolute 'endings of contact', although these are not without their own problems. For example, analysands will often go on to become part of the analytic community their analysts are part of; so although analysis has ended, face-to-face contact of some sort is still in the picture. Kantrowitz (2015) notes that in her study post-analytic contact sometimes interfered with the positive internalisation of the analyst and the analytic relationship that had been achieved in the treatment. In Etherington and Bridges' research (2011) participants were invited to return to the service/keep in contact as and when necessary; they note that one, who called to tell her former therapist about the birth of her first child, was then very disappointed to find that she no longer worked there.

But the therapist can have both a physical presence and an internalised one, in the client. While the face-to-face, here-and-now intersubjective experience of therapy is over, for the client, the therapist can and does live on (and vice versa for the therapist, though this is less relevant here). Klein (1957) more generally refers to the potential we have to carry round the internalised notion or experience of a dead person for the rest of our lives, and Gaines (1997) argues from a relational perspective that holding on to the lost object and maintaining continuity with it is no less important than detachment in the resolution of grief.

Edelsen (1963), Zinkin (1994), Tessman (2003) and Frank (2006) are just some of those who write about internalised representations of the therapist, and indeed of the therapeutic

relationship, as living on post termination. Reis (2010) points out that the therapeutic pair not physically meeting does not equate to their having no psychical relation to each other; both are living, breathing, dreaming, fantasising...just not together. My study supports the notion of the ongoing internalised presence of therapists, with participants often using the present tense in relation to their therapists, and sometimes speaking of how they, their voice or words live on in their mind in some way. Similarly, one of Etherington and Bridges' (2011) participants (albeit less 'immediately' post her ending than the participants in my sample), says: *"I don't need her physically, I've got her voice up here [points to head] and when a certain situation happens, I know what she'll say."* (p.15). Again there are individual differences within the participants in my study, reflecting their own psychological robustness in terms of ability to internalise something good. Relevant here is Murdin's (2000) reference to ending therapy as a climax where either loss may dominate, or there is a possibility of 'a renewable source that the individual keeps and develops after the end' (p.38).

Sub-theme (f): Ending therapy as a transition: looking back and looking forward

Janus, the god of transitions, with his two-faces, seems an appropriate symbol to represent this important aspect of therapy endings, and to underline that an ending is also a beginning. Britton (2010, p.39) likens analytic ending to the transition that takes place in *The Pilgrim's Progress* (Bunyan, 1907), when Pilgrim loses his companion Faithful, and survives only by finding a replacement, Hopeful (hope necessarily being future-relevant).

Endings prompt us into looking both ahead and behind. Several of my participants described a review process taking place, as their ending approached: what had been achieved, and what would they take forward. It may be that the preordained element of the ending sharpened this process, with its built-in rather than arrived-at finishing point, and its inevitable and visible 'future without therapy'. In some cases reviewing the work was formally initiated by their therapist; in other cases there was an element of it in the interview with me. As with 'resistance to finality', 'looking back and looking forward' may in part be a way of coping with or managing the ending; the two sub-themes have some overlap. Both involve avoiding the hard edge of an 'end'. With the entwined view of past and future there is also a connection with the notion of internalising (see sub-theme (e)). The notions both of 'transition' and 'internalising' point to the experience of 'ending' being actually quite elusive, if it exists at all - given the complexities of the human mind. Gabbard (2009) writes, 'whatever termination is, it is certainly not the end. Analysands continue trying to work through the loss of the analyst in fantasy, in dreams and in other relationships' (p.585). Also relevant here is the concept of *Nachtraglichkeit* (Reis, 2006), the idea of much of the important work of therapy being done after the end of sessions (thus 'ending' by no means

equating to finishing). Reis writes, 'who has had an analysis and not continued it after the official goodbye of termination? New experience calls forth memory and memory itself changes shape'; he says a patient's 'subjective present will loop back to the moments of the analysis and these experiences will rework the analytic work, as the analysis continues after its end' (p.601).

It seems to me that the classic psychoanalytic 'termination as loss' model involved more of a looking back than looking forward. Previous losses and endings were assumed to come to the fore, and, in line with the whole intrinsic difficulty around ending analyses at all, there was little sense of this being balanced with a future orientation. However, Davies (2005), one of the newer wave of relational psychoanalysts, allows for greater emphasis on the moving forward, post analysis, aspect of termination. She writes of the intent to give patients 'tools, knowledge, insight and self-awareness to enable them to construct for themselves, in our absence, when we are gone, new relationships ...that do not conform to the old, stereotypically neurotic and frustrating patterns of their past' (p.785). This has an optimistic ring – though of course written by a therapist not a client. Similarly, Schlesinger (2003) suggests one can view the post-analytic phase as the former patient continuing the same practice intermittently as needed, without the immediate monitoring of the analyst, and quotes his late colleague Joan Fleming's analogy of analysis ending being akin to a vessel dropping the pilot who steered it out of the harbour, leaving it to the captain to navigate the rest of the voyage. Interestingly one of Etherington and Bridges' (2011) participants uses a similar metaphor when she says, post ending: "*I know that I've got the tools to steer me back to shore....*"(p.15).

But both facing both past and future can involve elements of fear. Although in my study, in the comparing of 'then and now', there were references to positive changes, achievements and new strategies, for Hilda, for example, looking back involved the fear of **not** having changed, of still wrestling with the same issues, or possibly falling back to a needier place. And for several, looking forward held anxiety around coping alone and unpredictability, as well as the potential excitement of a developmental step.

The literature supports the notion of endings being a transition, where both directions are looked in. Mann (1982) talks of psychological treatment as working towards the patient facing up to his past in order to gain some mastery over the present and be freer for shaping his future. Marx and Gelso (1987, p.7) actually refer to 'the work of the termination phase' as essentially involving 'looking back', 'looking forward' and 'saying goodbye'. Jones (2013), in her essay on endings in poetry and psychoanalysis writes, 'gathering up and releasing are

essential elements in both forms of termination' (p.608); although this does not map perfectly onto 'looking back and looking forward' I feel there is a parallel, with the idea of 'taking stock of what has gone before' in gathering up, and an energy and movement in 'releasing' that could suggest the next step. Jones goes on to identify the subject of her paper as 'the pleasure in accepting what is, letting go of what isn't and continuing to move along in a generative way', again tying together notions of past and future.

Perhaps the word transition deserves more exploration. It suggests a movement, a passage, and in this sense is different from, almost at odds with, the word 'ending'. But it seems to be a good description of the experience of ending well, in relation to my participants. Ending is less about a moment, and more about a process, and the research interview felt a part of this. Chronologically the interview took place 'after' the ending of therapy, yet there was still a 'presence' of participants' therapy in the interviews (their use of present tense about it, for example), and a sense of participants in transition. The two directions of past and future cannot easily be looked at simultaneously, yet both are relevant to the end; the very preoccupation with both directions requires a bit of time and space – this is the transition of ending. I was also reminded of Winnicott's 'transitional object' in this context - with myself or the research interview as a whole, possibly having elements of this role, as participants moved through their ending (see also sub-theme (h)).

Sub-theme (g): Therapy ending prompting a paradoxical confronting of both strengths and vulnerabilities

This sub-theme offers a core element of the domain, 'Managing the ambivalence'. Lawrence-Lightfoot writes in her book *'Exit: the Endings that Set us Free'* (2013) that moments of ending are 'pregnant with paradox – the counterpoint and emergence of vulnerability and toughness, inertia and movement, urgency and patience, chaos and control' (p.5). She is talking from the point of view of 'choosing' exits, but I think the principle of endings revealing both strengths and weaknesses, and generally embodying paradox holds good for preordained endings too. Therapy endings are a testing time; they embrace consolidation and freefall; hope and fear; loss and gain. And thus they potentially test an individual's ability to confront paradox.

