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COUNTERTRANSFERENCE IN TERMINATION:

THERAPIST LOSS RESOLUTION AND FEAR OF INTIMACY

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By

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Abstract

This study examined therapist loss resolution and fear of intimacy as origins of countertransference reactions involving therapists' affective and behavioral responses to termination, potentially affecting therapeutic outcome. In this study, therapists responded to measures that assessed their fear of intimacy and loss resolution in their personal lives. Clients and therapists then completed measures of the therapists' behavior in the termination session, and therapists rated their anxiety during the termination session as well. Therapist loss resolution and fear of intimacy individually contributed to a limited amount of the variance in therapists' affective and behavioral reactions in termination sessions. However, when fear of intimacy and loss resolution were jointly considered, they accounted for a significant amount of the variance in both positive and negative countertransference behavior during termination, as well as therapists' state anxiety.

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Chapter 1: Introduction

Countertransference in Termination:

Therapist Loss Resolution and Capacity for Intimacy

Therapy is a relationship inherently destined for loss. Considering the amount of time people spend constructing and maintaining relationships, termination is contrary to what people seek in intimate relationships. In fact, termination is considered one of the most powerful periods in the therapeutic process. During this time, the therapist engages the client in revisiting the change process that occurred over the course of therapy. Understanding what creates a therapeutic termination experience for the client is essential in that ruptures occurring in the final session cannot be repaired. Termination should facilitate a positive ending experience for the client in which the loss of the relationship can be processed and feelings associated with the loss can be felt.

Researchers have demonstrated that successful endings are often characterized by various factors such as a mutual decision to end therapy, having the client explore what they did or did not like about counseling, the therapist talking more than usual about him or herself, and the therapist and client relating more as equals than in the past (Marx & Gelso, 1987). However, in termination, as in all stages of therapy, the therapist's unresolved issues have the potential to create countertransference reactions that disturb the therapeutic process. Areas of unresolved conflict in the therapist's life may lead to negative affective reactions such as anxiety (Hayes & Gelso, 1991; Sharkin & Gelso, 1993) that in turn may trigger countertherapeutic behavioral reactions during the session (Friedman & Gelso, 2000). Feelings of anxiety may also arise as a reaction to the therapist's worries about the client's ability to sustain health post-termination. Thus, it is important for the therapist to be able to distinguish between affective reactions

triggered by their own unresolved issues, and reality based reactions to the client or therapy relationship.

Researchers and theorists have defined countertransference in a number of different ways. Freud (1910/1958) suggested that analysts experience unconscious neurotic reactions to their client's transference, enacting their own defenses. This definition of countertransference, designated the classical definition, was expanded upon by Fromm-Reichmann (1948), Winnicott (1949) and other object relationists who concluded that all feelings and reactions on the part of the analyst could be deemed countertransference. This totalistic definition of countertransference saw these reactions as a means by which the therapist could gain further insight into the client. Finally, the integrative approach to countertransference developed by Gelso and Carter (1985) regards countertransference as "inevitable therapist reactions to clients that result from his or her own conflicts and needs rather than from reality-based reactions to clients" (Friedman & Gelso, 2000, p. 1222). In the integrative approach, therapists may have reality-based reactions to clients as well as reactions rooted in their own unresolved conflicts. The underlying premise of the integrative definition is that these unresolved conflicts can emerge when triggered by events in therapy. When therapists are aware of their unresolved conflicts, they have the capacity to differentiate between these and reality-based reactions, making use of reality-based reactions to further their insight into the therapy relationship and better managing personal conflicts that may disrupt the therapeutic process. In this study, I have chosen to focus on the integrative definition of countertransference because the termination of therapy has the propensity to invoke reality-based loss experiences as well as prior unresolved conflicts.

In reviewing studies that explored countertransference reactions to termination, the most prominent theme was that of an affective response to an unresolved loss history on the part of the

therapist (Boyer & Hoffman, 1993; Martinez, 1986; Noy-Sharav, 1998). The current study investigates two possible sources of therapist countertransference reactions that may arise in termination. The first source of potential countertransference focuses on the therapist's unresolved prior loss experiences, while the second emphasizes the possibility that unresolved fears of intimacy may trigger countertransference reactions during termination. While the concept of intimacy has not been directly applied to empirical studies of termination, the findings from several studies allude to capacity for intimacy as significantly affecting behavior, particularly in the final sessions of therapy (Doi & Thelen, 1993; Quintana & Holohan, 1992; Trull, Widiger, & Frances, 1987).

The constructs of fear of intimacy and loss resolution were chosen because they present two seemingly separate concepts that merge in the termination of therapy. One contributor to loss resolution is a fear of abandonment. For instance if a person fears loss they may avoid intimacy, rather than risk becoming close to someone and then suffering a loss. Quintana and Holohan (1992) found that successful termination sessions frequently included the therapist engaging in increased self-disclosure about their own experience in the therapy, minimizing the distance between themselves and their clients, and displaying heightened affect. These behaviors require that the therapist engage in an intimate relationship with the client. The ability to merge while in the process of separating requires the therapist to be comfortable with both intimacy and loss. The task for the therapist in termination then becomes engaging with the client in the final session while processing the loss of the therapeutic relationship. When the therapists' affective and behavioral reactions to loss and intimacy remain unconscious, the therapist may experience anxiety or engage in countertherapeutic behaviors in the final session.

A successful termination dictates that the therapist engage in more self-disclosures about the process and the client than may be typical in earlier sessions (Marx & Gelso, 1987). The therapist's expression of genuine and personal feelings about the therapy and the client during termination may lead to a deeper intimacy. Shane, Shane, and Gales (1997) defined therapeutic intimacy as the relatedness that develops between the client and the therapist based on the client's initial sense of trust in the therapist. Because self-disclosure enhances intimacy, it is possible that therapists with a fear of intimacy will not be able to engage as therapeutically in the termination session as therapists who do not fear intimacy. Fears of intimacy may originate from the fear of becoming enmeshed (Alperin, 2001), a lack of comfort with strong positive or negative feelings (Coen, 2002), or fears of losing power or control over the relationship (Kayser & Himle, 1994). The tendency to shy away from intimacy will inhibit the therapist's ability to join genuinely with the client in the loss experience and simultaneously maintain an objective distance. Intimacy inherently creates more equality in the therapy relationship and as a result, therapists who wish to maintain the power differential in the relationship may unconsciously shy away from expressing their true feelings during termination.

In fact, Hill, Mahalik, and Thompson (1989) examined 89 therapist self-disclosures made by eight therapists and found that seven of the eight therapists used "goodbye" closures in the last few minutes of the final session, mentioning the history of the work, feelings of connectedness, and loss. However, for three of the therapists, their "goodbye" disclosure was the only self-disclosure made in the course of therapy. It is also noteworthy that these therapists waited until the last few minutes to express their feelings and join with the client in feelings of loss, and leave to question what caused the initial resistance to this intimate discussion.

Countertransference reactions that occur in termination present a unique problem in that the ending must be processed in advance by the therapist and monitored closely throughout the final sessions with the client. Therapists who unconsciously fear abandonment or enmeshment, the extreme ends of loss and intimacy, respectively, may engage in more behaviors that are countertherapeutic.

Therapist loss history is cited in a number of studies as a variable that potentially affects therapists' reactions to termination (Boyer & Hoffman, 1993; Greene & Gellar, 1980; Martinez, 1986; Noy-Sharav, 1998). The client's experience moves from the subjective to the objective in the final session as the dyad is forced to experience the loss of a relationship together. Powerful feelings of loss in the here-and-now emerge simultaneously as past loss experiences are resurrected. While the client should be welcomed to experience feelings of loss in the final sessions, the therapist must be adequately resolved around his or her own losses in order to guide and support the clients' process. In the termination of therapy, as in any loss, the client and the therapist may pass through stages of grieving to differing degrees, affectively, cognitively, and behaviorally. Rather than staying with the client through the loss process, therapists with unresolved losses may unconsciously move too quickly through a review of the counseling process, pay little attention to the process of saying goodbye, become overbearing, or self-disclose inappropriately (Quintana & Holohan, 1992).

Goodyear (1981) posits that therapists may fail to recognize client feelings of loss when doing so would reinforce their own feelings of loss in response to the end of a meaningful relationship. Therapists with unresolved loss issues may struggle to verbalize their goodbye to a cared for client, instead directing their sadness inward and experiencing feelings of anxiety or depression. When previous loss experiences remain unresolved, defense mechanisms may

operate in order to protect one from the overwhelming feelings that may occur because of subsequent loss experiences. Considering this possibility, it is plausible that therapists with unresolved losses would be unconscious of their enactment of behaviors that serve to distance them from their clients in termination, yet affectively experience anxiety or depression.

Because of the intensity and finality of the termination phase, the therapist must continually examine his or her affective reactions to regulate potential countertransference behaviors (Ruderman, 1999; Weiss, 1991). It is possible that it is easier for therapists to talk about their feelings for clients in termination when they are positive. Therapists may resist self-disclosing negative feelings about the therapy relationship or ending as a defense against their own discomfort. However, therapists who were able to provide successful termination sessions most often: shared their feelings about the therapy with the client, hugged or shook hands with the client, talked more about themselves, and related more as equals then in the past (Quintana & Holohan, 1992).

Prior unresolved loss experiences may contribute to therapist loss responses, such as, being overbearing in self-disclosures, clinging to the client, giving advice, discouraging the client's affective expression, intellectualizing or otherwise failing to work through the termination process in a productive manner (Glenn, 1971; Penn, 1990). Affectively therapists who experience fears of abandonment, separation anxiety or other issues of unresolved loss may experience affective withdrawal, depression and other self-deprecating feelings (Glenn, 1971; Martin & Schurtman, 1985). While it is typical for the loss of any significant relationship to trigger feelings of sadness, the therapist must differentiate between their feelings of loss of the therapy relationship and the resurrection of unresolved losses. The therapist's management of unresolved affect may unconsciously determine his or her behavior in the final sessions. Though

a variety of affective responses to loss outside the therapy relationship may go unnoticed, a lack of loss resolution when conducting termination sessions could trigger behaviors that negatively affect the client.

When it is properly managed, countertransference can enhance treatment. Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) suggested that when therapists are able to identify countertransference triggers and origins they may become more able to repair alliance ruptures or derive insight into the therapy relationship. At times, the therapist's self-disclosure of countertransference issues related to the loss of the relationship may assist the client in processing the loss of the relationship.

A review of the literature reveals the importance of considering therapist loss resolution and fear of intimacy as factors that influence the way termination is conducted. While therapist loss resolution has been found to significantly influence therapist affective reactions to termination (Boyer & Hoffman, 1993), behavioral reactions are less well understood. In this study, the degree to which therapist loss resolution and fear of intimacy act as countertransference triggers for behavioral and affective reactions in the termination session of therapy were investigated.

Chapter 2: Literature Review

A successful therapy outcome is thought to be the result of many client, therapist, and relationship variables. One of the most poignant periods in which these variables converge is during the termination process. Freud believed termination to be such a powerful component of the therapeutic process that mistakes made by the therapist during this time could not be rectified. The termination of psychotherapy has been investigated intermittently in the literature since Freud's early contributions in *Analysis Terminable and Interminable* (1937/1963), and today continues to be most evident in the psychoanalytic journals, perhaps due to the emphasis on termination in longer-term therapy. Though it has been noted that procedures therapists use in termination can have a significant impact on the treatment outcome (Glenn, 1971; Kramer, 1986), the therapist's contribution to the process and outcome of termination is rarely considered in the literature (Goodyear, 1981). However, a small number of researchers have sought to study empirically how therapists' affect and behaviors influence the termination process (Boyer & Hoffman, 1993; Greene, 1980; Kramer, 1986; Noy-Sharav, 1998; Quintana & Holohan, 1992).

Many factors contribute to the therapist's facilitation of the final session. In all stages of therapy, including termination, the therapist's unresolved issues have the potential to create countertransference reactions. However, detrimental countertransference behaviors are the exception to the norm in all stages of therapy, most likely including termination. Hayes, McCracken, McClanahan, Hill, Harp, and Carozzoni (1998) surveyed eight therapists following sessions that were viewed by interviewers and found that termination was considered a trigger for countertransference reactions for most therapists. These researchers noted the necessity of therapist attention to personal conflicts around separation during termination. Hayes et al. posited that therapists must "check their lenses continually to both heighten their self awareness

and enhance their ability to recognize stimuli that are likely to trigger countertransference" (p. 477).

The current study investigates two possible sources of therapist countertransference reactions that frequently arise in termination. The first source of potential therapist countertransference is related to the therapist's prior experiences with loss. Additionally, therapists with an unresolved fear of intimacy may not be able to engage authentically with the client in the final stage of termination, possibly leading to a less therapeutic outcome.

Countertransference

The concept of countertransference has undergone considerable transformation from the time of its inception in 1910. Freud acknowledged the "beleaguered situation in which the analyst could find himself…at the mercy of intense affect, from which he needed protection" (Hamilton, 1996, p. 191). The definition of this construct continues to vary substantially between therapists and theoretical schools of thought. The psychoanalytic writings on countertransference address the three components of this concept as affect, cognition, and the concept of "play," which is a state of being somewhere between primary and secondary process. The early Freudian perspective on countertransference utilized the classical definition, which describes countertransference reactions as originating from the analyst's pathology in reaction to the client, much in the way transference referred to the client's unconscious pathological expressions directed toward the therapist. The object relationists were the first to recognize countertransference as an affective response on the part of the therapist. Later theorists from this school of thought (Fromm-Reichmann, 1948; Winnicott, 1949) described countertransference in a totalistic fashion positing that all reactions (cognitive and affective), whether realistic or not, on the part of the therapist in response to the client were countertransference. Finally, the

integrative approach to countertransference defined by Gelso and Carter (1985) regards countertransference as "inevitable therapist reactions to clients that result from his or her own conflicts and needs rather than from reality-based reactions to clients" (Friedman & Gelso, 2000, p. 1222). The integrative definition of countertransference focuses on the therapist's struggle to manage conflictual feelings resurrected in therapy with clients. Because this study focuses on the therapist's ability to manage conflictual feelings about loss and intimacy so that they do not manifest in the final sessions of therapy, the integrative definition of countertransference will be utilized.

In the final sessions of therapy, the client and the therapist share in the reconstruction of the history of the client's therapy (Weiss, 1991). It is important that the client and the therapist do not feel a sense of guilt about ending but rather recognize that one can feel sadness and still follow through with leaving (Weiss, 1991). When one or both parties feel guilty because of the impending termination, the tendency to minimize the importance of ending may emerge. The therapist must facilitate the leave taking process while simultaneously working through his or her own issues related to ending relationships and the individuation process. Klauber (1986, p. 202) pointed out that the literature neglects discussion of the effect on the therapist of having to form "relationship after relationship of the deepest and most intimate kind" with many patients and the grieving that must be involved at some level in ending with each one of them.

The termination literature focuses primarily on insight-oriented therapies, which tend to occur in a less rigid period than more directive therapies. Perhaps due to the variation in length of therapy, much of the analytic literature on countertransference reactions to termination focuses on the therapist's decision to terminate prematurely (Weiss, 1991). The analytic perspective views early termination as a primary form in which the therapist enacts negative

countertransference. However, countertransference can be both the provocateur of termination and the result of the highly emotional process of ending, often taking the form of affective and behavioral reactions within the final sessions of therapy. "An intense reaction by the therapist, even if it is clearly 'induced,' is probably intense because it triggers residual conflict, or activates archaic self and object representations in the analyst" (Livingston, 1991, p. 196). McClure and Hodge (1987) note the importance of the therapist recognizing that discrepancies are likely occurring in their perception of the client whenever strong feelings are present. In a study of 12 therapists and 36 of their clients, these researchers found that strong feelings of "liking" led therapists to misperceive the client as having a personality similar to theirs, and vise versa when they had strong feelings of dislike. Maroda (1991) suggested that narcissistic patients in particular might stir countertransferential resentment or envy in termination as they seek to display that their talent or success outdoes their therapist's. In less obvious ways, at some level all clients at termination engage in a healthy de-idealization of their therapists, as energy is re-directed toward the formation of new relationships (Maroda, 1991).

