Client and Therapist Constructions of the Experience of Ending
Psychoanalytic Psychotherapy: Tracing the Power Lines

By

Katharine Cowen (BSc Hons)

Thesis submitted in part fulfilment of the requirements for the degree of Doctorate in Clinical Psychology

University of Leicester

Word Count: 46,605

July 2003
Client and Therapist Constructions of the Experience of Ending Psychoanalytic Psychotherapy: Tracing the Power Lines

Thesis submitted by Katharine Cowen in partial fulfilment for the degree of Doctorate in Clinical Psychology at The University of Leicester, July 2003.

Abstract

This study adopted a social constructionist framework to explore how clients and therapists construct their experiences of termination from long-term psychoanalytic psychotherapy. To this end, six psychoanalytic therapists and three clients were interviewed and their accounts were analysed qualitatively using a discourse analysis approach. Prominent therapist discourses elaborated termination as a loss experience. Clients also constructed termination in terms of available discourses of loss, however, additional client narratives were generated which storied termination in a variety of other ways, such as conveying hopes for a new beginning. Analysis revealed certain contradictions between the discourses deployed by therapists and those of clients, for example, whilst therapists constructed termination as a typically mutual process, clients storied termination as a time during which they had felt powerless. Discourses of termination were thus examined with reference to the institutions and ideologies they support and the power relations they reproduce. Analysis revealed that the within-therapy focus that still persists in more traditional approaches to analytic psychotherapy reproduces specific power relations and reinforces a view of clients as in need of expert help. Therefore, the ways in which power is enacted within the therapeutic relationship tends either not to be seen or is not explicitly addressed within certain approaches to psychoanalytic therapy, specifically, within a local NHS psychotherapy service. As such, this study argues for the adoption by therapists of a critical, reflexive approach to the ways in which therapy is enacted within specific settings. Further, it calls for the issue of power to be explicitly addressed within the practice of therapy in order to make clients more powerful. In practice, as with recent feminist and post-structuralist developments within psychoanalytic theory and practice, this would mean acknowledging the lived realities of clients and connecting with the structural inequalities that position them within society.
Acknowledgements

I would like to extend my thanks to the following people for their help and, at times, understandably exasperated support during this research.

Firstly, I would like to thank Sam Warner (jack-of-all-trades supervisor) for her advice, interesting and inspirational discussion, expertise in motivating me when I wanted to throw in the towel, and for providing me with copious amounts of coffee. I wish to acknowledge the enthusiastic support and participation of therapists from the Derby Psychotherapy Unit. I would also like to thank them for their openness and honesty during the interview process.

I would very much like to thank the ex-consumers of the Derby Psychotherapy Unit who agreed to participate in this research, and in doing so, set in motion a process of self-scrutiny regarding my own approach to conducting therapy with people in distress.

Finally, I wish to give a massive thanks to my Mum and my partner Shahab for reading some of the gobbledygook that I had written and providing me with many, many words of encouragement and all their shoulders to cry on. I would also like to thank my sister, Fiona, for bullying me to keep going; my dog, Blue, for making sure I got my walks, and all my friends who will not be able to believe the fact that it is at last completed (the drinks are on me!).
Contents

List of Figures viii

List of Appendices ix

Chapter 1 – Introduction 1

1.0. An overview of the study 1

1.1. An overview of the introduction 3

1.2. The fundamentals of psychoanalysis 4

1.3. The Freudian approach to psychoanalytic psychotherapy 7

1.3.1 Instincts and psychic energy 7

1.3.2 The Unconscious 9

1.3.3 The structure of personality 10

1.3.4 The psychosexual stages 12

1.3.5 Causes of neurosis 15

1.3.6 Psychoanalytic psychotherapy 15

1.4. Post-Freudian psychoanalysis 16

1.4.1. The Object relations approach to psychoanalytic psychotherapy 16

1.5. The refashioning of psychoanalysis 22

1.5.1. Marxist engagements with psychoanalytic theory 23

1.5.2 Feminist and social constructionist engagements with psychoanalytic theory 25

1.6. The process of termination 32

1.6.1. Defining termination 32
1.6.2. The criteria for termination
1.6.3. The tasks and technique of termination
1.6.4. The meaning and effects of termination
1.6.5 Therapist reactions to termination
1.7. A critical analysis of the literature and rationale for the study
1.8. Aims of the study

Chapter 2 — Methodology

2.0. Overview of methodology
2.1. Research design
2.1.1. Qualitative approaches to research
2.1.2. Epistemological framework
2.1.3. Interviewing as a research tool
2.1.4. A discourse analysis approach
2.2. The present study
2.2.1. Reflexivity within qualitative research
2.2.2. The researcher's assumptions and interests
2.2.3. Ethical considerations
2.2.4. Recruitment and selection of participants
2.2.5. Inclusion criteria
2.2.6. The participants
2.2.7. Interview construction
2.2.8. Interview procedure
2.2.9. Data management
2.3. Analysis of data

2.4. Issues of evaluating research quality

2.4.1. Credibility

2.4.3. Dependability

2.4.4. Confirmability

2.4.5. Transferability

Chapter 3 – Analysis I

3.0. Overview of chapter

3.1. Relationship and its significance within psychoanalytic psychotherapy

3.1.1. Termination as an important phase in the therapeutic relationship

3.2. Endings in therapy and endings in life

3.2.1. Ending as separation – ‘Leaving the nest’

3.2.2. Ending as a new beginning – ‘Driving without an instructor’

3.2.3. Ending as traumatic loss

3.3. Preparation for ending/distinctions

3.4. Powerlessness and the lack of opportunity for negotiation

3.5. The struggle of ending

3.5.1. Struggles around independence/dependence

3.5.2. Struggles around the unknown of ending

3.5.3. The conscious and unconscious avoidance of ending

3.6. Feelings of responsibility for the therapist

3.7. Internalisation

3.8. Unfinished business
Chapter 4 – Analysis II

4.0. Overview of chapter

4.1. Discursive analysis of themes

4.1.1. Discourses constructing the importance of the relationship

4.1.2. The hierarchical construction of the therapeutic relationship

4.1.3. The construction of termination as a unique phase of analytic therapy

4.1.4. The construction of termination as an experience of loss

4.1.5. The construction of the importance of preparation for ending

4.2. Summary of chapter

Chapter 5 – Discussion

5.0. An overview of the chapter

5.1. Summary and overview of the study

5.2. Implications for psychoanalytic theory and therapy

5.3. Implications for research

5.4. Implications for policy

5.5. Critical evaluation of the study

5.5.1. Reflexive section

5.5.2. Critique of the study

5.6. Conclusions

References
List of Figures

Figure 1: Some developments in psychoanalysis since Freud 5
Figure 2: Some common assumptions shared by psychoanalytic theories 6
Figure 3: Childhood psychosexual stages described by Freud 13
Figure 4: Main steps in the qualitative research process 63
Figure 5: Extracts from the researcher's journal 69
Figure 6: Extract from research diary reflecting the iterative process of interviewing 80
Figure 7: Extract from research diary regarding interview procedure 81
Figure 8: Extract from research diary regarding the process of transcription 82
Figure 9: Quotes from the category 'symptoms reappearing' and reflexive comments 85
Figure 10: Quotes from the category 'barriers to establishing relationship' and reflexive comments 86
Figure 11: Quotes from the category 'therapist carrying on therapy to meet own needs' and reflexive comments 86
Figure 12: Quotes from the category 'time's up' and reflexive comments 87
Figure 13: An example of an index sheet for the discourse of 'relationship' 89
Figure 14: Flow diagram of discourse of 'ending as struggle' and component sub-discourses 90
Figure 15: Respondent perspectives sought and elicited during interviews 163
List of Appendices

Appendix 1 - Reply from Southern Derbyshire Ethics Committee

Appendix 2 - Answer to Southern Derbyshire Ethics Committee

Appendix 3 - Lay Person's Summary

Appendix 4 - Participant Information Sheet (Clients)

Appendix 5 - Opting In Form

Appendix 6 - Letter to Therapists (First Contact)

Appendix 7 - Participant Information Sheet (Therapists)

Appendix 8 - Draft Interview Schedule (Clients)

Appendix 9 - Revised Interview Schedule (Clients)

Appendix 10 - Revised Interview Schedule (Therapists)

Appendix 11 - Consent Form

Appendix 12 – Themes Generated in the Initial Stage of Analysis
1. Introduction

1.0. An overview of the study

The aim of this thesis is to explore client and therapist narratives regarding their experiences of termination from long-term psychoanalytic psychotherapy, and in particular to explore how clients and therapists understand the process of termination. However, an additional aim of this study is to utilise these narratives as the basis for a critical analysis of a psychoanalytic model of psychotherapy offered within a local NHS psychotherapy service. Ultimately, in conducting this twofold study I am seeking to provide some guidelines for addressing the ending of therapy and in doing so, seeking to situate these within an updated and expanded conceptualisation of psychoanalytic therapy.

The ending of therapy or termination is understood by some theoretical orientations to be an important phase in the therapeutic enterprise. Specifically, it has a long history within psychoanalytic texts (e.g. Garcia-Lawson & Lane, 1997), and more recently has been discussed within the field of counselling (e.g. Quintana & Holahan, 1992) and from the theoretical perspective of other psychotherapeutic approaches, such as narrative therapy (e.g. Epston & White, 1992).

Within the psychoanalytic literature, the significance of termination has generally been explained in terms of a loss experience for clients and has, on occasion, been highlighted as a potential loss experience for therapists also. More recently however, the issue of whether the ending of therapy constitutes an experience of loss has been
debated within constructionist approaches to therapy and alternative conceptualisations of the experience of termination have been proffered. As Epston & White (1992) argue, the preoccupation by psychoanalytic therapists with the "termination as loss" metaphor operates to reinforce the dependency of the person seeking help from the therapist. They prefer to see the ending of therapy as a "rite of passage from one identity status to another" (1992: 340).

The impetus behind this research arose from my observations within clinical interventions with clients, of the significance of the ending of therapy for the client and for myself, as "therapist". Juxtaposed with these observations regarding the apparent importance of anticipating and explicitly focusing on client and therapist reactions (thoughts, feelings and behaviours) to the ending of therapy, is the apparent lack of attention and thought given to termination within the therapeutic literature generated outside of the boundaries of psychoanalytic thought. In addition, the psychoanalytic literature on the subject of termination has tended to be unidimensional, in that therapists have commonly offered their perspective of the client's experience. Indeed, as will be demonstrated, the literature review conducted as the basis for this study failed to uncover any research from within a psychoanalytic frame that has sought client experiences of termination, as construed by the latter. The psychoanalytic literature on termination also remains firmly located within the therapeutic encounter, as opposed to being socially situated or including the experience of the therapist.

The following research primarily aims to investigate how the different positions of clients and therapists may give rise to different understandings of the experience of
ending therapy, referred to within the therapeutic literature as *termination*. This research therefore aims to represent and draw on the multiple versions of the experience of termination that are available from therapists and clients, thus emphasising the interactional nature of therapy and, finally, discussing the implications of these for clinical practice.

### 1.1. An overview of the introduction

Within the following chapter the literature is reviewed in order to critically examine the context in which the concept of termination has developed, and the theoretical contributions that have shaped the thinking and approach adopted by therapists to this aspect of the therapeutic encounter. The literature review that follows initially aims to focus down on the literature that pertains to the training and practice of the therapist's interviewed, and the therapeutic approach experienced by the clients included in this study; that is, the British Object Relations model. It will then go on to examine some of the challenges to, and revisions of, these theoretical approaches, originally by Marxist and feminist authors and more recently by social constructionist and post-structuralist writers. Finally, the psychoanalytic literature pertaining to the process of 'termination' from adult individual psychotherapy will be critically analysed. It will be demonstrated that historically, termination has been discussed almost exclusively from the perspective of psychoanalytic theorists and therapists, positioned as *experts*. Henceforth, only the therapist's view of the therapy and of termination is privileged. It will therefore also be argued that the literature that exists does not include the client's perspective of his/her experience of ending therapy. In addition, it will be suggested that given the emphasis within psychoanalytic training models that therapist's
themselves undergo personal therapy, and thus appreciate the position of being a client themselves, a further area which has been neglected is the perspective of therapists concerning their experiences of termination from their own personal therapy. It will be argued that this apparent neglect may reflect a wider reluctance within more traditional forms of psychoanalytic practice to acknowledge therapists as nothing less than 'expert' and as mentally healthy models for their clients. Finally, it will be argued that the literature on termination is solely focused on the internal experience provoked by termination and therefore neglects the social context in which the therapy is enacted. As will be demonstrated, this is despite the many developments that have occurred within psychoanalytic theory in recent times. In particular the impact and implications of feminist and social constructionist revisions of psychoanalytic theory, or lack thereof, on theorising around termination will be examined.

1.2. The fundamentals of psychoanalysis

The psychoanalytic movement originated with Sigmund Freud, however it has been subject to numerous revisions and has therefore provided the foundation for a number of divergent schools of thought. Thus, there are a wide variety of theories that may be categorised as 'psychoanalytic'. Therefore, the discipline is by no means coherent and actually contains numerous theoretical contradictions. However, space does not allow for a comprehensive discussion of all those theories falling under the psychoanalytic umbrella. Thus, the aim of the diagram on the following page (Figure 1) is to broadly represent some of the developments that have occurred since the inception of psychoanalysis by Freud.
Figure 1: Some developments in psychoanalysis since Freud

Freudian Theory

Ego Analysis
Grew out of Freud's later work.
Focuses on the functioning of the ego.
Combines a biological view of the individual with an understanding of social processes.
Concerned with the way the individual's needs & desires become adapted to social demands and is therefore similar in its general position to Freud's own views.

Kleinian Theory
The importance of the relational (object) world for development is emphasised.
However, the main focus is on an internal world of instincts that 'drive' the person.
'Phantasy' is seen as central to psychological functioning.

Object Relations Theories
The focus is on the relational context of development as opposed to Freud's placement of sexual & aggressive instincts at the centre of mental life.
Early relationships lay down basic psychic structures & internalisations, which provide the template for later relationships.
Thus, the quality of the relationships available to a person during the formative period of very early life is crucial to considering the person.

Lacanian Theory
Linked to the tradition of structuralism. Focuses on the way the individual becomes formed in the structures of language & culture and is therefore at odds with all other forms of psychoanalysis.

Feminist Object Relations

Feminist Post-structuralism
All psychoanalytic theories do, however, have their origins in Freud's work and all share some common assumptions and affiliations. These common threads are shown below in a table (Figure 2).

**Figure 2: Some Common Assumptions Shared by Psychoanalytic Theories**

<table>
<thead>
<tr>
<th>Some common assumptions shared by psychoanalytic theories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Existence of a dynamic unconscious made up of residues of infantile experiences and certain kinds of instinctual impulses, e.g. Freud's aggressive and sexual impulses.</td>
</tr>
<tr>
<td>2. Children develop by passing through certain stages, leading to complexity of psychic structure. However, disagreement about the nature of the developmental process is at the heart of differences between various schools.</td>
</tr>
<tr>
<td>3. The experiences of early life, primarily with parents, are of crucial significance for later life.</td>
</tr>
<tr>
<td>4. Freud's basic therapeutic approach, that is the underlying 'dynamics' of mental life can be uncovered and made conscious through intense examination of psychological and cultural phenomena of virtually any kind (dreams, slips of the tongue, works of art, 'neuroses'). For most analysts the therapeutic situation is the place where this happens most clearly.</td>
</tr>
</tbody>
</table>
1.3. The Freudian approach to psychoanalytic psychotherapy

Freudian psychotherapy originated in the work of Sigmund Freud (1856-1939), who developed it as the therapeutic application of the science of the human mind, which he called psychoanalysis.

1.3.1. Instincts and psychic energy

The theory of psychical determinism is central to the Freudian image of the person. This theory opposes the view that people cause their own behaviour through autonomous acts of choice and purports that the human mind and behaviour are motivated and directed by powerful innate forces. Thus, apparently random thoughts and the inability to recall a familiar word or idea have underlying reasons, which are usually unconscious (Freud, 1901).

The ultimate version of Freud’s theory states that we are motivated by two major instincts or drives, both of which are present from birth: sexual and destructive (aggressive). Instincts are biological entities represented in mental life by certain ideas. The sexual and destructive instincts were conceived of as in opposition to each other and to reality. As such, a major concern of Freud’s was with the conflict that occurs within the individual mind and between the individual and society, and the consequential repression of desires. The instincts are however at times conjoined, as in sadistic and masochistic behaviours.
An instinct becomes activated when some aspect of the body requires sustenance, producing a physiological state of increased tension (wish), which is experienced as unpleasant. The primary human goal of pleasure (the pleasure principle) is realised by taking action to reduce the unpleasant tension, which in turn satisfies the underlying instinctual need (drive reduction) (Freud, 1911; 1916-1917).

In Freudian theory, sexuality has a wide meaning and signifies a whole range of erotic, pleasurable experience associated with the body’s numerous sources of sexual gratification (the erotogenic zones) (Freud, 1920). For example, because the mouth is an erotogenic zone, behaviour such as eating and drinking involves the sexual drive. Freud refers to the psychic energy associated with the sexual instinct as libido. Libido attaches itself to mental representations of objects that will satisfy instinctual needs, a process known as cathexis. For example, a baby quickly learns that its mother is a crucial source of such instinctual satisfactions as feeding, oral stimulation and physical contact. Therefore it develops a strong desire for her and invests a great deal of psychic energy (libido) in thoughts, images and fantasies of her.

The destructive instinct signifies the idea that life itself aims at returning to its prior state of non-existence. Thus, the death instinct is in opposition to the erotic or life instincts (Freud, 1920). The repetition compulsion is cited as evidence of the existence of the destructive instinct because Freud observed that the compulsion to repeat often brought up material that could never have been pleasurable. The manifestation of the death instinct is expressed in all forms of aggressive behaviour and contributes to what Freud argued were the problems of individuals in society (Freud, 1930). Freud is therefore quite pessimistic about human nature and human relationships.
The illicit impulses that derive from the sexual and destructive instincts would not be tolerated within society, and in Freud's view this inevitably leads to *intra-psychic conflict* and the *sublimation* of these forbidden impulses into compromise activities. For example, aggressive impulses may be sublimated by becoming a surgeon. Furthermore, Freud suggests that individuals form relationships with one another exclusively to express the instinctual drives of sex and aggression and not, as successive psychoanalysts would argue, for the intrinsic satisfaction and sense of connectedness that relationships with others provide.