Ending therapy involves a loss: the loss of weekly sessions, of focused attention from another, of a relationship (whatever qualifications there are here). But there are also gains – the energy inherent in change (see Sub-theme (c)); a sense of movement; and ending losses themselves may be seen as gains: the loss of dependency potentially brings the gain of independence; the loss of the weekly sessions can open up time for something else. Loss

and gain map onto the human experiences of feeling vulnerable and feeling strengthened, which individual participants conveyed differing mixes of – but many did refer to **both** feelings being present around their therapy ending. It should be remembered none of them was going on to immediate further therapy, so perhaps all felt ‘strong enough’. Jason in fact looked back on a previous therapy ending as: ‘a complete void’, ‘a very scary time’ – but on that occasion he was referred on. Hilda, one of the more vulnerable participants, said she felt ‘lost again’ on the ending day itself, but also acknowledged ‘a kind of effort from me has grown’. Evelyn felt anxious as the final minutes ticked away, but also talked of having ‘found her voice’ while Andrea observed ‘you open yourself up a lot, become very vulnerable’ while holding on to the sense of having ‘made really good progress’.

Molnos (1995) suggests the very holding of the ambivalence of loss and gain, the ‘non-splitting’ of the positive and the negative, can itself be a strengthening and therapeutic process. This is echoed by Holmes’ (2010) assertion that the combined acceptance of both suffering and *carpe diem* is the antidote to despair – that there is something about the simultaneous acceptance of these two contrasting aspects of being human that fosters a perspective of life as worthwhile. For participants the full integration of loss and gain might not necessarily have been reached, but there were hints from some, as they expressed a sometimes paradoxical mix of sorrow, anxiety, even resentment, alongside recognition of the ‘rightness’ and galvanising potential of their ending. I believe this mix may also reflect the wider existential tension between ‘growth through relationship’ versus ‘growth through separation’; to me, psychological health involves both finding meaning through relationship and the capacity to acknowledge the essential fact of our aloneness.

Winnicott, the great embracer of paradox, holder of contradiction, invites us to consider that the ability not to know and the tolerance of uncertainty are essential to feeling alive (Philips, 1988). This acceptance of uncertainty is integral to Winnicott’s ‘going-on-being’, and Silverman (2010 p.168) points out that it is the patient’s capacity for going-on-being that makes it possible to ‘experience the moment in its fullness and its impermanence’ and to ‘grieve the loss of analysis while experiencing the richness of living beyond it’ (a clear echo of the ‘Managing the ambivalence’ domain here).

More empirically, Walsh (2003), in writing about endings across service settings, offers a list of clients’ reactions to ending, embracing both positive and negative responses. Examples of the positives include: pride in accomplishments and increased sense of competence (even when the ending does not occur under optimal circumstances the process may demonstrate to the client that she has greater competence for managing the loss than previously

imagined (Levin, 1998)); increased real-world activity; a new capacity for other attachments; sadness ('actual, not just regressive'); and relief. The more negative reactions on Walsh's list include: avoidance of the topic, denial of the topic's significance; an extreme sense of loss; recurrence of old problems or introduction of new ones; missing sessions; expressions of anger, and aggressive acting out. Similarly, as mentioned, in Roe et al's 'Feelings Toward Terminating Therapy Scale' (2006) both positive and negative feelings emerged, although the former outweighing the latter. And Etherington and Bridges (2011), in their discussion, underline the ambivalence their participants felt about their endings.

Sub-theme (h): The post-ending therapeutic function of the interview itself

One of the most important findings in my study is that the experience of the research interview itself appeared to be of significant benefit to participants. In my qualitative research life I have seen interviews be experienced as enjoyable, enriching, helpful and even healing, but I still had not anticipated my research interviews would seemingly have such a key therapeutic function. It made me consider the bias of my sample: self-selected, these were clients who were proactively opting to talk through their ending with another; some gave reasons of 'wanting to help' and so forth, but could it also be that they had a particular sense of unfinished business; of something needing processing? It may in some cases have been more about blurring or softening the ending, dulling its pain. The therapists too, where they introduced the option (all but one case) may have thought it might be helpful, both for their clients and possibly themselves; again, perhaps the research opportunity may have sweetened the difficult pill of ending, or even offered an escape from processing the ending during the therapy. The decision to volunteer itself may have stopped some of the possible processing, as in all cases receiving the invitation to participate preceded the actual therapy ending.

In any case, there was a strong sense from participants that having the space to talk about their ending was valuable. We saw in the empirical work (Marx and Gelso, 1987, Quintana and Holahan, 1992) that clients coming up to ending appreciate time in the therapy being devoted to discussing termination, although in these studies the ticking of items on the 'Termination Behaviour Checklist' can seem quite a crude measure. In my sample therapists often did introduce the topic of ending, but it was noticeable in participants' accounts that there was often not much about what this brought up or led to. In the light of my observations about the elusiveness of endings, and of endings really being transitions, I hypothesise that an ending may be more easily reflected on **after** its crux than during. Bulkeley (2009) refers to ending as a 'passage', a 'time of turbulence as we rearrange our mental furniture without the lost 'other'' (p.305); she postulates that the sense that one has passed through

something only really becomes apparent after the event. For participants, reflecting on their ending with me meant not only had they had some (even if relatively limited) chance to gain a temporal perspective but also that a 'space' was being opened up. I, as a therapist-researcher, was perceived simultaneously to have some connection with their own therapist and a third party distance. Moreover, it seemed that being asked about their ending in itself tended to prompt some processing of it. Here I am reminded of Anderson's notion (1997) of the 'not yet said' referring to how meanings are articulated in the process of conversation (rather than necessarily existing per se before they are they spoken), linking with Strong (2004) who encourages researchers to 'accept our participation in the yet-to-be-spoken' (p.217).

Finlay (2016, p.6) writes that 'relational-centred research can be therapeutic and potentially transformative'. Some of my participants observed that it proved illuminating to reflect on other aspects of their therapy, as well as on its ending – and again perhaps there was some liberation in doing this in a safe space, with someone other than their own therapist. Psychoanalyst Ron Britton (2015) talks of the value of 'triangular space' in relation to loss. Britton is referring to self, lost object and its symbolic representative as the three points of the triangle, and is pointing out that this allows an integration of subjectivity and objectivity; a less primitive position than the 'dyadic' one composed of one self and one other. Perhaps there is a parallel here with an actual third, me the therapist-interviewer, opening the space for a participant to take both a subjective and objective position, in relation to their 'loss' of therapy; and this in itself having healing properties.

Other qualitative empirical studies support the idea that endings-research itself can have a processing role for participants. Kantrowitz (2015) reports that 15 of her 82 analysand participants spontaneously contacted her to say how helpful it had been to talk about their experience, some stating that it had served as a further working through of termination; this was particularly when they had described negative feelings. Kantrowitz suggests the interview may have helped them discharge painful affect by sharing it, which I would observe is at the heart of mourning, and I am reminded of Shakespeare's '*Give sorrow words. The grief that does not speak / Whispers the o'erfraught heart and bids it break*'. (*Mac. IV. 3. 209-210*). In line with this, Bulkeley (2010) talks about being stuck in limbo unless we can mourn our losses, and that in 'remembering' we are 're-membered', put back together, as it were.

Other participants in Kantrowitz's study (2015) felt it a pleasure to have the interviewer witness their positive accounts, attachment and mastery existing simultaneously. Kantrowitz

says her participants, some of whom were speaking years after their endings, also found it useful, as mine did, to talk about their more general 'analytic experiences' as well as their endings.

Long (2007), writing about working with terminally ill patients, talks of how transformative the bare essentials of mirroring, holding and mutuality can be; that 'feeling those thoughts are acknowledged and tolerated by another can provide a sense not just of reassurance but of still having existence, even as that existence is coming to an end' (p.244). This may have some relevance in the context of a relational-centred interview on therapy ending, in that affirmation of existence may be what a participant feeling diminished by ending therapy may need.

Augur (1986) talks about the end of therapy being an active process requiring the availability of sufficient energy to support the ending, and the research interview might be seen as offering additional energy to the mix – an interested third party. Maybe this in itself was of value, and a counterbalance to a possible sense of something waning. Related to this is the idea of the enquiry itself having an empowering potential for participants. This was noted by Etherington and Bridges (2011) in relation to their narrative case study, where participants' feedback emphasised their pleasure in having their views taken seriously and being treated as 'experts' on their own experiences.