Taking into consideration the amount of time people spend constructing and maintaining relationships, termination is contrary to what people seek in intimate relationships. Weiss (1991) noted the omnipresent difficulty all humans have in terminating relationships. Therapy is inherently a relationship destined for loss. In order for the therapist and client to establish a working alliance and develop some level of intimacy, the ultimate ending is often not considered or its effect is downplayed. Subsequently, the grieving process can take many forms, such as refraining from important self-disclosures about ending, failing to process the loss experience, or shying away from difficult affective reactions, for both the client and the therapist.

Loss Resolution

Penner, Dovidio, and Albrecht (2000) defined personal loss as "the instance in which one person loses the companionship of a valued other" either to death or termination of the relationship (p. 62). Over time, loss can be accepted if one moves sufficiently through the stages of grief. Kübler-Ross (1997) clearly delineates the five stages a person passes through when dying, which are mirrored by those suffering the grief of loss. Kübler-Ross believed that a person typically goes through denial and isolation, anger, bargaining, depression and finally, acceptance. Similarly, in the termination of therapy, the client and the therapist may pass through each of these stages to differing degrees, whether affectively, cognitively or behaviorally. The psychoanalytic school of thought believes that loss resolution or acceptance is accomplished through the withdrawal of bonds from the lost object, freeing energy to be cathected onto new attachment objects. However, Marwitt and Klass (1995) stipulated that while it is important to loosen the bond with the lost object, the relationship with the lost object must also be reconceptualized. A simple replacement of the lost object and denial of the loss will not lead to acceptance without attending to the grieving process. In all situations of loss, it becomes important for people to integrate parts of what was lost into themselves in order to heal and feel whole again. In termination, it is important for the client and the therapist to process both what they are losing and what they have gained from one another and their work together. This discussion may facilitate for both people the understanding that the emptiness felt in saying goodbye has the potential to become filled by what they have gained from the other person.

When grief goes unresolved, as evidenced by substantially prolonged periods of mourning or dissociating from the loss, complications can result. Bereavement pathologies have been identified in a number of studies and include absent, chronic, or delayed grief. Horowitz,

Siegel, Holen, and Bonanno (1997) identified the existence of a complicated grief disorder, which involves severe separation anxiety, intrusive thoughts, feeling increasingly alone and empty, avoiding tasks related to the loss, loss of interest in personal activities, and some sleep disturbance, lasting more than a year after the loss experience. Additionally the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV, APA, 2000) recognizes "Bereavement" as a category to be used "when the focus of clinical attention is a reaction to the death of a loved one." The DSM-IV acknowledges that many people may experience the symptoms generally characteristic of Major Depressive Disorder (i.e. anorexia, insomnia) at this time. However, a differential diagnosis should be made between bereavement and major depressive disorder based on six additional factors: "1) guilt about things other than actions taken or not taken by the survivor at the time of the death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged or marked functional impairment; and 6) hallucinatory experiences other than thinking that he or she hears the voice of or sees the deceased person".

While most reactions to loss are not so extreme, inadequate loss resolution on the part of the therapist may inhibit "working through" the termination of psychotherapy with the client. A therapist may not have been able to resolve his or her own issues of personal loss in the past for many reasons, such as fear of abandonment, complicated grief, or countless others. Regardless of the reason that the therapist has not been able to resolve personal grief issues, the fact that they have not may render them unable to engage in therapeutic behaviors necessary during the separation that occurs when terminating with clients. It is likely that the therapist's own unresolved issues around loss will be triggered, perhaps unconsciously, in their experience of

loss at the end of therapy, causing negative affective reactions. Therapists may then unconsciously move too quickly through termination, paying little attention to the process of saying goodbye. However, when therapists are able to identify and examine the causes of negative affective feelings arising in themselves during termination, they may be able to effectively manage their countertransference subsequently making better use of their reactions. Hayes et al. (1998) suggested that when therapists are able to identify countertransference triggers and origins, they may become more able to repair alliance ruptures or derive insight into the therapy relationship. Likewise, in termination therapists may be able to refrain from detaching or becoming distant from the client, failing to process the loss experience or shying away from self-disclosures that would facilitate a more therapeutic ending for the client.

The therapeutic relationship is a "communal" one in which one person is designated to help the other, without the expectation of reciprocity (Penner et al., 2000). Typically, the awareness of another person's loss generates the comparison of one's own situation to the situation of the person experiencing the loss (Thompson, Cowan, & Rosenhan, 1980). Perhaps because of this human tendency and the therapist's expectation that the client will be more severely affected by the loss, the therapist may be apt to deny his or her own loss experience. Thompson and his colleagues investigated the impact of negative affect on altruism by having 36 participants listen to an audiotaped story of an imagined best friend dying of terminal cancer. Two sets of audiotapes were played. Half of the participants listened to a tape describing the best friend's own worry about the friend's sickness (they were to imagine they were the best friend), while the other tape concentrated on the ill friend's feelings. Participants were told that after completing this experiment they could help a graduate student who needed people to answer 200 difficult multiple-choice questions for her study, which served as a measure of

altruism. Findings indicated that participants who attended to the feelings of the sick friend were more altruistic than participants who attended to their own feelings of grief. The decision made by one person to help another person was based on the negative affective reaction that resulted from their comparison of their situation to that of the suffering person. When participants felt as if they were witnessing another's harm in the tape, they were significantly more likely to be altruistic than participants who focused on their own sadness rather than the ill friend's.

Separation Anxiety

Freud's ideas on separation anxiety and mourning went largely unnoticed when he first began to acknowledge the significant impact they had on patients (Bowlby, 1973). At the time, the profound impact the fear of loss of an object and the object's love would have on a client was not understood. Freud (1926) noted a new understanding of separation anxiety, which included anxiety as the reaction to losing a coveted object, and mourning as the pain resulting from the loss of the object. Bowlby posited that when a person feared loss and was confronted with it, the reaction incited "immobility, increasing one's distance from the object and increasing proximity to another object" (p.89). The methodical way in which one was thought to advance and retreat from objects was linked to the idea that one object is protective while the other is threatening. Bowlby believed that when a permanent loss occurred, the anger that resulted did not serve a purpose. When a loss was temporary a person displayed anger which served to remind the person not to leave again. However, he argued that because permanent loss is less frequent, directly following its occurrence people could rarely come to terms with the finality. Bowlby proposed the idea of the expression of anger acting as an "affectional bond." Anger as affection is meant to be protective reminding the other how much they will be missed. If this "affectionate

anger" continues, it actually weakens the bond between objects alienating the other person as affection turns into vengeance.

Separation anxiety, as well as submissive, clinging behavior also tends to be characteristic of a fear of abandonment. People with strong needs for attachment leading to fears of abandonment tend exhibit these behaviors and have difficulty separating from relationships (Doi & Thelen, 1993). Though on the extreme end of the spectrum such behaviors may be characteristic of dependant personality disorder, they may emerge to a lesser extent in therapists during the termination phase of therapy.

Loss and Cognitive Interdependence

The cognitive aspect of loss has received less attention in the literature than affective and behavioral components. "Cognitive interdependence" refers to the mental representations of the self-in-relationship that support motivation and behavior, as oriented toward maintaining the relationship (Agnew, 2000, p. 385). Hobfoll, Ennis, and Kay (2000) argue that the functional nature of relationships, which is considered of utmost importance evolutionarily and culturally, is fortified by love. The experience of loss due to romantic break-ups, infidelity, change in location, or loss of job can result from the deliberate actions of one party in the relationship. Agnew believed that responsibility for the end of the relationship is a predominant factor in the subsequent experience of loss. The thoughts of the person who makes the decision to end may be less likely to be affected by strong emotions, particularly when it is the case that their deepest sense of self has not undergone substantial change. The cognitive and affective reactions are likely to differ substantially based on the role of "the leaver" and "the abandoned" (Agnew, 2000). Thus it is important in termination for the therapist to consider whose decision it was to end the therapy relationship and if their decision follows a pattern of being the "leave taker" or

the "abandoned." Such a consideration seems especially important in these days of managed care and brief therapy, when external factors may hold a strong presence in the therapist's decision to terminate.

The Therapist

Therapist loss history has been cited as a variable that potentially affects therapists' reactions to termination (Boyer & Hoffman, 1993; Martinez, 1986; Noy-Sharav, 1998). As human beings, we inevitably suffer multiple losses throughout life. As Judith Viorst wrote, "loss can dwell within us all our life" (1998, p. 33). These losses may be more or less significant, or resolved, depending upon individual coping style and mechanisms. Experiences of loss are likely to influence the way that we deal with future losses. Headington (1981) postulated that by understanding a person's reaction to loss in a single situation, one could begin to understand the person's behavior in future situations of loss. Headington's presumption suggests that therapists' reactions to previously suffered losses will influence their behavior in termination. As the therapist enters into the termination phase with a client it is important for him or her to recognize the therapist's tendency to place great value on the examined inner life, "overvaluing perhaps the understood life relative to the future-oriented way most ordinary people choose to lead their lives" (Hamilton, 1996, p. 224).

In termination, the literal loss of the significant other in the therapeutic alliance collides with the therapeutic relationship's typical isolation from the outside world. This collision of realities in termination provides a realm in which both the client and the therapist sometimes experience powerful feelings of loss simultaneously, in the "here-and-now," as influenced by prior loss experiences (Fox, Nelson, & Bolman, 1969). While the client is entitled to experience this loss in the final sessions, the therapist must be adequately resolved around his or her own

losses in order to effectively guide the client through the process. Only a few empirical studies have investigated the idea that the therapist's response to prior losses may influence termination (Boyer & Hoffman, 1993; Greene, 1980; Greene & Gellar, 1980; Martinez, 1986).

Throughout life, some of the most difficult moments are spent saying goodbye and termination is not likely an exception. Goodyear (1981) posits that therapists might not recognize client feelings of loss when doing so would reinforce their own feelings of loss in response to the end of a meaningful relationship. In a related study, Greene and Gellar (1980) surveyed therapists-in-training (N= 71) and experienced clinicians (N= 34) regarding their managerial and affective responses to termination. Using the Therapist Termination Questionnaire (TTQ) and the Boundary-Fusion Test, they found that therapists with heightened anxiety about termination tended to minimize personal boundaries and draw closer to their patients. The therapeutic role was often abandoned in order to satisfy the therapist's need for either intimacy or isolation (Greene & Gellar, 1980). These findings suggest that therapists may unconsciously abandon their usual therapeutic role in termination in order to satisfy their own needs resulting from conflicts over merging or separating. Additionally therapists with a fear of intimacy or unresolved losses may be unable to adequately facilitate and participate in a therapeutic termination.

Martinez examined the number of therapist losses in relation to feelings about termination and found no significant relationship. However, Martinez failed to take into consideration aspects such as time since occurrence and impact, accounting only for the number of losses (Boyer & Hoffman, 1993). Furthermore, and perhaps more importantly, the number of losses suffered is not necessarily equal to the impact or resolution of loss. Boyer and Hoffman corrected for some of the limitations in Martinez's study by investigating the role of therapist

loss history and its relationship to therapist's reactions to termination. In a study of 117 licensed therapists, they found that therapist grief resolution as measured by the Texas Revised Inventory of Grief (TRIG) predicted affective responses to termination. Two affective reactions to termination were predicted utilizing the Therapist Termination Questionnaire (TTQ). Boyer and Hoffman found a positive correlation between severity of grief reaction and depression at termination. They also found that therapists who perceived their clients to be more sensitive to loss experienced greater anxiety at termination than those who did not. While previous research has looked at the therapists' perception of loss and its impact on affect and behavior in therapy, a recent study (Hayes, Yeh, & Eisenberg, in press) found that clients perceived bereavement counselors who had more unresolved grief around the loss of a loved one to be less empathetic.

Boyer and Hoffman's (1993) findings are aligned with Bowlby's (1973) conceptualization of separation anxiety. Bowlby discovered that the loss of a significant person encourages an adverse reaction or separation anxiety, particularly when it goes unresolved. Therefore, it is likely that therapists with less resolved losses would be more apt to experience anxiety in termination sessions. In most countertransference research, anxiety has been a consistent indicator of the provocation of therapists' unresolved issues (Bandura, 1956; Rosenberger & Hayes, 2002). Therapists with unresolved loss issues may struggle with verbalizing their goodbye to a cared for client, instead directing their sadness inward and experiencing feelings of depression. When previous loss experiences remain unresolved, defense mechanisms may be utilized to deal with subsequent loss experiences. Considering this possibility, it is plausible that therapists with unresolved losses would be unconscious of their enactment of behaviors that serve to distance them from the client in termination, yet affectively experience anxiety or depression.

Loss at Termination

While psychoanalysis focuses in the termination phase on the reactivation of memories of loss from the early developmental stages (Ruderman, 1999), it is likely that more recent experiences of loss are provoked as well. Because of the intensity of the termination phase, the therapist must continually examine his or her countertransference and affective reactions (Ruderman, 1999; Weiss, 1991). Few studies have measured the therapist's inner process as they move through termination with their clients (Ruderman, 1999). Ruderman recognized that even analysts themselves tend to write about the termination process as if they were not in it with the patient. The apparent evasion of discussing the vulnerabilities experienced by the therapist during termination mirrors the "denial and avoidance" frequently seen in clients during the final phase of therapy, and characterizes the first stage of Kübler-Ross' theory (1997).

The possibility that the mutual mourning of termination could be beneficial to the therapeutic process is rarely considered. Practice has typically been such that the therapist is expected to contain his or her affective reactions to terminating in an effort not to burden the client. Ackerman and Hilsenroth (2001) summarized some of the personal attributes of the therapist, which may lead to ruptures in the alliance including being rigid, aloof, tense, uncertain, self-focused, critical, and using inappropriate self-disclosures. However, as Maroda (1991) points out, clients in the process of saying goodbye typically seek answers to questions about the therapist's feelings about ending with them. It is possible for therapists to express how much they have cared for and will miss the client in the final moments of therapy. In order for such a process to occur, therapists must be open to the intimacy that grows within the therapeutic relationship as they expose themselves more personally in the final therapy sessions.

Wachtel (2002) makes the important distinction that the termination of therapy with one therapist need not be the termination of therapy all together. He suggests that due to the predominantly interpersonal nature of therapy, the outcome of therapy with one therapist is different than it would be with another one. Therefore, a client should not be led to believe that they may not benefit more from therapy with another person (Wachtel, 2002). Wachtel also posits that termination is a time for humility, particularly for the therapist, who is joining the client not through empathy, but through experiencing his or her own personal reaction to the loss in the moment.