### 1.3.2. The unconscious

According to Freud (1900), the majority of mental processes and their contents lie outside conscious awareness in the *unconscious*. This was not a new concept at the time, however Freud's idea of a 'dynamic unconscious' distinguished his observations from those of his contemporaries. This concept described the idea that *repression* is intimately linked with the contents of the unconscious, with repressed material having a life of its own and a motivating effect on individuals, of which the conscious mind is unaware (Freud, 1915). Unconscious ideas may, however, impact on the person indirectly through conscious or preconscious (those thoughts that may be temporarily out of awareness but are easily retrievable) ideas that are seen as associatively linked with unconscious ideas and act as substitutes for unconscious thoughts (Freud, 1900).
1.3.3. The structure of personality

Freud went on to describe a tripartite, structural model of the mind (1923) incorporating the id, the ego and the superego. The id is conceived as a system of biological needs present from birth and includes the instincts and the total supply of psychic energy. It is concerned entirely with its own needs for physical gratification and is seen as a self-contained component of the psyche, isolated from reality and totally illogical and amoral. The id forms mental images of objects that will satiate the individual, a process called wish-fulfilment. The irrational, impulsive, and image-producing mode of thought representative of the id is known as the primary process (Freud, 1911). The primary process has no sense of time and is not affected by experience, so childhood instinctual impulses and repressions exist in the adult id as strongly as though they had just occurred. Primary process thinking is thus evident within neurotic symptoms, certain varieties of psychosis, dreams, and plays a prominent role in parapraxes (e.g. slips of the tongue, apparently random thoughts, self-inflicted injuries).

The ego is described as the part of the psyche responsible for adaptation to external reality and spans the conscious, preconscious and unconscious domains unlike the id, which is entirely unconscious. The ego begins to develop in the first year of life out of the id and its formation is aided by experiences that help the infant to distinguish between self and 'not-self'. The growth of the ego weakens the id by drawing psychic energy from it. As the child learns to distinguish id images from objects in the environment, fantasised wish-fulfilment (the domain of the id) is seen as being replaced by reality-oriented behaviour. Thus, the ego forms realistic plans of action in
order to satisfy the demands of the id and in doing so suspends the pleasure principle in favour of the reality principle. The rational, problem-solving and reality-oriented mode of thought representative of the ego is known as the secondary process (Freud, 1911). The ego responds to threats from the external world, from the libido of the id and from the severity of the superego with corresponding forms of anxiety (Freud, 1923). Realistic anxiety is the ego’s response to threats from the environment; neurotic anxiety is generated in response to dangerous impulses from the id, and moral anxiety derives from acts or wishes that violate the superego’s standards of right and wrong. To cope with these various threats and the associated anxiety, the ego deploys defence mechanisms. Freud described a whole host of possible defences such as reaction formation (threatening impulses are unconsciously replaced by diametrically opposed beliefs), denial (the denial of a threatening aspect of reality by the ego), projection (process of attributing an aspect of oneself to someone else) and displacement (dangerous impulses are displaced from one object to another).

However, perhaps the most important of the defences is repression whereby threatening material is unconsciously eliminated from awareness and the individual is unable to recall it on demand (Freud, 1915).

The final structure, the superego, is seen to be associated with ethical and moral conduct. The superego begins to develop out of the ego during the third to fifth year of life, in response to the ego’s internalisation of the punishments and rewards of significant persons. It is the vehicle for the conscience, which delineates and punishes illicit thoughts and actions and it provides the ideals by which the ego can measure and reward itself.
1.3.4. The psychosexual stages

Within the Freudian scheme, male and female sexuality derives from an originally bisexual base. He described a number of hypothetical psychosexual stages through which children pass, with each one characterised by a particular *erotogenic zone* that serves as the primary outlet for libido (Freud, 1905). For example, during the first 12 to 18 months of life, the child's sexual desires are focused within the oral region and sucking at the breast or bottle provides erotic pleasure as well as essential nourishment. At each stage of psychosexual development, Freud claimed that there is a crisis or conflict that the child must deal with. During the oral stage, because food does not always appear at the moment of hunger and the child must eventually be weaned from the breast, frustration and conflict are inevitable. If the child has feeding problems, or if the weaning process is traumatic, the child may become fixated in the oral stage and may develop an *oral* personality. Freud envisaged such a person as passive and excessively dependent on other people. However, if fixation occurs after the child has developed teeth, Freud conceived that the child is likely to turn out to be aggressive and verbally sarcastic.

Thus, during these stages the child experiences certain satisfactions and frustrations of the sexual drive, ultimately associating these with particular constellations of external conditions, leading to the formation of images of other persons (*objects*) and relations with them. Freud's psychosexual stages are represented in Figure 3 below.
The Oedipal complex in boys has been described as the boy’s wish to possess his mother and his consequent jealousy of his father, as well as his affection for his father and jealousy toward his mother (Freud, 1930). Oedipal feelings are extremely powerful and ultimately lead to severe conflicts. The boy imagines that his illicit wishes will lead to a withdrawal of his father’s love and protection. In addition he concludes that girls originally possessed a penis but that it was taken away as punishment, and that he will suffer the same fate if he persists in his Oedipal wishes.

To alleviate this intense castration anxiety, he abandons his Oedipal wishes and replaces them with a complicated set of attitudes. He intensifies his identification with
his father but this time wishes to be like him and develops a powerful reaction formation, recognising that he cannot do certain things that his father does. He thus learns to defer to authority. These identifications and prohibitions are incorporated into the superego and help bring about its formation, with the prevention of Oedipal sexuality and hostility becoming its primary, unconscious function.

Girls are also seen as entering the phallic stage with similar twofold attitudes for both parents. The young girl is seen to regard her clitoris as an inferior penis and thus develops penis envy, which may lead to neurotic sexual inhibitions, or to strong wishes to become a boy, and masculine behaviour. Freud thus asserts that girls feel and are biologically inferior to boys and are arrested in development, unable to reach male potentials. The girl intensifies her envious attachment to her father, regards her mother as a rival, and consequently she unconsciously transforms her wish for a penis into a wish for a baby from her father. Thus, Freud’s ideas on female development have been the subject of fierce criticism by feminists throughout the history of psychoanalysis, for understandable reasons.

In Freud’s interpretation, whereas the masculine Oedipus complex is resolved by the castration complex and is given up because of castration anxiety, the feminine equivalent is instigated by the castration complex. However, in both sexes the Oedipus complex comes as the climax of infantile sexuality. Thus, for Freud, the self is formed as a consequence of the loss of the desired object, in an attempt to become like the lost love and, hence, sexuality is reordered within the cultural framework of instituted gender relations.
1.3.5. Causes of neurosis

Within the Freudian model, an overcoming of the strivings of the Oedipus complex and the attainment of adult sexuality is necessary for normality. Thus, an unconscious adherence to Oedipus tendencies is typical of the neurotic mind and the capacity of the ego is weakened by the loss of libido to strong childhood fixations. The ego is therefore unable to cope effectively with the frustrations of reality, or with the demands of the id and superego and its function becomes impaired. Thus, the desires of the id force themselves toward expression. Mechanisms of defence are then deployed and, thus, conflicts appear in disguised forms as symptoms however, there is usually an associative link between the form or content of the symptom(s) and the underlying unconscious concern.

1.3.6. Psychoanalytic psychotherapy

Psychological change is therefore seen to occur as a result of a reduction in the intensity of the unconscious urges pressing towards consciousness or a strengthening of the defences. The Freudian Psychoanalyst seeks to assist the person in becoming more self-aware as it is understood that although clients are aware they are troubled, they do not know what is at the root of these difficulties. Thus, the analyst’s role is essentially to listen to the client and then to formulate and share their ideas about what is going on in the person’s unconscious mind. The aim of Freudian psychoanalysis is therefore to transform symptoms into insights and to facilitate the ‘working through’ of this unconscious material (Freud, 1914).
CHAPTER 1

1.4. Post-Freudian psychoanalysis

Psychoanalysis has undergone dramatic change since the time of Freud, in that attention has shifted from the intra-psychic world of the self to relations between self and other; the interpersonal sphere. For many contemporary theorists, the human subject's inner world is constituted through relations with others. The following section therefore seeks to demonstrate how this recognition of the two-person foundation of human psychology has led psychoanalytic debate away from issues of Oedipal conflict and sexual repression to a concern with the pre-Oedipal social world within a child's psychic development, and emotional disturbances in ego-formation.

1.4.1. The Object Relations approach to psychoanalytic psychotherapy

Developments that occurred within the post-Freud era and which became known as 'Object Relations' theory and therapy specifically concerned the recognition that human relatedness is the crucial backdrop against which a sense of selfhood is formed. Whereas Freud's individualism defines the development of human psychology in terms of sexual drives and unconscious desire, object relations theory sees a fundamental linkage between self-formation and the environmental and emotional provisions offered by significant other persons (Grotstein, 1995). Individuals want relationships with others for the intrinsic satisfaction of such connectedness, and not simply to reduce drive energy. Furthermore, object relations theorists suggest that the quality of interpersonal relations is the structuring force of unconscious desire (Brown, 1967). Indeed, as Fairburn argues, 'It is not the libidinal attitude which
determines the object relationship, but the object relationship which determines the libidinal attitude' (Fairburn, 1941: 34).

Contemporary British Object Relations theory originates from the works of Melanie Klein, William. R. D. Fairburn, D. W. Winnicott & Harry Guntrip. Melanie Klein, a contemporary of Freud, became interested in psychoanalysis early in her clinical career and although she was an innovator within the field of psychoanalysis, she accepted as fundamental the common themes of Freud's theory (Brown, 1967), as described previously in this chapter. Rather, her area of interest was different from Freud's as she emphasised the importance of pre-Oedipal events in determining later psychological development and disturbance (Brown, 1967). More importantly for modern psychoanalytic psychotherapists, she championed the idea that the human psyche is constructed as a result of the child's attempts to deal with significant figures in their life (typically, parental figures) rather than with biological impulses (Cashdan, 1988).

However, Klein placed precedence on the notion of a death instinct and thus theorised that children were driven less by the need to control erotic impulses than by a need to control the destructive feelings and fantasies directed at significant figures in their life. A large part of these destructive impulses are seen as being projected initially onto the mother figure and are conceived of in terms of "positions" through which the child organises their experience (Klein, 1997). Kleinians see the analyst as a receptacle for the patient's projections of internal figures and the feelings that surround them, thereby influencing the analyst's emotional state (Nuttall, 2000). The projected parts of the patient also undergo modification while held by the latter. These are then re-
CHAPTER 1

experienced by the patient through an introjective mechanism, whereby parts of the analyst are internalised and alter aspects of the patient’s psychic world. With these developments in psychoanalytic theory came a move away from the idea of early analysts of a ‘neutral’ therapist simply receiving and reflecting the patient’s transference. The analyst in this scenario was, in many respects, outside the interaction, relatively unaffected by the patient’s transferences but commenting on them in order to promote insight and understanding. However, awareness of the two-person relationship came to be seen as an indispensable tool within approaches to object relations therapy (Kahn, 1997).

Klein’s theory therefore stresses the importance of the ‘object world’ of other people for development, however, it simultaneously focuses away from real world concerns toward an internal world marked by fantasy, splitting and various complications of psychic process and structure. As such, Kleinian theory contains significant theoretical differences from other object relations authors, concerning the central place of fantasy versus the object world for the development of the individual psyche. Indeed, psychoanalysts who take as their influence the theoretical works of William R. D. Fairburn, D. W. Winnicott and H. Guntrip, amongst others, are often referred to as the Independents, thus to distinguish themselves from the Kleinian tradition.

William Fairburn outlined a maturational sequence within which the most influential relationship is that between the mother and child (Fairburn, 1954). Fairburn’s interest lay in the way that dependency is experienced within the very early interactions between mother and child, and how these become incorporated into the child’s ego (Brown, 1967). In this scheme and other object relations frameworks, the psyche is to
some extent determined by the reality principle from the beginning, as the infant’s ego is always oriented towards forming relationships. Thus, Freud’s tripartite structural theory is abandoned in favour of a relationship-seeking ego having the potential to develop into a unified self (e.g. Guntrip, 1973).

Both Winnicott and Fairburn see the young child as being initially merged with its mother, and thus, does not have a separate sense of self in this very early stage of development. Fairburn refers to this phase as ‘immature dependency’ (Fairburn, 1954) and Winnicott as the ‘baby-and-mother field’ (Winnicott, 1956). Winnicott describes in detail what he sees as a characteristically nurturing environment, that is, a ‘holding’ and mirroring environment that is perfectly responsive to the infant’s needs and gestures, but at the same time is non-intrusive by definition (Winnicott, 1956). As implied by all their metaphors of holding and containment, object relations theorists therefore typically concentrate on the role of the analyst as a maternal figure (e.g. Winnicott, 1956).

Fairburn replaces Freud’s psychosexual stages with a scheme based on the quality of relationships with others, where transition from one stage to the next depends on the successful resolution of a graded pattern of separations (Fairburn, 1954). Within this scheme however, circumstances dictate that the mother is experienced in both good and bad ways, the latter arising because a mother cannot always be there physically and emotionally for her child, as her own needs necessarily interfere with this process at times. However, the child’s dependency constrains the child’s options for dealing with this, and, as a result, the object is internalised in an attempt to control it more
successfully and the ‘good’ and ‘bad’ components of the mother are split off from one another.

The split off bad object can take one of two forms: the “exciting object” or the “rejecting object”. Each of these inner objects also give rise to separate ego states through a process of “parallel ego splitting” (Fairburn, 1954). The latter of the potential bad objects comes about through the experience of a mother who behaves with hostility towards her child, or who is emotionally distant. The rejecting object gives rise to an anti-libidinal ego, which is the part of the ego that is consumed with anger and yet desperately longs for acceptance and connectedness. Fairburn sees children controlled by this ego state as filled with rage.

The other form that the bad object can take (exciting object) is seen as arising from interactions with a mother who teases and tempts her child so that consequently the child feels frustrated and empty. This gives rise to an infantile libidinal ego and a child governed by this ego state is described as feeling frustrated and deprived. Thus, it can be argued that in Fairburn’s view the negative aspects of one’s parents which are internalised are an actual reflection of parental behaviour, as opposed to Klein’s view that these are a product of the child’s own innate destructiveness projected onto an external object.

According to Fairburn’s scheme, internal object relations are, strictly speaking, endopsychic structures whose very existence reveals relational failures. Thus, the basis for the development of later psychopathology derives from the child’s attempts to preserve the positive aspects of the mother by splitting off the painful negative ego
states, which are then not amenable to conscious control and are thus experienced as inner feelings of persecution (Fairburn, 1952). Thus, it is only when relationships prove difficult or frustrating that the reality principle gives way to the pleasure principle. As such, within this scheme and those of other object relations theorists, fantasy is not so much generative or creative but rather a consolation for, or escape from external frustration. Hence, unconscious processes are largely a distortion of human development and indicative of psychopathology (Guntrip, 1961).

Thus, although disparities exist between these different object relations theories on, for example, the relative influence of social and biological factors on the process of psychological development, and therefore whether human nature is inherently 'split' or becomes so through inadequate developmental settings, the root of pathology is still seen as originating within an 'unconscious'. Thus, in common with the Freudian scheme, psychological distress is conceptualised as resulting from the person's inability to manage, rationally, inner states of intense conflict arising from childhood. Through focusing on the role of fantasy and internal conflict, the person's agency and responsibility in the creation of their distress is therefore arguably implied. Hence, certain psychoanalytic frameworks can be criticised for potentially inviting a view that psychological disturbance is located firmly within the individual and past relationships with parental figures. The current social and political structuring forces to which the person is subject on an everyday basis are therefore excluded from the therapeutic frame. Thus, such frameworks are likely to close down the ways in which clients can construct the origins of their distress, and hence, clients may also narrativise their distress in this way. Furthermore, it can be argued that an internal focus carries with it
the danger of compounding the distress of people that have been victims of circumstance, rather than reducing or eradicating it.

Indeed, like many psychoanalytic constructs the unconscious can simply be seen as a metaphor for understanding human behaviour, however, as argued by Gellner (1992), metaphorical constructs such as these are storied within certain psychoanalytic theories and therapies as if they are real. This process of concretising abstract concepts functions on one level to perpetuate a particular way of understanding psychological difficulties that may, in certain contexts and with certain individuals, be highly valuable. Arguably however, this process simultaneously closes down other ways of thinking about and talking about the client’s lived experience within the therapy, which may be equally or more pertinent to their current predicament.

1.5. The refashioning of psychoanalysis

In view of this argument, the following section therefore seeks to demonstrate the variety of ways in which psychoanalytic theory has been developed when it has been applied in political contexts. It will be demonstrated that a marrying of psychoanalytic theory with political and post-structuralist theoretical perspectives has proved to be extremely productive, and psychoanalysis has been refashioned to encompass a multiplicity of issues and political perspectives. For example, it will be argued that the encounter between psychoanalysis and feminism generated new political and therapeutic insights, and challenges. Moreover, it will be argued that the revision of psychoanalysis in the wake of post-structuralist and postmodernist theory has opened up a reflective space for understanding the intersections between identity, culture and
politics. The aim of these latter developments is to make psychoanalysis more relevant and useful to modern societies and lifestyles.

1.5.1. Marxist engagements with psychoanalytic theory

Critiques of psychoanalysis have arisen from numerous disciplines and political movements over recent decades. The growth of New Left politics in the West during the 1960s, and the concomitant emphasis on exposing inequalities within society, provided the context for a turn to psychoanalytic theory by Marxist and feminist authors (e.g. Brooks, 1973; Mitchell, 1974). As the following sections seek to demonstrate, these writers advanced an argument that 'psychological problems' presented for psychotherapy were typically a psychic expression of social pressures and tensions, rather than psychopathological in origin. Thus, psychoanalysis was analysed anew as a consequence of a merging with the political disciplines of socialism and feminism.

During this period, Marxist critiques of psychoanalysis were driven by the key conceptual force of a presumed political irrelevance of psychoanalytic theory and practice for society. Thus, psychoanalysis has been commonly criticised by Marxist writers as a 'bourgeois discipline', opposed to radical activity. For example, as Timpanaro (1976) argues, psychoanalytic theoreticians and practitioners have been guilty of ignoring the obvious explanations behind emotional and psychological phenomena. The explanations for the latter, as he argues, are seen as residing in the social fabric of people's lives, that is, in the material circumstances of persons and the
social context of class divisions. Psychoanalysis relies instead on something fundamentally unknowable and mysterious. He makes the following comments:

*While the accusation of pansexuality often levelled at psychoanalysis is largely wide of the mark, the charge of psychologism is ... much more accurate. The preferred explanation is always the most tortuous and complicated, and thus the most 'misanthropic' (Timpanaro 1976: 178).*

Thus, psychoanalytic theory systematically obscures the social base of human life & depersonalises the individual, depicting 'human behaviour as the manifestation of the play of forces of the unconscious and id, ego, super-ego, rather than as a meaningful act revealing the world' (Brooks 1973: 334). Furthermore, these perceived failures of psychoanalysis can be accounted for by situating the body of theory within its socio-historical context. Henceforth, as argued by Timpanaro (1976), the traditional practice of psychoanalysis has been incapable of seeing beyond an "ideological" horizon delimited by the class interests of its bourgeoisie roots (1976: 12).