3. LIMITATIONS AND CHALLENGES OF MY STUDY, AND INDICATIONS FOR FURTHER RESEARCH

As I passionately believe the therapeutic relationship is co-created and that intersubjectivity is at the heart of our work, a more complete study on endings would clearly have explored therapists' experience as well as clients'; and there is inevitably some sense of a 'missing side' in this research. However, to investigate both would have been over-ambitious in the context of this project, although the field is open for further work here.

Another, and linked, fundamental limitation I have reflected on, is the notion of looking at an individual's experience of a preordained therapy ending with knowing little (only what has been gleaned in the interview) of their history, psychological make-up, and relationship with their therapist – with all the complexity of its transference elements. I have highlighted that ending therapy is a very individual experience, played into by these factors, but with the snapshot that one depth interview offers, I can only guess and suggest at specific processes

that there was not time to explore, or that the individual may not themselves have been aware of.

I set out to look at preordained endings in medium-term therapy; in the event, all my participants came from a charitable service setting. This common factor cannot be ignored - as observed, there is a certain gratitude in being offered subsidised therapy at all, while the service itself is a significant 'third' in the picture. It may well be the case that a preordained ending in a private therapy setting (for example in cases where a therapist is known to be moving house, or going on maternity leave) could raise a different balance of issues and emotions for clients.

Seven out of the eight interviews in my study turned out to be within a month of participants' endings, although I originally stipulated a criterion period of up to three months. While this 'immediacy' of the fieldwork could be seen as a limitation, in that none of my participants had had much time to experience life post therapy, it also meant the ending itself was fresh in mind, as well as giving the sample a homogeneity in this respect. Few if any other studies have captured this temporal closeness to the ending, and its lead-up, giving mine an original slant. Undoubtedly it would be interesting to do a comparable study at a greater time distance from ending when the 'effect' of having ended (including the preordained aspect) may have become clearer, as well as – perhaps – the overall 'success' of the therapy, and how this related with having to end. Similarly, it would have been interesting to do a second, later, interview with this sample, but, as with participant checking, this would have introduced a whole complication to do with ending a more drawn-out relationship with me, the researcher, as well as a substantial extra layer of data. In terms of scope, I judged that involving this second stage would have been too ambitious for this study.

A criterion of participation was that participants were not going straight into further therapy. Yet all were open to the idea of further therapy at some point. The literature suggests that many in a service setting will have the option of being re-referred, especially when an ending is linked with a trainee's placement ending. In retrospect I feel it may have been unusual that this option was apparently not discussed with any of my participants at the time of ending, and it is a point I now wish I had asked them more specifically about. Was the absence of mention of this to do with therapists' judgements, general lack of resources – or the participants themselves, perhaps not hearing the option, or feeling such allegiance to their therapist they had no desire to move to another? It was also the case (as it happened) that all participants but one had had previous therapy, and therefore at least one previous ending; sometimes these endings were referred to, and comparisons made. For some,

having had a previous ending might have reduced the impact of the current ending, although perhaps less so if the therapeutic relationship being researched was considered more meaningful. A further study might either compare different endings more specifically, or stipulate that participants had had no previous therapy experience.

My sample, as mentioned, was self-selected, and as such, as Kantrowitz (2015) notes, consisted of individuals who 'want to tell their story'. I tried to counteract this bias a little by offering a small expenses payment, but in the event the payment was considered incidental by most and certainly not the main prompt to volunteer. My participants may have felt a particular desire to talk about their ending for a number of reasons, including: valuing their therapy especially highly, feeling the loss acutely, and/or wanting implicitly to please their therapists through whom the invitation had usually come. All my participants seem to have had basically good relationships with their therapists; I suspect clients who have more negative relationships with their therapists might not have volunteered, not least because most perceived a link between me and their therapists, as, at minimum, part of a common community. Participants' therapists themselves may have opted to help me recruit because of their own difficulties with client endings, or may have selected particular clients to give my flyer to, because they had a concern about these clients' endings, or thought the research might be specially beneficial to these clients. Alternatively, therapists may simply have wanted to do their bit towards research in the field. Further research with therapists, exploring their feelings around client endings, would be interesting to shed light here.

My interview with Bianca, with her psychiatric diagnosis and history of psychiatric care, prompted me to consider whether I should have restricted my sample in terms of psychological health or history. As it stands, this interview (along with Hilda's) was useful in suggesting more vulnerable clients may have more difficulty with a preordained ending, albeit a qualitative indication from a tiny base; it flags up the need for further research.

I experienced my interviews as delivering rich and thought-provoking material. Jason, a wheelchair-bound young man, reported treasuring his therapist's words that he had been an inspiration to him, an able-bodied man. However, in the main I was disappointed that there was not more about the intersubjective experience from participants: most offered limited if any perceptions about what their therapists were or might have been experiencing. And perhaps it is the built-in 'limited' nature of the therapy that affected this; some did note that their therapists would be experiencing endings all the time, given the prescribed limits of the service, implying the whole experience could be seen as inevitably a bigger deal for client than for therapist. This in itself might have been a slightly painful realisation for participants,

and therefore not one to dwell on. I believe this area of clients' perceptions of therapists' experience of ending would be an interesting one to research more specifically.

I found myself intrigued by the gift-giving in some of my participants' endings, and have speculated on the various functions of this. In this study there was not time to explore it in depth, but I think the subject of therapy ending gifts might be an interesting focus of future research.

Given that this study indicates the interview itself had therapeutic potential, it would be fruitful to research this very issue, perhaps using a matched (as far as possible) sample: half given a 'post therapy' interview, and half not; with a comparison made some time later. Other aspects of a post-ending session would also be interesting to research – for example, should it be (/be presented as) more of an enquiry or a therapy session; is prior contact between the client's therapist and the interviewer/therapist useful or detrimental, and so forth.

4. CONCLUSION AND CONTRIBUTION TO THE FIELD

Conclusion

I went into my research assuming that I knew what an ending was. During the research process I began to question this assumption. I embarked on my project in the shadow of my sister's death, along with the philosophical viewpoint from Heidegger that we are the sole species conscious that we will die. I expected endings to carry with them the spectre of death too – the ultimate human ending. In the event, I concluded that other experiences of endings are different from death (I am taking death as something human beings cannot look at retrospectively): other endings embrace both a 'before' and an 'after' state, with some impact carried from one into the other. This research has brought home to me the 'transition' aspect of an ending: rather than a moment, an ending is experienced as a 'movement through' into a different state, and a feature of which is both taking stock of what has gone before, and considering what lies ahead.

Critically, and in many ways, endings have a duality about them, beyond the simple fact that every ending is a beginning. This research suggests that both acceptance and resistance are present in the experience of ending preordained therapy, and managing the ambivalence around this is the challenge each client will respond to in their own individual way. Preordained endings link with a sense of inevitability and frequency of endings in life,

and some element of relief. Moreover, there is the now-or-never 'carpe diem' of an imposed ending, which can itself be the spur to change. Endings may also stimulate feelings of achievement and pride, and the sense of a developmental step. But loss is also part of the picture of ending, typically prompting resistance to finality, a 'holding on' to some part of what is being lost. Internalising the therapist is a positive aspect of this, with its implication of permanent inner world alteration.

Ending therapy prompts a confrontation of a 'new' self, the self no longer in therapy; thus it tests a person's survival capabilities, bringing an awareness of strengths and vulnerabilities – in different measures for different individuals. And ending therapy is an individual journey. Each person faces it with their own unique psychological orientation, behaviour patterns and history. It seems that a focus on the ending of therapy with an interested and empathic third party, offering the opportunity to revisit and process feelings in the presence of another, is in and of itself of value.

Contribution to the field

I see my research potentially contributing both to knowledge and clinical practice. It contributes to the relatively small body of empirical studies that focus specifically on endings, and the even smaller sub-set of this where clients are given a qualitative voice.