Intimacy

Intimacy has been characterized as including such attributes as "openness, honesty, mutual self-disclosure, care, warmth, protection, helpfulness, devotion, mutual attentiveness, commitment, surrender of control, dropping of defenses, emotional attachment, and distress when separation occurs" (Rubenstein & Shaver, 1982, as cited in Detschner & Thelen, 1991, p. 218). Composed of so many different aspects, intimacy is a difficult construct to operationalize. Because the construct of intimacy is extensive and multifaceted, researchers seeking to measure it have typically utilized self-report instruments aimed at measuring specific features or stages of intimacy (Doi & Thelen, 1993). While the concept of intimacy has not been directly applied to empirical studies of termination, the findings from several studies allude to intimacy as a significant contributor to therapeutic outcome, especially in final sessions. Quintana and Holohan (1992) conducted a study in which 85 counselors at 31 university counseling centers were asked to report on two recent short-term counseling cases and the termination behaviors that occurred in the final sessions. They found that the majority of counselors reported revealing more of themselves in termination than at other times in therapy, particularly when they felt

counseling was successful. When counseling was believed to be unsuccessful, the counselor was significantly less engaged with the client. A successful termination necessitates the therapist engaging in more self-disclosure regarding the process and the client than may be typical, particularly if the therapist's theoretical orientation is something other than interpersonal. It is likely that therapists who have chosen to practice from an interpersonal perspective will be more inherently comfortable with self-disclosure in the here-and-now due to the necessity of such practices when conducting therapy from an interpersonal perspective. Because self-disclosure enhances intimacy, it is possible that therapists with a fear of intimacy will not be able to engage as productively in termination as therapists who do not fear intimacy. The merging and separating process inherent to therapy, and termination in particular, requires the therapist to experience the loss with the client and yet be separate enough to be helpful. A propensity to shy away from intimacy will inhibit the therapist's ability to join genuinely with the client in the loss experience and simultaneously maintain an objective distance. The concepts of fear of intimacy and loss collide in the termination process where fear of intimacy is preemptive to closeness and fear of abandonment is more likely to lead to separation anxiety. Doi and Thelen (1993) found in a study of employees at a state psychiatric hospital (n =171) who completed the Fear of Intimacy Scale (FIS) and other measures (e.g., Adult Attachment Scale, Collins & Read, 1990) that the fear of intimacy was inversely related to self-disclosure, and directly related to loneliness and trait anxiety. These researchers found an unexpected relationship between fear of intimacy and fear of abandonment, however, when trait anxiety was statistically controlled for the correlation became nonsignificant. Researchers have utilized the differentiation between avoidant and dependent personality disorder to display the contrast between the seemingly diametrically opposed fears of intimacy and abandonment (Doi & Thelen, 1993). Trull, Widiger,

and Frances (1987) conducted a study utilizing semi-structured personality interviews with 84 inpatients in order to analyze the differential diagnosis of avoidant personality disorder with schizoid and dependant types. While these researchers discovered none of the patients diagnosed with schizoid personality disorder met the criteria for either dependent or avoidant personality disorder, they found that 71% of patients with avoidant disorder also met the criteria for dependant personality disorder and 50% of those diagnosed with dependant personality disorder met the criteria for avoidant personality disorder. Each dependant symptom positively correlated with items on the avoidant symptoms list (e.g. "Hypersensitivity to rejection" "Unwillingness to enter relationships" "Desire for Affection and Acceptance", "Subordinates own needs"). While this study was based on DSM-III criteria for personality disorders, the findings suggest that a person can possess both avoidant and dependent traits simultaneously. According Trull, Widiger, and Frances (1987) there is the potential for a person to have difficulty initiating and separating from relationships, and while perhaps the suggestion of personality disorders is extreme, the findings suggest that a fear of intimacy and abandonment may simultaneously exist with some frequency. In the termination of therapy the desire for connection and the fear of loss collide potentially causing anxiety as an individual attempts to reconcile opposing wishes.

Hayes et al. (1991) found that experts in the area of countertransference and transference rated self-insight and self-integration as highly important factors in the management of countertransference. Items pertaining to the therapist's self-awareness and self-other awareness measured self-insight. Items that referred to the therapist's level of emotional stability and ego-boundaries measured self-integration. Therapist self-integration, anxiety management and conceptualization skills have both been found to be positively correlated to client outcome in previous studies (Gelso, Latts, Gomez, & Fassinger, 2002; Hayes, Riker, & Ingram, 1997).

Based on these findings, it would be important for therapists to be aware of their affective and behavioral patterns in situations of loss as well as anxiety around closeness, so that countertransferential reactions during termination do not negatively influence therapy outcome. The importance attached to self-integration in managing countertransference (Hayes et al., 1991) supports the notion that the therapist needs to be able to participate in the separation and individuation process with each client as they move from the first session to the last.

Existing literature suggests a direct relationship between intimacy and attachment style (Mayseless & Scharf, 2007; Reis & Grenyer, 2004). While the relationship between therapist attachment style and therapy outcome has been considered, capacity for intimacy as a therapist factor is far less apparent in the literature. In a recent study Mohr, Gelso, and Hill (2005) explored the possibility that counselor attachment could moderate the effect of client attachment on session evaluation and countertransference behavior in 93 first counseling sessions. In Mohr et al's study, the researchers ascertained that insecure attachment falls within two major overarching categories, that of anxiety or avoidance. In this study, the researchers utilized Bartholomew and Horowitz's (1991) four category model for conceptualizing adult attachment patterns. In this model, secure attachment refers to low anxiety and low avoidance, while fearful attachment refers to high anxiety and high avoidance. Preoccupied attachment refers to a pattern of high anxiety and low avoidance, and the fourth category, dismissing attachment refers to low anxiety and high avoidance. Mohr et al. found that countertransference was best predicted by the unique combination of counselor and client attachment. Trainees higher in fearful attachment were more likely to exhibit distancing countertransference behaviors with preoccupied clients than with dismissing clients. Trainees higher in dismissing attachment were more likely to engage in distancing countertransference behavior with preoccupied than with dismissing clients.

These counselor trainees were also more likely to exhibit hostility toward preoccupied clients, while trainees higher in preoccupation were more likely to express hostility toward dismissing clients. Trainees lower in dismissing attachment were more likely to exhibit distancing behavior with dismissing clients rather than preoccupied ones. An earlier study by Dozier, Cue, and Barnett (1994) found that insecurely attached case managers intervened less deeply with clients with dismissing attachment patterns and more deeply with clients with preoccupied attachment patterns, while no difference in treatment existed for securely attached case mangers. The unique combination of attributes such as attachment needs inherent to an individual interacts with the attributes of others, interpersonally influencing dyads involved in a therapeutic relationship. These findings suggest that an insecure attachment style may contribute to a therapist's inability to engage in an intimate therapeutic relationship with specific clients.

Considering these factors, attachment style could be considered one of the primary constructs leading to capacity for intimacy although the direct relationship between these constructs has not been studied. Although there has been an extensive amount of research conducted on attachment, for the purposes of this study, only its relationship to intimacy is considered. Although some longitudinal studies have found that early secure attachment leads to more cognitive, social, and emotional competence in later life, other studies have found no consistent relationship between the two constructs leading to inconclusive results (Beckwith, Cohen, & Hamilton, 1999). Despite these results, the desire for intimacy has been posited to originate during the first developmental phase in which the infant's desire to become emotionally tied to the caregiver emerges (Mahler, Pine, & Bergman, 1975). If the child does not internalize the ability to sooth itself through the formation of a secure attachment, the ability to form intimate relationships as an adult may be stifled by fears of engulfment and abandonment,

inhibiting the ability to engage intimately in relationships (Prager, 1995). Perhaps intimacy is avoided when the potential cost is loss or abandonment by the treasured object.

Barriers to Intimacy

Alperin (2001) posited that in order for a person to achieve an "intimate state of relatedness to others, he or she must have resolved certain intrapsychic conflicts related to his or her own development" (p.138). Alperin links three domains to the capacity for intimacy: childhood personality development, individualistic American ideals, and sexual conflicts resulting from "unresolved oedipal fears connected to homoerotic longings" (p.152). He attributes the American difficulty in achieving intimacy to the prevailing cultural philosophy of autonomy and self-sufficiency, resulting in the importance of separation-individuation, well defined ego boundaries, and a strong need for privacy. Alperin states that the "good enough" mother's provision of a stable holding environment paves the way for a successful separation-individuation process, which is an essential prerequisite to the capacity for intimacy. When such a positive process occurs, the child learns to sooth him or herself. However, when these provisions are not made, a child grows into an adult who tremendously fears engulfment and abandonment in adult relationships. Because intimacy can only occur through temporary mergers between people, "permeable ego boundaries and the temporary loss of distinction between the self and the other" are necessary (Alperin, p.141). However, the idea of even temporary merger and connectedness runs contrary to American cultural ideals causing intense anxiety especially for those not provided with an optimal holding environment. Persons who did not achieve resolution in the separation-individuation phase experience intense fears of abandonment, and greatly fear intimate relationships, because they have never achieved a strong positive self-regard.

Factors that hinder the development of intimacy have been found from a cognitive perspective to lead to either avoidance or subversion. Kayser and Himle (1994) identified eight dysfunctional beliefs about intimacy that lead to inhibition or resistance in relationships. The following are examples of dysfunctional beliefs about intimacy:

> (1) If I become close to someone, he/she will leave me, (2) If I have any conflict in a relationship, I cannot be intimate, (3) I will lose all personal control and power in relationships, if I am intimate, (4) I am solely responsible for the lack of intimacy in my relationships (5) I must do everything my partner wants, in order to be a truly intimate person and achieve intimacy, (6) If I am a good (e.g. parent, husband) then I will get intimacy in return, (7) I must always have strong loving feelings toward my partner before I can be intimate, (8) I can't experience intimacy without having sex in a relationship.

When considering the possibility that therapists may hold some of these dysfunctional beliefs about intimacy, their influence on the psychotherapy process becomes evident. For example, a therapist who believes that self-disclosure depletes the power they have in the relationship may shy away from expressing their true feelings during termination.

Intimacy in Therapy

The final sessions of therapy may involve more vulnerability from the therapist than previous sessions. A self-reliant therapist will be able to take on the role of providing a secure base for clients in termination having had the experience of relying upon a significant person in their own life during a time when they experienced loss. Sussman (1992) postulated that people with a strong need for intimacy are often attracted to becoming therapists because of the emotional intensity and close human contact inherent to the relationship. However, it is unlikely

that needs for intimacy can be, or should be fulfilled by clients. While the fulfillment of therapist needs through clients, is contrary to the boundaries of the therapeutic relationship, frequently clients present with their own issues preventing them from experiencing intimacy with anyone. Alperin (2001) noted that it is usually a sign of health and a signal that the termination process should begin when a client displays the ability to engage intimately and appropriately with others.

Quintana and Holohan (1992) found that counselors who believed cases to be unsuccessful characterized termination sessions as having little review of the counseling process, fewer attempts to bring closure to the therapist-client relationship, and a more limited discussion of the client's feelings about the end of counseling. They found that therapists in general tended to focus on the positive aspects of termination rather than the negative. It is possible that it is easier for therapists to talk about their feelings for clients in termination when they are positive. However, as Alperin (2001) noted "hatred, homicidal rage, and destructive envy" are just as relevant to intimacy as love (p.147). Recognition of negative feelings by the therapist also assists the patient in forming a well-integrated internal world. However, there seems to be little discussion in both successful and unsuccessful cases of the client's negative or dysphoric feelings during the termination phase of therapy. While it may be difficult for therapists to self-disclose negative feelings about the relationship and ending, successful terminations most often included: the therapist sharing feelings about the therapy with the client, hugging or shaking hands with the client, the therapist talking more about his or her self, and the dyad relating more as equals then in the past (Quintana & Holohan, 1992). Engaging successfully in these termination behaviors requires a potentially difficult discussion, in which the therapist must engage with the client in a less differentiated way than in previous sessions, creating more

intimacy. These findings suggest that therapists with a fear of intimacy may not be able to engage in termination behaviors necessary for an optimally successful termination. Hill, Mahalik, and Thompson (1989) investigated 89 therapist self-disclosures and their perceived helpfulness. They noted in their study that seven of the eight therapists used "goodbye" closures in the last few minutes of the final session, mentioning the history of the work, feelings of connectedness, and loss. For three of the therapists, their "goodbye" disclosure was the only self-disclosure made in the course of therapy. In essence, by self-disclosing the therapist is simultaneously increasing intimacy in the relationship and processing the loss.

Shane, Shane, and Gales (1997) believed that therapy requires intimacy on the part of the therapist. Shane et al. defined intimacy as the relatedness that develops between the client and the therapist based on the client's initial sense of trust in the therapist. The "sharing and giving of oneself" is considered foundational to forming a positive new experience for the client. Shane et al. stipulated that psychoanalysts in particular practice constrained intimacy within the therapeutic relationship. The analyst seeks to provide optimal gratification and frustration without missing unconscious meaning, while making an effort to maintain neutrality, which stifles the possibility of engaging intimately with the client. A self-psychology orientation may allow for a slightly more engaging therapist than other schools of psychodynamic thought, though it does not explicitly deal with some of the more profound intimacies of the "real relationship" (Hamilton, 1996, p.103). Interpretations of extratransferential happenings within the therapeutic relationship are not central to the self-psychology concept (Hamilton, 1996). However, psychoanalysis has always considered hate and aggression to be among the most difficult and important affective reactions in therapy, in intimacy, love is undeniably equally important. The therapist must have the ability to integrate a range of affective states and tolerate

ambiguity in order for intimacy to occur (Alperin, 2001). In termination, the therapist's expression of genuine and personal feelings about the therapy and the client may invariably lead to a deeper intimacy.

In *Affect Intolerance in Patient and Analyst,* Coen (2002) discusses the expectation that therapists are able to get caught up in the client's and their own strong feelings and yet maintain objectivity enough that they can continually provide therapy for their clients. Coen posited that clients and therapists construct barriers to protect themselves from powerful emotions in the room, limiting the extent of the therapeutic outcome. Coen noted that a phenomenon seems to occur in which therapist and client avoid loving feelings, emphasizing what is wrong between them rather than what is right. In many cases, therapist and client seem more comfortable with "angry and dissatisfied" feelings than with "the openness and vulnerability of feeling close and loving" (Coen, 2002, p. 140). It is not surprising that such a phenomenon frequently occurs in this dyad. The therapist has chosen a career where very little self-disclosure is required, and the client is often suffering from interpersonal issues related in some way to intimacy. In fact, Horowitz (1979) found that difficulty with intimacy is one of the most common issues identified by therapy outpatients. It is possible that the powerful feelings resulting from interactions within the therapeutic dyad is deflected in an effort to keep the therapy room "safer" or less threatening for both parties. In psychodynamic therapy, these deflections may come from the therapist in the form of interpretations, which attribute the client's strong feelings to significant people in the client's life, other than the therapist. The deflecting that occurs, because of the therapist's discomfort with his or her own strong affective reactions, is only one response. In other cases, countertransference feelings are enacted through a distancing from the client (Gelso, Latts, Gomez, & Fassinger, 2002; Hayes & Gelso, 1993; Yulis & Kiesler, 1968). Negative

countertransference is not a conscious choice on the part of the therapist, and is usually only recognized retrospectively. Whether countertransference related enactments with the client are brief or more lengthy, in order for them to be overcome, the therapist must give due attention to their own affective reactions throughout the process. Early life experiences with others dictate our behavior in later intimate relationships (Prager, 1995). Countertransference reactions that occur in termination present a unique problem in that the ending must be processed in advance by the therapist, and monitored closely throughout the final sessions with the client. The therapist needs to anticipate countertransference reactions that may occur in the final session, recognizing that there will not be further sessions in which interactions can be clarified.

Countertransference in Termination

In termination, as in all situations of loss, a variety of emotions may be evoked in the therapist. A typical response could range from feelings of anxiety, guilt, sadness, relief, anger, apathy, to somatic complaints (Glenn, 1971). Penn (1990) believed that it was unlikely that a therapist would not experience an affective response to termination unless impeded by their own defenses. Therapist affect during the final sessions may contribute to a range of counter-therapeutic behaviors in termination. The avoidance of addressing the finality of termination could result from the unconscious needs of the therapist, related to an array of unresolved conflicts (Martin & Schurtman, 1985). Guilt could result from pre-mature termination enacted by a client who has not met therapeutic goals, causing a therapist to question his or her own adequacy (Goodyear, 1981). When goals remain unmet, it becomes important for the therapist to engage in a discussion with the client regarding unfinished business in the face of termination (Penn, 1990). Anxiety, a feeling common to therapists during termination for a variety of reasons may stem from their own fears about the client's ability to sustain health without therapy

or the therapist. Early childhood experiences of loss may lead to separation anxiety, contributing to therapist loss responses in termination (Glenn, 1971). Martin and Schurtman (1985) wrote that therapists who experience depression or other self-deprecating feelings in response to termination often respond by clinging to the client and giving advice. The end of therapy often triggers sadness as the therapist's unresolved losses are resurrected in the termination session (Goodyear, 1981). The therapist's management of unresolved affect may determine his or her behavior in the final sessions.