In part, it is argued that these criticisms derive from the ways in which psychoanalysis has historically been applied. For example, from the dismissiveness with which analysts have sometimes greeted political action (Gordon, 1995), from the moralism implicit and explicit in psychoanalytic therapy and from the use made of some analytic therapies apparently to explain away oppressive practices, for instance father-daughter rape (Masson, 1992).
These arguments therefore constitute a powerful indictment of purely intra-psychic 'causal' explanations for psychological difficulties and emotional distress, which have characterised traditional psychoanalysis. Furthermore, when taken in conjunction with the various feminist and post-modernist positions that have emerged within psychoanalytic theory, and which will be explicated in the following section, they have provided psychoanalysis with a different platform for formulating appropriate responses to individual distress.

1.5.2. Feminist and social constructionist engagements with psychoanalytic theory

Left-wing politics also provided the context for a turn to psychoanalysis by feminist theorists. The fundamental goal of the latter theorists is to problematize and analyse gender, which includes attention to how gender is constituted, how it is experienced and how we think or do not think about it. Juliet Mitchell's book, *Psychoanalysis and Feminism* (1974), and her claim that 'a rejection of psychoanalysis and of Freud's works is fatal for feminism' began the appropriation of psychoanalytic therapy by feminist writers and therapists. Prior to this, early feminist critiques of Freudian theory made originally by Simone de Beauvoir in *The Second Sex* (1949), and then later by Germaine Greer in *The Female Eunuch* (1970), had derided Freud as 'phallocentric' and thus as legitimating women's social subordination (both cited in Mitchell, 1974). Indeed, numerous examples can be found within Freud's writings of his negative view of womanhood. In his 1925 paper, 'Some Psychical Consequences of the Anatomical Distinction between the Sexes', he asserts that it is because of the relative weakness of the female super-ego that women never possess as developed an ethical awareness as do men. As discussed in an earlier section, Freud is referring here to his highly
contentious theory of the female Oedipus complex, in the grip of which girls are seen to remain for a long period of time, and, indeed only ever leave it incompletely and with difficulty. It is for this reason that girls are described as having *weaker* super-egos.

Indeed, as set out by Mitchell, Freud's definitions of womanhood are synonymous with the following characteristics: 'masochism', 'passivity', 'vanity', 'jealousy' and 'a limited sense of justice' (1974:113-118). Thus, women are held by Freud to be intellectually inferior to men and are instead viewed by him as the representatives of the negative attributes of emotion and sensuality. However, as Frosh (1987) argues, these latter female attributes, although characteristically patriarchal and biologically reductionist, have allowed a feminist revaluation of Freudian theory by the likes of Juliet Mitchell.

The basis of Mitchell's (1974) sympathetic reading of Freud is a cultural analysis of his theories regarding femininity. The argument here is that Freudian notions such as 'penis-envy' are in fact metaphors and that what is symbolised by this concept, for example, is the girl's growing realisation that she is cut off from the sources of power in society. Like the critical eye cast on psychoanalysis by Marxist theorists, she argues that Freudian psychoanalysis as it has been popularised can rightly be criticised as guilty of perpetuating a bourgeois and patriarchal ideology, and in particular the subordination of women. However, it is the way in which Freudian theory is applied in practice that is crucial. Though psychoanalysis may be understood and applied as if it were prescriptive for patriarchy, it actually offers the tools for an analysis of the
symbolic forms through which patriarchy and gender roles are internalised (Mitchell, 1974).

This early engagement with psychoanalytic theory by feminist authors during the 1970s reflected the shifting concerns of the Women's Liberation Movement and feminist theory. Psychoanalysis therefore came to be acknowledged by some as potentially providing the conceptual tools for exploring the internalisation of patriarchal ideology (Warner, 2000a). However, not all feminists have been able to accept the position of Mitchell. For example, as Nancy Chodorow argues, there are limitations on the extent to which Freudian theory can be understood as descriptive of the real world under patriarchy, rather than as advocating a sexist ideology (Chodorow, 1989).

Chodorow (1997) articulates the specificity of female subjectivity and desire, suppressed and devalued under patriarchy. Further, she criticises the widespread view that gender differences are essential, that women are fundamentally different to men, and that these differences must be recognised, theorised and maintained. Therefore, in Chodorow's view, gender difference does not involve an *essence* of gender. As she argues, gender differences and the experience of difference, like differences among women, are socially and psychologically created and situated. She therefore advocates a rereading of psychoanalytic theory that stresses the relational ego and which emphasises the structuring forces contained within society and internalised through relationships with others (Chodorow, 1989). The crucial implication here for psychoanalytic practice is that the psychic structures that underpin patriarchy can be altered and transformed.
Further developments within feminist psychoanalytic theory have therefore taken two broadly divergent routes. The first group, heralded by Juliet Mitchell, are indebted to Lacanian psychoanalysis and are concerned to deconstruct gender terms with reference to the symbolic, that is, language. Lacanian feminists have therefore highlighted the links between language and the patriarchal symbol of the phallus as the signifier of difference (Flax, 1990) The other approach to feminist psychoanalytic therapy has adopted object-relational frameworks for women and, as such, is committed to the analysis of sexuality and gender, against the backdrop of interpersonal relations (e.g. Chodorow, 1978, 1989; Eichenbaum & Orbach, 1982; 1995).

The object relations approach in feminist theory and therapy accords prime importance to the early mother/child bond, that is, the pre-Oedipal period, in determining the development of an emergent psychic structure, sense of self and of gender (Orbach & Eichenbaum, 1995). These theorists are therefore concerned with the construction and reproduction of gendered subjectivities within the person's internal psychic world and their external social world, as mediated through the mother-infant bond. Feminists drawing on object relations theory focus on the child's powerfully ambivalent feelings towards the primary love object of the mother, in order to attempt to trace dominant social constructions of femininity in contemporary culture (Heenan, 1998). Therefore, the existence of psychic life, as a powerful determinant in the politics of everyday experience is not denied within the feminist object relations framework. Indeed, it is seen as an integral part of the woman's experience. However, feminist psychotherapy rejects any view of self which is conceived outside of patriarchal culture; rather, seeing women's individuality,
personality and reality as shaped by the material world and as currently influenced by it.

Thus, as Taylor (1990) argues, the source of women's distress is different to that of men. An understanding of this distress requires looking at what is going on for all women psychologically within the present conditions of patriarchal societal relations. However, since most current theory and practice is imprisoned within this conventional patriarchal ideology, it is inevitable that psychotherapy partakes of that ideology, and therefore that it is permeated by sexism (Heenan, 1998). Therefore, as Flax (1990) argues, despite the centrality of the concept of reciprocity in traditional object relations theory, the mother never appears as a complex person in her own right. Indeed, the mother's own processes are simply isomorphic to those of her child. Thus, as Flax (1990) articulates, the insights of post-modern and feminist theories can, and have, contributed to an improved analysis of these difficulties within psychoanalysis.

Feminist psychoanalytic psychotherapy involves a way of seeing, understanding, and making connections between the psychological state of women and their structural position. Feminist psychotherapy therefore acknowledges and works with the possibility of reality in women's predicaments without denying the existence of psychological process (Eichenbaum & Orbach, 1982). Thus, feminist psychoanalytic therapy deconstructs the interrelationships between the internal, psychological and the external, social world. As has been argued elsewhere (e.g. Heenan, 1996), this focus mirrors that of post-structuralism with its concern with the 'project of subjectivities'.
Post-structuralist theory views modern forms of life as increasingly marked by a kaleidoscopic variety of forces and events. As such, the cultural and institutional processes of modernisation have penetrated the heart of selfhood and created new forms of personal identity. For post-structuralism, contemporary cultural experience becomes permeated by fragmentation and, thus, human subjects are understood to inhabit a world of surfaces, images and fragments, where meanings no longer have any lasting moral value (Burr, 1995). Psychoanalysis has in recent years made significant contributions to these theoretical debates. Social constructionist revisions of psychoanalytic theory and practice have responded to critiques (such as the Marxist critiques during the 1970s) that there is no acknowledgement within the institutional bodies of psychoanalysis of the social & historical roots of the discipline, and that this effects a blinkered perspective in terms of the activity of conceptualising the struggles within people's lives (Samuels, 1992; 1993; Ellis, 1997). Methods of analysis for understanding the connections between cultural trends and new patterns of self-organisation have also been developed and have been used to trace shifting psychic identifications as played out in the cultural sphere (e.g. Ratigan, 1995; Timimi; 1996; Ellis, 1997).

For example, Ellis (1997) argues for a more inclusive and non-prejudicial approach to working with client’s diverse sexual identities. She draws on Foucault’s account of ‘The History of Sexuality’ (1978, cited in Ellis, 1997) to present a historically and culturally situated analysis of sexuality, thus demonstrating how sexual identities resist a-social and a-historical definition in the way that traditional psychoanalytic depictions of homosexuality would suggest, in defining the latter as biological or psychological fact. As described in an earlier section of this chapter, Freudian theory
depicts sexual desire as an initially undifferentiated, innate biological drive that becomes associated with particular objects via the Oedipus complex. Within this scheme, homosexual relationships are defined as arising from disturbed psychosexual development. The implication therefore in working within certain psychoanalytic frameworks with individuals identifying as gay, lesbian or bisexual has been that these sexual identities are incomplete and immature forms (Richardson, 1981a; O'Connor & Ryan, 1993). Hence, in seeking to utilise a psychoanalytic frame in working with individuals identifying as gay/lesbian/bisexual, Ellis (1997) situates the problematic of sexual identity by highlighting the social construction of sexual practices from the eighteenth century to present day.

To conclude, the previous sections have demonstrated how psychoanalytic theory and therapy have increasingly diversified since their original development by Freud. This diversification of theoretical and therapeutic approaches originally reflected an increased awareness of the role of the social sphere in the psychological development of individuals. From the original intra-psychic focus of Freudian orthodoxy, object relations theorists emphasised a two-person approach both in the development of theory and the ways in which these were understood to operate in applying them to therapy. Thus, the contributory role of the therapist came to be acknowledged and worked with within the therapeutic endeavour. More recently, developments within, for example, feminist and social constructionist psychoanalysis have deferred to the external social and political sphere in the interrogation of individual psychic development. As such, they emphasise the structuring forces of psychological development as deriving from inter-subjectivity, whereby the political forces that exist
within society and which position people in specific ways enter into the individual psyche via relationships with others.

However, this study takes as its specific focus the phase of therapy referred to within the literature as ‘termination’. For reasons of economics it was not possible within the scope of this study to examine client and therapist constructions of the process of psychotherapy in its entirety. Also, it was the process of therapy coming to an end that specifically interested the researcher. Further, it is an aspect of psychotherapy that is often marginalized within the literature in favour of descriptions of processes of therapeutic engagement.

1.6. The process of termination

1.6.1. Defining termination

Termination describes the ending of something, for example, the ending of therapy. It is the term that has traditionally been employed within the psychoanalytic literature to describe the ending phase of therapy. Following a 1938 survey of members of the British Psychoanalytical Society, Glover (1955, cited in Novick, 1982) proposed the addition of a formal, well-defined terminal phase in therapy, which originally led to the tripartite psychoanalytic process. He wrote, “...unless a terminal phase has been passed through, it is very doubtful whether any case has been psychoanalysed” (1955:140). Indeed, prior to Glover’s theorising on the importance of an identified termination phase, psychoanalysts had been ending treatment as each one saw fit.
Freud (1937) wrote that setting a termination date appeared to accelerate change in some cases, however he did not introduce the concept of a terminal phase. Hence, following Lorand's (1946 cited in Frank, 1999) comment that psychoanalysts knew very little about termination, psychoanalysis began to turn its attention to clarifying when and how to terminate. Thus, a steady stream of papers began to appear dedicated to the discussion of this area, many of which also attempted to delineate the meaning of, and reactions to, termination for clients (e.g. Balint, 1950; Buxbaum, 1950; Loewald, 1962; Ekstein, 1965; Panel, 1975).

Termination has been categorised in the literature as either mutual, unilateral or forced (e.g. Fieldsteel, 1990, Garcia-Lawson & Lane, 1997). The latter category includes endings that are not planned and occur, often prematurely, as a result of extraneous factors in the client's, or therapist's, life. Forced terminations also include the abrupt ending of therapy due to the illness or death of the therapist or client.

In particular, the working through of the mutually agreed termination has often been discussed (e.g. Firestein, 1978, Dewald, 1982) and although termination in all its forms has predominantly been regarded as a loss experience, planned, mutually agreed endings are considered to be the ideal (e.g. Golland, 1997). Premature termination initiated by the therapist is considered to be the most problematic for both client and therapist, and various anecdotal client reactions have been cited, such as "catastrophic anger, grief or disillusionment" (Elkind, 1995: 331).

One of the major differences outlined in the literature between forced and planned endings is that "if termination is premature or forced by circumstances, the client
experiences more anger, regression, and narcissistic injury" (Fortune, Pearlingi & Rochelle, 1992: 171). Interrupted treatment, it is argued, also differs from planned and forced termination in that there is no time to process the termination. This research is concerned with the experiences of clients and therapists in the course of planned or mutual endings and the literature on forced termination is therefore not within the scope of this literature review, although inevitably there will be some overlap.

However, given that therapy and the process of termination are socially situated, these absolute distinctions represented within the literature are likely to be much more complex in practice and warrant further investigation, utilising methods that allow for this complexity to emerge.

1.6.2. The criteria for termination

This section will examine the literature that has sought to identify those criteria to be utilised by therapists to determine the timing of termination within the psychotherapeutic process. The criteria for termination are naturally bound up with ideas about the nature of emotional health and the goals of the particular therapeutic model in use. It was within the boundaries of psychoanalytic theory and therapy that termination was first given consideration, and thus the concept of termination has a greater history within psychoanalytic and psychoanalytically derived literature, thought and practice. Criteria suggested in the literature as markers for determining termination thus reflect the therapeutic goals and theoretical discourse of psychoanalysis.
The writings of Freud (e.g. 1913, 1937) made reference to the significance of termination. However, they failed to discuss the criteria, characteristics and management of the ending of an analysis (Frank, 1999). The closest Freud came to providing some guidelines for termination for his followers were his ideas that treatment was brought to a close when the unconscious became conscious and when id was replaced with ego (Freud, 1933a). Symptomatic relief, a sense of wellbeing, an understanding of the unconscious conflicts and their derivatives, and improved personality organisation and functions constituted the criteria for the ending of analysis (Blum, 1989). However, these process and outcome goals were expected to be achieved gradually without the need for a terminal phase (Hurn, 1971). Ferenzi in his paper, “The Problem of Termination of Analysis” (1927 cited in Frank, 1999), wrote that, “the proper ending of analysis is when neither the physician nor the patient puts an end to it, but when it dies from exhaustion” (1927:85).

One of the criteria for ending which appears in the psychoanalytic literature is that of symptomatic improvement (e.g. Nunberg, 1954 cited in Firestein, 1978; Dewald, 1972; Panel, 1975; Siporin, 1975 cited in Kramer, 1986). Wolberg (1972) stated that most patients regard relief of symptoms as the best measure of positive gain, although he cautioned that practitioners should not accept this as a reliable index of therapeutic success. The utility of symptom disappearance as a sole criterion has been questioned (e.g. Firestein, 1978) on the basis of such phenomena as flight into health or transference cure.

*Flight into health* refers to a rapid subsidence of symptoms, which is not explainable on the basis of the therapeutic experience. *Transference cure* again refers to the
prompt disappearance of symptoms but the reasons for this occurrence are regarded as bound up with the client’s transference towards the therapist (Firestein, 1978).

_Transference_ is the term that is used within psychoanalysis to describe the way in which the client perceives and responds to the therapist and the reactions he/she unconsciously provokes. This process is seen as being influenced by the tendency to see the relationship with the therapist in the light of the client’s earliest relationships, and unconscious attempts to try to engender replays of early difficult situations. What the client _transfers_ onto the therapist can also represent a replay of how an early relationship had been wished for. Thus, _transference cure_ may be a consequence of transference wishes to please the therapist, identification with the idealised therapist or transference fears of emotional attachment with the therapist (e.g. Shechter, 1993), rather than due to the resolution of the original conflicts that brought the individual into therapy. More recently the views of practising analysts regarding symptomatic improvement have moderated and a mitigation or tolerance of symptoms is favoured along with the addition of other criteria determining termination (e.g. Garcia-Lawson & Lane, 1997).

Other criteria for termination variously apparent in the psychoanalytic literature have been summarised by Firestein (1978: 226-227) as follows: symptoms have been traced to their original conflicts and the infantile neurosis has been identified as insight developed; object relations have improved and are free from transference distortions; penis envy and castration anxiety have been mastered; the ability to distinguish between fantasy and reality has been sharpened; acting out has been eliminated; the capacity to tolerate some measure of anxiety has improved; sublimations have been strengthened; the capacity to experience pleasure without guilt or other inhibiting
factors has improved; the ego has been strengthened; working ability (which is viewed as being inextricably linked with many aspects of ego function, libidinal and aggressive drive gratification) has been enhanced. Some authors have emphasised one or other of these criteria, however, according to Firestein, for a majority of the 30 published works that he reviewed there was overall agreement that a combination of these structural criteria can be used as markers for termination.

Most of the available termination literature from a psychoanalytic perspective emphasises the importance of reviewing the transference situation in determining the appropriateness of termination. However, some authors have particularly advocated this approach (Levenson, 1976; Levy, 1986). Levenson, for example, suggested that the client should be able to view the therapist, "as a real person, not simply attacking him or forgiving him as a failed parent but bringing a loving and constructive effort to engaging him and changing him" (1976: 340). Ferenzi (1955 cited in Kramer, 1986) argued that by the time of termination, the client should be able to relate to the therapist in a less subordinate manner and stop idealising or depreciating him or her.

Gold (1996) has however commented that resolution of the transference neurosis is difficult to appraise prior to termination and is thus not a reliable indicator for termination. Firestein's (1978) survey of psychoanalytic therapists concluded that many of the real effects of analysis would only be observable over time and not readily apparent at the end of treatment. This seems to suggest that despite attempts to delineate the criteria thought to indicate the appropriate timing of termination, the decision to terminate can only be arbitrary at best. Gaburri (1985) has suggested that criteria for termination are unnecessary and do not exist. However, it can be argued
that as a purposeful intervention in someone’s life there needs to be some criteria available to guide the client and therapist in deciding when therapy can appropriately be brought to an end.

This section has thus demonstrated that a variety of criteria have been advanced with the intention of providing guidance for the therapist in determining the appropriate time to begin considering termination. The following section therefore seeks to explore the tasks and techniques of termination variously described within the psychoanalytic literature.

1.6.3. The tasks and technique of termination

This section will review the literature that has sought to provide guidance to psychotherapists in approaching and working through the process of termination. It will be argued that whilst there is a sizeable literature available which discusses the criteria to be utilised when deciding on the timing and appropriateness of termination, there is little available to the therapist who seeks direction in how to approach this period of therapy. In particular it will be argued that one of the potential influences on the way in which psychoanalytic therapists approach termination with their clients is likely to be their personal experience of termination within their own experiences of therapy.