Contribution to knowledge

My study adds weight to the growing but relatively non-traditional view that endings have individual specificity, rendering strict formulaic guidance inappropriate. Notwithstanding this, my study suggests there could be some useful reconceptualising around therapy endings. Seeing endings as transitions, a 'moving through', rather than a closing off, could usefully challenge some customary assumptions around 'loss' being paramount. My research indicates that therapists could usefully attune to the idea that endings are likely to bring up paradoxical feelings around potential developmental steps forward, alongside resistance, and awareness of vulnerabilities; and it is in the managing of these that clients will be tested and may need supporting.

In terms of preordained endings specifically, this research suggests such endings may be more 'accepted' by clients than might have been assumed, in line with the familiarity of preordained endings in all parts of our lives, as well as some degree of relief that the inherent element of dependency in being a therapy client is bounded. My study also offers some endorsement to those who believe that a known, approaching ending can of itself

galvanise clients into a 'carpe diem' mindset. However, there are indications that more vulnerable clients find it harder to muster a more positive orientation towards ending.

Reviews at the end of therapy are not uncommon, and my research supports the value of the therapeutic dyad recognising both retrospective and anticipatory directions being present at this time.

The research suggests – albeit obliquely – that therapists may need to look at their own fears and resistances around ending; what are the deeper reasons for suggesting email updates, or even giving clients flyers for participating in research into endings?!

Application to clinical practice and dissemination of findings

In terms of clinical practice, one specific suggestion indicated by this work, is the idea of introducing a standard practice post-ending 'processing' session with another therapist. It might be argued that in cases of less successful therapy, where clients are left feeling disappointed or frustrated, this final session with a third party could have particular value. We have the reputation of psychotherapy to consider, and offering a client the opportunity to talk through their experience – whatever it has been - with another professional could, in my view, enhance this.

Clearly there needs to be further research into this, possibly involving pilot studies in a couple of service settings, not only to explore potential gains, but also identify what might be the losses or drawbacks of having an 'extra' processing session. Might therapists feel their client endings are diminished, contaminated or stolen from them in some way? Might clients lose the chance for a therapy ending to be truly developmental, through the blurring of it? Might my participants' enthusiasm for their extra session, (and my own suggestion now for introducing it), itself be founded on a 'fear of loss and resistance to finality'? On a practical level, might it ask too much of already-stretched therapy resources? But if it turns out there is real value in introducing the post-ending session, or at least in offering it, how best should it be done? How long after ending? And with whom? (In contexts where there is an initial assessment, the assessor might conceivably 'book-end' the therapy, carrying out the processing session too.) What preparation, if any, might be useful? What ethical considerations might there be?

This study endorses offering extensions within the framework of preordained endings. Participants who were given extensions tended to value them greatly, and make good use of them; participants conveyed a sense that they would have suffered in the absence of the

extension, and the work overall would have been far less effective – but that having the extension itself as a one-off, and absolute (no further elasticity) was also important, it seemed. However, it should be noted that these observations are based on subjective reports; again, further research into this area – of exploring the value or otherwise of extensions within preordained time-limits - could be interesting.

This research suggests that spoken reflections from the therapist about working with the client and specifically about the impact the client may have had on them are remembered and valued. Perhaps we as therapists should all bear this in mind as we end with our clients, and if possible offer up an authentic reflection of the imprint the client has left on us.

In terms of dissemination of the findings, I have ideas around both publishing and more interactive contexts. The subject matter of endings has very wide relevance – to all psychotherapists, supervisors, and practitioners in related fields such as social work and the probation service; those working in service settings in particular may be dealing with preordained endings. The first, usually unpaid, placement of trainee therapists is also frequently a context for ‘preordained endings’, as by definition the trainees will typically be moving on after a specific time period. Workplace Employee Assistance Programmes are also often of limited duration.

My research findings lend themselves well to both more journalistic contexts and academic ones. I can envisage articles in such magazines as the BPS’s *The Psychologist*, and BACP’s *Therapy Today*, each of which is mailed to 40-50,000 readers; both encourage an informative, engaging style of article. I might consider, too, the BPS DoC *Counselling Psychology Review* - more specialist, and more research-focused, but with a much smaller readership. BACP’s journal, *Counselling and Psychotherapy Research (CPR)*, published quarterly, and peer-reviewed, has specific emphasis on research, and promotes reflexive writing, as well as reaching a wide range of practitioners and ‘those who shape practice’ such as policy makers, supervisors and managers; my work could fit well here. *Psychology and Psychotherapy – Theory, Research and Practice* is another more academic context to which I might submit a paper.

Workshops with trainees or practitioners, focusing on client endings, is another route I am considering, and I am in discussion with a colleague about putting together a CPD course that would include this. In my NHS context we have quarterly meetings with fellow mental health workers in the borough, and disseminating my findings among them, perhaps through a lunchtime session, is also something I am proposing.

5. SOME FINAL REFLEXIVE THOUGHTS

Of the many challenges inherent in writing up this study, one of the most painful has been the rejection of material. To some extent, this has reared its head in each of my chapters, with whole books and articles sometimes being reduced down to token references, methodology explanations and justifications minimised, and thoughts curtailed. Most difficult of all was the Findings Chapter, since I had such a wealth of data, a great deal of which seemed interesting and relevant. My first draft of this chapter was 25,000 words – about 10,000 words too long. Editing at the initial stages had a positive, streamlining, almost cleansing aspect, but further down the line I found deleting whole chunks and sections, sometimes containing thoughts or quotes I really felt had value, tough. This in its way is about loss and ending too; the parts of the analysis that have made it to the final written stage will 'live on', in published form; the rest will have passed through my mind, and may enter the odd discussion, but in some sense will be consigned to having had their day, having less permanence and less transferability.

As a therapist-researcher, I felt privileged to be given an insight into my participants' worlds, much as I am with my clients, as a therapist. I was aware that the recency of their therapy ending might have conferred on my participants a particularly ready openness to talk to me, essentially another person in the therapy arena. I found the issue of how much I should steer participants back to the topic of their endings, when they were talking of other aspects of their therapy, a challenge. Partly this was because I felt that IPA should allow flexibility in terms of what (potentially related) experiences participants wanted to range over, and I was keen to avoid being too directive, as is more usual in market research. But partly I was simply curious to hear about participants' therapy experiences, and was aware that at the back of my mind I was wondering how my clients would talk about theirs, as well as thinking about my own therapy.

Of course conducting this research has made me think a great deal about endings, both therapy endings and others. My own therapy has been privately paid for and the endings have not been preordained. The last ending I planned to coincide with the end of my formal training; I felt sadness at the loss of a long relationship, but I also felt liberated, and excited about my new beginning, out in the world as a qualified therapist. In my short-term (eight-session) NHS work, our endings are preordained. I have become aware of the difference between my experience (as therapist) and the client experience of ending; for the latter it is often more impactful (although by no means without impact for me). But it is the case that from my point of view my short-term clients' endings are a regular occurrence. I have

reflected that my feelings are perhaps blunted by the frequency of ending, which is sad, and maybe indicates I am not fully present for the client; but it is also something of a relief and perhaps a survival strategy.

In neither my short-term NHS work nor my private practice do I experience 'medium term, preordained' endings with my clients, but endings do of course feature in both. I now keep in mind notions of duality and ambivalence, likely to be present in some kind of individually specific mix in each client ending. I have a sharper awareness now of the link between fear of loss and resistance to finality – on both our parts. In my NHS work, patients at the practice can be re-referred after six months; to what extent I reference this, or clients inquire about it, now has enhanced significance to me, in light of this awareness. My research has underlined the greater difficulty vulnerable clients typically have with ending, and the special attention needed here, be it to encourage self-belief and resourcefulness, where authentically possible, or to signpost further sources of support.

The empowering feelings inspired in a couple of my participants by their therapists' encouraging and confidence-building words at the end of their therapy has made me aware of my own role here, in my practice. I think consciously, when ending, about what I can authentically offer in terms of affirming my clients; observing positive changes I have noticed over time; reminding them of their psychological strengths, of obstacles overcome and aspects of their lives that are going well, as well as disclosing something of the impact they have had on me. How this has landed with my clients I can only have an inkling of, via a facial expression or comment at the time – but these do indicate that my voicing of my positive subjective experience of them is of value. It would take further, after-the-event, research into this to know more.