Therapists with unresolved losses may endure the ending in a detached manner, denying both themselves and their clients of the potentially beneficial process of ending (Glenn, 1971). Possible therapist reactions to termination include affectively withdrawing and intellectualizing termination with the client (Glenn, 1971). Similarly, Penn (1990) found that therapists often withdraw emotionally, discourage the client's affective expression, are "countertransferentially gratified" by the client's overwhelming sense of loss, relate to the client about feelings of separation, or act indifferently. The end of this real and significant relationship for both the therapist and the client may provoke strong discontent felt and displayed in a variety of ways (Goodyear, 1981). Though a variety of affective responses to loss outside the therapy relationship may go unnoticed, a lack of resolution when conducting termination sessions could lead to behaviors that negatively affect the client.

Necessary Components of the Therapist's Facilitation of Termination

Typically termination consists of three major themes: looking back, looking ahead, and saying goodbye (Marx & Gelso, 1987). Marx and Gelso found in a study of former counseling center clients (N= 72) that clients preferred to have their counselors explore feelings about ending, and that in most cases that occurred. More surprising is their finding that most clients in

the study felt pervasively positive about the termination of therapy. The researchers speculated that this finding, which runs contrary to most of the existing termination literature, is perhaps explained by the notion that much of the existing literature portrays the therapist's perspective. Marx and Gelso noted that the therapist's negative perspective could be due either to countertransference reactions, or a heightened sense of affective awareness to which the client remains unaware. When one party in the therapeutic relationship decides upon termination, it is likely the "abandoned" person will experience a greater reaction to a loss that is beyond his or her control. Kübler-Ross (1997) suggested that it is imperative that the physician/therapist be tolerant of the patient's "rational and irrational anger" (p. 67). Sharkin and Gelso (1993) found in a study of 38 counselor trainees that therapist anger-proneness significantly correlated with anger felt towards and discomfort with an angry client. They posited that the therapist's experience of being uncomfortable with one's own anger might make being the target of the client's anger result in feelings of anxiety in the therapist, which may result in feelings of discomfort with the client. These findings seem particularly relevant in termination sessions, which have the potential to be filled with many affective reactions from the client, both positive and negative. It is important that the therapist is able enough to sit with various affective reactions to provide an adequate holding environment for the client in the final sessions. Reception to the client's expression of anger will likely facilitate a greater acceptance of the loss later on. It is also possible that either member of the therapy dyad will attempt to hold onto the relationship by bargaining for more sessions with good behavior, complements, or in the therapist's case, interpretations of resistance. Both reactive and preparatory depression prior to the loss are different yet integral components of saying goodbye that need to be handled by the therapist with different responses. Reactive depression is more related to the shock of realizing

what will be lost. In preparatory depression, a person is beginning to come to terms with all that will be lost. Termination of therapy is often final, and like death from a terminal illness, requires the processing of finality and loss prior to the actual experience.

As in all aspects of therapy, the process of termination varies based on one's theoretical orientation. Given that, it is important to point out some of the similarities and differences in termination procedures based on theoretical underpinnings. Curtis (2002) describes several criteria that she uses for termination with clients in a relational or interpersonally oriented psychoanalytic therapy. Curtis suggests that the therapist;

> (1) consider reducing the frequency of meetings and scheduling a second appointment some time after the second to last meeting (2) review with the client their stressors and pointing out the new ways in which they have been responding (3) assess what has been accomplished and what areas continue to need work (4) ask the client for feedback about what was helpful and what was not, and any relationship between negative aspects and the decision to terminate (5) attempt to equalize the relationship by focusing on client contributions to change and revealing something personal and (6) when the relationship has been particularly long or intense the therapist should mention that he or she would be pleased to hear from the client at some time in the future.

Curtis (2002) explains her personal frustration when she does not hear from clients for some time after termination and discusses wondering what has happened to them. She notes her disagreement with many classical analysts' ideas on neutrality and countertransference, and acknowledges that they would find her feelings inappropriate. Curtis goes on to defend her feelings stating that analysis in which the patient lays down on the couch several times a week is

very different from once a week therapy, and that they do not lead to the same feelings. While it is unlikely that the same level of intimacy cannot be obtained in once per week therapy as analysis, I concur with Curtis' conclusion that "in any therapy, there is a trust and a vulnerability that makes the relationship a special one, and this leads to a type of attachment that is rarely, if ever experienced in the face-to-face, rational world of adults in our culture" (p. 357).

Greenberg (2002) suggests a set of eight principles that guide his termination procedures in experiential therapy. The principles Greenberg believes are essential to therapeutic termination are: viewing the client as an agent that guides the termination, viewing change as an ongoing process with no end point, attending to separation and loss issues, empowering the client or equalizing the relationship, consolidating new meanings, predicting relapse, tapering sessions, and offering the possibility of a future relationship. Because the research has shown a connection between revealing self-disclosures and increased intimacy it is particularly poignant that Greenberg mentions that he would attempt to de-elevate himself from any client beliefs about his pre-eminence that the client may have established during therapy. He contends that the process of getting the client to see him as a fallible human is often accomplished through engaging in more self-revealing discussions and attributing change to the client. Greenberg notes that the termination process usually involves for both participants' feelings of sadness at ending a relationship, saying goodbye, and separating.

Goldfried (2002) discussed the difference that exists between the termination phase in the psychodynamic model versus the cognitive behavioral model. He noted that little emphasis is placed on the end of the therapist-client relationship in cognitive behavioral therapy (CBT), where the main focus is client coping skills and relapse prevention. However, he posits that in more complex cases such as those involving clients with Borderline Personality Disorder being

treated with Dialectical Behavior Therapy (Linehan, 1993) the issue of loss of the relationship through termination plays a more central role in the final phase. In essence, the attention given to termination seems to depend more on the client's diagnosis and treatment model than the significance of other factors.

Wachtel (2002) comments on psychodynamic, CBT, and experiential therapy converging in the perspective that the client should take from therapy a "sense of empowerment" derived from an awareness that changes were made by their own efforts. While Wachtel posits that this should occur throughout the therapeutic process it is noteworthy that it seems to occur somewhat differently in termination. There seems to be more of an inclination to accomplish the task of client empowerment through therapist self-disclosure during termination. The literature does not explain why the tendency to elevate the client's position in relation to the therapist occurs through self-disclosure only in the final phase of therapy. Wachtel posits that intimate contact with other human beings has the ability to "lessen the pain of existence and eventual mortality through caring and compassion" (p.374). It is possible that in the final moments of therapy the therapist may seek a more intimate bond with the client, perhaps seeking a way to hold on, be held onto, or sooth their own distress about saying goodbye.

Management of Countertransference in Termination

When it is properly managed countertransference can enhance treatment, helping clients and therapists to heal, as is typically the case in termination. In order to understand further the role of countertransference management it is important to distinguish between countertransference feelings and countertransference behaviors (Robbins & Jolkovski, 1987). Countertransference feelings occur as a response to the client, which can be beneficial when an awareness of feelings allows the therapist to gain a greater understanding of the client.

Countertransference behaviors on the other hand refer to the actions made by the counselor in response to feelings, and have the potential to be harmful when acted upon negatively. This does not necessarily indicate that the therapist should withhold their negative feelings toward the client. According to Rogers (1957), termination may be one of the instances when a therapist may "talk out" some of their feelings with the client, particularly when they are preventing the therapist from either unconditional positive regard or empathy. Rogers (1957) posited that in order for positive personality change to occur in the client, the therapist must be within the confines of the relationship a "congruent, genuine, integrated person…freely and deeply himself…accurately representing his experience" (p. 97). He concluded that even when the therapist's feelings seem counterproductive to the therapy, it is essential that he or she not deceive the client by misrepresenting their true feelings.

Robbins and Jolkovski (1987) conducted a study of doctoral level counseling and clinical graduate students (N= 58) in order to test four hypotheses related to countertransference behavior. They operationalized countertransference behavior as counselor withdrawal from the work. They hypothesized that; (1) theoretical framework would mediate the effects of awareness thus affecting countertransference behavior, (2) those counselors with higher levels of awareness would have lower levels of countertransference behavior, (3) theoretical framework would effect withdrawal of involvement, and (4) higher levels of emotional threat evoked by "provocative clients" would generate higher levels of countertransference behavior. Robbins and Jolkovski found their two first hypotheses supported. Theoretical orientation and awareness were found to interact and effect countertransference behavior. Additionally, they found that therapists who were aware of their countertransference behaviors were able to remain engaged productively in

the therapeutic interaction. However, theoretical framework on its own did not predict withdrawal of involvement.

In termination the opportunity is presented for the client and the therapist to work through issues of loss and mourning. As Maroda (1991) points out, the productive use of countertransference is attained not only through the therapist's consultation with colleagues, self-analysis and in some cases a return to personal therapy, but also through the expression of countertransference in the therapy session. Maroda believes that clients capable of insight are most often aware of the countertransference problem occurring and frequently seek to discuss it openly in therapy. Contrary to the popular notion that discussing instances of countertransference during the session would be harmful to clients, Maroda believes that not to engage in the resolution of transference and countertransference is "arrogant and disrespectful…a gross underestimation of the patients ability to help solve such conflicts" (p. 165). In termination, the therapist's self-disclosure of countertransference issues related to the loss of the relationship may bring closure to the relationship. Termination work with every client will incite a different reaction from the therapist. At times, the therapist may be relieved to see a client go, and at other times very sad. It is likely that relationship factors will mediate the therapists affect and behavior in the final session as well. Tickle-Degnen and Rosenthal (1990) found in a meta-analytic study on the effects of non-verbal behavior on the establishment of rapport, that nonverbal involvement behaviors were more facilitative of intimacy in non-helping interactions. Nonverbal involvement behaviors included "forward trunk lean, smiling, nodding, direct body orientation and uncrossed arms" (p. 290). While in non-helping relationships these behaviors correlated strongly with intimacy, in helping relationships there was only a small effect size. Considering these findings, Prager (1995) believed that therapists must be aware of

the lessened impact of non-verbal behaviors in the establishment of intimacy, as the client may perceive attempts at intimacy as part of their role as a helping professional and therefore less genuine. Because each client is different, it is important to tailor the expression of feelings and behaviors during termination to the individual client. A client who is not capable of engaging in mutual grieving will not solicit the therapist to express affect in the session.

The Present Study

A review of the literature revealed the importance of considering therapist loss resolution and fear of intimacy as factors that may influence the way termination is conducted. While a relationship exists between therapist loss resolution and affective reactions to termination (Boyer & Hoffman, 1993), behavioral reactions are less well understood. Fear of intimacy has not been directly tied to the termination of psychotherapy in the literature. In this study I chose fear of intimacy as a construct because it gets at the "inhibited capacity to exchange personally significant thoughts and feelings with another individual who is highly valued" (Doi & Thelen, 1993). In Deuctner and Thelen's (1991) operationalization of this construct, content, emotional valence, and vulnerability were all speculated to be components of the anxiety experienced in or at the prospect of close relationships (i.e., fear of intimacy). However, many of the catalysts for intimacy, such as comfort disclosing one's feelings about the process, expressing both positive and negative affective reactions, and the ability to merge with another momentarily while maintaining individuality, are all therapist abilities that facilitate therapeutic final sessions with clients. I investigated these ideas further by examining the degree to which therapist loss resolution and fear of intimacy correlate with countertransference behaviors and affective reactions in the termination sessions of therapy. Hence, my first hypothesis was that therapist loss resolution would be positively associated with displays of therapeutic termination behaviors.

Second, I hypothesized that therapist loss resolution would be inversely related to feelings of anxiety during termination session and to countertransference behavior. Third, I hypothesized that fear of intimacy would be negatively correlated with displays of therapeutic termination behaviors. Fourth, I hypothesized that fear of intimacy would be positively correlated with anxiety during the termination session and with countertransference behavior.

Hunsley, Aubry, Vestervelt, and Vito (1999) found in a study of former clients (N=87) and their therapists at a university counseling center that there is little concordance between therapist and client decisions to terminate. They also found that although therapists were able to detect when a client had terminated because they had attained their goals, therapists were not aware of instances in which the client's primary reason for termination was dissatisfaction with therapy. It is significant that therapists hardly ever reported attributing therapy termination to their own failures, but clients did in one third of the cases. Given these findings, and the fact that the client's perception of therapist behavior is relevant to level of satisfaction, the following study solicited both perspectives.

Chapter 3: Method

Participants

The names and addresses of 309 psychologists were obtained as a list from both the North American Society for Psychotherapy Research (NASPR), and the phone book of a mid-sized mid-Atlantic town. In order for therapist participants to be eligible for inclusion in the study, two criteria had to be met. They had to be currently seeing adult clients for therapy and plan to terminate with a client in the next few months. Client participants were eligible if they had recently terminated individual psychotherapy with a therapist participant. Initial questionnaires were returned by 80 therapists of whom 30 were unable to participate because they did not meet one or both criteria for inclusion. Of the 30, twenty respondents stated that they were not currently seeing adult clients for therapy. Six therapists had retired and no longer saw clients. Four did not anticipate termination sessions in the next few months. Thirty-two initial packets were returned due to undeliverable addresses. This resulted in a final sample of 50 therapists who completed the initial questionnaire, a return rate of 20% (50 therapists of the original 247 for whom accurate addresses were obtained). Twenty-three therapists completed a second mailing containing the dependent measures.

Of the 50 therapists who participated, 32 were women and 18 were men. They ranged in age from 27 to 70 years, with a mean age of 50.4 years (SD = 11.42). The sample was predominately White (96%), with the race of the other four participants remaining unknown. Sixty-nine percent of the participants had their Ph.D., 2% had a Psy.D., 20% had a M.A. or M.S., and 8% had another type of Master's degree. The majority of participants had received their clinical training in counseling psychology (46%), clinical psychology (28%), or social work (9%). The number of years of clinical experience ranged from 1 to 46 (M = 18.4, SD = 10.5).

Most participants conducted therapy within a private practice (79%), while a remaining 11% practiced in universities, 6% in hospitals, and 4% in clinics. Therapists reported seeing from one to seventy clients per week for therapy ($M = 17.0$, $SD = 15.2$).

The decision to terminate the cases under investigation in this study was usually mutual (73.9%). However, 21.7% of the decisions to terminate were made unilaterally by the client and 4.3% by the therapist. Termination of therapy was most often left open to the possibility of reengaging in therapy at a later date (69%), while 26% of terminations were permanent, and only 1% were temporary. The total number of sessions in the cases under investigation ranged from 6 to 450, with a mean of 75.2 sessions ($SD = 108.5$). The amount of time that most clients had been in therapy with the therapist varied. The largest percentage of clients had been in therapy 4-6 months (39%), followed by 17.5% who had been in from one to two years, 17.5% more than two years, 17% 7-12 months, and 9% 1-3 months.

In order to ascertain the predominant theoretical orientation of therapists, participants completed a Likert scale rating how much their current therapeutic practice was guided by each of six theoretical frameworks. The scale ranged from 0 (not at all) to 5 (very greatly). The means and standard deviations for each individual framework follow: integrative ($M = 3.8$, $SD = 1.3$), humanistic ($M = 3.3$, $SD = 1.3$), cognitive ($M = 3.1$, $SD = 1.1$), psychoanalytic ($M = 2.9$, $SD = 1.6$), systems ($M = 2.7$, $SD = 1.5$), and behavioral ($M = 2.3$, $SD = 1.2$). It is noteworthy that there was a direct relationship between the integrative approach to treatment and cognitive ($r = .27$, $p < .05$), humanistic ($r = .27$, $p < .05$), and systemic ($r = .39$, $p < .01$) frameworks, suggesting that those who practiced an integrative style were most likely to be incorporating these three frameworks into their practice, but not psychoanalytic ($r = .192$, $p = .09$) or behavioral approaches ($r = .05$, $p = .37$).