According to Kramer (1986), little work has been done on developing theoretical and practical frameworks to guide the therapist in the termination of open-ended psychotherapy. This is a view that has recently been echoed by Frank (1999).
Nevertheless, numerous psychoanalytic papers are available which discuss a variety of techniques utilised within the practice of bringing analytic psychotherapy to an end (e.g. Levy, 1986; Garcia-Lawson & Lane, 1997). Garcia-Lawson & Lane (1997), for example, discuss the idea that the termination period should include sufficient time for the client and therapist to experience, work through and resolve the transferences and their reactions to termination. This view is echoed elsewhere (e.g. Levinson, 1977; Frank, 1999). The term *working through* appears to be utilised within these papers as a way of conceptualising the process of bringing the client's transferences regarding the termination into consciousness and into the therapeutic arena and then addressing the origins of these and allowing the client to experience their emotional impact. *Working through* is seen as a process necessitated by the powerful emotional reactions provoked by termination, which, as the next section will demonstrate, are predominantly characterised as those pertaining to the experience of loss. According to Ekstein (1965), the process of *working through* helps the client to gain insight into his/her transference feelings and facilitates the process of replacing "neurotic" thinking with realistic appraisals of the task of termination.

In a 1982 survey of the termination practices and views of twenty psychotherapists in private practice, Kramer (1986) found that most of the therapists he interviewed believed that the client should initiate termination, although this expectation on the part of the therapist was not routinely communicated to the client. Indeed, much of the literature on the techniques of termination suggests that the idea of termination is something that typically occurs to both therapist and client at approximately the same time and is therefore not seen as something that necessarily needs to be addressed explicitly (e.g. Levy, 1986). Commensurate with this view, Kramer discovered that
termination was seldom discussed explicitly at all during treatment by the therapists interviewed, and most did not report any means by which they prepared clients for the timing and method of mootong the ending of therapy. Kramer (1986) has thus argued that such a lack of explicit direction is likely to make this aspect of the therapeutic journey an ambiguous one for clients. Furthermore, taking into account the fact that the therapeutic relationship as traditionally enacted within psychoanalytic therapy is characteristically hierarchical, it can be argued that unless the therapist's expectations of the client are made explicit then clients are unlikely to raise the idea of ending.

The therapists in Kramer's study justified their lack of explicit direction to the client as a necessary part of the development of autonomy by the client. A circumstance within which therapists reported having initiated termination was where the client was deemed to have achieved maximum benefit from therapy but had not initiated termination of their own accord. A further situation where therapists reported that they had initiated termination involved strong counter-transference reactions to the client, where it was felt that the therapy could not beneficially continue.

Kramer's findings led him to make the following recommendations to therapists:

- Therapists should discuss termination with clients early in the treatment and periodically throughout the length of the relationship.
- In order to avoid uncertainty for the client this discussion should include the therapist's expectations of who (client or therapist) should initiate termination.
1.6.4. The meaning and effects of termination

The following section will examine the meanings attributed to termination within the psychoanalytic literature and the inevitable effects that these meanings are seen as stimulating. It will be demonstrated that the psychoanalytic literature has predominantly regarded termination as a loss experience for the client. However, a recent contribution to the literature from a social constructionist perspective has debated the validity of this view and this will be examined. Finally, it will be argued that the available literature on the meaning of termination for individuals is written solely from the perspective of therapists and therefore there is a need to represent the experiences of the client in this area of clinical importance.

Within psychoanalytic approaches to therapy, the relationship between client and therapist is held as the medium through which change occurs, and thus the meaning of termination for the client, and to a lesser extent for the therapist, has been discussed and emphasised. A review of the termination literature reveals the prominent view that a process mirroring that of grief following the loss of a loved one, characterises the termination phase (e.g. Frank, 1999). Thus, the following reactions have been described: anger, rage and narcissistic hurt; then efforts to prolong the therapy through bargaining or demonstrating the need for further treatment; then depression; and finally, if the working through process is successful, acceptance of termination (e.g. Firestein, 1974; Palombo, 1982).

Within the literature, debate has focused on the issue of whether the therapist is mourned in the sense of a real relationship ending or whether the loss experienced by
the client is concerned with who the therapist unconsciously represents, in other words a transference object. Blum (1989) believes the therapist is mourned primarily as a transference object. However, he also acknowledges that a real relationship has developed, characterised by its own unique intimacy, and thus that the loss of the therapist and therapeutic process are experienced. Others concur with this latter viewpoint and argue that the meaning of these feelings reflects the patient's reaction to the loss of the therapist, an important person in his/her psychological life (e.g. Novick, 1982; Shane & Shane, 1984; Blum, 1989; Bergmann, 1997).

Frank (1999) believes that the termination phase holds a special significance in that it presents an opportunity to work on pre-Oedipal material and the symbolic separation from the client's parents, whom he purports the therapist unconsciously represents. Gold (1996), however, believes that termination, and the mourning it entails, are linked to the ultimate renunciation of an infantile position by the client. The impending loss of the relationship is also constructed within the literature as reawakening previous losses and as recreating the separation-individuation crisis (e.g. Levinson, 1977).

The effects of termination described within the literature reflect the presumption that loss is always the dominant experience. Thus, in Firestein's (1978) review of the literature on the subject of termination, one of the effects of termination he emphasises and which has been widely discussed, is what he refers to as, "dramatic symptom exacerbation". This phenomena has been discussed by other writers (e.g. Saul, 1958 cited in Mahrer et al., 1991; Ekstein, 1965) and is seen an example of "nihilistic
flight”, that is, negative ways of avoiding termination (e.g. Northen, 1988 cited in Fortune et al., 1992).

Pedder (1988) has suggested that the concept of termination in psychotherapy and psychoanalysis is inappropriate because of its negative and finite connotations that fail to convey positive hopes for a new beginning. Indeed, issues of separation and grief were not in evidence within Kramer’s (1986) exposition of termination. Furthermore, Epston & White (1992) have provided an alternative to the termination-as-loss metaphor and suggest a rite-of-passage analogy. As they argue, the prevalence of the loss metaphor within analytic psychotherapy may subtly function to reinforce a dependency of the client on the therapist. This is because the termination-as-loss metaphor carries with it a set of concomitant practices such as an increase in interpretations during the termination and a process of working through. Thus, in inviting the client to experience the ending of therapy as one of loss, the therapist also invites the dependency of the client on the mystified, ‘expert’ knowledge they are seen to hold. Thus, Epston & White (1992) argue that in defining termination as an experience of loss, the psychoanalytic literature has eclipsed from view alternative and perhaps more fruitful ways of conceptualising and facilitating the termination.

1.6.5. Therapist reactions to termination

This section will examine the literature that has sought to investigate the reactions of therapists to termination. It will be demonstrated that very little has been written in this area and it will be argued that what literature is available is located firmly within the therapeutic encounter and does not therefore take account of the therapist's
situating circumstances or, indeed, the interaction between the client and therapist's cultural backgrounds. Furthermore, despite developments within the general psychoanalytic literature that emphasise the therapeutic relationship as enacted inter-subjectively, a significant proportion of the termination literature would still have us believe that although therapists experience counter-transference feelings (significantly, these feelings are described as being provoked by the client) they are impervious to other feelings. For example, personal feelings of inadequacy or anxiety brought about by financial difficulties. Given that many therapists are also clients in other settings this section will also highlight the absence within the literature of the therapist experience of the ending of their own personal therapy.

Gold (1996) has noted the changed conceptualisation of the therapeutic encounter from the early concept of an essentially one-person approach (the focus being the client as described by the therapist), with its concentration on transference issues and their resolution. He defines the current field of study as that of the two-person system with an emphasis on an appreciation of the varieties of counter-transference experience of the therapist (e.g. Semel, 1985). Indeed, he argues that previous to this shift in psychoanalytic thinking, the experiences and emotional reactions of the therapist either in the context of the ending of their own personal therapy, or in the multiple endings with their clients would not have been considered relevant to their role as therapist. However, as demonstrated previously in this introductory chapter, contrary to Gold's view, in certain quarters psychoanalytic theorising and practice is now constructed around the inter-subjectivity of client and therapist. This shift towards a more social and political psychoanalysis does not therefore seem to have permeated the psychoanalytic literature that takes as its specific focus the termination.
As Gold (1996) has suggested, other therapies have perhaps been aware and emphasized within their practice the interactive nature of therapy, such as the ‘collaborative empiricism’ of Cognitive-Behavioural therapy (CBT). However, in the case of the CBT model this does not seem to have necessitated the therapist looking internally to investigate what they are bringing to the therapeutic encounter. Therefore, within certain contexts where therapy is enacted, the therapist is still held to be the emotionally healthy model for the client and the therapist’s own emotional life and vulnerabilities still do not appear to be considered relevant to the therapeutic relationships of which the therapist is a part.

However, within certain studies, and, in particular, the study conducted by Viorst (1982), attention has been drawn to the similarity in the reported range and intensity of feelings within termination to those hypothesised to be experienced by clients. Viorst conducted interviews with twenty analysts, the majority of whom stated that most terminations evoked a sense of loss for them. This included feelings of sadness, loss, anger, and re-experiencing of previous losses. Indeed, Martin & Schurtman (1985) contend that an incomplete separation from parents may cause anxiety, particularly feelings of abandonment, when the therapist is faced with the client's leaving.

It can be argued, however, that whilst the reporting of such studies has clearly contributed towards the acknowledgement that psychotherapy is enacted in a social context, they fall short of situating the termination within its wider and current socio-political context. The therapist experiences that are often highlighted are those that occur within therapy and are either seen as provoked by the client or as referring back
to the therapist's unresolved feelings pertaining to relationships with parents. This work is, however, important because the unresolved feelings of the therapist may indeed interfere with the process of ending therapy and may complicate the process for clients (see Treacher, 1989). However, the situating social context of the therapist may be equally important, if not more important in accounting for both the client and therapist's experiences of ending. Moreover, it can be argued that these accounts still serve the interests of orthodox psychoanalytic establishments as they function to reinforce the theories on which traditional approaches to psychoanalytic psychotherapy are based. For example, in highlighting what are constructed as counter-transference reactions to termination these accounts reinforce the utility of abstract concepts such the transference and counter-transference. In addition, in emphasising a hypothesised link between the therapist's reactions to ending with a client and unresolved issues with the parents of the therapist, the absolute assumption on which psychoanalytic theory is based, that the family is the crucial site of socialisation, is also reinforced as a 'truth'.

1.7. A critical analysis of the literature and rationale for the study

Taking a critical look at the literature reviewed in this chapter, it is clear that although psychoanalytic theorising has progressed in a variety of politically useful ways and has therefore acknowledged that therapeutic practice is a socially situated endeavour, the termination literature itself fails to emphasise the ending of therapy as the socially negotiated phenomenon that it is. Therefore, as has been demonstrated in the literature review, only the accounts of therapists are available to us should we wish to understand how the ending of therapy is understood and experienced. These accounts
thus resonate with the idea of an index patient under the gaze of and subject to the
d judgement of the expert. Thus, it can be argued that the termination literature is
representative of, and reproduces, historical relations of dominance in that only those
deemed as belonging to the 'knowledge' class have the authority to speak about a
given area (Foucault 1977; 1981 cited in Burr, 1995). Because of the powerfulness of
these dominant accounts, avenues for investigating the experiences of clients in
relation to the termination have therefore likely been closed down.

As Kruger (1986) has highlighted, the vicissitudes of the client are usually given in
detail in the standard descriptions, case histories and papers written by therapists and
theoreticians, but the client is rarely given the opportunity to explicate his/her
experience of the therapist and the therapeutic situation. The client's reflections on
what happened and how he/she experienced the various themes of psychotherapy, in
this case termination, are not systematically used to arrive at an understanding of what
therapy is. These absences are therefore likely to continue to reinforce the notion that
therapists are the experts and that they are in the best position to describe the
experiences of their clients.

In recent times the significance and meaning of termination for clients has been
debated (e.g. Quintana, 1993) and the termination as loss discourse has been
challenged, as this literature review has highlighted. It can therefore be argued that the
powerfulness of the discourses contained within the psychoanalytic theory of
termination invite and privilege particular experiences and subjugate or overlook
others. Hence, the available literature on termination does not adequately address the
potential complexities, differences of experience and meaning of termination from the
perspective of those who therapy is meant to serve. Thus, one of the aims of this study is to attempt to redress this balance and expand on the descriptions of termination provided in the literature.

Furthermore, as has been demonstrated earlier in this chapter, additional gaps exist in the available literature on the subject of termination, in the area of therapist experiences. Whilst psychoanalysis was defined by an intra-psychic approach, therapists traditionally overlooked their own influence within the therapeutic equation and the social influences acting on them. The influence of the therapist on the work of therapy and the social and political factors bearing on them were unseen. However, as this review has sought to demonstrate, psychoanalytic theory and therapy has, in certain contexts, been applied for social and political ends. As such, many psychoanalytic therapists are concerned to take account of both the internal world of their clients and the social world that situates them. However, these developments are not represented within the psychoanalytic termination literature. Hence, the literature does not discuss external issues impacting on the termination such as therapist gender, racial identity, sexuality, social class, experiences of training, perceptions of role, issues to do with therapist status and funding, or indeed payment for therapy. For example, financial incentives may be one reason why therapists practising psychoanalytic psychotherapy outside of the NHS prolong therapies with clients.

In addition, a potentially important area neglected by the literature is the context of training therapy, which is a requirement of psychoanalytic therapists. Hence, termination may arise because one’s training has come to an end and not because symptom alleviation has occurred or the transference has been resolved.
A limited literature explores the therapist's emotional responses to termination in the context of the ending of therapy with their clients. However, Novick's (1997) comments on the negative reactions which he received after he published an account of his own emotional response to termination illustrates the institutional resistance to therapist admissions of sentience. The literature available within this area has enabled more of an understanding of the way in which the therapist's counter-transference and reality-based reactions can interfere with the ending of treatment (e.g. Dewald, 1982; Novick, 1982; Viorst, 1982). Therefore to some extent this limited research echoes the developments that have recently occurred elsewhere within psychoanalytic theory in defining psychoanalytic therapy as an inter-subjective approach.

As already mentioned, a further gap in the literature arises out of the recognition that therapists are often clients too. Of course not all therapists or clinical psychologists will have had the experience of personal therapy and certainly personal therapy is not a prerequisite for either clinical psychology training or further specialist training in cognitive, behavioural or cognitive-behavioural therapies. However, psychotherapeutic training in psychoanalytic models requires that the training therapist be in personal therapy for the length of their training. Therefore, whilst psychoanalytic practice necessarily accords a very large level of importance to the need for the therapist to place him/her-self in the position of client, the literature does not give credence to these two different perspectives. Thus, in the same way that the client perspective on the experience of termination is lacking, so also is the therapist as client perspective of the experience of termination.
Blum (1989) is one of very few individuals writing of termination who has cited the therapist’s own experience of the ending of his/her therapy as crucial to their future practice as therapists. The therapist’s personal experience of termination with themselves in the position of client may thus be viewed as deterministic, and is seen by Blum as one of a range of models which will influence the therapist’s ideas about how to conduct termination and what to focus on with the client. What is not clear from the literature then is the role that the therapist’s experience of termination from personal therapy plays in the way that they construct ideas about termination within their practice.

References to therapist’s personal experiences of therapy seldom appear in the literature, however, when they do, the experience is labelled as a *training* therapy (e.g. see Blum, 1989). Clear differences between a *training* therapy and a *normal* therapy can indeed be identified, such as the tendency for therapists to have post-therapy contact with their ex-therapists over a prolonged period, where the dynamics of the relationship are transformed (Novick, 1997). Depending on what model is being applied within therapy a normal client may have follow-up but the boundaries of the therapeutic relationship would still be expected to apply. Therapists in training therapy also have a vested interest in learning the model from their therapist although it could be argued that this also applies to the client who it is hoped will take the model with them when they leave. Despite these contextual differences there are also likely to be great similarities between so-called *training* therapies and *normal* therapies and a focus on training therapies precludes the fact that many practising therapists of whatever persuasion enter personal therapy in much the same way as clients.
Indeed, Blum (1989) has explored this issue and concluded that a therapist’s initial training therapy is likely to attempt to tackle personal difficulties similar to those of clients who seek therapy through the normal channels. They may also engage in repeated therapies for similar motives to many of their clients. This will of course be a very individual thing but the point highlights the richness of experience that is seldom evident within the available literature and perhaps a desire to cast the therapist’s personal therapy in a different light to the experience of the client who is not a therapist. Leigner (1986) perhaps makes an important point when he writes of therapists, “it is time for us to discard the myth of their intrinsically superior mental health”. It therefore seems that therapists have legitimated a lack of open discussion of their own termination experiences and the role of these experiences in shaping how they address termination with clients, through labelling their own therapy as a training therapy.

Importantly, recent developments within psychoanalytic theory and therapy has realised that psychotherapy does not take place within a vacuum, yet the literature on termination remains situated firmly within the therapeutic encounter, rather than within the wider socio-political context within which psychotherapy is enacted (Pilgrim, 1992). Arguably therefore, the termination literature still maintains an emphasis on the individualistic focus of more traditional approaches to psychoanalytic psychotherapy, such as orthodox Freudianism or unmodified object relations frameworks. It is therefore no wonder that the social context in which termination of therapy takes place is subjugated from view within this body of literature.
1.8. Aims of the study

The initial aims of this study are therefore to explore client and therapist narratives regarding their experiences of termination from long-term psychoanalytic psychotherapy, and to explore how clients and therapists understand the process of termination. In other words, this research concerns itself with the variety of ways that termination is talked about by those involved in the process of psychotherapy. In utilising a social constructionist perspective, it is argued that psychoanalytic theory of termination is not an area of knowledge that has been discovered but is an effect of social processes. This research thus aims to engage with a range of understandings of experiences of termination and by doing so acknowledges that all accounts are a valid source of knowledge in their own right. The central aims of this study are therefore:

- To represent and explore client and therapist narratives regarding their experiences of termination from long-term psychoanalytic psychotherapy, and in particular to explore how clients and therapists understand the process of termination.

- To utilise these narratives as the basis for a critical, discursive analysis of the therapeutic context constructed within psychoanalytic psychotherapy.

- To consider the implications of the findings for psychoanalytic theory, therapy and research.

A qualitative methodology was utilised in this study as this best reflected the researcher's purpose in carrying out the research. Qualitative methods emphasise the importance of examining the individual's subjective experiences and how they
understand events in their lives. Rather than relying on experimentation and statistical
techniques, qualitative research facilitates an examination of experiences as
understood through the eyes and words of those experiencing them. Commensurate
with the aims of this study, qualitative research also creates the possibility of forms of
inquiry that can be better integrated with clinical practice.
CHAPTER 2

2. Methodology

2.0. Overview of methodology

In the previous chapter it was established that a qualitative methodology would best meet the aims and epistemology of this study. This chapter will therefore begin with a brief discussion of qualitative research methods and how these compare to quantitative methods. This is followed by an outline of the epistemological framework for the study and the use of interviewing as a procedure within qualitative research. The collection and analysis of data within this study is informed by the approach of discourse analysis. Thus, a discussion of this methodology will be offered and in particular the way in which this was utilised within the present study will be described. Finally, this chapter seeks to provide a detailed outline of the procedures followed in this study.