I am someone who is highly aware of time and relates well to deadlines, planning my steps and building in just enough leeway for emergencies, so that I can usually meet them without undue anxiety. Perhaps this is one reason for my attraction to researching preordained endings. But this doctoral research study itself has had no preordained ending! The relative generosity and flexibility of the institutions involved in terms of a finishing date have in some ways made this doctorate more difficult for me. I have tried to set my own deadlines, but without an external one have allowed other work, as well as family crises, to take priority. I have come to see a preordained ending as a friend; open-endedness as an enemy. In some ways I find living in the moment easier when there is a preordained ending, as the ending is dealt with and can almost be bracketed off, while an unfixed ending constantly hovers in consciousness as something yet to be nailed.

But I hope I am finally reaching an ending, in submitting this thesis. If and when I get through, I am wondering what mixture of exhilaration, relief and loss I will feel. For so long it has filled up any potential spaces in my life – if not actually working on it, feeling that I should be, or at least thinking about it. I am prepared for all the paradoxes inherent in ending to kick in....how well will I manage my ambivalence?!

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APPENDICES

Appendix 1

After the line-by-line analysis of transcripts, I took my (broadly) 'chronological experience' headings, and plotted my three-colour comments and verbatims by participant, plus emerging sub-themes within each experience. In the final column I jotted my thoughts in relation to higher level themes emerging across the findings as a whole.

TABLE (a) REPRESENTING THE STRUCTURAL SUMMARY OF WHAT I DID BY HAND ON A3 SHEETS

(for more detail, see subsequent tables on two themes * (Appendix 2))

<i>A3 headings – 'chronological experience' themes:</i>										
Participants' backgrounds, key issues, psychological orientation, attachment patterns	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes within 'chronological experience' theme	Higher-level themes?
Previous therapy experience	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes (as above) ...	Higher-level themes?
Prompts to seeking therapy this time, and route in	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Assessment process and assignment of therapist	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's relationship with their therapist	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Presentation of/response to the limited time period *	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
The question of extension	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Feelings towards the service provider	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's reflections on their experience of therapy overall	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?

Continuation of TABLE (a) REPRESENTING THE STRUCTURAL SUMMARY OF WHAT I DID BY HAND ON A3 SHEETS

Experience of therapy as the ending approached	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Experience of the final session *	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Emotional experience of ending	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's reflections on the effect of the ending/ having to end	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
How has it been for participant, since ending?	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's experience of endings in general	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
The question of possible contact with the therapist in the future	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Feelings around having more therapy in the future	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's post ending reflections	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
How did participant come to decide to participate in the research?	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?
Participant's experience of the interview itself	Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes ...	Higher-level themes?

Note

There was some overlap between the chronological experience themes

Not every 'chronological' theme, or indeed emergent theme within these, was able to be covered, or covered more than briefly, in the Findings, due to word count and the need to prioritise

Some of the data in relation to routes in to therapy etc was covered in the Methodology chapter

* Analysis charts for these two themes follow...

APPENDIX 2a: PRESENTATION OF/RESPONSE TO THE LIMITED TIME PERIOD

Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes within the 'chronological experience' theme	Higher level themes?
<p>Presented as a year - seemed wonderful. Longer than previous more 'piecemeal' offers. L.389 Relief, gratitude.L410. Idea of 'I qualify for a year' – both a 'right' and dictated to But also anxiety that wouldn't be enough L.466</p>	<p>P thought in terms of 6m; ended up going on as long as possible L5. 'Flexibility as we went' L232 –cf P's wavering beh'vr patterns P skews it to being best for T that he went on to end of T's placement L235/247. Time limit = 'part of the deal' – note lg (contract /lottery). Contrasts with t'py in past (w Jungian 'breadhead') went on too long/ v <u>hard</u> to end L477/493/ 510</p>	<p>P initially expected fewer months than ended up having L190; yet also knew from past exp 'wouldn't be 5 mins'- & didn't want time limit L1075/1078 End date later came as surprise (slight shock?) L210; at this point P expected a yr; shields her vulnerability - businesslike: books Spanish lessons; had 'enough notice'; a 'natural end' L222/234; yet also imagines enforced ending 'cld be difficult' if mid 'heavy stuff' L630 (projection?)</p>	<p>P was told 'up to a yr' – thought cld be less L144; yr seemed long L150. In practice went quickly. 'It was the length of time they offer' – acceptance L278. Later – felt time pressure 'to complete' etc (see later 'as ending approached' theme) Constant mixed feelings around time limit – acceptance and fear</p>	<p>P privately expected 6-10 sessions, then told longer but finite L43. T, some sessions in, mentioned 'you get about a year' L197 – 'pleasant surprise' to P; seemed generous; had no doubts he'd take maximum offered</p>	<p>Memory vague – knew would be limited (psych support always has been in past) didn't want to think about it till had to</p>	<p>T did suggest start with 6 wks (P: 'I didn't think anything of it) but went on full yr + extension. P emphasises charity/ pro bono - knew not open-ended, but has always had (expected?) longer term t'py (sees herself as high-need case). Praises T as 'very clear' – to mask own fear/ anger around there being an end</p>	<p>'I knew it was kind of time limited' L110/115. His t'py invariably has been – says (later) 'always against my will' L869, but observes was paying £10 vs others - £100, so a bargain. Expected would end when T finished her placement – which she then extended by 2m; L130 – Mixed feelings - both annoyed/relieved that goalpost moved L140/150/154 Accepts did have the choice (re extra 2m) L176</p>	<p>-Gratitude (cf previous exp of shorter/bec subsidised) -Not taking it in/not able to -Blurring factors (moving goalposts) -Paradoxical perceptions around time – scarily long/not enough -Service' as 3rd party entity, granting, dictating - Always option for participant of ending <u>early</u> – can blur 'prescribed' aspect of ending -Relief of there being an end -May respond to enforced ending by taking (some) control themselves</p>	<p>Blurry quality to 'ending' ; resistance to thinking about it? self-protective? Paradoxical perceptions & exp of time Acceptance of there <u>being</u> an ending Relief? – vs never-ending Individual responses to 'prescribed' aspect – the 'other' in control Ambivalence re enforced ending</p>

APPENDIX 2 (b): EXPERIENCE OF THE FINAL SESSION (1)

Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes within the chronological experience theme	Higher level themes?
<p>Didn't want to cry – wanted to end on +ve note L1230 (hard)-cried <u>after</u>; wanted T to think she'd be OK L1240/1244 Forgot diary (with pros & cons) L1217-anxious. Gave card & gift (careful thought L1304) 'couldn't help myself'; knew not allowed – but T accepted! L1299 Hugged L1315 Made imp decision – to report assault; step forward L1220 Left feeling +ve – 'I can do this' L1318. Fervent gratitude 'I was very very grateful' L1393</p>	<p>Sense of achievement in staying the course (35 receipts). L 295 P wanted to convey his regard & appreciation L843'without sentimentally laying it on too thick' L872 P unusually clear – T 'said it was honour to work w me' L848/852 Warm handshake; no hug Made wisecrack as left (to diffuse pain?) L894</p>	<p>(NB yesterday) Admits 'bit' sad – may never see her again L485 Recalls exposing her vulnerability to T; opened up in way hadn't with anyone else L490/L500 Ordinary parting words – 'she wished me all the best....'; she'd really enjoyed working with me L538/578. P thought of giving hug – 'she didn't appear to be forthcoming'; questioned – my place to? L550; same as previous T. Underlines imbalance – for them only</p>	<p>P took away diag 'for ever'; something for future; also sense of loss (T not working with her on it) L354. But 'things for the future' Held in emotion - would have 'wasted' the time L893; telling self not to be silly L910; 'would have been too much' L920; cried lots L467; 'all the way home' L887 Sense of egg timer.. 'oh my gosh' L534-unsafe feelings; would it end early? Disappointm't in ordinariness of session</p>	<p>Less client to counsellor, more person to person L449 Nothing new, no new material (bec no possibility to explore) Paperwork – partly resentful; L462/470/474 partly grateful (distraction) – masked his extreme emotions L779/784 Lots of silence L480 Previous ending – also nothing special; relief; 'good for me' – would have gone to pieces L754;768 T said P was 'inspiration' L793; big impact .</p>	<p>Lots of forms; P thought – lots has changed since started (+) L832 Session quite 'superficial' overall L834 T gave her card – symbolic (chrysalis -> butterfly) L865/880/890/905; T said 'honoured' to work with her L960 (meant a lot) P gave T tulips – feared writing card L938 Hugged T – T accepted, unlike previous ('stiff') L1650</p>	<p>Bought card – last min L374; to say thank you etc L380. T opened it at start of session – hugged P (P pleased) L394/396 P disengaged – as partner arriving from Germany; father dying L634/642 But P intends to contact her in 3m....L647</p>	<p>Autumn – new (lesser) parking restrictions; he got car closer; so familiar ritual changed- from before entered room. (Seasons coming and going...things end) Bit anxious as approached – knew rule-breaking/bending L504/508 ...gave T gift L194 (almost immediately – T didn't open) and hug;- to distract? To take (switch) control?' Rules are meant to be broken' L520 – retreats into madness L524 Gift – novel about therapy w sig end (T in love with client) – projection? (twist</p>	<p>- More person to person; boundaries blurring -'Holding it in' – to protect/ endorse T; of necessity - no processing time -Loss; finality; 'never see T again' cf death -Rule breaking – gifts -Overstepping boundaries -Sense of agency (eg asking for hug) -Gift-giving – various roles? Eg. distraction from pain/ in cahoots w T (vs service) -Disappointm't; lack of celeb/ anti climax -Loss of depth – move from therapeutic into</p>	<p>Shift in T-P relationship Loss of rel'ship key loss Ending = now or never; 'carpe diem' Sense of own strength (breaking boundaries; decision-making) Also sense of vulnerability 'Time is right' to end? Part of acceptance – Looking both back and forward; transition</p>