The overall client response rate was very low (N = 10). Eight were female and two were male, and their ages ranged from 26 to 59 (M = 42.6, SD = 12.1). All clients were Caucasian. Seven of them were married and three were divorced.

Therapist Instruments

Loss Resolution. The Texas Revised Inventory for Grief (TRIG) developed by Faschingbauer, Zisook, and Devaul (1987) was used to assess the therapist's present grief reactions with respect to significant loss experiences. The original measure contains two scales evaluating resolution of loss in the past and present. For this study, only the Present Feelings Scale was used (see Appendix A). For the purposes of the present study, loss was not defined in terms of death only but instead it referred to any significant personal loss. This scale is composed of 13 items rated on a Likert-scale from 1 (completely true) to 5 (completely false) measuring present thoughts, feelings, memories, opinions, and attitudes regarding a significant loss the participant has chosen to consider while completing the questionnaire. Examples of TRIG items are "Even now it is painful to recall memories of what I had" and "I am unable to accept this loss." A higher mean score on the TRIG indicates a more resolved loss. TRIG scores ranged from 1.93 to 4.64 in this study (M = 3.41, SD = .67). When Boyer and Hoffman (1993) utilized this measure for losses non-specific to death, the alpha coefficient was .82 for the Present Feelings scale. The original TRIG has an alpha coefficient estimate of .86 on the Present Feelings scale and split-half reliability was .88 (Faschingbauer et al., 1987). In the present study internal consistency was .87. Construct validity of the Present Feelings scale was tested against the assumption that females would score higher than males, due to the traditional suppression of emotional awareness and expression in Western culture, which results verified (Faschingbauer et al., 1987). Additionally construct validity was measured through a comparison of the scores for

widows/widowers and non-blood relatives, with respect to the loss of the spouse. As predicted the Present Feelings scale scores were significantly higher for spouses than other non-blood relatives (Faschingbauer et al., 1987).

Fear of Intimacy. The Fear of Intimacy Scale (FIS) was used to measure the therapist's capacity for intimacy in interpersonal relationships. The FIS is an anxiety-based measure developed by Descutner and Thelen (1991). The FIS contains 35 items rated on a Likert-scale from 1 (not at all characteristic of me) to 5 (extremely characteristic of me). Thus, a high score on the FIS indicates a greater fear of intimacy. While the FIS was designed to measure fear of intimacy in close, dating relationships, it is unique among measures of intimacy in that it can be used whether or not a participant is currently in an intimate relationship (Doi & Thelen, 1993). Items in the questionnaire are based on the definition of fear of intimacy as "inhibited capacity of an individual, because of anxiety to exchange thoughts and feelings of personal significance with another individual who is highly valued" (Descutner & Thelen, 1991, p. 220). Examples of FIS items include; "I would feel uneasy talking with O about something that has hurt me deeply" and "I would feel uneasy with O depending on me for emotional support" (where O indicated the person who would be in the close relationship with you). The fear of intimacy construct takes into account three defining attributes: (1) content defined as communication of personal information, (2) emotional valence defined as strong feelings about the personal information exchanged, and (3) vulnerability defined as high regard for the intimate other. FIS scores ranged from 1.09 to 3.57 in this study (M = 1.88, SD = .48). Internal consistency for the FIS has been estimated at .93 (Doi & Thelen, 1993). In this study internal consistency was .90. Construct validity of the FIS was assessed through comparison with the Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980) where a significant positive correlation was found (r = .48).

Additional evidence of validity has been found in terms of a negative relationship between the FIS and the Jourard Self-Disclosure Questionnaire (Jourard, 1964) in several studies: r = -.55 (Descutner & Thelen, 1991) and r = -.27 (Doi & Thelen) and the Miller Social Intimacy Scale (Miller & Lefcourt, 1982) r = -.60 (Descutner & Thelen, 1991). However, the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) elicited two different sets of results; initially a negative relationship was detected (r = - .39) by Descutner and Thelen, and later no significant relationship in a study by Doi and Thelen. Additionally, Doi and Thelen found a significant relationship between the FIS and trait anxiety (r = .49) and social anxiety (r= .40). Test-retest reliability has been estimated to be .89 over a one month period (Descutner & Thelen, 1991).

Therapist Anxiety. The State-Trait Anxiety Inventory- State subscale (STAI-S) developed by Spielberger, Gorsuch, and Lushene (1970) was used to measure therapist state anxiety during the termination session. The STAI- S consists of 20 items rated on a 4-point Likert type scale ranging from (1) *not at all* to (4) *very much so* in terms of how the respondent feels at the moment. Examples of state anxiety items include "I feel anxious" and "I feel comfortable." Higher scores reflect greater anxiety. For the purpose of this study, the form was titled Self Evaluation Questionnaire, so that participants were not persuaded to endorse or not endorse feelings of anxiety based on the questionnaire's title (see Appendix A). Instructions were worded so that therapists indicated how they felt during the final therapy session. STAI-S scores ranged from 1.05 to 2.35 in the present study (M = 1.57, SD = .33). Spielberger et al. (1970) reported internal reliability coefficients ranging from .83-.92. In the present study, internal consistency was .85. Spielberger et al. (as cited in Sharkin & Gelso, 1993) demonstrated that items and total scores on the STAI-S differentiate between stressful and nonstressful

conditions. Several other studies have also utilized the measure as an affective indicator of countertransference (Hayes & Gelso, 1991; 1993).

Termination behaviors. The Termination Behavior Checklist-Therapist (TBC-T), designed by Quintana and Holohan (1992), contains 38 items encompassing six subscales: Discussion of the End of Counseling (7-items), Review of Counseling and Goal Attainment (5-items), Closure in the Counselor-Client Relationship (7-items), Discussion of Plans for the Future (5-items), Client Expression of Affect about the End of Counseling (9-items) and Problematic Termination Reactions (4-items) (see Appendix A). The therapist responds to each item by checking whether the listed client or therapist behavior occurred during the termination phase of the therapy. The TBC-T is based on the Termination Behavior Checklist (TBC) developed by Marx and Gelso (1987), but includes an additional 20 items. Therapists completed all 38 items of the TBC-T as a self-report questionnaire in order to ascertain their perceptions of their behaviors in the final session. However, only the 20 items that were found by Quintana and Holohan to distinguish between successful and unsuccessful outcomes at $p < .05$ were used in the analyses. Examples of positive items include; "You tapered off the frequency of sessions" and "You and client related more like equals than in the past." While an example of a negative item would be, "Client devalued therapy". Four items comprised the negative behaviors scale and 16 items make up the positive behaviors scale. The range of scores for positive items was 2.00 to 16.00 in this study ($M = 9.78$, $SD = 3.87$). The range of scores for negative items in this study was 0.00 to 4.00 ($M = .74$, $SD = .96$). Test-retest reliability over one week on the TBC-T has been estimated to be .89 (Quintana & Holohan, 1992). In the present study, internal consistency for the TBC-T was estimated to be .76. Further evidence of the construct validity for the TBC-T

has been demonstrated by the measure's ability to discriminate between therapeutic and counter therapeutic therapist behaviors that occur during termination (Pietro, 1998; Schulman, 1999).

Client Instruments

Therapist termination behaviors. Marx and Gelso (1987) developed the Termination Behavior Checklist (TBC). The TBC contains 18 items, which reflect only positive termination behaviors. The client responds by checking whether the listed client or therapist behavior occurred during the termination phase of their therapy (see Appendix A). Items on the TBC were developed from a review of the termination literature and refined by a team of experts. Content validity for this measure was ascertained from ratings given by three counseling psychologists who had written or presented papers on termination. These judges rated each item on a 5-point Likert scale as to how relevant it was to the study of termination. All items included met the pre-established criterion of a rating of at least 3 by two of the judges. Examples of items include "You shared your feelings about ending with your therapist" and "Your therapist talked more about him/herself". Test-retest reliability was established by comparing number of items checked on two separate testing occasions, once two weeks after termination and again a week later, with a Pearson coefficient of .88 ($p<.001$). In the present study, internal consistency was estimated to be .65. In the present study scores ranged from 6.00 to 15.00 ($M = 10.70$, $SD = 2.54$). Due to the low client return rate, the TBC was used only as evidence of validity for the therapists' perceptions of termination behaviors as measured by the TBC-T. Therapist positive TBC-T scores correlated significantly with client TBC scores ($r = .904$, $p < .001$).

Countertransference behavior. Items from the Inventory of Countertransference Behavior (ICB) and the Countertransference Behavior Measure (CBM) were combined in a single measure (see Appendix A). The ICB was designed by Friedman and Gelso (2000) and

contains 21 behavioral items, encompassing two subscales: Negative Countertransference and Positive Countertransference. The 11 item negative subscale includes items assessing inappropriate levels of counselor control, withdrawal, and hostility. The 10 items on the positive subscale include therapist behaviors that are inappropriately familiar or overly supportive in some way. The ICB was designed to be completed by supervisors regarding their trainee's behavior in a specific session. In this study, clients rated their therapist's behaviors in the final session of therapy on a five-point Likert-type scale, where 1 = little to no extent and 5 = to a great extent. Friedman and Gelso stated that although the items are related to countertransference, no mention of this is indicated on the form. Instead, the clients will receive a form titled "Final Session Questionnaire." The instrument was originally designed with the stem "the counselor." For the purposes of this study the stem was changed to "your therapist" followed by one of the 21 stem endings. An example of positive item is "Your therapist engaged in too much self-disclosure during the session" while an example of a negative item is "Your therapist rejected you in the session." In the present study, scores on the Positive Countertransference subscale ranged from 1.00 to 2.46 (M = 1.29, SD = .51), while scores on the Negative Countertransference subscale ranged from 1.00 to 1.18 (M = 1.03, SD = .06). In the study by Friedman and Gelso, a significant correlation was found between the Countertransference Index (Hayes et al., 1997) and the ICB providing evidence of convergent validity.

The Countertransference Behavior Measure (CBM) was developed by Mohr, Gelso, and Hill (2005) to measure supervisors' appraisals of therapist countertransference behavior. Similar to the ICB, the CBM is designed to reflect overt countertransference behaviors. This measure contains 10 items and includes some of the same items as the ICB. The CBM consists of three

subscales: Dominant Countertransference Behavior, Distant Countertransference Behavior, and Hostile Countertransference Behavior. Only items with a factor loading of at least .40, and which loaded on a single subscale, were included in the measure. Although there is some overlap between the ICB and the CBM items statistical analyses were run separately for the two measures. In this study, clients rated CBM items on the same Likert- scale as the ICB items. In addition, the same stem change from "The counselor" to "Your therapist" was made for each CBM item. Examples of items on the Dominant Countertransference subscale are, "Your therapist provided too much structure in the session" and "Your therapist directed you inappropriately in the session." Mohr et al. found convergent validity of the three subscales to be supported through significant correlations with supervisor ratings based on a single item and a multi-item inventory of countertransference management ability. Internal consistency for the "Final Session Questionnaire" was estimated to be .76 in the present study.

Procedure

The initial packet was mailed to the 309 therapists randomly identified, through a list obtained from NASPR (N=208) and psychologists listed in a mid-Atlantic town's phone book (N=101). Therapists who received the initial mailing were mailed a letter explaining the purpose of the study and asking them if they would like to participate. Criteria for participation were explained at the outset on the consent form. Therapists who did not meet criteria for participation were instructed to return the incomplete questionnaire so that the reason for noncompletion was known. The first letter explained to therapists that if they chose to participate, they would receive a second mailing. The second mailing asked therapists to give a measure to the next client they terminated with (to be returned separately) and complete one final set of measures themselves. The initial mailing included a consent form describing the purpose

of the study, a few demographic questions (see Appendix B), the Fear of Intimacy Scale (FIS), the Texas Revised Inventory for Grief (TRIG), and a bag of herbal tea to both encourage participation and thank therapist participants for their time. All therapists were considered eligible to participate if they were actively seeing adult clients and anticipated a termination with a client in the next two months. For the purposes of this study, "anticipated" terminations included both those initiated by the therapist or the client, as well as those mutually decided upon by both parties. These criteria were outlined on the consent form included in the first mailing. A reminder letter was sent to therapists who had not responded to the initial mailing three weeks after the initial mailing. A second follow up letter was sent six weeks after the initial mailing.

Once responses were received from the first mailing, the second mailing was sent. The second mailing consisted of a therapist packet and a client packet. The therapist packet included a Termination Behavior Checklist – Therapist (TBC-T) and the State-Trait Anxiety Inventory (STAI). The clients' packets consisted of a consent form describing the purpose of the study, a few demographic questions (see Appendix H), a Termination Behavior Checklist (TBC), an Inventory of Countertransference Behaviors (ICB), and a Countertransference Behavior Measure (CBM) to be completed and returned separately from their therapist's packet. A reminder letter was sent to therapists who had not completed the second mailing approximately six weeks after the mailing had been sent. The follow up procedure was repeated three months after the second mailing had been sent and included another set of copies of both the therapist and client measures along with the reminder letter. Approximately six months after the second mailing had been sent, a letter was sent to therapists asking them to complete the final measures themselves following their next termination session, even if they did not feel comfortable asking a client to

participate at this time. All instruments mailed to therapists and clients were counterbalanced to decrease the likelihood of an order effect.

Chapter 4: Results

Preliminary Results

On average therapists tended to report limited fears of intimacy (M = 1.88). Therapists tended to have slightly more than moderate loss resolution (M = 3.14). Both therapists and clients tended to view therapists as engaging in many positive termination behaviors (Therapist M = 8.91, Client M = 10.70), and few negative termination behaviors (M = .74). While therapists exhibited both positive (M = 1.29) and negative countertransference (M = 1.03) in the final session, as a whole the sample tended to exhibit slightly more positive countertransference, though very little overall. Table 1 presents the descriptive data for all measures.

Table 1

Descriptive Information for Primary Measures

	Mean	SD	Range
Total FIS (N= 50)	1.88	.48	2.49
Total TRIG (N=50)	3.41	.67	2.72
Total STAI (n=23)	1.57	.33	1.30
TBC-T pos (n=23)	8.91	3.79	14.00
TBC-T neg (n= 23)	.74	.96	4.00
CT (n =10)	1.15	.22	.71
Neg CT (n=10)	1.03	.06	.18
Pos CT (n= 10)	1.29	.51	1.56
Total TBC (n=10)	10.70	2.54	9.00

Note: FIS = Fear of Intimacy Scale; TRIG = Texas Revised Inventory for Grief; STAI = State Trait Anxiety Inventory; TBC-T = Termination Behavior Checklist – Therapist, Pos CT= Positive Countertransference, Neg CT = Negative Countertransference, TBC = Termination Behavior Checklist.

Primary Results

Due to the small sample size it was determined that effect size rather than inferential statistics would be used to determine significance. Cohen (1992) proposed that small, medium, and large effect sizes correspond to *r* values of .10, .30, and .50, respectively. In this study Cohen's guidelines were used to interpret significance. The first hypothesis was that therapist loss resolution would be directly related to therapeutic termination behaviors and inversely related to negative termination behaviors. To test this hypothesis, Pearson correlation coefficients were calculated. The results generally did not support the first hypotheses. No relationship was observed between TRIG scores and positive termination behaviors (r = -.01) and only a small effect was found between TRIG scores and negative termination behaviors (r = -.19).

The second hypothesis was that therapist loss resolution would be inversely related to state anxiety during termination. To test this hypothesis a Pearson correlation coefficient was calculated. The results revealed only a small effect (r = -.11).