2.1. Research design

2.1.1. Qualitative approaches to research

The issue of what constitutes quantitative or qualitative methodologies is not a simple one, to which the long and, at times, vociferous history of the quantity-quality debate is perhaps testimony. However, despite this complexity, given space limitations only a brief summary of each of the research paradigms follows. The reader is therefore referred elsewhere for a more comprehensive discussion of these paradigms and the historical construction of their opposition based around notions of what is and is not 'good science' (e.g. Henwood & Pidgeon, 1992; Henwood, 1996; Woolgar, 1996).
Quantitative or experimental methods of research are typically invoked in the service of the natural science approach, which has a long history within psychology. The latter assumes a realist ontology; that is, that there is an objective reality to be discovered and therefore advocates the use of experimental methods as a way of ensuring that ‘accurate’ discoveries are made about the empirical world (Henwood & Pidgeon, 1992). The generation of testable hypotheses that are grounded in theory and the collection and statistical analysis of numerical data (quantification) therefore underpin this approach to research.

In contrast, central to the qualitative research paradigm is an emphasis upon description and the representation of reality through the eyes of the participants. Thus, qualitative research is theory generating and privileges the development of concepts from the data. In this case the data tends to be unstructured and non-numeric and may include interview scripts, written texts and visual material. In a qualitative approach, emphasis is therefore placed on the interpretative study of an issue or problem and the researcher is central to the research process (Banister, Burman, Parker, Taylor & Tindall, 1994). Thus, not only are the views of participants revealed, but so too is the subjectivity of the researcher.

As Kvale (1996) argues, qualitative methods should not be thought of as merely some soft technology added to the existing quantitative arsenal of the social sciences. Rather, he argues the mode of understanding implied by qualitative research involves alternative conceptions of social knowledge, meaning, reality, and truth in social science research.
As discussed in the previous chapter, it was felt that a qualitative methodology would be the most appropriate means of investigating client and therapist constructions of their experiences of the ending of therapy. There are several reasons why this is the case. One reason is the lack of research that has been undertaken in this area, particularly with respect to the client’s experience of termination. Henwood & Pidgeon (1995) argue that qualitative methodologies may be particularly suitable for uncovering and understanding phenomena about which little is known or to gain a novel perspective on well-studied phenomena (Bryman, 1988).

A further reason for utilising a qualitative methodology is that the meaning of experience through the eyes of participants can be more effectively accessed than if a quantitative design were employed (Henwood, 1996). As Kruger (1986) argues, research into the meaning and processes of psychotherapy cannot be elucidated by the quantitative, correlational approaches of standard psychological research. Furthermore, the promise of qualitative research is that it creates the possibility of forms of inquiry that can be better integrated with clinical practice. Although the present study incorporated a semi-structured interview schedule in order to guide the areas covered within interviews, participants were encouraged to elaborate on these areas and to raise areas of importance for themselves. Thus, the flexibility offered by qualitative methodologies allows potential for the emergence of new perspectives and new ways of viewing established contexts other than those privileged within for example, in the case of this study, the institution of psychoanalysis.

The qualitative paradigm encompasses numerous different methodological frameworks and approaches to carrying out research, however within this broad
church there is considerable debate about the relative merits of each method
(Charmaz, 2002). Like the ongoing quality-quantity debate these tend to be anchored
around notions of what constitutes valid forms of inquiry and warrantable knowledge.
Thus, despite constructionist revision, the method of grounded theory has recently
been referred to as a ‘post-positivist’ mode of inquiry (e.g. Stevenson & Cooper,
1997). That is, it is seen by some writers as occupying a position of compromise
between the extremes of the absolute objectivism of positivist inquiry and the
relativism of some constructionist approaches. It is therefore heralded as satisfying
some of the requirements of ‘good’ positivist research and as contributing towards the
undermining of the dichotomy between ‘soft’ qualitative and ‘hard’ quantitative
research. However, whilst this approximation to ‘science’ is perceived favourably by
some, it is also seen as a betrayal of constructionism by others.

2.1.2. Epistemological framework

Social constructionism necessarily stands in opposition to the positivist and empiricist
view in traditional science that the nature of the world (knowledge) can be revealed by
observation, and that what exists is what we perceive to exist. It therefore takes a
critical stance towards taken-for-granted knowledge (Burr, 1995). The interactions
between people in the course of their everyday lives are seen as the practices within
which our shared versions of knowledge are constructed and therefore there is no
given or determined nature to the world or people. Thus, social interaction of all
kinds, and particularly language, is of primary interest to the social constructionist
researcher.
Furthermore, what we regard as ‘truth’ (which varies historically and cross-culturally), i.e. our current accepted ways of understanding the world, is a product of the social processes and interactions in which people are constantly engaged with each other and not of objective observation of the world. We can therefore talk of numerous potential ‘social constructions’ of the world and each different construction invites a different kind of action from people. Descriptions or constructions of the world therefore sustain some patterns of social action and exclude others (Gergen, 1999).

A social constructionist perspective includes the idea that multiple realities and perspectives exist around any one area of experience and therefore addressing a range of experiences, as this research seeks to do, is viewed as particularly important. The aim of social enquiry from a social constructionist standpoint is moved from questions about the essential nature of people or society and towards a consideration of how certain phenomena or forms of knowledge are achieved by people in interaction. Knowledge is seen as something that people do together. Indeed, one example of how psychoanalytic psychotherapy has been socially constructed is revealed in Freud’s withdrawal of his seduction theory, which followed its criticism by the wider psychoanalytic establishment (Owen, 1992).

By adopting a social constructionist epistemology, this research does not seek to prove or disprove the theories which have been expounded on termination and which were critically examined in the previous chapter. It is, however, recognised that these theories represent versions of the experience of termination and are therefore by no means definitive or the truth of termination. By rendering psychoanalytic theories of termination incomplete, this research seeks to expand on the narratives that are
available in the literature on the process of termination. This is achieved by being inclusive of both clients and therapists and by recognising that the different speaking positions which people occupy, within different social contexts, may give rise to different understandings of the area under investigation (e.g. therapists can occupy, amongst others, the speaking positions of therapists and clients). It is therefore anticipated that the findings of this study will locate the process of termination within its social and dialogic context, thus elaborating ways of conceptualising the ending of therapy.

2.1.3. Interviewing as a research tool

Interviews are a frequently employed means of securing knowledge within research practice. Typically, interviews are located within a broader methodological framework, such as a survey or a case study and this framework will generally determine the status accorded the material generated from the interview (Gubrium & Holstein, 2003). Thus, a range of theoretical positions can be adopted when interviews are an integral part of research. For example, a researcher assuming a positivist, realist epistemology may utilise the interview as a means of uncovering 'factual' information. In this case, the interview is likely to follow a structured format, deliberately limiting what the respondent can talk about with the aim of maximising the 'scientific' credibility of the data. Warren (2002) argues, however, that by restricting the range of responses available to subjects or by using grossly inclusive coding categories in subsequent analysis, positivist researchers have been systematically blind to variability. Furthermore, variability is often suppressed by
selectively reading the accounts of subjects in line with a preferred theoretical 'story' (Warren, 2002).

In contrast, in the context of qualitative research methodologies, interview participants are more likely to be viewed as meaning makers (Kvale, 1996). Thus, as with the present study, the epistemology of the qualitative interview tends to be constructionist. A semi-structured interview was utilised as the means of gathering information in this study and interviews were conducted according to an interview guide (see appendices 9 & 10), which focused on certain themes and included suggested questions.

Researchers generally use semi-structured interviews when their aim is to obtain a detailed picture of a respondent's beliefs about, or perceptions or accounts of, a particular topic (Warren, 2002). The method allows the researcher and respondent much more flexibility, as respondents are encouraged to define the important dimensions of a phenomenon and to elaborate on what is relevant to them, rather than being guided by the researcher's *a priori* notions of relevance. In this study, the purpose of the qualitative research interview was to generate and understand client and therapist narratives of the experience of termination from long-term psychoanalytic psychotherapy.

As highlighted by Luff (1999), when people are engaged in interviews, the researcher and respondent speak to each other from varied perspectives and not stable and coherent standpoints. Thus, as the respondent speaks their perspective may shift from one standpoint in their experience to another. Hence, it was acknowledged in the case of this study that during the course of an interview respondents would speak from a multitude of standpoints, such as that of a parent, a client, a therapist, an employee, a
member of an ethnic minority or from the standpoint of being gay. Thus, in the qualitative version of interviewing these perspectives are taken into account by the researcher in understanding the meaning-making process.

2.1.4. A discourse analysis approach

Discourse analysis is an umbrella term for a collection of different approaches to language. However, two broad characterisations of discourse analysis can be distinguished: that which focuses on discourse practices and that which predominantly focuses on the study of discursive resources. For example, the work of Potter & Wetherall (1987) can be located within the latter area.

In Potter & Wetherall’s (1987) application of discourse analysis, the focus of interest is the performative, action-oriented function of language and in this sense language is seen as constitutive and therefore as worthy of study in and of itself. This constructive and constitutive notion of language is differentiated from a traditional, realist view of language as a transparent medium that ‘reveals’ the world as it is to us (Harper, 1995). Further, Potter & Wetherall see accounts as constructed to achieve particular social goals rather than simply representing and expressing intra-psychic events. Because people’s talk is seen as constructed to perform certain actions (not necessarily intentional), attention is directed towards the variability in talk, which reveals that speakers are drawing on different linguistic repertoires (interpretative repertoires). Thus, the participant’s discourse is of interest in its own right, and questions asked of the text are typically of the following type: ‘How is the talk constructed?’ What does it achieve?’
Potter & Wetherall (1987) contend that nothing exists outside of text and therefore that what people say has no relation to either a world outside or a world inside (beliefs, attitudes, feelings). However, the position of this study is that what clients and therapists talk about in the context of interviews does have some ongoing significance and ‘reality’ for them beyond the bounds of that particular constructed context and that it is part of their ongoing self-story. Giorgi (1995) has described this view as reflective of a phenomenological stance.

As in the present study, other discourse analysts (e.g. Harper, 1996) are concerned with the wider implications of people’s talk and therefore take as their focus the effects and consequences that certain accounts may have. The aim here is more political and, as in Harper’s study, links are made between the texts under study and the wider cultural and institutional discourses of which they are a part. This form of discourse analysis acknowledges that some discourses (e.g. those of therapists) are more powerful than others (e.g. those of clients).

In applying a discourse analytic lens to the talk of clients and therapists, the present study therefore seeks initially to generate discourses or narratives pertaining to the primary area of interest to this study, that is, experiences of termination from long-term psychoanalytic psychotherapy. In doing so, these discourses are acknowledged simply as versions of the phenomena under discussion and not therefore the sine qua non of termination. The steps taken in this study in order to generate the discourses is represented in the figure below (see figure 4).
Figure 4: Main steps in the Qualitative Research Process (adapted from Orford, 1995)

1. Have preliminary ideas re: sources & content. E.g. Experiences in position of client and therapist and psychoanalytic literature on termination

2. Collect (relatively unstructured) data. Process of interviews – see sections 2.2.7 & 2.2.8

3. Make record of data in form of text. Process of transcribing interviews – see section 2.2.9

4. Code text into categories. Process of coding & categorising – see section 2.3 & appendix 12

5. Make preliminary interpretations. Process of reading and re-reading initial categories and revising these – see section 2.3

6. Identify core themes or categories. Process of identifying discourses and sub-discourses – see section 2.3

7. Write final account.

One or more further rounds of data, becoming more structured in sampling and/or data collection techniques.

Process of interviewing and coding informed by initial and subsequent findings
Finally, following the generation of discourses and sub-discourses, the next step was to explore which particular power relationships, ideologies and institutions these are supportive of and therefore which realities these discourses privilege, and which they close down (i.e. what discourses were absent from the talk of clients and therapists).

In producing a particular reading of talk or text discourse analysts do not claim to discover truths or even to produce a definitive reading. It is therefore acknowledged that the same text could be read and interrogated in many different ways and therefore the reading that is generated is a constructed *version*. Thus, discourse analysis takes into account the interdependency between the researcher and the researched in the production of versions and, hence, reflexivity is emphasised (Gill, 1996). Hence, openness on the part of the researcher to their interests and philosophical stance, personal experiences and values is advocated so that the basis for a reading of the data is made explicit.

The current study therefore seeks to acknowledge that there are always multiple ways in which any topic, issue or concern is storied into being and therefore aimed initially to generate multiple accounts around experiences of termination. Thus, it does not seek to claim epistemological superiority for the themes that emerge.
2.2. The present study

2.2.1. Reflexivity within qualitative research

From the perspective of constructionism any knowledge of the social world that is created is knowledge produced from one perspective. When we write or talk we are involved in producing versions of events, phenomena and feelings (Adkins, 2002). It is therefore important for researchers operating within the social constructionist paradigm to engage in reflexive examination of their expectations for the study they are conducting as well as their preconceptions and theoretical orientation (Stiles, 1993). It is thus generally expected that the researcher offer some description of their values, history and assumptions to the reader. The aim of this is to enable the reader, consumer or user of the knowledge to gauge the stance of the researcher when appraising the value of a study. However, as Gill (1998:32) observes:

*Papers start with what seems to be little more than a ritual incantation of the identities occupied by the author, with little or no attempt to reflect on the significance of these positions for the research. It is as if by simply stating them one has somehow become reflexive, and eradicated their effects.*

Thus, in seeking to avoid this accusation, the current study addresses the issue of reflexivity in a number of ways. Initially, the following section seeks to provide a basic overview of my experience, perspectives and assumptions in undertaking this study. Included in this overview are three extracts from the research diary kept. As recommended by a number of authors (e.g. Lincoln & Guba, 1985; McLeod, 1996), throughout the study I recorded my general thoughts and feelings regarding the
subject area of the research as well as methodological decisions, expectations, assumptions, observations and emerging themes. As McLeod (1996) has noted, the use of a journal encourages the researcher to externalise the research process and analysis, thus highlighting the researcher’s role in the construction of the findings.

Extracts from the research diary are also provided in the sections on interview construction, interview procedure and data management. The inclusion of these extracts aims to demonstrate some of my thinking as the study progressed and therefore make visible the interaction between myself as researcher, and the material under scrutiny. Section 2.3 provides a detailed account of the process of analysis undertaken. Each stage of the analysis is accompanied by examples of the data that went into the construction and elaboration of categories, and a ‘reflexive box’ that aims to make explicit some of my interpretative processes that accompanied and influenced the analysis as it progressed.

2.2.2. The researcher’s assumptions and interests

I am a 34-year old white, middle-class, heterosexual, female. This study was conducted in order to fulfil the criteria necessary to complete a Doctorate in Clinical Psychology. This was my first experience of using a purely qualitative methodology. Prior to training I had worked in Social Services, NHS and University settings and the research conducted within these settings mainly utilised survey methodologies.

My own personal and professional experience had a substantial impact on the choice of topic area researched and the development of the research questions. Since the
completion of the initial core placement within clinical psychology training I have been aware that bringing therapeutic contact to an end with clients can have its own particular complications. The original placement allocated to me fell through and I was eventually placed within a local adult mental health service under the supervision of a psychoanalytic practitioner. In my experience, this was not a mainstream placement as these tend to be provided in settings strongly affiliated with cognitive-behavioural approaches to therapy. Before gaining a place on the clinical training course I had developed a naive interest in psychoanalytic ideas and therefore was pleased to be given such an opportunity. However, I was aware that the experience I was gaining was very different from that of my peers and at times this left me feeling isolated and undervalued in view of the favoured theoretical leanings of the course.

Although unsupervised in cognitive-behavioural approaches (CBT), I attempted during this initial placement to utilise the latter approach in formulating and working with the issues presented by certain individuals. This allowed me to compare my experience as therapist when attempting to conceptualise and put into practice two quite different ways of working 'therapeutically'. I certainly cannot claim proficiency in either of these approaches, however I began to notice that in the relationships developed within a psychoanalytic framework, as compared to those developed within a CBT framework, stronger affective reactions within the client towards myself as the therapist appeared to be provoked over time. At the time I did not understand why this might be and, rather, was confronted by the immense difficulty of bringing these relationships to an end. This complexity did not only derive from my attempt to manage carefully the feelings of the client, but also derived from the difficulty that I
CHAPTER 2

too experienced in extricating myself from these relationships, and in maintaining my professional boundaries.

Therefore, as a consequence of the latter experience and others, over the course of my learning and development as a clinical psychologist I have come to reflect on the nature of the relationship between client and therapist and the negotiation of power between the two, mediated by the theoretical frameworks we choose to operate in (i.e. cognitive-behavioural, behavioural, psychoanalytic, systemic). However, I have to say that it was not my intention in undertaking the current study to examine the dimensions of power within relationships formed in the context of psychoanalytic 'therapy'. Although it is my suspicion with hindsight that this was perhaps an unarticulated sub-agenda, in prioritising a desired understanding of client experiences of ending therapy.

I have also been aware that the ways in which the client and therapist approach and address the ending of therapy impacts on how it is experienced and the emotional valence of this experience. In drawing attention to the latter point there is also a considerable amount of uncertainty after therapeutic contact ends on how the process has impacted on the client. One way of addressing this uncertainty would be to provide a follow-up meeting, however this has not always been possible within the time constraints of a six-month placement. The research question was thus partly a result of my experiences of the apparent complexity of the ending of therapy, my anxieties about whether I had facilitated endings in the right way and, to my knowledge, only superficial attention to this aspect of our work within the clinical psychology training. When I turned to the literature on endings it came to my attention
that the therapist’s view of what clients experience at this point in the therapeutic process predominates and that the client’s perspective had rarely been sought.

The following extracts are taken from the early part of the reflexive journal that I kept throughout the length of the study and focus on my experience of being in the position of ‘therapist’ and the therapy coming to an end:

**Figure 5: Extracts from the researcher’s journal**

**12th September 1999**
I have been meeting with one of my clients on my adult specialist placement for eight-and-a-half months now, on a weekly basis, and we are now two meetings from the end. Today he mentioned that since I initially raised the issue of ending with him (approximately 6 weeks ago) he has found our meetings particularly productive and helpful. He told me that now when he is attempting to think emotional issues through in his mind he imagines himself in session with me and he addresses the issue in the form of a conversation between us. He said this internalised process helps him to see things more clearly and to explore issues systematically.

**19th September 1999**
My client was again discussing today in our penultimate meeting how he feels that he has taken into himself a process for objectifying the issues that he continues to struggle with. He again mentioned that the approaching end to our meetings has intensified his current emotional experiences and has forced him to look more closely at what is happening within himself and to feel his feelings more acutely. He described this as a “focusing”.