EXPERIENCE OF THE FINAL SESSION contd (2)

Pamela	Philip	Andrea	Evelyn	Jason	Hilda	Bianca	Marcus	Emergent themes within the chronological experience theme	Higher level themes?
		<p>professional, 'one way st' L568. 'wasn't cold'; 'was with some emotion'; Some desperation/ disappointment from both of them? L588/589. P also says she'd 'said all she wanted to' L1117 – making work fit the time? Already disengaged ?</p>	<p>L594/L850. Paperwork – 'little bit of paper' L904 'very sharp' L595 (loss) P. asked for hug L1016 – T gave; P wanted to 'mark' the session L1033; something 'solid' L1036</p>	<p>Handshake at end.</p>			<p>on P's own past) Says gift helped ending L565/ helped him express something +ve.L570. Hug – was unsure, slightly awkward but went OK L688/699 Wanted to reflect on gains L385 Also 'blacked out' elements of ending – T said something about their work, he now questions what. Felt sad – 'not overwhelmingly' L729</p>	<p>social sphere? -significance of T honouring working with P -taking something with them – words; diagram; card -Paperwork – interferes/ distracts – but can be relief -looking back over gains; then and now -m/f differences?</p>	<p>Final session & ending's significance – 2 difference things</p> <p>Acceptance and resistance both present</p> <p>Individual differences – much bigger deal for some than others</p>

APPENDIX 3(a)
Extract from Evelyn's interview

Black (descriptive) – as is
Blue (conceptual) – underlined
Red (linguistic) - circled

1010

P: I don't know if it was mainly because Elizabeth's such a lovely person....in fact, yeah, I can still feel – there was warmth from her... ..and then it was time, all of a sudden and she says 'OK this is it'...

present tense

Pays tribute to T as 'lovely person' / the warmth from
Stark change from warmth to 'all of a sudden' ending

• Internalized
('I can still feel')
• Sense of myo ending

1015

I: And how did you actually part...? In that final therapy session?

P: I actually asked her – can I have a cuddle! (laughs)...so I actually asked her for a hug...and said thank you for everything, that you've helped me...so it was sort of like.....
- was looking back

Suggests boldness - can P. believe it of herself?

Upbeat as she relates asking T for a hug
Wanted to thank T for helping her

• Gratitude
• P. taking the initiative (courage / agency)
• Switching power dy
• Breaking boundaries

1020

I: So she responded...?

P: Yes, yes – she was willing, so she said yes...and she gave me the hug...and she said don't worry if – you know....

element of T. surrendering to P?

T gave P. the hug she asked for
(What's going on for T
Concern for P?)
- Keeping emotions bound by boundaries

I: Don't worry if?

P: ..if you need any help in the future, there is other places and stuff

T alludes to other sources of psych. h

1025

P. not listening / wanting to take in? (possibly angry?)

APPENDIX 3(a)
Extract from Evelyn's interview (contd)

1030

I: Do you think she would have hugged you if you hadn't made a move?

P: No - she wouldn't of! But I felt like I needed a hug - to say like 'thank you for everything'...I've gained so much from there...and it's like a 'good bye'....but I approached a hug...whereas...that was the only thing different in the session (apart from writing the paper), so for me I ended it... how I wanted to end it, by giving the hug...but um....

1035

I: It sounds as if you felt pleased about that?

P: Yes, it made me feel good actually, when I gave the hug....like it felt like a solid 'this is the end', instead of sharply ending, it was like a nice ending...however it would have been nice to have gone back and said, this is like what I've been doing, or - whatever...once..like a kind of review session or something...to make sure you're on track.

1040

... and when I left that last time I was quite emotional...very emotional...though I don't know if this was because I was due on my period! [laughs] My hormones were everywhere...because I was due on, so I'm usually a bit....sensitive...

1045

[me..reverting to hug - not following P's ref to 'other places' - lost opportunity?]

P. convinced T wouldn't have made the move to hug if she hadn't

Agency of P coming to fore at ending: made choice; got a need met; felt good

Hug was the only mark of difference apart from the paperwork: hug was how P. wanted to end it

Hug: expressed gratitude marked end session in +ve way

Paperwork - impose Hug - choice (something to go away)

Reciprocity?
Felt good to hug

P. reflects hug gave 'solidity' to end - (blunted the sharpness of parting)

Repeats (see earlier) wishful desire to have review booked - desire for it not to finish

Refers (again) to being very emotional when left final session

Then suggests PMT could have influenced her emotionality
P reluctant ever now to really
Review - to show T. OK ('what I've doing') - 2 for support? ('make you're on track')

APPENDIX 3(a)
Extract from Evelyn's interview (contd)

I: What was going on in your mind while you were crying, for those couple of hours...?

P: ...I felt like I'd achieved something....which felt so good...but it was like sad that it's finished, sad that it's all of a sudden ended. It was actually very sudden...so it was just very emotional...and...there's nothing that can prepare you to end a relationship...with counselling...it's a different kind of relationship - not to see somebody, that you know is alive...but that you won't see them again

1050

1055

• unpreparedness -
(paradoxical element as earlier felt 'right' to end)

hard mixed feelings when crying: (reflects) she felt good about achieving something, simultaneously sad that therapy was over. Felt sudden. Not prepared.

T - client relationship
B unique

• T-C relationship
unique - as it
the ending between
them

• Pain of ending a relationship even though (especially?) person continues to 'be'

Appendix 3(b)
Extract from Pamela's interview

Black (descriptive) – as is
Blue (conceptual) – underlined
Red (linguistic) - circled

1505 I: And finally, how does it feel having talked about it for an hour and a half? How has it been, to do this interview?

P: Actually, it's been very beneficial...very cathartic...um...I see it as an extension of my therapy, because nobody else wanted to talk to me about it; no-one has sat down and

Sees interview as having been a catharsis, of value
Also 'an extension of my therapy'

1510 said to me – how are you doing, Pammy? I know your therapy's finished...how are you feeling? No-one has...no-one cares, really...it's just not that interesting to anyone

No-one else is interested

else, so to me – talking to you today...I know I haven't got fondness; also depersonalised to make more bearable? my Mondays any more ...so to me – you coming here,

* Awareness of her ending
* But I was interested
* 'You coming here' - I made the effort

1515 and having this interview - it's my little bit of therapy
(laughs) release

Feels like her 'little bit of therapy'

- Interview has therapeutic aspect?