The third hypothesis was that therapist loss resolution would be inversely related to countertransference behaviors. To test this hypothesis Pearson correlation coefficients were calculated. Contrary to the hypothesis, the results revealed a moderate effect size in the direct relationship between TRIG and positive countertransference scores (r = .40). The results did not indicate a relationship between TRIG and negative countertransference scores (r = .04).

The fourth hypothesis was that fear of intimacy would be directly related to negative termination behaviors, and inversely related to positive termination behaviors. To test this hypothesis, Pearson correlation coefficients were computed. The results suggested a small effect

size between the FIS scores and positive termination behaviors (r = -.20) and no relationship between the FIS scores and negative termination behaviors (r = .09).

Fifth, I hypothesized that fear of intimacy would be directly related to state anxiety during the termination session. To test this hypothesis, a Pearson correlation coefficient was computed. A small effect size was found suggested between FIS scores and STAI scores (r = .28).

The sixth hypothesis was that fear of intimacy would be directly related to countertransference behaviors. Consistent with the hypothesis, a small effect size was found to exist between fear of intimacy and negative countertransference behaviors (r = .27). Contrary to the hypothesis, a moderate effect size was found in the inverse relationship between fear of intimacy and positive countertransference behaviors (r = -.36).

Additional Analyses

To examine the potential effects on the dependent variables of the independent variables when considered in combination, six simultaneous multiple regressions were conducted. In each the FIS and TRIG scores were the predictor variables. Again, due to the small sample size it was determined that effect sizes rather then inferential statistics would be used to determine significance. Cohen (1992) considers effect sizes in multiple regression to be a function of explained variance (R^2) divided by unexplained variance ($1-R^2$). Small effect sizes are considered to be .02-.14, whereas medium effects are .15-.34, and large effects are .35 and higher.

Therapist loss resolution and fear of intimacy, entered as a set were, found to have a moderate effect size in the prediction of both positive (effect size = .212) and negative countertransference behaviors (effect size = .190). These factors account for 16% of the variance

in negative countertransference behaviors and 18% of the variance in positive countertransference behaviors in the termination session. All other dependent variables had small effect sizes when considered with loss resolution and fear of intimacy as the predictor variables (see Table 2). Fear of intimacy and loss resolution explained about 9% of the variability in state anxiety at termination. However, when the beta weights are considered, it is evident that, fear of intimacy is responsible for the majority of this variance (FIS β = .285).

Table 2

Regression Analyses with Therapist Loss Resolution and Fear of Intimacy Predicting Positive and Negative Termination Behaviors, Countertransference, and State Anxiety

Source	*df*	R	R^2	F	p value	Beta TRIG	Beta FIS	Partial r TRIG	Partial r FIS
STAI	2, 20	.294	.087	.947	.405	.076	.285	.080	.286
TBC-T pos	2, 20	.204	.042	.435	.653	.058	-.195	.059	-.195
TBC-T neg	2, 20	.281	.079	.860	.438	.266	.097	.267	.101
Pos CT	2, 7	.418	.175	.743	.510	.292	-.161	.231	-.130
Neg CT	2, 7	.400	.160	.665	.544	.401	.539	.307	.398
TBC	2, 7	.155	.024	.086	.918	.204	.175	.150	.130

Note: STAI = State Trait Anxiety Inventory; TBC-T Termination Behavior Checklist – Therapist, TBC = Termination Behavior Checklist, Pos CT= Positive Countertransference, Neg CT = Negative Countertransference.

Exploratory analyses revealed a significant inverse relationship between therapist loss resolution and fear of intimacy (r = -.327, p < .05). That is, therapists who had greater fears of intimacy tended to have more unresolved losses in their personal lives, as vise versa. In addition, an inverse relationship was detected between therapist anxiety and positive termination behaviors (r = -.359, p < .05). Therapists who experienced more state anxiety during termination tended to engage in fewer positive countertransference behaviors according to their clients. The direct relationship between the therapist anxiety and both negative termination behaviors (r = .549, p < .01), and negative countertransference behaviors (r = .800, p < .01) was also significant. According to both therapists and their clients, therapists tended to exhibit more

negative termination behaviors and negative countertransference behaviors when their state anxiety was greater. Table 3 includes Pearson correlation coefficients among all primary variables.

Table 3

Intercorrelations among Primary Variables

	Variable							
Variable	1	2	3	4	5	6	7	8
1. **TRIG**	___	-.327	-.113	-.025	-.188	.085	.401	.037
2. **FIS**		___	.284	-.196	.093	.038	-.359	.269
3. **STAI**			___	-.359	.549	-.514	-.420	.800
4. **TBC-T Pos**				___	-.156	.904	.421	-.062
5. **TBC-T Neg**					___	.081	-.307	-.241
6. **TBC**						___	.696	-.136
7. **FSQ Pos**							___	-.245
8. **FSQ Neg**								___

Note: TRIG = Texas Revised Inventory for Grief; FIS= Fear of Intimacy Scale; STAI = State Trait Anxiety Inventory; TBC-T Termination Behavior Checklist – Therapist, TBC = Termination Behavior Checklist, FSQ= Final Session Questionnaire.

Correlation coefficients were computed between all primary variables and demographic variables. Exploratory analyses were conducted and a number of effect sizes that were medium to large were detected. A medium effect size was found in the inverse relationship between fear of intimacy and number of clients per week (r = -.35). State anxiety was inversely related to a number of clients seen per week for therapy (r = -.53), age (r = -.53), and years of practice (r = -.45). A moderate effect size was found in the inverse relationship between therapists' age and negative termination behaviors (r = -.41), and a large effect size in the inverse relationship between therapist age and negative countertransference behaviors (r = -.72). Therapists' years of practice was inversely related to negative termination behaviors (r = -.45), while a large effect size was detected in the inverse relationship with negative countertransference behaviors (r = -

.58). Finally, a moderate effect size was detected between therapist age (r = .36) and adherence to an integrative approach to treatment.

When correlation coefficients were calculated between therapist theoretical orientation and other variables, several significant relationships were found. A large effect size was found between greater adherence to a psychoanalytic model and greater state anxiety in termination (r = .52, p < .01). This is noteworthy in that greater adherence to all other models, Behavioral (r = -.47), Cognitive (r = -.53), Humanistic (r = -.48), Systems (r = -.39), and Integrative (r = -.40), had an inverse relationship with state anxiety at termination (p < .05). Loss resolution was inversely related to a systems approach to treatment, with a moderate effect (r = -.31) and an integrative approach to treatment, with a small effect size (r = -.25). A moderate effect size was detected between a cognitive behavioral approach to treatment and seeing more clients per week (r = .361).

The dependent variables were also analyzed in relation to the type of termination that occurred (i.e., temporary, permanent) and no significant relationship was detected. However, a relationship emerged between "decision to terminate" and one dependent variable. A shared decision to terminate was directly related to positive termination behaviors (r = .42) with a moderate effect size.

Chapter 5: Discussion

Researchers suggest that a moderate amount of variance in therapy outcome is attributable to therapist effects (Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Okiishi, Lambert, Nielsen, & Ogles, 2003). But what exactly makes some therapists better or worse than others? One possibility is certainly that some therapists are better than others are at terminating. This may be due in part to therapists' loss histories and fears of intimacy. This study set out to decipher the extent to which therapist fear of intimacy and loss resolution contributed to therapist state anxiety and behaviors in the termination session. Most of the hypotheses were not supported. Therapist loss resolution was not associated with displays of therapeutic termination behaviors or inversely related to feelings of anxiety during termination session and to countertransference behavior. Fear of intimacy appeared to be a somewhat better predictor of termination behaviors in this study but yielded only a small effect size in inverse correlations with displays of therapeutic termination behaviors and the direct relationship with state anxiety during the termination session. The most interesting finding, contrary to hypotheses, was the moderate effect size that was found in the direct relationship between therapist loss resolution and positive countertransference behaviors and the inverse relationship between fear of intimacy and positive countertransference behaviors.

The current study found that therapists who are more afraid of intimacy tended to also be less resolved around losses. While this was a correlational study, the direction of this phenomenon can be speculated upon. One possibility is that attachment works as a moderating factor. The experience could have the propensity to make one afraid of becoming close to others. As Bowlby (1973) found many of the main causes of anxiety in children stem from an absent caregiver, a caregiver departing, or a caregiver discouraging of proximity. In cases in

which the parent is the cause of the anxiety, children will frequently not have a caregiver to turn to for comfort. Such a pattern led to increased anxiety in the child and the development of a maladaptive attachment pattern. Loss in these cases had led to an attachment pattern that may affect capacity for intimacy. A recent study by Mayseless and Scharf (2007) focused on the correlation between adolescents' attachment representations, as measured by the Adult Attachment Interview (AAI, Hazan & Shaver, 1987), and capacity for intimacy in close relationships. These researchers note that mature intimacy requires separateness within the relationship. As mentioned earlier in this paper, securely attached adults will experience low anxiety over abandonment and high comfort with dependency and closeness. Avoidant adults low anxiety over loss and low comfort with closeness. Ambivalently attached adults report high anxiety over abandonment and intermediate levels of comfort with closeness. Mayseless and Scharf found that attachment style predicted capacity for intimacy four years later in their sample of adolescent males (N = 80). Considering the attachment and intimacy research, it seems that a patter may exist by which a child experiences a loss, is not comforted, develops a maladaptive attachment style, which later in life predicts capacity for intimacy and ability to deal with later life losses.

While there is virtually no existing literature which would explain this phenomenon further, Levitz-Jones and Orlofsky (1985) conducted a study that investigated how college age women (N= 89) who had high versus low capacity for intimacy dealt with separation. They found that low intimacy women tended to have a greater need to defend against the reality and impact of separation. This may explain why therapists who had greater fears of intimacy in the present study, tended to shy away from engagement in termination behaviors that would give further credence to the loss experience. In Levitz-Jones and Orlofsky's study, low-intimacy

women also tended to have a greater tendency toward depression in the face of separation and loss. Their high-intimacy counterparts tended to have significantly lower need to defend against the reality of loss, because their need for closeness was balanced by a desire for autonomy. This suggests that therapists with a low fear of intimacy in the present study might be more able to engage in an intimate discussion about the separation process, even as the relationship is ending, as they are equally interested in autonomy. Considering the finding in this study between fear of intimacy and loss resolution, it would be important to include measures of depression and defensiveness as additional dependent variables in future research.

Countertransference Behavior in Termination

Another important finding in the current study was the moderate effect sizes that were detected in the relationships between positive countertransference behaviors and both fear of intimacy (r = -.36), and therapist loss resolution (r = .40). These findings suggest that therapists who have fewer fears of intimacy and more resolved losses tend to engage in more positive countertransference behavior in the final session. These therapists were more likely to be perceived by clients as engaging in behaviors such as "befriending them", "behaving in a submissive way", "talking too much", "colluding with them", and "engaging in too much self-disclosure". While countertransference behavior, whether positive or negative, is typically considered problematic, these positive countertransference behaviors correlated significantly with the presence of positive termination behaviors from the client's perspective. When the therapist displayed positive countertransference behavior, the client was more likely to say they engaged in behaviors like "thanking the therapist", "asking personal questions about the therapist", "stating what they had liked and disliked about the therapy", and "shaking hands with or hugging their therapist". Clients also reported that their therapists had shared more about

themselves and invited them to return if needed. Finally, clients perceived that both parties mutually "shared their feelings about ending the work" in the final session.

Although it is unclear whether fear of intimacy and loss resolution are malleable constructs, it appears that therapists who tend to be more comfortable with intimacy and able to resolve loss sufficiently are better able to work through the termination process with their clients. These findings indicate that countertransference behaviors, when positive, may lead to more successful termination sessions. In sessions prior to the termination of therapy, these "positive" countertransference behaviors could be considerably problematic, perhaps suggestive of poor boundaries on the part of the therapist. Colluding with one's client in the midst of therapy could prevent the therapist from engaging in therapeutic behaviors, which require the therapist to take a stance in contradiction to the client, such as reframing cognitive distortions, or providing unsettling interpretations of material. However, in the termination session, collusion with the client in the experience of a realistic loss could facilitate a positive atmosphere in which the client and therapist express their feelings about ending. In a similar fashion, too much self-disclosure could be very burdensome to a patient in the midst of therapy. When a therapist's impaired judgment leads them to self-disclose, the client may feel overwhelmed and perhaps question the therapist's ability to tolerate their negative affect, or view their the therapist as unable to view the differences in their experiences. However, in the termination session clients in this study found that therapist self-disclosures contributed to more positive termination sessions. Perhaps this is because in the final session the client sees the therapist's self-disclosures as a personal reflection of what they have meant to the therapist, and signifies closeness in the midst of separation. The therapist may be utilizing their self-disclosures in an effort to demonstrate to the client how to work through loss and ending, in hope that the client

will mirror his or her behavior. These findings lend empirical support to several existing theories on the importance of the therapist empowering the client in the termination session, by equalizing the relationship (Curtis, 2002; Greenburg, 2002; Wachtel, 2002).

However, an alternative explanation for this finding is that the tendency of these clients to rate their therapists' positive countertransference behavior as therapeutic, may be sample specific. It is possible that therapists who agreed to participate and the clients who chose to respond may have felt a greater sense of closeness than those who did not.

Both predictor variables also strongly contributed to the variance in negative countertransference behaviors in the termination session. When therapists had greater fears of intimacy and poorer loss resolution, they clients were more likely to say their therapists engaged in negative behaviors such as, "treated me in a putative manner", "distanced him or herself from me", "rejected me" or "behaved as if he or she was 'somewhere else'" during termination. It appears that the negative countertransference behaviors which suggest "disapproval or a lack of affirmation in some way" (Friedman & Gelso, 2000, p. 1227) were not viewed as therapeutic by clients, the way that positive countertransference behaviors were at termination.

State Anxiety at Termination

Although much of the etiology of therapists' state anxiety at termination is unknown, fear of intimacy and loss resolution account for 9% of the variance. Bolmont and Abraini (2001) found that low moods and state anxiety on Spielberger's measure of state anxiety could largely be combined into a single construct. Perhaps the increased state anxiety at termination could be due to the negative affective response commonly involved in loss and endings. While all the factors from which state anxiety is derived in this context are beyond the scope of this paper, it is clear that this construct is connected to behavioral outcomes. Increased state anxiety in the

therapist during termination was associated with both fewer positive termination behaviors as reported by both therapists and clients with greater negative countertransference and negative termination behaviors.

Eysenck and Calvo (1992) theorized that state anxiety affects cognitive processing, such that available capacity of working memory is reduced, limiting processing efficiency and the amount of storage that can be dedicated to cognitive tasks. While this process may be adaptive in situations of danger where an individual needs to respond immediately in a functional manner, it may lead to a tendency to adhere to familiar therapeutic behaviors rather than adjusting to accommodate behaviors that are effective in final sessions. While state anxiety induced limitations on the comparison process may limit ambiguity in stressful situations, it may also lead to relatively rigid categorization (Dean, Kiem, Clark, & Hyatt, 2007). When this theory is applied to the present study, it implies that a therapist would be particularly unlikely to diverge from standard practice in the final session when experiencing increased state anxiety. Therefore, therapists who inform their practice based on theories that discourage self-disclosure, any physical contact (e.g., handshakes), and strictly suggest the maintenance of a circumscribed therapeutic relationship, would be likely to refrain from positive countertransference by habit, perhaps inadvertently appearing distant or disapproving to clients in their effort to maintain overfamiliarity.