**18th October 1999**
Whilst reading a review of the termination literature (Firestein, 1974), I was reminded again of the closing sessions with my clients on my final adult placement. In the section entitled, “Special occurrences in the termination phase”, Firestein discusses the wishes of clients at the ending of their therapy. He mentions the wish to give the therapist gifts or to leave something behind for fear of being otherwise forgotten. This reminded me of the two clients who brought me gifts in their final sessions, however in retrospect they seemed to signify different things. One of these gifts, a pen, felt like a gift of gratitude. The other gift, an intricately carved Celtic cross, seems to have had more of a symbolic significance and perhaps had more to do with a wish on the part of the client to be remembered by me, or a wish for me to carry him with me in some way. I have to say it worked as well as I have not forgotten him!
Furthermore, as a trainee clinical psychologist who has been involved in personal therapy I am aware that therapists are subject to at least two apparently conflicting stories. A prevalent discourse positions therapists as mentally healthy models for their clients, and a more recent discourse dictates that therapists explore and become aware of their own personal vulnerabilities in relation to their clients. Clearly, the availability of these contrasting discourses through which to interpret one’s experiences can produce uncertainty and confusion for therapists who engage in personal therapy. Is the experience of personal therapy something to be valued and to be drawn on when engaging in therapy with clients, or is it something that stigmatises therapists whilst the practice of therapy continues to position clients as ‘damaged’ individuals? Thus, an observation that shaped the focus of the research is that therapists very rarely mention their own experiences of personal therapy and in particular their experiences of the end of their therapy(s). Thus, one of my assumptions when I began this research was that owing to the discourse that positions therapists as mentally healthy and which still appears to dominate the practice of psychological therapists (clinical psychologists or otherwise), therapists are seldom inclined to reflect on their personal experiences of their therapy.

Personally, I feel that the experience of personal therapy can at times be extremely useful and informative when engaging in therapy with clients. I think that it has helped me to be more empathic, in that sometimes the experiences a client is describing resonate with my own and the issues and feelings that I have struggled with. However, at times this has felt unhelpful and I have experienced a feeling that the boundary between the client’s experiences and my experiences has become blurred. A crucial way in which I feel being in therapy has helped me in my work with
clients is in connecting with the powerlessness that clients may feel in the face of a supposedly all-knowing 'expert' therapist.

Personally, I have sought the assistance of two therapists in the past, one of who worked within a cognitive-behavioural framework and the other within a psychoanalytic framework. On reflection I am surprised to say that I felt least powerful in the CBT-oriented therapy and for this reason I think it was of dubious benefit to me. In part, I think this was linked to the male gender of the therapist and the differences between us in age, in that he was an older man who was obviously experienced in his work. I felt, however that his approach was somewhat jaded and complacent. Knowing that I was at that time on the training course, he assumed that I had done much of what he saw as 'basic' CBT work on myself. He therefore skirted over much of this work and in doing so left me floundering. My experience of the therapist was that he set the agenda over the course of our meetings and therefore failed to acknowledge how powerless I felt. For this reason in particular I began to opt out of the therapy passively and my commitment waned. In a sense this was the only way that I was able to express my alienation from the process. The therapist did not pick up on these feelings and I did not feel able to express them, hence, my lack of commitment led him to suggest that we bring our meetings to an end. I do not recall feeling any sense of loss although I was angry and disappointed at what I felt was his arrogant blindness. I also recall feeling patronised by him and felt that this was connected with the fact that I am a woman and this instantly afforded him power over me, to which I had simultaneously bowed.
My second experience of therapy was much more positive and took place with a female psychoanalytic therapist. I felt much more of a connection to this particular therapist and I am certain that this was to do with being two women together. The process felt much more collaborative and was helpful to me although the dynamic was still a hierarchical one, in that I felt less powerful in relation to the therapist. However, I was not made to feel insignificant and culpable in the way that I had come to feel in my previous experience of being in therapy. The decision to end the therapy was initially raised by the therapist, however I do remember feeling somewhat relieved, perhaps because I had not felt able to raise this myself. This time I was aware initially following termination that I missed our meetings and missed being in her presence as she had offered a sense of safety, containment and acceptance.

2.2.3. Ethical considerations

Ethical approval for the study was sought from the Southern Derbyshire Ethics Committee. Approval for the study was granted on 20th August 1999 however, prior to gaining approval it was necessary to answer some concerns outlined by the ethics committee (see Appendix 1). One of the criteria for inclusion in the study, decided in conjunction with my field supervisor, was that therapists who had agreed in principle to be included in the study should identify one or two potential participants who they deemed to have experienced fairly 'good' endings. As discussed in the introductory chapter, the literature does not represent the view of clients on their experiences of ending from psychoanalytic psychotherapy. Hence, a decision was reached that for the purposes of this study the focus would be on those clients who were deemed by their previous therapists to have ended their therapy favourably. However, it was
acknowledged that this issue was likely to be more complex than a simple judgement made by one's therapist of whether someone's ending had been predominantly 'good' or 'bad' suggested. By including those clients who were deemed to have experienced 'good' endings it was thought that the likelihood of interviews inducing unnecessary emotional distress for participants was reduced. However, the ethics committee urged me to also include clients deemed to have experienced 'bad' endings. The response to this request therefore followed two lines of reasoning (see Appendix 2). Firstly, it was stated that the study acknowledged the complexity behind the distinctions of good/bad, mutual/unilateral/prolonged and that just because therapists thought certain people had a 'good' experience of ending did not necessarily mean that clients would construct their experiences in the same way. Secondly, the reply stated that if indeed these distinctions were valid on some level then in the view of the researcher it would not be ethical to contact clients who had experienced 'bad' endings. A further point was made that it would have been very unlikely that therapists would have consented to contact or include such persons. Indeed, two therapists demonstrated a reluctance to contact clients whom they deemed to have experienced 'good' endings and although one reconsidered but was then unable to identify anyone suitable, the other opted out of this process.

I concluded from these negotiations with the ethical board that the points of disagreement between us were based on fundamental differences regarding what is considered 'good' research and that their concerns reflected a bias towards empirical research. Thus, the conception of the ethical board appeared to reflect a realist philosophy whereas my views in undertaking this research were embedded within a social constructionist framework.
The purpose of producing a lay person’s summary, as well as a participant information sheet (for both clients and therapists) was to inform potential participants as fully as possible about the following issues: the purposes of the research, the researcher’s investment in carrying out the research, what exactly would be expected of them if they decided to participate and what would happen to the information collected via the interviews. In order to further facilitate informed consent, I also offered to meet with participants to discuss the study in more detail if they decided that they needed more information before making a decision about whether to become involved or not. Two therapists and one client opted to meet me in person before agreeing to go ahead with the interviews. However, before the process of interviewing began I realised that the wording of the participant information sheet (see Appendix 4) may have indicated to potential respondents that they would not be asked to comment on their own experiences of therapy. My intention had been to convey the idea to potential participants that they would indeed be asked to comment on their own experiences of therapy, but that if they felt certain information was too private or simply did not want to disclose certain things then that would be perfectly acceptable and, indeed, encouraged. I therefore thought that it was possible I had misguided potential respondents and that it was on this basis that people had opted in to the study. I thus contacted those people who had opted in by phone to discuss this feared discrepancy. However, no-one expressed a desire to avoid discussing their own experiences of therapy and termination, and, indeed, it was because of their desire to talk about their therapy that the three clients had opted to be involved. The therapists that had opted in to the study also had no objections to discussing their own experiences of therapy.
Throughout the study, a key ethical consideration was the maintenance of confidentiality. Although some client and therapist pairings were involved in the study, therapists were not aware whether the client(s) they contacted had volunteered to be involved. Therapists were not asked within interviews to make comment about named clients so it was not possible to trace any of the information obtained through interviews back to any of the clients participating in the study.

Furthermore, in order to protect the anonymity of participant’s audiotapes of interviews were kept in a locked drawer and all identifying information was edited from interview transcripts. Consent forms (see Appendix 11) were shredded following interviews as these contained the names of participants.

I was aware of the potential significance of the interviews to both therapists and clients and that there was the potential that distressing issues might be re-invoked in the process. If participants were to present in distress I intended that my first action would be to offer my support to them. To this end I provided clients with my contact details. I also advised participants that an additional option for obtaining support, should they need it, would be for them to contact their GP, who would then take the appropriate action by either making a re-referral to their previous therapist or a local CMIIT. This measure was agreed with the therapists who took part in the study. Participants were also made aware that the taping of the interview could be halted at their request and reminded during the process of interviewing that they were free to withdraw from the process at any point.
2.2.4. Recruitment and selection of participants

Initial contact was made with psychotherapists through a local NHS specialist psychotherapy service. One of the psychotherapists employed within the service agreed to meet with me to discuss the aims of the research and then took this information back to a weekly team meeting. At that meeting, a number of therapists gave their permission for me to contact them with a view to becoming involved in the study. All of the therapists employed within the service were predominantly engaged in the practise of long-term psychoanalytic psychotherapy. A total of ten psychotherapists were identified to me, all of who were initially contacted by letter (Appendix 6). Enclosed with the letters was a copy of the participant information produced specifically for therapists (Appendix 7). The latter sheet also carried a section where therapists could provide their consent in principle to be included in the study. Of those therapists volunteering their involvement (seven of the original ten), each was requested to select one or two of their previous clients with whom they had completed therapy within the last three years. This task proved to be more difficult than originally anticipated as the majority of therapists discovered that they had not ended therapy with many long-term psychotherapy candidates within that time period.

Psychotherapists who were able to identify one or two names were requested to make contact in written form with the person. In these letters, therapist’s also enclosed a lay person’s summary (Appendix 3), a participant information sheet for clients (Appendix 4), and an opt-in form (Appendix 5) as well as a stamped addressed envelope for replies. The names of clients and any personal information that may have identified
people was kept confidential so that the researcher only became aware of the personal identity of the three clients volunteering in principle to be included in the study.

2.2.5. *Inclusion criteria*

Criteria for inclusion in the study were that individuals should either be a practising psychoanalytic psychotherapist or a client who had ended long-term psychoanalytic psychotherapy therapy within the previous three years. ‘Long-term’ was defined as any therapy over 6-months. In attempting to identify previous clients suitable for interview, therapists were asked to identify those clients whom, in their opinion, had experienced a ‘good’ ending. No other criteria were used to select participants. Originally, the aim was to interview four clients and four therapists, however only three of the six clients identified as fitting the inclusion criteria volunteered their involvement. Thus, the balance was shifted and six therapists as well as the three clients were included in the study.

2.2.6. *The participants*

Nine people, four female and five male, were interviewed in total. Six of these were practising psychoanalytic psychotherapists and three had attended the specialist psychotherapy service as clients and had ended their therapy within the last three years. Each of the previous clients of the psychotherapy service had one experience of therapy and each of these therapies had lasted between three and five years. One of the clients was employed within the probation service, one worked for the local council
and one had trained as a priest but was not in employment at the time of interview. All were located within the ethnic group of white European and one identified as gay.

All of the psychotherapists included in the study had personal experience of psychotherapy, both in the context of training therapies and those sought independently of training. Amongst the therapists interviewed, the minimum number of separate therapy episodes was one and the most was four. Two of the therapists were in ongoing psychotherapy at the time of the interviews. Psychotherapists had a variety of professional backgrounds. Two therapists had a background in nursing, three in clinical psychology and one in social work.

### 2.2.7. Interview construction

Data were gathered using a semi-structured interview. Separate draft interview schedules were designed for the purposes of interviewing clients and therapists (see Appendix 8 for draft interview schedule for clients). The design of these was informed by my clinical experience, my readings of the literature and my own experiences of being a client. These included:

- Experience of ending
- The meaning of ending for the different parties involved
- Participants views about the meaning of ending for others
- Links to other endings such as prior losses
- Negotiation of ending
- Who decides to end/who raises ending
• Activities during the ending phase

• Participant’s feelings about doing the interview

An initial section was included in the schedule referred to as ‘context setting’ questions. These were included as a means of setting the scene for the interview and as a way of establishing rapport. The main areas of questioning aimed to elicit as wide an understanding as possible on the experience of termination. Thus, clients were not only asked for their perspective but they were also asked for their opinion on what other clients and therapists might experience in given situations. Likewise, therapists were asked to answer questions on their experience as a therapist and as a client and they were also asked for their theoretical opinion on what client’s experience during termination. These different levels of asking questions reflected the aim of the study to produce rich, multi-layered data on the experience of termination.

Prior to the beginning of interviews, the draft schedule was piloted with one therapist from the specialist psychotherapy service and one person known personally to me, who had an experience of therapy. Piloting of the interview schedule enabled me to anticipate any difficulties that may be experienced by the respondents, for example, in terms of question wording or sensitive areas and to give some thought to how these difficulties might be handled. A number of modifications were made to the schedule following the two pilot interviews (see Appendices 9 & 10). In particular the length of the original schedule was reduced by substituting questions with ‘signposts’. These were intended to offer brief reminders of the questions I wanted to ask and of areas that may arise. The use of ‘signposts’ also ensured that I was less constrained by the questions on the schedule and more able to follow the lead of the interviewee.
As interviews progressed, consistent with the model of qualitative research shown in Figure 4, I followed up areas of interest and cogency from the initial readings of transcripts from early interviews. This technique was similar to that outlined within descriptions of grounded theory method where it is referred to as 'simultaneous data collection and analysis' (e.g. Charmaz, 1995; 2000; 2002). Therefore, ideas of what the interview should cover changed and developed as the interviews progressed (see Figure 6).

Figure 6: Extract from research diary reflecting the iterative process of interviewing

4th October 1999
Following on from my thinking the other day after I had interviewed therapist three, and regarding the theme of avoidance, this is an area that has emerged in all of the interviews so far. In the context of interviews with therapists the issue of avoidance is flagged up as an important area of concern for therapists themselves in that they often find that it is not only the client that is attempting to prolong the therapy and avoid the ending. Thus, avoidance is not a single concept but there appears to be client and therapist avoidance and these are conceptualised in different ways as involving different processes. Indeed, client avoidance is more likely to be described as indicative of underlying pathology and dependency needs but does not appear to be constructed in this way when therapist avoidance is being discussed. The theme of avoidance also emerged in a discussion I had with my field supervisor. My thinking has been elaborated, at least in part, by the process of cutting up the interview transcripts. It occurred to me that perhaps many psychoanalytically trained therapists have difficulty with goodbyes, which perhaps may explain why they gravitate towards a model of therapy traditionally characterised as 'long-term'. It is only conjecture but if this were the case then perhaps the literature on termination that addresses the client's experience of termination also contains the projections of therapists in that perhaps they often do not own their avoidance of termination but project this onto the client.

2.2.8. Interview procedure

All the therapists opted to be interviewed at the premises of the specialist psychotherapy service. Two clients opted to be interviewed at their homes and one
client opted to be interviewed on the premises of the psychotherapy service.

Participants were initially provided with the relevant participant information sheet to read prior to beginning the interview and were encouraged at that point to ask any questions that they may have had. At that point a consent form (Appendix 11) was handed to participants so that written consent could be obtained for the process of taping and transcription of the interviews. Once again it was stressed verbally to participants that they were free to withdraw from the study at any time and that if they did not wish to answer questions regarding their personal experiences of therapy then they did not have to do so. This procedure within the current research has been acknowledged in an earlier section (2.2.3) as problematic.

Interviews were between 1-2 hours in duration. The interview was guided by the schedule rather than dictated by it so that areas of interest to me and areas of importance to the participant could be explored in depth. The aim in doing so was to enter the psychological and social world of the respondent and respondents were encouraged to guide the process as far as possible. Interesting phenomena noted during interviews were recorded in a research diary (see Figure 7.).

Figure 7: Extract from research diary regarding interview procedure

19th August 1999
I have been thinking about the influence that the respondent's gender has had on the jointly constructed process of the interview. Interestingly, I think that I felt more able to probe the female therapist regarding her personal experiences of therapy than the male therapist I have interviewed. At this stage, I think I would account for that with reference to the greater awareness of differences in status between myself and a male therapist than myself and a female therapist. In the interview with the male therapist it felt like the power differential was greater than with the female therapist — very interesting!
2.2.9. Data management

Interviews were transcribed as soon as possible following the completion of an interview. Tapes were transcribed verbatim to ensure no loss of detail. It was not deemed necessary to include a detailed transcription system, as the focus of the study was the content and function of participant’s talk rather than the way in which things were said. Nevertheless, pauses and hesitations were included but were not timed.

Each transcript was numbered according to the order in which it took place and each line of transcript was numbered sequentially. Transcripts are available as a separately bound addendum.

Potter & Wetherall (1987) have discussed the constructed nature of the transcription process and this feature of transcription was discussed in the context of the research diary (see Figure 8.).

**Figure 8: Extract from research diary regarding the process of transcription**

19th August 1999

_19th August 1999_

_I had read in the book by Potter & Wetherall (1987), chapter eight, that, “transcription is a constructive.....activity”. In attempting the initial transcription I began to realise this for myself. Some of the stresses on words and intonations are very idiosyncratic and this is very difficult to describe verbally, never mind trying to represent these in a transcription. The pauses and inflection tell a story of their own however, this may be interpreted one way by me and another by someone else._
2.3. Analysis of data

As stated in an earlier section (see section 2.1.4) the initial aim within this study was to elicit from the transcription data, the dominant narratives generated in the talk of clients and therapists on the subject of their experiences of termination. It was therefore necessary to utilise a process for structuring an initial coding of the interview material (see Figure 4).

There are different ways of talking about how to manage data within qualitative methodology, however a common feature of many qualitative methods (e.g. grounded theory; thematic coding; qualitative content analysis; discourse analysis) is that the textual material is analysed initially through a process of coding (Sarantakos, 1998). Categories are mostly developed from the text but are also received from the literature available on the area under investigation. In addition, these approaches share an emphasis on finding evidence to support categories developed at an early stage of analysis from within the text. Evidence, typically in the form of quotes, is either assigned to these latter categories or increasingly abstract categories are developed that incorporate concepts generated at an earlier stage of analysis.

The nine interviews resulted in one hundred and ninety-three pages of transcript. During the initial stages of coding I carefully read and re-read the transcripts, a process described by many discourse analysts as ‘immersion’ (e.g. Gill, 1996). It was during this process that I began to develop initial categories and in doing so physically cut up transcripts and put them into separate envelopes corresponding to these as they were identified in the data. Some of these categories derived from my reading of the
CHAPTER 2

termination literature and some were generated from the transcription data. As
highlighted above, this process is similar to the procedure of, for example, ‘open
coding’ in grounded theory, which involves naming and categorising phenomena
through close examination of the data (Flick, 2002). However, in the case of this
study, coding was carried out at the level of sentences and paragraphs rather than the
line-by-line coding advocated by grounded theorists (e.g. Charmaz, 2000). One reason
for this was the importance of reading and interpreting a piece of text within its
discursive context. That is to say that what precedes and follows a passage may
provide crucial clues to its meaning and function (Jupp, 1996). Passages of text that
appeared ‘borderline’ in terms of whether they belonged in a particular category were
included. This process ensured a close fit with the data and meant that some sections
of text were represented within more than one category.