I: I wondered if you felt it had stirred things up...? in any unhelpful way?

1520 P: No...because ..it's been a while, talking about the assault and the termination and everything....I can talk about it now without it affecting me, still is affected, um...but that's the whole thing she said you need to do; she said you'll get to depersonalise Jane?

Says hasn't been stirred up in an unhelpful way, but does refer to her trauma

T suggested she needed/would get to point of being able to talk about the trauma without feeling too disturbed

: Interview as practice ground for something talked about in therapy - but create bridge from therapy

APPENDIX 3(b)
Extract from Pamela's interview (contd)

(95 mins)

1525

a point where you talk about it and it doesn't register any more. But don't stop talking about it because you're frightened of what feelings it's going to bring forth. Own it. Speaking in T's voice

T-Encouraged her not to fear the feelings speaking about the trauma might bring up; to face them

I: So it's been a bit of a practice ground for that, perhaps?

1530

P: Yeah. Definitely. Yup. emphatic

P is replaying / underlining something learnt in therapy

I: And talking about the actual ending? Was there anything negative for you about that..?

Interview^{was} offered the chance to talk about the ending itself, rather than just anticipate it

1535

P: No. I think it's actually been quite good, because I haven't been able to talk to anybody about the actual ending...I talked about it coming to an end, but it would have been nice to have talked to somebody about the actual ending of it; maybe have another therapist to say - well how do you feel about the actual end? But I haven't been able to do that, because it just - ended.

'Am I the therapist'?

Talked about 'coming to an end' but still a suddenness in the experience

1540

I: So you've had a bit of an opportunity... in both senses - recent & sudden

Did you do 'processing' of the end actually go on (in the therapy)?

APPENDIX 3(b)
Extract from Pamela's interview (contd)

1545

P: Yes....yes. Because you don't know how you're going to feel until after it's ended. So, talking about the end in the run up to it is neither here nor there....it's not until after it's ended...then you can talk about it. So - it's been very therapeutic for me, very beneficial for me, to be able to speak about it, to you.

2nd person - distancing?
- meets me directly; brave?

I: Finally, I'm going to give you £20. Part of the interview is to ask you what you feel about having £20 as a reimbursement for expenses..?

1550

P: I mean I didn't expect it...! I mean, I'm going to take it and give it to my two friends who are doing a charity marathon on Sunday, and I'm not going to be here to see them, and I wasn't able to afford to give them anything because I'm going on holiday tomorrow, to go and spend some time with my sister - because she's having an operation to remove her breast, for cancer..so to me it's very poignant that I've now been able to give one some money for cancer, and one for another good cause, so -

1555

I: ...great, but it doesn't sound as if the £20 was originally a motivation for you...?

1560

Talking about ending in retrospect is different to 'in prospect'

Openly acknowledges has been therapeutic & beneficial to talk about the ending

Research itself - a therapeutic instrument

Expenses money wasn't expected But P. has a plan - to give to 2 friends running charity marathon, one a cancer charity - her sister is undergoing a mastectomy, so it touches her she can donate to the cancer cause / has special relevance

Expenses not a motivation but has allowed her an expression of agency

APPENDIX 3(b)

Extract from Pamela's interview (contd)

P: No, it wasn't. Because - I was under the understanding I was just going to help you out and as far as I was concerned, that was my only motivation...to be able to talk to someone about it...had you not paid me, had no money been there, I'd still have spoken to you about it. The money was never the issue for me.

1565

I: Sounds as if you didn't really notice it on the 'ad'..?

P: No...I was quite surprised that you even offered it, to be quite honest! (laughs)

1570

Compensates payment not to
drive force to participate

Ambiguity/paradox in
what was key motivation -
'help you out' and 'talk to
someone'

• Complexity within
the motivation -
same wish for me/my
needs to take centre
stage, though ultimately
being able to talk to
someone about it -
seems of prime importance

the key
point?

repeats

person-to-person frankness

Invitation to participate in a doctoral research project

(TO BE PLACED IN RELEVANT COUNSELLING/PSYCHOTHERAPY ORGANISATIONS)

How do clients experience a preordained ending of medium-term therapy, and the sessions leading up to it?

Is your therapy coming to an end in the near future (or has it recently ended)? Would you like to take part in a research study? It would involve a 1½ hour depth interview about the 'ending' of your therapy. Participants will receive a £20 reimbursement for their time/expenses.

My name is Clare Mansfield and I am in my fourth year of a doctorate in counselling psychology and psychotherapy, part of which involves conducting my own original piece of research. I am studying at the Metanoia Institute/Middlesex University.

Below is some information about eligibility and what participating in my research would entail. If you decide you are interested you will be given a fuller information sheet and consent form. At any point feel free to contact me to ask questions.

1. Who is eligible?

You would be eligible to take part in the study if you have had had therapy for between six and eighteen months and 'had' to end it because of external factors: factors to do with the service. It may be that

- you have had the maximum period of therapy the service offers
- that your therapist is leaving the service, **or**
- that you are moving away from the institution offering the service

In total I am looking for eight participants who fit one or other of the above criteria.

It is completely up to you to decide whether or not to take part.

If you intend, on ending therapy, to go straight in to further therapy with another therapist, you would not be eligible to participate in this study.

2. What does taking part involve?

Taking part involves being available for a one-off face-to-face interview (lasting 1½ hours), at a time to suit you. The interview would take place in your own home or workplace (or at my home, or my consulting rooms in north London, if you prefer). I will give you £20 to reimburse you for your time/expenses.

All information collected about you during the course of the research will be kept strictly anonymous and confidential; your name and address will not be passed to any third party.

The study has been reviewed by the Metanoia Research Ethics Committee.

3. Contact for further information

Clare Mansfield (researcher)

clare@claremansfield.co.uk Tel: 0207 482 2201 or 07970 449907 (Feb 2012)

To: clients at [XX counselling service]

ANY TIME FROM JANUARY TO JUNE 2013

Are you about to have to end your therapy (or perhaps you have just ended it)?

Would you be interested in participating in a research study involving an interview?

You need to be ending your therapy because you have reached the maximum period the service offers (or because your therapist is leaving the service); in other words, the end date has been pre-determined.

The length of your therapy needs to have been between 6 months and two years, and you need to have no plans to go straight into further therapy with someone else, at this point.

If you would be interested in taking part in a doctoral research study, I would be immensely grateful to hear from you.

Participation would involve a 1½ hour depth interview with me, about the 'ending' of your therapy – at your convenience. You would receive a £20 reimbursement for your time/expenses.

Please do email, phone, or text me – for further information.

My name is **Clare Mansfield**, and I am in the fifth year of a doctorate in counselling psychology and psychotherapy at the Metanoia Institute.

clare@claremansfield.co.uk

Tel: 0207 482 2201 or 07970 449907

Do you have or know a client who is about to have to end their therapy (or has just ended it)?

Either because....

- they have had the maximum period of therapy the service offers
- or
- their therapist is leaving the service
- or
- they are moving away from the institution offering the service

(The length of therapy needs to have been between 6 and 18 months)

If they would like to take part in a research study, it would involve a 1½ hour depth interview about the 'ending' of their therapy. Participants will receive a £20 reimbursement for their time/expenses.

Contact for further information

Clare Mansfield (researcher) Year 4 DCPsych

clare@claremansfield.co.uk

Tel: 0207 482 2201 or 07970 449907

Invitation to participate in a doctoral research project
(PARTICIPANT INFORMATION SHEET)

How do clients experience a preordained ending of medium-term therapy, and the sessions leading up to it?

You are being invited to take part in a research study. My name is Clare Mansfield and I am in my fourth year of a doctorate in counselling psychology and psychotherapy, part of which involves conducting my own original piece of research.

Before you decide if you wish to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this. If you decide to take part, you will be given a copy of this participant information sheet and a signed consent form to keep.