Unexpected findings emerged based on the theoretical framework of the therapist. This study found a relationship between state anxiety at termination and a primarily psychodynamic approach to treatment. While additional research is necessary to better understand this finding, it suggests that practicing from this theoretical framework may induce uncomfortable affective states on the part of the therapist. Perhaps, Robbins and Jolkovski's (1987) discovery that

theoretical framework mediates effects of awareness thus affecting countertransference behavior, provides some insight into this unexpected finding. The central role that countertransference plays in psychoanalytic therapy and the importance of self-awareness of one's affective reactions is responsible for the greater tendency to endorse items indicative of state anxiety. While one may intuitively reason that the greater state anxiety in psychodynamic therapists during the termination session is due to longer therapeutic relationships with clients, leading to a perhaps a closer relationship, this did not appear to be the case. The only significant relationship that emerged between the therapists' theoretical framework and number of sessions was an inverse correlation between cognitive therapy and both the number of sessions ($r = -.433$, $p < .05$) and the duration over which the sessions occurred ($r = -.505$, $p < .01$). The finding that cognitively oriented therapists were also more likely to be in private practice and see clients for fewer sessions, over a more brief periods of time may be in part due to the influence of managed care and restrictions on the number of covered sessions. Because cognitive therapists in this study tended to have far fewer sessions on average with many more clients, it is possible that they did not experience the closeness in relationships with clients that therapists who saw fewer clients for longer periods of time developed. It appears that therapists who see fewer clients may be closer to the ones they do have perhaps explaining the increase in state anxiety. Perhaps future research should include a measure of working alliance or closeness in order to assess the depth of the relationship between the therapist and the client.

Another possible explanation for the inverse relationship between state anxiety and a psychodynamic theoretical orientation is perhaps the analytic therapists' lack of comfort with the behaviors found in "successful" termination sessions, for example decreasing neutrality and engaging in self-disclosure. Engagement in behaviors consistent with "successful" termination

sessions are found more typically in therapists' adhering to a humanistic framework, throughout the therapy process. Therefore, engagement in termination behaviors is likely to be more comfortable and less anxiety provoking than for analytic therapists for whom the engagement in such behaviors is quite foreign. However, it is possible that the heightened anxiety in psychoanalytic therapists is a trait that leads them to pursue training in the psychodynamic technique because it fits better with their personality characteristics. For example, it is possible that more formal and distant therapists will gravitate toward a psychodynamic orientation. Van Wagoner, Gelso, Hayes, and Diemer (1991) compared psychodynamic, learning, and humanistic therapists on five qualities theorized to be important to the management of countertransference; self-insight, integration, empathy, anxiety management, and conceptualizing ability. They found that all reputedly excellent therapists from all three orientations were generally rated as equivalent on these theorized qualities, with one exception. Psychodynamic therapists were rated more favorably than humanistic therapists were on their conceptualizing ability. Considering these findings, perhaps it is the attributes that contribute to greater success in one area, that lead to a downfall in another. The psychodynamic therapist may maintain a distance from the client, which allows for a more accurate case conceptualization, yet increases the therapist's anxiety in the final session when the therapist merges with the client in the ending experience.

In considering the direct relationship between state anxiety and negative therapist behaviors in termination, one must entertain the possibility that clients may evoke negative termination behaviors in therapists, which in turn generates anxiety. A third variable may be at the root of both the therapist and the client's behavior. For example, a client may unravel in the

last session or him or herself off emotionally. The therapist may not want to behave in a critical or hostile way, but may be pulled to do so, resulting in an anxious reaction.

Implications for Training and Practice

The results point to some broad implications for trainees. The dearth of empirical evidence on the importance of training beginning therapists to become aware of countertransference forms a noticeable gap in the literature (Davis, 2002). Both the therapist's recognition of countertransference reactions and the therapist's decision as to when to disclose them to the client have both been identified as factors that may affect the therapeutic relationship or outcome (Myers & Hayes, 2006). As research points out, the decision to self-disclose is often informed by the therapist's countertransference reactions (Davis, 2002; Ehrenberg, 1995). The findings support the suggestion that it is important for students to understand the extent to which their personal tendencies may influence their countertransference behavior. Another noteworthy finding was the inverse relationship between age and years of experience and state anxiety at termination. This finding could be used to normalize the feelings of anxiety that beginning practitioners may feel initially during termination sessions.

Limitations

Several limitations in the current study should be addressed. First, the 20% response rate to the initial mailing may suggest self-selection bias and limits the external validity of the study's findings. Methodologically, future studies should use a sampling method in which the researcher has direct access to both the therapist and the client to ameliorate the low response rate of clients. The most effective method would involve utilizing a college counseling center, for example, where both therapists and clients could be more easily tracked, terminations could be monitored and perhaps a greater inclination to participate in research would exist. University counseling

centers offer an ideal option in that clients are more likely to be capable of participation than inpatient settings, for example.

The second limitation involves a small sample size. Prior to beginning the study, a power analysis was conducted to ascertain how many participants would be needed. In this analysis assuming significance tests with an alpha of .05, and power equal to .80, with the expectation of a medium effect size, N needed to be equal to or greater than 67. Based on the original sample size I anticipated at least a 25% return rate. The expected return rate was not met perhaps due to methodology which required the therapist to complete measures on two separate occasions, and that they ask a client to participate. Several therapists voiced that they did not feel comfortable asking clients to participate but did so themselves. It is possible that other therapists did not feel comfortable responding to somewhat invasive questionnaires about fears of intimacy and losses. Historically, countertransference tends to be a difficult construct to measure (Hayes, 2004). Inherently, the therapist's potential triggers for countertransference must be unearthed, requiring very personal self-disclosures.

The lack of racial diversity both among therapist and client participants is also a strong limitation in this study. Thus, the generalizability of the findings may not extend to therapists and clients representative of various cultural backgrounds. Finally, another limitation is that the therapists were asked to respond to questionnaires that measured dependent variables retrospectively following the termination session. In future studies it would be beneficial to include a method that relies upon external raters' perceptions of termination behaviors.

Overall, sample characteristics, in addition to the small sample size, may have contributed to small and null effects. There is the possibility that a self-selection bias occurred one two levels. Fist, the therapist made the decision whether or not to participate and then

decided if they would ask a client. Although therapists were asked to give the client packet to the next client they terminated with, we cannot be certain that this was done. Perhaps therapists picked clients with whom they had a positive relationship, which may have led to a more restricted range in scores. In addition, terminations in which a client unilaterally terminated therapy abruptly were probably not included, as the therapist would not have had the opportunity to give the client packet to the client in a planned final session.

Because therapist factors have been shown to be such an integral part of the therapy process and outcome (Wampold, 2001), it is important to continue to empirically study the way in which they contribute to successful and unsuccessful termination sessions. However, the complexity of termination factors, and the difficulty in measuring countertransference reactions, presents a difficult task. Future research may focus on the incorporation of working alliance measures, to better understand the pre-termination relationship between the therapist and the client, as well as measures of therapist attachment style and feelings of depression after termination.

Conclusion

This study did support the perspective that reactions to termination are multifaceted, and involve many contributing factors. "Good termination affirms what has been worthwhile and healthy, names what has been hurtful and diminishing, offers thanksgiving for what has been constructive, asks forgiveness for what has been destructive and enables everyone to move on" (Dozier, 1996). In summary, the findings indicate that loss resolution and fear of intimacy each contribute somewhat to therapists' positive countertransference behaviors in termination sessions, and jointly account for almost a fifth of the variance. In addition, state anxiety in the final session is associated with behaviors that are more characteristic of unsuccessful

terminations and less engagement in positive countertransference behaviors. Considering the stronger relationship between fear of intimacy and state anxiety, as opposed to loss resolution, it is possible that the tendency to engage in therapeutic, albeit positive countertransferential behavior is more a factor of one's comfort with intimacy than one's ability to resolve loss. In fact, a person's ability to resolve losses may be dependent upon their ability to become intimate with others, through self-disclosure and a willingness to expose feelings of vulnerability. This intimacy seemed to be attained in successful terminations through the therapist's increased self-disclosures and engaging in a various behaviors that served to align them more with the client, decreasing the power differential. These "positive countertransference" behaviors correlated highly with the clients' perception that the termination was successful and therapeutic.

In research, as in termination, one must be able to anticipate unknown outcomes. It may be said with certainty that all relationships one day cease to exist in their present form. By remaining attentive to the inherent finality of therapy, therapists may have the foresight to change their process of ending, thereby perhaps changing the outcome. The great playwright Arthur Miller (1986) once said, "if I can see an ending, I can work backward". In termination the therapist who can see the end and anticipate their reactions, informed by insight into affective and behavioral reactions to loss, may then work backward from the inevitable ending to better prepare both themselves and their client for the separation that is yet to come.

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Appendix A

Texas Revised Inventory for Grief

Directions: For the purpose of this survey, please consider a single event that you consider a significant loss in your life (i.e. divorce, loss of a loved one, moving etc.). Please circle the number, which corresponds to the statement that best describes your feelings about that loss.

1	**2**	**3**	**4**	**5**
completely true	***mostly true***	***true & false***	***mostly false***	***completely false***

1.) I still cry when I think of my loss.	1	2	3	4	5
2.) I still get upset when I think about what I lost.	1	2	3	4	5
3.) I cannot accept this loss.	1	2	3	4	5
4.) Sometimes I very much miss what I had.	1	2	3	4	5
5.) Even now it is painful to recall memories of what I had.	1	2	3	4	5
6.) I often think about what I had.	1	2	3	4	5
7.) I hide my tears when I think about what I had.	1	2	3	4	5
8.) No one/ Nothing will ever take the place in my life of what I had.	1	2	3	4	5
9.) I can't avoid thinking about what I had.	1	2	3	4	5
10.) I think it's unfair that this loss occurred.	1	2	3	4	5
11.) Things and people around me still remind me of what I lost.	1	2	3	4	5
12.) I am unable to accept this loss.	1	2	3	4	5
13.) At times I still feel the need. to cry for what I have lost.	1	2	3	4	5

FIS

Part A Instructions: Consider a *close* relationship you have been in or are currently in. In each statement, "O" refers to the person who is/was in the close relationship with you. Rate how characteristic each statement is of you on a scale of 1 to 5 as described below, and put your responses on the answer sheet.

1	**2**	**3**	**4**	**5**
not at all characteristic of me	*slightly characteristic of me*	*moderately characteristic of me*	*very characteristic of me*	*extremely characteristic of me*

_____ 1.) I would feel uncomfortable telling O about things in the past that I felt ashamed of.

_____ 2.) I would feel uneasy talking with O about something that has hurt me deeply.

_____ 3.) I would feel comfortable expressing my true feelings to O.

_____ 4.) If O were upset I would sometimes be afraid of showing that I care.

_____ 5.) I might be afraid to confide my inner most feelings to O.

_____ 6.) I would feel at ease telling O that I care about him/her.

_____ 7.) I would have a feeling of complete togetherness with O.

_____ 8.) I would be comfortable discussing significant problems with O.

_____ 9.) A part of me would be afraid to make a long-term commitment to O.

_____ 10.) I would feel comfortable telling my experiences, even sad ones, to O.

_____ 11.) I would probably be nervous showing O strong feelings of affection.

_____ 12.) I would find it difficult being open with O about my personal thoughts.

_____ 13.) I would feel uneasy with O depending on me for emotional support.

_____ 14.) I would not be afraid to share with O what I dislike about myself.

_____ 15.) I would be afraid to take the risk of being hurt in order to establish a closer relationship with O.

_____ 16.) I would feel comfortable keeping very personal information to myself.

_____ 17.) I would not be nervous about being spontaneous with O.

_____ 18.) I would feel comfortable telling O things that I do not tell other people.

_____ 19.) I would feel comfortable trusting O with my deepest thoughts and feelings.

_____ 20.) I would sometimes feel uneasy if O told me about very personal matters.

_____ 21.) I would be comfortable revealing to O what I feel are my shortcomings and handicaps.

_____ 22.) I would be comfortable with having a close emotional tie between us.

_____ 23.) I would be afraid of sharing my private thoughts with O.

_____ 24.) I would be afraid that I might not always feel close to O.

_____ 25.) I would be comfortable telling O what my needs are.

_____ 26.) I would be afraid that O would be more invested in the relationship than I would be.

_____ 27.) I would feel comfortable about having open and honest communication with O.

_____ 28.) I would sometimes feel uncomfortable listening to O's personal problems.

_____ 29.) I would feel at ease to completely be myself around O.

_____ 30.) I would feel relaxed being together and talking about our personal goals.

Part B Instructions: Respond to the following statements as they apply on a scale of 1 to 5 as described in the instructions for Part A.

1	**2**	**3**	**4**	**5**
not at all	***slightly***	***moderately***	***very***	***extremely***

_____ 31.) I have shied away from opportunities to be close to someone.

_____ 32.) I have held back my feelings in previous relationships.

_____ 33.) There are people who think that I am afraid to get close to them.

_____ 34.) There are people who think that I am not an easy person to get to know.

_____ 35.) I have done things in previous relationships to keep me from developing closeness.

Termination Behavior Checklist- Therapist

Directions: Please check the box to the left of each statement that reflects an event that occurred in the final session(s) or termination phase of therapy.

_____ 1.) Mutually decided when to end therapy

_____ 2.) A final date was set

_____ 3.) Therapy ended for external reasons

_____ 4.) You tapered off the frequency of sessions

_____ 5.) The end was a significant event in counseling

_____ 6.) Used the end to process the client's experiences of loss

_____ 7.) Client wanted to extend length of counseling

_____ 8.) You recommended therapy end early

_____ 9.) You summarized the work.

_____ 10.) Assessed the extent to which goals had been attained

_____ 11.) Client stated that he/she liked things about counseling.

_____ 12.) Client stated that he/she disliked things about counseling.

_____ 13.) Client asked questions about how counseling works

_____ 14.) Client thanked you

_____ 15.) You shared feelings about therapy with the client

_____ 16.) You hugged or shook hands with the client

_____ 17.) You talked more about yourself

_____ 18.) You and client related more like equals than in the past.

_____ 19.) Client asked personal questions about you.

_____20.) Client gave gift(s) to you

_____21.) You discussed the client's plans for the future.

_____22.) You invited the client to return to counseling

_____ 23.) You suggested other types of help for the client

_____ 24.) Client wanted opportunity for future contact with you.

_____ 25.) Client plans to receive more counseling in the future.

_____ 26.) Client shared feelings about ending.

_____ 27.) Client expressed feeling healthy.

_____ 28.) Client expressed pride.

_____ 29.) Client expressed feeling calm.

_____ 30.) Client expressed concern.

_____ 31.) Client expressed frustration.

_____ 32.) Client expressed feeling afraid

_____ 33.) Client experienced a sense of significant loss.

_____ 34.) Client expressed feeling alone.

_____ 35.) During termination client raised new problems

_____ 36.) Client wanted to extend length of counseling.

_____ 37.) Client devalued therapy.

_____ 38.) Client idealized you and/or therapy.

SELF-EVALUATION QUESTIONNAIRE

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Please think back to the final therapy session with the client you gave the packet to. Read each statement and then indicate with the appropriate number how you felt during that final session. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your feelings best.

1	**2**	**3**	**4**
not at all	***somewhat***	***moderately so***	***very much so***

_____ 1. I felt calm.

_____ 2. I felt secure.

_____ 3. I was tense.

_____ 4. I was regretful.

_____ 5. I felt at ease.

_____ 6. I felt upset.

_____ 7. I was worrying over possible misfortunes.

_____ 8. I felt rested.

_____ 9. I felt anxious.

_____ 10. I felt comfortable.

_____ 11. I felt self-confident.

_____ 12. I felt nervous.

_____ 13. I was jittery.

_____ 14. I felt "high strung."

_____ 15. I was relaxed.

_____ 16. I felt content.

_____ 17. I was worried

_____ 18. I felt over-excited and "rattled."

_____ 19. I felt joyful.

_____ 20. I felt pleasant.

Termination Behavior Checklist

Directions: Please check the box to the left of each statement, when the statement reflects an event that occurred in the final session of therapy.