The initial coding process generated seventy-eight envelopes (see Appendix 12 for a
complete list of the 78 initial categories) pertaining to thematic categories. The 78
categories were descriptive of relevant concepts that began to emerge in the data.
Some of these were labelled with the actual words used by the participant as they
afforded the best description of the category they represented, e.g. “leaving the nest”;
“driving without an instructor”.

Five of the 78 initial categories are shown in the following figures and in order to
illustrate the process further, the categories are accompanied by some examples of the
sections of text that were contained within the envelope corresponding to that category
(see Figures 9-12). The examples of categories generated during the analysis and
shown in the following figures are also accompanied by sections taken from the
reflexive diary and therefore demonstrate some of my thoughts and impressions as the analysis proceeded. Inevitably, therefore these thoughts will have influenced the shape of the analysis as it proceeded and they are shown here in order to make the process of identifying categories as transparent as possible for the reader.

**Figure 9: Quotes from the category 'symptoms reappearing' and reflexive comments**

- **Symptoms reappearing**
  
  “I found some of these key issues cropping up again towards the ending” (3: 243-244 Male client)

  “It's more it seems to me like a touching base and going back to the beginning and, and checking out, you know, like er the kind of try it for size again” (6: 418-420 Female therapist)

These comments reflected a theme within the termination literature, however in the literature actual ‘symptoms’ are described as re-emerging whereas client and therapist as client narratives appear to focus on the re-emergence of specific issues. When read in context, some of these issues pertain to those areas that clients did not feel had been adequately addressed.

To be honest I was surprised when a male client talked about issues of importance re-emerging for him when the end of his therapy was approaching. I’m not sure why that is but can only speculate that it is linked to an idea I have that discourses of symptoms re-emerging are linked to the experience of dependency and I did not expect this to be an issue for male clients.
CHAPTER 2

Figure 10: Quote from the category 'barriers to establishing relationship' and reflexive comments

- **Barriers to establishing therapeutic relationship**

  "This kind of enclave that she had which kind of didn’t, which never really got involved in relationships, it was always kind of kept separate from them" (7: 489-490 Male therapist)

This category for some reason provoked quite strong emotions in me as I think I felt that the client was being blamed in some way for therapy not being as successful as it could have been, in the therapist’s view. It resonated with my first experience of therapy as I wondered whether my therapist thought that I hadn’t been able to engage fully in the relationship rather than recognising that my waning commitment was linked to his insensitivity and dominance.

Figure 11: Quotes from category 'therapist carrying on therapy to meet own needs' and reflexive comments

- **Therapist carrying on therapy to meet own needs**

  "You get close to people and you don’t want to say goodbye" (2: 534-535 Male therapist)

  "I think what can happen and has happened to me as a therapist before is that I let the thought of ending slip during the termination phase" (4: 665-667 Male therapist)

Certain therapists were quite open about their experiences of finding endings difficult. This seemed to have occurred with certain clients who therapists felt they had formed a close bond with. However, we did not go into further depth about these experiences and in hindsight I wonder if therapists are able to identify what it is about specific clients that means they develop a stronger bond. When I think about my own work I think the clients that I often have difficulty ending with are those of a similar age and same gender or couples of similar ages to my own parents.
Figure 12: Quotes from category ‘time’s up’ and reflexive comments

- ‘Time’s up!’

“I thought if I couldn’t, if I said no this time she’d probably say something like well you’ve had as much as you can get” (5: 131-132 Female client)

“I suppose a lot of them [therapies] don’t actually go that long, you know, keep you going that long actually, some don’t believe in going over eight weeks” (9: 104-105 Male client)

In particular, quotes relating to the client’s idea that their therapy had somehow run out made me think of the experience of powerlessness. Powerlessness was a theme that had emerged during several of the interviews with both clients and therapists talking about their experiences as clients. It wasn’t named as such but was something I kept returning to in my head during certain interviews. In one interview in particular, with the female client, I wondered whether she felt powerless in relation to me. I was particularly uncomfortable in that interview as I felt that she had consented to be interviewed in the hope that she could re-establish a connection with her therapist, who was also female.

Powerlessness was also something that reminded me of how I had felt during my first experience of therapy. In terms of how I remembered that manifesting I felt a resonance with the experiences the female client described, although I felt that she had been quite damaged by that experience whereas I did not feel that I was particularly. I think that may have had something to do with the therapist being an older man which perhaps prevented a deeper connection from being established in the first place, but I’m not sure.

The next stage of the analysis involved identifying recurrent discursive forms within the data and in order to do this a shift in my thinking was required from one of seeing the categories as reflecting underlying social and psychological realities, to seeing these as accounts constructed to perform certain functions. Potter and Wetherall (1987) describe this process as suspending one’s belief in what is normally taken for granted in the use of language. It has also been described as a process of ‘rendering the familiar strange’ (Toren, 1996). In reality this was not an easy shift to make and I
struggled to move away from seeing the categories as nothing more than issue-based. Most methodologies employed within research carry with them explicit procedures for utilising that method. In contrast, however, no such guidelines exist for the researcher looking for a recipe for how to do discourse analysis. There is therefore no right or wrong way to carry out a discourse analysis (Burr, 1995). However, this makes it a very difficult process to learn and apply. I therefore had to address these difficulties many times within supervision and it was here that I was helped to make the shift from thinking about what was said to thinking about this in conjunction with how things were said, and what effects these constructions might have.

The analytic process involved looking for features shared by accounts as well as differences in both the content and form of accounts, and ultimately identifying discourses and sub-discourses. A discourse is defined as, “a system of statements which constructs an object” (Parker, 1992). In other words, discourses are particular ways of describing phenomena. For example, termination was variously described and constructed as: 1) a traumatic ending; 2) a ‘normal’ loss; 3) a transition; 4) and experience of individuation; 5) a new beginning. All of these ways of constructing the termination have different effects in terms of what feelings they invite from the client, what actions they institute from the client and therapist and which institutions they support.

This process of identifying the discourses contained within the coded accounts was supported by the recording of the characteristics of discourses and sub-discourses on index sheets as they were developed and articulated. Much of this process took place within supervision and helped me to clarify patterns of discourses within accounts. An
example of an index sheet corresponding to the discourse of ‘relationship’ is shown below (Figure 13).

**Figure 13: An example of an index sheet for the discourse of ‘relationship’**

<table>
<thead>
<tr>
<th>Discourse of ‘relationship’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Constructed through the following sub-discourses:</strong></td>
</tr>
<tr>
<td>• Transference</td>
</tr>
<tr>
<td>• Focus on primary relationship (with mother/father) – hierarchy?</td>
</tr>
<tr>
<td>• Everything linked back to relationship</td>
</tr>
<tr>
<td>• Exclusive to psychoanalytic model</td>
</tr>
<tr>
<td>• Termination as a crucial part</td>
</tr>
<tr>
<td><strong>Mirrors other relationships</strong></td>
</tr>
<tr>
<td>• Primary relationship as key to later relationships</td>
</tr>
<tr>
<td>• Loss re-invoked in ending</td>
</tr>
<tr>
<td><strong>Relationship in the termination</strong></td>
</tr>
<tr>
<td>• Loss of transference relationship – fantasised</td>
</tr>
<tr>
<td>• Loss of ‘real’ relationship</td>
</tr>
</tbody>
</table>

Flow diagrams were also utilised as a means of assisting the researcher in the process of elaborating the content of the discourses and their sub-discourses (e.g. see Figure 14).
In addition, by following the leads developed in the initial stages of the analysis and the emergence of the discourses, such as that of ‘powerlessness’, I was able to discern that there were absences within the talk of therapists. For example, when therapists
discussed client experiences, they did not articulate powerlessness as one of those potential experiences.

The final stage of the analysis involved re-reading the text and asking certain questions of the accounts. As discussed in an earlier section, different approaches to discourse analysis vary in terms of what it is they are looking for in a text and what they wish to draw attention to. The kinds of questions asked by different approaches to discourse analysis are not self-evident and the same text can be interrogated in a whole range of different ways (Burr, 1995). The present study did not seek to investigate the minutiae of how the accounts of clients and therapists were constructed. Rather, in seeking to understand the implications and effects of the discourses generated the following questions were asked:

1. *Which institutions are supported by the discourses contained within the talk of clients and therapists?*
2. *What power relations are produced and reproduced by these discourses?*
3. *What are the ideological effects of these discourses?*
4. *What actions do the discourses justify or proscribe?*

Finally, in the interests of transparency data are made available to the reader in the main text so that assumptions made by the researcher are open to alternative interpretations.
2.4. Issues of evaluating research quality

The evaluation of qualitative research is a contentious issue and because of the different epistemological assumptions that tend to frame this kind of research it is generally agreed that empiricist understandings of notions of reliability and validity do not provide a suitable means of judging its utility (Potter, 1996). However, a number of alternative criteria against which the quality of qualitative research may be evaluated have been suggested. Lincoln & Guba (1985) have suggested four criteria for establishing the *trustworthiness* of qualitative data and the ensuing analysis: credibility, dependability, confirmability and transferability. These will be discussed below with reference to this study.

2.4.1. Credibility

Lincoln & Guba suggest a variety of techniques for improving and documenting the credibility of qualitative data. One such technique is that of triangulation, that is, the use of multiple referents to draw conclusions about the validity of the interpretations of the data. This can be attempted in a number of ways, for example, by employing multiple data sources in a study. Typically, triangulation is utilised as a way of confirming the 'truth' of the findings (e.g. Maheady, 1999) and therefore reflects the view that what has been produced and written is simply the neutral disinterested recording of research. However, the version of termination this study has produced is acknowledged as no less constructed, contingent and action-oriented than the discourses it sought to critique. Furthermore, as this study contends, social science
texts, far from being simple, neutral or transparent reflections of the research process are acknowledged to be, in fact, complex rhetorical accomplishments (Stringer, 1990). Thus, in the case of this study it is argued that triangulation of this sort is inconsistent with the epistemology of the researcher, the aims of the study and the acknowledged constructed status of the findings reported.

The researcher did, however, attend to the issues of indexicality, reflexivity and inconcludability as described by Parker (1994). In addressing the issue of indexicality, I have aimed to be as specific as possible within a discourse analytic study in detailing every aspect that may have influenced the research process and reported findings. Thus, I have aimed to make the process I followed transparent to the reader. With regard to reflexivity, I have attempted to articulate in detail my role in shaping the research (see sections 2.2.2 & 5.4.1). Further, in terms of inconcludability, I have acknowledged that the analysis presented is my reading and analysis of the accounts of respondents.

In addition, the researcher engaged in a process of investigator triangulation during supervision. That is, throughout the process of analysis, the interpretative process was scrutinised by my supervisor largely because the researcher felt unconfident about whether the interpretations were the 'right' ones. This uncertainty about whether interpretations of the data were 'right' or 'wrong' originated from the researcher's background in research utilising quantitative methods.

Another criterion for credibility advanced by Lincoln & Guba is prolonged engagement with the data. Interviews took place over a period of five months during
which time the researcher was engaged in the processes of transcription and the reading and re-reading of transcripts in order to inform the ongoing interviews. The purpose of this immersion in the data is also to begin the process of coding. A further way in which the researcher demonstrated a prolonged engagement with the data was in the cutting up of transcripts in order to physically place these fragments of text within envelopes corresponding to emerging categories and discourses. The activity of cutting up transcripts was very labour intensive and absorbing and it was through this process that the researcher developed an in-depth understanding of the language and constructions of respondents.

A further criterion of credibility is that of respondent or member validation. This is considered by Lincoln & Guba to be the most important technique for establishing the credibility of qualitative data. This technique was not employed within this study for reasons derived from the social constructionist epistemology of this study. Thus, a taken-for-granted notion of the researcher is that the data collected are constructions made by the respondents in a particular context and that the reported findings are provisional and situated. It is therefore likely that if the study were to be repeated with the same respondents then different things would emerge. However, it is likely that in a broad sense similar discourses would be generated. Thus, member validation is not an appropriate criterion on which to judge this study, as the findings are acknowledged as provisional and situated within a specific context and time.
2.4.3. Dependability

An assessment of the dependability of qualitative research relates to whether interpretations are internally consistent and whether they have utility. To this end, the researcher has endeavoured to demonstrate in detail the ways in which the analytic conclusions were arrived at by illustrating these with bodies of text. Coyle (1995) has emphasised that this process allows the readers of research to discern for themselves whether the interpretations made by the researcher appear to be valid and dependable. Thus, it also affords the opportunity for consumers of the research to offer alternative interpretations. However, in my experience, it is very difficult to articulate the process involved in doing discourse analysis. The lack of clear and detailed descriptions of how to go about doing discourse analysis is likely testament to this finding. Indeed, Gill (1998), in reflecting on the difficulty in explaining how to do discourse analysis writes, ‘the essence of doing discourse analysis seems to slip away; ever elusive, it is never quite captured by descriptions of coding schemes, hypotheses and analytical schemas’ (1998: 143).

2.4.4. Confirmability

In qualitative studies, the issue of confirmability focuses on the characteristics of the data. In this study, efforts were made to meet the criteria of confirmability through a process of documentation of the data to facilitate openness within the research. Some of this documentation has been presented within the present report in the form of diary extracts, reflexive descriptions, flow charts and an example of an index sheet.
Transferability refers to the extent to which the findings from the data can be transferred to other settings and is thus similar to the concept of generalisability. This study could be criticised on the basis that the sample were self-selected and could have done so for a multitude of different reasons. For example, clients may have felt morally obliged and were thus motivated to volunteer because they thought the research might be of benefit to other clients. They may also have been motivated to volunteer because of their feelings of gratitude to their previous therapist or because they felt that there may be a chance that they would get to meet with the therapist again. However, given that the focus of discourse analysis is the discourses themselves rather than the individuals interviewed, the representativeness of the respondents is not a relevant criterion for evaluating this research. However, the representativeness of the sample of discourses generated by the study is a relevant criterion for evaluating the study's quality. Thus, as mentioned in an earlier section, it is recognised that if the study were repeated different things would indeed emerge, however the broad discourses that were generated would also still be expected to emerge.

As elaborated in earlier sections of this chapter, the present study has also generated a range of implications and theoretical questions of relevance to certain models of psychoanalysis and, I would argue, to any practitioner adhering to a model of psychotherapy that is presented as a 'truth'. In the context of this study, object relations theory and therapy have been challenged on the basis that the discourses embedded within certain forms of analytic theory and therapy construct isolated contexts in
which clients get situated. Thus, it is argued that the lived realities of client's lives are overlooked in favour of a privileging of the formative influences of early relationships with parents, as a way of accounting for their distress. Thus, the present study challenges certain forms of psychoanalytic theory, therapy and research to examine their cultural and historical roots in order to situate the institution within its wider socio-political context.
CHAPTER 3

3. Analysis I

3.0. Overview of chapter

The following two chapters provide an account of the analysis. The present chapter sets out the discourses of termination generated from the interviews. Then chapter four seeks to explore the functions and effects of these discourses in terms of the power relationships they reproduce, the ideologies and institutions they support and the potential impact of these for the client's experience of therapy.

Section one of this chapter seeks to demonstrate how, for the therapists interviewed, the relationship between client and therapist is regarded as uniquely important and powerful. This major theme is of course not a new concept and functions to locate these narratives firmly within the object relations tradition and its ‘two-person’ approach to therapy, discussed within chapter one (e.g. Grotstein, 1995). The second part of section one then illustrates the significance of the process of termination as one stage of the therapeutic relationship. Section two argues for the different metaphors that are imported in constructing versions of the meaning of the ending of therapy. Section three sets out those themes pertaining to the area of preparation for ending, whereas sections four, five and six explore the potential complications of the ending of therapy and consequences for the client of these. Section seven seeks to demonstrate how the process of internalisation is represented within client and therapist narratives, and, finally, section eight explores stories of unfinished business.
3.1. Relationship and its significance within psychoanalytic psychotherapy

As the following extract illustrates, the relationship that is established between a client and therapist, within the context of a psychotherapeutic endeavour, is assumed to be the pivotal component:

It’s about relationship I guess. Interview 7; line 270 (Male therapist)

The relationship between client and therapist is seen as important because it is understood as a unique relationship, as the following account exemplifies:

There’s something quite powerful and meaningful there, it’s a special relationship, you know, we can, we can talk to our therapists in a way that we have never and probably will never again talk to another person. 7; 276-279 (Male therapist)

Within a psychoanalytic framework the relationship between client and therapist is therefore understood as uniquely important. In the following account, the significance and complexity of the relationship within psychoanalytic psychotherapy is explained by invoking the idea that at the point when clients enter their therapy and a relationship with the therapist they carry with them an established map for relationships. It is this map that is seen as guiding the person’s experience and expectations within relationships, and therefore their behaviour towards others, including the therapist:

I see very early relations as laying down a sort of template um, and then later childhood relationships sort of adjust that template slightly um, but I think people do come into their adult relationships including their relationship with a therapist with
that template so um, how they relate to you including how they experience the ending is going to be informed by that. 1; 508-513 (Female therapist)

Thus, the here-and-now relationship between client and therapist connects with and mirrors other past and current relationships outside of therapy. Therefore, when the client and therapist enter into a relationship, theirs is not the only relationship that is active within the therapeutic context because it is seen as informed by the relationship template that both the client and therapist carry internally. It can therefore be argued that the client’s first relationships provide the themes of interpersonal life and all subsequent relationships, including that with the therapist, feature the development and recapitulation of those themes.

The concept of transference refers to the notion that clients unconsciously treat their therapists as a surrogate for a significant figure in their life, and that aspects of relationships outside of the therapeutic relationship, both past and present, are re-experienced and enacted between client and therapist.