1. What is the purpose of the study?

There are different reasons why a person's therapy comes to an end. Sometimes therapy is open-ended, and the 'end' is found/chosen as the process evolves. Sometimes it is a planned short-term process (for example six or ten weeks). Sometimes (in fact quite often, it seems) it is longer term than this, but still has a preordained limit or end date: in other words, the therapy is not specifically short-term, but an ending is imposed, often by the service offering it (and connected with resources); or maybe by the therapist's contract in the service coming to an end. It is this 'imposed ending' of medium-term therapy (six to eighteen months) that I am interested in. How do clients experience this, and the sessions that lead up to it? I believe the findings of my research will help therapists working in these contexts to understand and serve their clients better.

My plan is to conduct my research interviews during 2012, with the aim of writing up the study in 2013.

2. Why have you been chosen?

The service which has given you this invitation is one where there can be 'preordained' endings of one kind or another. You would be eligible to take part in the study if you have had had therapy for between six and eighteen months and 'had' to end it because of external factors: factors to do with the service. It may be that

- you have had the maximum period of therapy the service offers
- that your therapist is leaving the service, **or**
- that you are moving away from the institution offering the service

In total I am looking for eight participants who fit one or other of the above criteria.

If you intend, on ending therapy, to go straight in to further therapy with another therapist, you would not be eligible to participate in this study.

3. Do you have to take part?

It is completely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

4. What does taking part involve?

Taking part essentially involves being available for a one-off face-to-face interview (lasting one-and-a-half hours), at a time to suit you (day or evening; weekday or weekend). The interview would take place in your own home or workplace (or at my home or my consulting rooms in north London, if you prefer). There is no preparation required for the interview; you just need to have finished therapy (had a preordained ending of therapy) in the previous three months – but ideally the interview would take place quite **soon** after the ending itself. The interview will be recorded, but everything you say will be confidential (see **para 6** below). Once the interview has been conducted, your participation in the study is over. You will receive £20 a reimbursement for your time and expenses.

5. What are the possible benefits and risks of taking part?

My hope is that you will find taking part in the study an interesting and enriching experience. It may stir up thoughts and feelings of various kinds that you might not otherwise have had, but there would be a chance to talk these through in the interview. Ultimately, of course, you will be the judge of what effect the experience of talking about your therapy ending has on you. Perhaps it is important to note that although I am a therapist, you are being invited to participate in a research interview and not a therapy session.

In the long term I hope the study will help therapists (and through them, their clients) in approaching and managing preordained endings better.

6. Will your taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly anonymous and confidential; your name and address will not be passed to any third party.

Recordings of the interviews will not be listened to by anyone outside my research team. Verbatim quotes may be used in the final report, but in no case will they ever be attributed to individuals by name; if there is any danger of the quote itself identifying any individual it will not be included.

All data will be stored, analysed and reported in compliance with the UK Data Protection legislation.

7. What will happen to the results of the research study?

As a post-graduate doctoral research project, the study is likely to be published, probably in 2013/14. A copy of the final project will be available in the Metanoia Institute library, and also via Middlesex University and the British Library.

To reiterate: no participant will be identified in any report/publication.

8. Who has reviewed the study?

The study has been reviewed by the Metanoia Research Ethics Committee.

9. Contact for further information

For further information, please contact:

Clare Mansfield (researcher)
Metanoia Institute
13 North Common Road
Ealing
London, W5 2QB
020 8579 2505 (Metanoia main switchboard)
clare@claremansfield.co.uk
0207 482 2201 (Clare's work number)

Werner Prall (Clare's research supervisor)
Metanoia Institute (as above)
wernerprall@talktalk.net

Thank you very much for considering taking part in this study.

February 2012 – PIS version 3

CONSENT FORM

Participant Identification Number:

Title of Project:

How do clients experience a preordained ending of medium-term therapy, and the sessions leading up to it?

Name of Researcher: Clare Mansfield

Please initial box

- | | |
|---|--------------------------|
| 1. I confirm that I have read and understand the participant information sheet datedfor the above study and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. | <input type="checkbox"/> |
| 3. I understand that my interview will be taped and subsequently transcribed | <input type="checkbox"/> |
| 4. I agree to take part in the above study. | <input type="checkbox"/> |
| 5. I agree that this form that bears my name and signature may be seen by a designated auditor | <input type="checkbox"/> |

Name of participant	Date	Signature
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Name of person taking consent (if different from researcher)	Date	Signature
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Researcher	Date	Signature
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1 copy for participant; 1 copy for researcher



13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Clare Mansfield
DCPsych programme
Metanoia Institute

2nd March 2012

Ref: 3/11-12

Dear Clare

Re: How do clients experience a preordained ending of medium-term therapy and the sessions leading up to it?

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Subject Specialist (Research), DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Registered in England at the
above address No. 2918520
Registered Charity No. 1050175

How do clients experience a preordained ending of medium-term therapy, and the sessions leading up to it?

INTERVIEW GUIDE

(please note

- that I would not expect to cover these sections strictly in order; one or more may merge into the other, and I would be led by the participant here, but would hope to cover all this ground, to some extent (depending on the willingness of the participant) in each interview
- also, I am aware that some of the questions, as written, sound very direct, which adds to the schedule's structured feel; in practice I will put questions more gently/obliquely, or not even phrase them as a question; for example: 'I wonder how it was for you when...' 'maybe you can describe to me...' 'could you tell me a little bit about how it felt...'; my stance will be open and exploratory throughout)

1. **Factual background** Can you tell me a bit about the period of therapy you had: what was the service/context, how much time did you have, what was the reason for its ending, etc
2. **Emotional background** Could you tell me a little about what prompted you to have therapy in the first place and what you hoped to get out of it; what is your overall feeling about the experience, looking back on it (*allow participant to answer simply/summarily if they prefer at this point (can return to explore in more depth later); or follow participant more deeply into the experience if they choose to go there*)
3. **The lead-up to the end of therapy** Can you take me through exactly what happened...(possible prompts: *when was the last session and were the sessions leading up to it continuous or broken for any reason; from when were you consciously thinking about it/when was it first in your mind; how was it dealt with by your therapist; what mention was made of the ending and at what point; what did you feel about how your therapist dealt with it; can you tell me something of those final sessions....let's concentrate on the last four: what do you recall of these – the overall feeling/ anything specific/ anything that felt important; to what extent, if at all, were you aware of a 'change' from the therapy period before; can you describe to me all the feelings you had at that time; what about your therapist: what seemed to be going*

*on for her/him; and what about between you: how was your relationship during that time; any changes; what was the mood/energy level of the sessions; what did it throw up for you/the two of you; how did you feel about therapy **having** to end; etc) [NB I would be listening out for links between the original 'aim'/end of the therapy, and the 'end' itself, and would probe further if this theme seemed present]*

4. **The ending of the therapy** How was it at the very end; can you describe the last session and how you felt (*possible prompts: feelings as you walked in, during, and right at the end; sense of the feelings between you; how did it compare with expectations – if any; what actually happened at the 'goodbye'; what did you make of it all – how big a deal was it for you, how meaningful, in relation to other parts of the therapy process/journey etc*)
5. **Endings in general** What do you generally feel about endings; what do endings tend to mean for you (*possible prompts: what have been significant endings – whether major or minor - in your life; to what extent if any were other endings called to mind by this ending; how do you tend to deal with endings generally, etc*)
6. **The ending of the therapy in retrospect** Looking back on it, how do you feel about it now (*possible prompts: has your perspective changed; what do you think ending did for you, in terms of your therapeutic journey; could prompt with ...what are your feelings around your therapist now/what, if anything, does your therapist mean to you now; What do you think would have happened if you hadn't ended then;*)
7. **Feelings about the interview**
 - Why did you decide to participate (*possible prompts: in what way did you feel talking about the end of your therapy might benefit you; were you interested in helping for any other reason; what feelings did you have in relation to the time/expenses reimbursement, etc*)
 - How has it felt, talking about the ending of your therapy; has anything changed for you, during/as a result of this process; (*mention to participant the option of contacting me at any later stage if they want to talk through anything that has disturbed them, or feels 'unfinished' in relation to the interview*).

Thank and close.

Further detail on timings of research interview: how soon after ending therapy?

Andrea 1 day	Philip 6 days	Hilda 10 days	Pamela 16 days	Jason 16 days	Evelyn 21 days	Malcolm 'about a month'	Bianca 'about six weeks'
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