_____1.) You thanked the counselor

_____2.) Summarizing the work

_____3.) Assessing how much goals had been attained

_____4.) Discussing your plans for the future

_____5.) Counselor sharing his/her feeling about ending the work

_____6.) Setting a date for the final session

_____7.) You sharing your feelings about ending with the counselor

_____8.) Counselor inviting you to return if you feel the need

_____9.) You and the counselor hugging or shaking hands

_____10.) You stating things about your counselor that you liked and disliked

_____11.) You feeling like you and your counselor were relating more like equals than you had in earlier times.

_____12.) Counselor suggesting other types of help and other places to get help

_____13.) You asking counselor personal questions about him/her

_____14.) Counselor talking more about him/herself

_____15.) Tapering off the frequency of sessions

_____16.) You asking counselor questions about how counseling works

_____17.) Other _____

_____18.) You giving a gift to the counselor

Final Session Questionnaire

Directions: For each item, please fill in the number that best describes your therapist's behavior in the last session.

1 **2** **3** **4** **5**

little to no extent ***to a moderate extent*** ***to a great extent***

_____ 1.) Your therapist colluded with you in the session.

_____ 2.) Your therapist rejected you in the session.

_____ 3.) Your therapist oversupported you in the session.

_____ 4.) Your therapist befriended you in the session.

_____ 5.) Your therapist was apathetic toward you in the session.

_____ 6.) Your therapist behaved as if he or she were "somewhere else" during the session.

_____ 7.) Your therapist talked too much in the session.

_____ 8.) Your therapist frequently changed the topic during the session.

_____ 9.) Your therapist was critical of you during the session.

_____ 10.) Your therapist spent time complaining during the session.

_____ 11.) Your therapist treated you in a punitive manner during the session.

_____ 12.) Your therapist inappropriately apologized to you during the session.

_____13.) Your therapist acted in a submissive way with you during the session.

_____14.) Your therapist acted in a dependent manner during the session.

_____15.) Your therapist inappropriately took on an advising tone with you during the session.

_____16.) Your therapist distanced him/herself from you during the session.

_____17.) Your therapist engaged in too much self-disclosure during the session.

_____18.) Your therapist behaved as if she or he were absent during the session.

_____19.) Your therapist inappropriately questioned your motives during the session.

_____20.) Your therapist provided too much structure during the session.

_____ 21.) Your therapist directed you inappropriately during the session.

_____ 22.) Your therapist dominated the session.

_____ 23.) Your therapist was hostile toward you during the session.

_____ 24.) Your therapist acted parental during the session.

Appendix B

Therapist Demographic Form

1.) Age: _____

2.) Gender: _____

3.) Ethnicity: _____

4.) Race: _____

5.) Degree Held:_____ In what discipline? _____

6.) Practice Setting: _____

7.) Total Years in Practice: _____

8.) Average # of Clients per Week: _____

How much is your current therapeutic practice guided by each of the following theoretical frameworks?
[0 = Not at all ... 5 = Very greatly]

1. Analytic/Psychodynamic	0	1	2	3	4	5
2. Behavioral	0	1	2	3	4	5
3. Cognitive	0	1	2	3	4	5
4. Humanistic	0	1	2	3	4	5
5. Systems Theory	0	1	2	3	4	5

6. Please describe your theoretical orientation briefly:

_____

_____

[0 = Not at all ... 5 = Very much]

7. To what extent do you regard your orientation as Eclectic/Integrative?	0	1	2	3	4	5

Therapist Demographic Form 2

Please answer the following questions with regard to the client you have just terminated with.

The decision to terminate was made by the (please circle one):

A) Therapist
B) Client
C) Therapist and client together

Is this termination (please circle one)?

A) Permanent
B) Temporary
C) Could be either permanent or temporary

Total # of sessions with this client? _____

Over what period of time? _____(weeks, months, years)

Client Demographics

Gender: _____

Age: _____

Race: _____

Ethnicity: _____

Relationship Status (circle one): Single Married/Partnered Divorced Widowed

Amt. of time since last session: _____

Appendix C

Therapist Cover Letter Initial Mailing

Dear Dr.

My name is Joslyn Cruz and I am currently a doctoral student in counseling psychology at Penn State. My advisor Dr. Hayes and I are writing to request your help with a study we are conducting on the termination of therapy (IRB # 23176) for my doctoral dissertation. Your participation as one of a small group of selected professionals would be extremely helpful and greatly appreciated. Enclosed you will find a brief survey that we would ask you to complete and mail back to us in the postage paid envelope that is provided. If you decide to complete the survey, another brief survey will be mailed to you upon our receipt of this survey. The second survey should be completed after your next termination with an adult client. In the second mailing, we will also be enclosing a client packet, which we would request you give to the next adult client (i.e. 18 years or older) with whom you terminate therapy. We will enclose a standardized recruitment script as a guide to invite your client to participate. Your client's responses should be returned separately from your own. We know that your time is highly valuable, so we have intentionally kept the survey as concise as possible. Would you please consider taking 5-10 minutes to complete the survey and asking a client to participate as well? While it may be uncomfortable for you to recruit a client for participation, I hope that you will consider the benefit that could come from better understanding of the factors that lead to therapeutic termination sessions.

Please know that all of your responses will be strictly confidential; a code will be our only method of tracking responses. Codes will be used to pair therapist and client responses, and to keep track of respondents so that we do not bother you with follow-up mailings. Random codes will be assigned upon data entry so that responses cannot be tied to participants' identities. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, Penn State's Social Science Review Board, and Penn State University's Office for Research Protections. If you would like to receive a summary of our findings, you may send an e-mail to jmc615@psu.edu requesting the results of this study. We will gladly inform you as soon as they are available.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University. This study involves minimal risk and your participation is voluntary. We recognize that you may feel awkward recruiting a client to participate, and ask you to consider the contribution you would be making to research that could potentially help therapists to facilitate more therapeutic termination sessions. Your must be 18 years of age to participate in this study. You may decline to answer any specific survey questions or withdraw your participation in this study at any time. Your completion and return of the enclosed survey constitutes provision of informed consent. If you have any questions or concerns about the study, please feel free to contact Joslyn Cruz at (917) 627-0179. If you have questions about your rights as a research participant, you may contact Penn State's Office for Research Protections at (814) 865-1775. We are grateful for your willingness to consider participating in this study.

Sincerely,

Joslyn M. Cruz, M.S.Ed.
Doctoral Candidate Counseling Psychology
jmc615@psu.edu
(917) 627-0179

Jeffrey A. Hayes, Ph.D.
Professor of Counseling Psychology
The Pennsylvania State University
312 CEDAR Building
University Park, PA 16802
jxh34@psu.edu (814) 863-3799

Client Mailing

Joslyn Cruz, M.S.Ed
Doctoral Candidate in Counseling Psychology
The Pennsylvania State University
jmc615@psu.edu
(917) 627-0179

Jeffrey A. Hayes, Ph.D.
Professor of Counseling Psychology
The Pennsylvania State University
jxh34@psu.edu
(814) 863-3799

Dear Client,

My name is Joslyn Cruz and I am currently a doctoral student in counseling psychology at Penn State University. My advisor Dr. Hayes and I are writing to request your help with a research project we are conducting on Therapist Behavior in the Final Session of Therapy (IRB # 23176) for my doctoral dissertation. We are investigating techniques therapists' use when ending therapy with clients. We are interested in understanding what therapists can do and say to create more therapeutic endings for their clients. Your therapist has given you this packet because you have recently ended therapy with him or her, and we would greatly appreciate your input. We recognize that your time is valuable, so we have intentionally kept the study as brief as possible. Would you please consider taking 5-10 minutes to complete the questionnaires?

Enclosed you will find a few demographic questions followed by two questionnaires regarding what took place in the final session of therapy with your therapist. If you choose to participate in the study, please complete both sides of each page and return the completed survey in the postage-paid envelope provided.

Please know that all of your responses will be strictly confidential. The survey asks for no personally identifying information; only the code listed at the top of your survey will be used to track your response. Your therapist will not ever have any access to your survey responses. Your decision to participate in this study will not affect any possible treatment you may seek in the future with your therapist, and is voluntary. The research is investigating the occurrence of certain events, not individuals, so that your confidentiality will be protected. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, Penn State University's Social Science Institutional Review Board, and Penn State University's Office for Research Protections.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University. Should you decide to participate in the study, by completing the questionnaires, there is a small risk that you may come to recognize things about your therapy that you did not while you still seeing your therapist. It is important that you recognize this risk as a possibility, as your final therapy meeting with your therapist has already occurred. You must be 18 years of age or older to participate in the study. You may decline to answer any specific survey questions or withdraw your participation in this study at any point in time. Your completion and return of the enclosed survey constitutes informed consent. For questions or comments about the study, please feel free to contact Joslyn Cruz at (917) 627-0179. If you have questions about your rights as a research participant, you can contact the Office for Research Protections at (814) 865-1775.

Thank you in advance for your willingness to complete the enclosed survey. It is our hope that the information gained for this research will help the counseling profession to better understand what behaviors are most effective for therapists to engage in during the final session of therapy.

Sincerely,

Joslyn M. Cruz, M.S.Ed. Jeffrey A. Hayes, Ph.D.

This informed consent form was reviewed and approved by the Social Science Institutional Review Board and Office for Research Protections (IRB# 23176 Doc. #1) at The Pennsylvania State University on 06-05-2006. It will expire on 05-02-2007. (DWM)

Appendix D

Therapist Cover Letter – 2nd Mailing

Dear Dr.

Thank you for taking the time to complete the initial survey. Enclosed in this packet are the second and final surveys to be completed after your next termination with an adult client. Enclosed is a brief questionnaire for you to complete following your next termination session with an adult client who has agreed to participate, and a brief questionnaire for your client to return separately from your own. A standardized recruitment script has been included as a guide to invite your client to participate. While it may be uncomfortable for you to recruit a client for participation, I hope that you will consider the benefit that could come from better understanding of the factors that lead to therapeutic termination sessions.

Please know that all of your responses will be strictly confidential; a code will be our only method of tracking responses. Codes will be used to pair therapist and client responses, and to keep track of respondents so that we do not bother you with follow-up mailings. Random codes will be assigned upon data entry so that responses cannot be tied to participants' identities. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, Penn State's Social Science Review Board, and Penn State University's Office for Research Protections. If you would like to receive a summary of our findings, you may send an e-mail to jmc615@psu.edu requesting the results of this study. We will gladly inform you as soon as they are available.

This research has been reviewed and approved by the Institutional Review Board at The Pennsylvania State University. This study involves minimal risk and your participation is voluntary. We recognize that you may feel awkward recruiting a client to participate, and ask you to consider the contribution you would be making to research that could potentially help therapists to facilitate more therapeutic termination sessions. Your must be 18 years of age to participate in this study. You may decline to answer any specific survey questions or withdraw your participation in this study at any time. Your completion and return of the enclosed survey constitutes provision of informed consent. If you have any questions or concerns about the study, please feel free to contact Joslyn Cruz at (917) 627-0179. If you have questions about your rights as a research participant, you may contact Penn State's Office for Research Protections at (814) 865-1775.

We are grateful for your willingness to consider participating in this study.

Sincerely,

Joslyn M. Cruz, M.S.Ed.
Doctoral Candidate Counseling Psychology
jmc615@psu.edu
(917) 627-0179

Jeffrey A. Hayes, Ph.D.
Professor of Counseling Psychology
The Pennsylvania State University
312 CEDAR Building
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Therapist Reminder Letter- Mailing 1

Date

Return Address

Dear Dr.

Recently we wrote you asking you for your help with a research project we are conducting on the termination phase of therapy. Because we have not received your survey, we are writing now to see if you would consider completing it. We are only sampling a small group of mental health professionals, so your response is crucial to ensuring a representative sample. If you have already returned your completed survey, please accept our sincere thanks for your time. If you have not yet completed the survey, would you please consider taking a few minutes to fill it out? Should you need a replacement copy please feel free to contact me at jmc615@psu.edu or (917)627-0179; we would be happy to send you one. Thank you again for your help.

Sincerely,

Joslyn M. Cruz, M.S.Ed
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Professor

Therapist Reminder Letter - Mailing 2

Date

The Pennsylvania State University
327 Cedar Building
University Park, PA 16802-3110

Dear Dr.

After receiving the survey you returned to us, we mailed you the second set of surveys (for you and a client) as part of a research project we are conducting on the termination phase of therapy. At this time we thought we would send you a reminder, asking you to please complete the second survey, and offer the client packet to your client after your next termination session. We are only sampling a small group of mental health professionals, so your response is crucial. If you have already returned your completed survey, please accept our sincere thanks for your time. If you have not yet completed the survey, please consider taking a few minutes to fill it out after your next termination session. Should you need a replacement copy please feel free to contact me at jmc615@psu.edu or (917)627-0179; I would be happy to send you one. Thank you again for your help.

Sincerely,

Joslyn M. Cruz, M.S.Ed
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Professor

Therapist Final Reminder Letter – Mailing 2

January 10, 2007

The Pennsylvania State University
327 Cedar Building
University Park, PA 16802-3110

Dear Dr.

At this time I have decided to send one final reminder asking you to complete the second set of surveys. We greatly appreciate your continued participation in our study of termination in psychotherapy. If you feel comfortable asking a client to participate, please do so and give them the survey labeled "client". If you do not feel comfortable asking a client to participate, but would like to participate yourself, please mail back the therapist packet following your next termination session. We are only sampling a small group of mental health professionals, so your response is crucial. If you have already returned your completed survey, please accept our sincere thanks for your time. If you have not yet completed the survey, please consider taking a few minutes to fill it out after your next termination session. Should you need a replacement copy please feel free to contact me at jmc615@psu.edu or (917)627-0179; I would be happy to send you one. Thank you again for your help.

Sincerely,

Joslyn M. Cruz, M.S.Ed
Doctoral Candidate in Counseling Psychology

Jeffrey A. Hayes, Ph.D.
Professor

Joslyn M. Cruz

43 Hudson Avenue
Apt. F
Nyack, NY 10960

EDUCATION

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Ph.D. in Counseling Psychology, December 2007

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Graduate School of Education, New York, NY
M.S. Ed. in Counseling, June 2002

NEW YORK UNIVERSITY, College of Arts and Sciences, New York, NY
B.A. in Psychology, May 1999

UNIVERSITY COLLEGE LONDON, London, England
Courses in psychology and geography

PROFESSIONAL AFFILIATIONS

American Psychological Association, Student Affiliate 2000 - present
Society for Psychotherapy Research, Student Affiliate 2005 – present

POSITIONS HELD

HUDSON RIVER REGIONAL PSYCHOLOGY INTERNSHIP PROGRAM
APA Accredited Clinical Psychology Internship
Rockland Psychiatric Center and Middletown Mental Health Clinic, Orangeburg and Middletown, NY
Pre-Doctoral Psychology Intern — September 2006- August 2007

PARNALL CORRECTIONAL FACILITY, Psychological Services Unit, Jackson, MI
Staff Psychologist — November 2005- August 2006

THE MEADOWS PSYCHIATRIC CENTER, Centre Hall, PA
Advanced Practicum Therapist — May 2005 – June 2005

COUNSELING AND PSYCHOLOGICAL SERVICES, THE PENNSYLVANIA STATE UNIVERSITY, University Park, PA
Practicum Counselor — June 2004 – May 2005

CEDAR CLINIC, THE PENNSYLVANIA STATE UNIVERSITY, University Park, PA
Practicum Supervisor — January 2005- June 2005

CAREER SERVICES, THE PENNSYLVANIA STATE UNIVERSITY, University Park, PA
Practicum Counselor — January 2004 - May 2004

TAFT HIGH SCHOOL, Guidance Department Bronx, NY
School Counselor — September 2002- August 2003

PUBLICATIONS

Hayes, J.A. & Cruz, J.M. (2006). On leading a horse to water: Therapist insight, countertransference, and client insight. In L. Castonguay and C. Hill (Eds.), *Insight in Psychotherapy: Definitions, Process, Consequences and Research Direction*. Washington, DC: American Psychological Association.