It can be argued that it is this feature of the therapeutic relationship that lends a unique aura of emotional intensity and contributes to its central focus. It is therefore no wonder that the relationship within psychoanalytic psychotherapy is regarded as the medium of therapeutic work:

Something opens up in that which is, you know, immensely powerful. 7; 279 (Male therapist)

It is because of the transference and the way in which the therapeutic relationship is seen as connecting with the client’s relationships outside of therapy, that the
relationship is regarded as a powerful force of psychological change. However, the therapeutic potential for change via the medium of the relationship and the operation of transference is seen as being a result of the greater amount of time spent within psychoanalytic therapy:

I guess because psychodynamic psychotherapy tends to be longer than other forms of therapy often then there’s more chance of that deeper relationship developing perhaps. 1; 218-220 (Female therapist)

It can thus be argued that the psychoanalytic therapist develops a greater knowledge of their client’s internal world and hence, can make the links between the client’s mode of relating to them and the client’s past experience of relationships that may be contributing to that. The depth of the relationship is not, however, unique and it is acknowledged that clients and therapists do form attachments in the context of other theoretical approaches to therapy practice:

I don’t think doing cognitive behaviour therapy stops you getting attached to people. 2; 548-549 (Male therapist)

However, despite the potential for the development of significant relationships within other therapeutic approaches, as the following extract illustrates, these are seen as failing to utilise the relationship in the same way as the psychoanalytic approach. They therefore miss the therapeutic potential that is opened up in viewing the relationship itself as a vehicle for learning and, hence, psychological change, because of the way in which it invokes the person’s interpersonal past and present:
It's just an opportunity that's too good to miss and that might, I suppose for me other therapies do miss it. 7; 281-282 (Male therapist)

Within the psychoanalytic framework, any stage in the therapeutic relationship can be understood as a crucial vehicle for the development of insight and learning about the self and one's relationships. The ending is therefore an important part of that process because of the potential that this phase of therapy has for illuminating the emotional conflicts that the client may carry with respect to the experience of relationship endings and/or separation.
3.1.1. Termination as an important phase in the therapeutic relationship

The process of bringing therapy to an end or termination is thus regarded as an important opportunity for increased psychological insight, as the following quote exemplifies:

It does recognise that termination isn't just something to get through its also something which an immense amount can be learned from. 7; 271-272 (Male therapist)

Additionally, because of the time spent in the therapeutic relationship, the ending of therapy within a psychoanalytic psychotherapy approach will be of great emotional significance for the client, as the following extract elucidates:

For my therapy and for the therapy of the patient I've described we've had a long period of time to develop the relationship, so I think the ending will have a different significance because of that length of relationship and depth of relationship than if I'd only met with someone for twenty sessions. 1; 602-605 (Female therapist)

Because the relationship extends beyond the here-and-now, via the transference, to make links with the person's past and current relationships outside of therapy, then it can be argued that it is both conscious and repressed unconscious psychological phenomena that emerge in the ending phase of psychoanalytic therapy:

It touches that part of you that you tend to ignore and avoid getting in touch with, the bit that's, you know, so upset about an ending, yeah. 5; 544-545 (Female client)
Some of this material may relate to the client’s feelings about the end of the relationship with the person of the therapist and the loss of what the ‘real’ relationship has provided for the individual:

I think it reflects feelings about what’s actually happening here now in a very real way, the reality of, you know, this relationship or this department or whatever it means. 8; 466-468 (Female therapist)

The therapeutic relationship within psychoanalytic therapy is, however, understood to be multidimensional because the relationship is the gateway to the person’s other relationships external to therapy. Hence, different levels of meaning are seen to be of significance to the experience of ending therapy:

Oh I think there’s many levels, I mean I think, and hopefully you’ll touch on the many levels. 8; 465-466 (Female therapist)

The multidimensional phenomena that arise in the ending of therapy also relate importantly to the feelings arising from the transference meanings of the ending of the relationship with the therapist. The therapist is seen to have come to represent key figures, experiences, wishes, fantasies, and yearnings from childhood.

As the following account argues, feelings of loss may potentially result from a renunciation of the client’s yearnings to have their transference wishes gratified and also from an experienced repetition of previous losses and relationship endings:

And obviously in terms of the transference in terms of what it’s repeating for them in past experiences or what fantasies they might have about the ending. 8; 468-470 (Female therapist)
3.2. Endings in therapy and endings in life

As has been demonstrated in the previous sections, the relationship within psychoanalytic therapy is seen as the central therapeutic medium. Its centrality derives from the way in which the relationship between the client and therapist is seen as a stage on which aspects of the client’s relationships external to therapy, which have become internal to the person, are played out via the transference. Crucially, it has been argued that this provides the therapist with an opportunity to encourage growth of the client’s self-knowledge, and therefore increases their potential for change, by making them aware of the feelings and impulses that are being expressed towards the person of the therapist.

The ending of therapy is therefore an invaluable part of this process of developing insight and re-experiencing feelings and provides a link to the client’s experience of endings in life. The following account introduces the view that the way in which the ending of the therapeutic relationship is experienced is related to and mirrors other relationship endings and transitions that occur outside of therapy:

I do believe that the experience of ending for most people is related to the experience of separation and loss. 4; 126-127 (Male therapist)

Endings in life might be seen as permanent in terms of loss or as a non-permanent separation. Therefore, the ending of therapy can be understood metaphorically as either loss or separation, or both, as in the following account:
It also has the elements of all separations and loss, which means it has elements of a new beginning, of a transition, but also of having to give something up which was important. 4; 128-130 *(Male therapist)*

Absolute endings, where the client and therapist end the therapy and do not arrange any follow-up, are seen as evoking feelings associated with permanent loss and death. Relative endings, where the client and therapist make provision for future follow-up, are compared to the experience of non-permanent separation. Therefore, the feelings that are evoked by these two approaches to ending can lead to very different experiences for both clients and therapists, in terms of the phenomenology:

Well on one level I think the ah, the symbolic equivalent of an absolute ending is death and the um symbolic equivalent of a, of another form of ending is separation and I think that makes for a, for a difference in the quality of the experience. 4; 151-153 *(Male therapist)*

Whether the ending of therapy is understood as a loss experience or one of separation, any ending also evokes new beginnings, as is illustrated in the following account:

It’s just part of a very fundamental template about leaving things behind and going on to new things and in a way that’s characteristic of each transition stage. 4; 392-393 *(Male therapist)*

This section has demonstrated how the ending of therapy can be portrayed metaphorically as either an experience equivalent to that of non-permanent separation or permanent loss. It has also been shown that the experiences of separation and loss also contain an element of a new beginning. These will be examined in turn in the following sections.
3.2.1. Ending as separation – 'Leaving the nest'

In the following account, the ending of the relationship between client and therapist is conceptualised as the ending of a dependency relationship, and is therefore portrayed as an important transition:

But I think it’s the ending in therapy is particularly different, significant, whatever because um, well like a parental relationship it’s a relationship where you um are looking to someone for help and guidance in some form. 1; 521-524 (Female therapist)

Thus, the experience of ending therapy can at times be seen as mirroring and re-invoking the fundamental separations that occur from parents in life as one develops. This includes the earliest separations that typically occur from one’s parents:

The things that get re-worked in that termination are often from very early on and, you know, our memory fails us around those very early separations, you know, what was it like when, you know, mum left us at the school gate for the first time. 7; 388-390 (Male therapist)

The ending of therapy can also be conceptualised as a comparable process to that which takes place when an individual leaves home and by doing so chooses to become independent and self-sufficient. In this way the ending of therapy is therefore framed as a positive and healthy progression when it mirrors the experience of normal individuation:

I’m thinking about the parental analogy a bit like a feeling when you leave home and you’re feeling, you’re a bit scared but you probably feel you’re ready to do it, you’re probably feeling you’re old enough and it’s about time, um a separation that might
happen, a good separation that might happen from parents for example, you know, it wasn’t that they kicked you out or you’ve run away, it was that you’ve, you know, you’ve got to eighteen, nineteen or whatever it might be and felt, ‘well I’m probably just about ready’, and parents are a bit anxious but they think, ‘well you know I’ll cope’, so it’s sort of, that’s the analogy really, I imagine those sorts of feelings in both therapist and patient. 1; 717-725 (Female therapist)

The end of therapy can thus be portrayed as a normal developmental transition. The process of leaving home, for example, typically involves a process of negotiation with one’s parents about when to leave and how this should be carried out. Ultimately, however, it is the person that is leaving home and leaving the security of the dependency relationship that exercises the bulk of control, through their decision about their readiness to make such a transition. However, it is anticipated that parental support, or in the case of therapy, therapist support, will ensure that the transition is a smooth one.

The ending of therapy can therefore be storied as a process that maps onto the fundamental separations that occur in life from one’s parents and the transitions that form part of a process of individuation. Such fundamental separations in life inevitably involve elements of loss, however when termination is storied in this way it is predominantly positive in its connotation. But individuation is not only about endings as it also features new beginnings and it is this aspect of termination that will now be examined.
3.2.2. Ending as a new beginning – ‘Driving without an instructor’

The end of therapy can be seen as the beginning of a new phase in the life of the individual and in the following extract the beginning of this new phase is storied through the use of the metaphor of a newly qualified driver. The image created is of the therapist as an instructor or educator who holds ‘expert’ knowledge and who imparts this to the novice. To extend the metaphor further, the therapist may therefore be seen as bringing the client to a position where they have enough knowledge and experience to be able to go back out into the world alone and safely:

It’s the start of a new phase of your life really and just feeling like you’re driving the car without the instructor at the side of you. 5; 658-660 (Female client)

In describing the end of therapy as a new beginning the emphasis is therefore shifted from the experience of ending to the continuing process of individual development that is seen to occur post-therapy:

I definitely go along with a view that, you know, the end of therapy is you know is not, not really the end it’s just, it’s the beginning of something else, and um, um, but you know much learning, much change, etc, perhaps even more goes on afterwards, after the experience of therapy. 2; 814-817 (Male therapist)

The process of ending therapy can therefore be understood as mapping onto the predominantly positive transitions that occur in life, such as the process of leaving home for the first time to embark on a new life as an adult. However, the experience of ending therapy may sometimes be seen as mirroring and re-invoking the potentially
more painful experiences of traumatic separation or permanent loss, as will be illustrated in the following section.
3.2.3. Ending as traumatic loss

It has been argued that by describing termination as mirroring the process of individuation then it is largely depicted as a positive experience for the client. In contrast, when feelings of loss of control are re-invoked in the ending of therapy (whether that is within the transference or in connection with the real relationship) then it may be understood as comparable to the experience of real death, as the following account exemplifies:

It's kind of like thinking about someone you've lost in a way. 5; 532 (Female client)

The ending of therapy can therefore evoke feelings of powerlessness within the transference or in association with the 'real' relationship. As such, the emotional experience that is associated with the experience of losing a loved one in life can be invoked in the experience of ending therapy:

I was aware for a time at least that there was maybe some, some parallel between, you know, in terms of feelings of pain and so on, with er, with finishing therapy and with losing my boy. 3; 417-419 (Male client)

Discourses that construct the ending of therapy as an experience that mirrors a permanent loss are instrumental in suggesting that clients go through a grieving process when their therapy ends. This is illustrated below:

I suppose it may be felt as a kind of grief as well, a period of grieving. 8; 668-669 (Female therapist)
The ending of therapy can therefore be seen as comparable to the experience of permanent loss. However, the loss of the relationship with the therapist as experienced by the client may be constructed with reference to various characterisations of relationships that exist outside of therapy.

As the following account illustrates, the therapist is seen as someone to whom the client has opened up and to whom they have imparted privileged knowledge about the events of their life and their innermost feelings:

It's a person that you've not known for very long but who sort of knows you, knows all, you know, all my life sort of thing. 9: 208-209 (Male client)

Thus, the ending of the relationship with the therapist is compared to the loss of a trusted friend:

I think at the end of it, it was like losing a friend if anything. 9: 423 (Male client)

However, it is not only notions of friendship that are evoked within the therapeutic relationship. The ending of the relationship with the therapist can also evoke similar feelings to those experienced at the end of a more intimate relationship. The following account illustrates how the end of therapy can bring about feelings of jealousy and a desire for exclusivity or faithfulness by the therapist:

I remember making some joke about they could close the department down now because I felt I didn't want him to see anybody else, you know, but I did in a jokey way, stop working now I don't want to share you. 8; 163-166 (Female therapist)
The previous sections have demonstrated how the end of therapy can be seen as mapping onto the separations that may typically occur in an individual’s life. Thus, the end of therapy can at times be described as mirroring the process of individuation. In this case an individual is storied as making positive choices and negotiating with the therapist about when they feel ready to leave therapy. They are also likely, according to these narratives, to experience some control over the process of ending their therapy.

However, the end of therapy can at times be seen as mirroring the more negative experience of permanent loss and/or traumatic separation whereby a grieving process is invoked. This can be seen as a transference phenomenon or as occurring in connection with particular conditions that are met within the real relationship with the therapist. In this case it is likely that clients are either not given the opportunity to exercise some control over when and how to end their therapy, or do not feel sufficiently empowered to do so, perhaps because of the inherent power imbalance within the therapeutic relationship.

The similarities that are therefore seen to exist between the ending of therapy and the experience of endings in life are evoked through widely available discourses of loss and separation. Importantly, however, the ending of therapy is also differentiated from endings in life in various ways. These are discussed in the following section.
3.3. Preparation for ending/distinctions

As it has been argued within the previous sections, the ending of therapy is regarded as a crucial stage within the practice of psychoanalytic therapy. Its importance is in part derived from the way in which the meanings evoked by the ending extend beyond the immediate therapy experience to the person’s relationship history, thus broadening the relevance of the ending. Hence, a process of preparation of the client for ending is considered paramount and is seen as distinguishing the ending of psychoanalytic therapy from the ending process of other therapies:

I think the difference for psychodynamic psychotherapy is that the ending is probably more explicitly addressed and worked with, in the therapy. 1; 224-226 (Female therapist)

This process of preparation is also seen as distinguishing the ending of the therapeutic relationship within analytic psychotherapy from other endings occurring in life:

It’s the only permanent separation which is predictable and can be felt about and thought about in advance, and I think that’s a very unusual feature. 4; 470-471 (Male therapist)

Because of the focus on preparation of the client for ending within psychoanalytic therapy, this process can thus be seen as providing an opportunity for a new experience of ending:

So I don’t think that the end of therapy can only be an experience of your other endings, I hope it can be experienced as different. 8; 517-518 (Female therapist)
However, because of the emphasis on ‘the relationship’ as the therapeutic medium within psychoanalytic therapy rather than on the meeting of specific goals, then it may be seen as difficult to judge when the therapy can appropriately be brought to an end:

Its difficult to know when you’ve reached the finish line really because its not er, there’s nothing to clearly define it and there’s something um, in this work that relies on relationships and relationships are never clear-cut. 7; 262-265 (Male therapist)

Despite the difficulties that are seen to exist in knowing when a therapy of psychoanalytic orientation can appropriately be brought to an end, therapists may be seen as picking up on clues within the material that clients bring that indicates they have been thinking about the ending, either consciously or unconsciously:

I’m listening for something either explicit or implicit that I then might pick up and say, “well you know it almost sounds like you’ve been talking more and more about things, you know, what it would be like without your therapy or, you know, in this way or that”, or, “this dream seems to suggest such and such”, whatever it is ... it’s in the material and maybe I’ve picked it out but generally I’d always want to try and link it to something. 2; 692-696; 696-697 (Male therapist)

Thus, when the issue of bringing the therapy to an end has initially been raised then the actual timing of the end of therapy is planned in advance. However, the process by which client and therapist reach a decision about when the therapy will end can be understood in fundamentally different ways. An agreement regarding the timing of the ending can on the one hand be seen as being arrived at in a passive way, as the following account illustrates:
My experience of it is not that there’s an end-point of the therapy that the client gets informed about but rather there is a time when an ending becomes thinkable, and after it’s become thinkable it becomes discuss-able, and then when it’s discussed then we agree on an ending date, and in a sense I don’t know about that any more than my patient does in advance until we’ve agreed on one. 4; 490-494 (Male therapist)

Therefore, the decision of when to end the therapy is portrayed as a mutual one with an equal distribution of power between the client and therapist as they move towards the ending. In contrast however, the process of coming to the decision of when to end can be defined as an active one of negotiation between both parties, as in the following account:

Its negotiated you know, it gets negotiated really. 6; 214 (Female therapist)

The implication here is that the decision about when to bring therapy to its end is reached via a process of shifting and negotiated power between client and therapist. In this way the process of deciding when to end is portrayed as a more active process but at the same time still predominantly mutual. However, because it is the client’s therapy then therapists are understood as having a preference for client initiation of the ending:

I suppose really um, my ideal would be really for the patient to raise it. Why, because I think then there’s a sense of um, of ownership of it. 2; 687-688 (Male therapist)

Indeed, the therapist can also be seen as making a concerted effort to encourage the client to be proactive in setting a date for the end of their therapy:
When I said something about maybe setting himself an ending date and I wasn’t giving him a time limit, he could have said I’ll go in a year or whatever, I was trying to get him to set it himself. 8; 536-539 (Female therapist)

It can be argued that this process also contrasts with the experience of endings in life, which are typically seen as evoking feelings of powerlessness and where there is little opportunity for the individual to negotiate over how and when to end a relationship:

Its being talked about in a different way and struggled with where I think it just happens normally, and it doesn’t get talked about, and feelings aren’t expressed because they feel too dangerous or unsafe or whatever. 8; 533-535 (Female therapist)

Thus, for individuals who have experienced real losses where these may be re-invoked by the ending of therapy, it can be argued that a process of shared negotiation of ending with the therapist can be seen as a contributing factor in the creation of a new experience of separation. This is illustrated in the following account:

I believe some of that was a different experience. I think he struggled with something he hadn’t been able to struggle with somebody before. 8; 519-521 (Female therapist)

However, despite the portrayal of therapists as having a preference for clients initiating and eventually bringing their therapy to an end, it is also understood that under certain circumstances the therapist may bring the therapy to an end. Thus, a therapist bringing therapy to an end can be storied as a positive action when it is deemed that the decision to end is made on the basis of being in the client’s best interests:

If in their judgement that is the best thing to do either because they feel that there’s
nothing further that they can do for the patient, um, for another sort of sound reason.

1; 425-426 (Female therapist)

Therapists can therefore be seen as unilaterally bringing therapy to an end for positive reasons. However, as in the following account, when a therapist ends a therapy for reasons that are internally motivated, such actions may be justified through the argument that this would only be likely to occur for ‘valid’ reasons:

Occasionally I think it would be because they’re fed up with the client and they want to get rid of them, but that would also be a, or just fed up and frustrated and I guess they’re more likely to be situations where there’s not good supervision around or perhaps with very difficult clients or therapists who are sort of a bad match in some way. 1; 694-697 (Female therapist)

In whichever way the decision about when to end is reached, because it is planned then the ending is understood as predictable. This is seen as being in contrast to the way endings typically occur in life, where they can often be forced upon the person or at least it is not likely to be possible to predict an ending with precision:

Well there’s one major difference in that it’s planned, many endings aren’t planned at all, very few of us go around ending various relationships and saying, you know, well lets sleep together another four times and then call it a day. 5; 548-550 (Female client)

Because the end of therapy is planned in advance then the client and therapist have time in which to prepare. The time available to client and therapist in which to process the emerging material is seen as a crucial aspect of preparation in the sense that it allows clients to express and work through their hopes, fears and disappointments about the forthcoming ending. It can be argued that this process facilitates the transition from a position of having therapy to one of not having therapy:
CHAPTER 3

I think the length of time that my therapist gave me was enough, I think if it had been like a few weeks or something it might have been a little bit like jumping in at the deep end. 9; 123-125 (Male client)

Furthermore, clients who have been identified as having experienced early developmental difficulties and who are perceived as having developed a particularly dependent relationship with the therapist are often given an extended termination period:

Many patients in psychodynamic psychotherapy, particularly the early developmental difficulties, do need longer, you know, they’re just getting into therapy after a couple of years. 8; 368-370 (Female therapist)

Thus, within the ending phase, the potential significance of ending to the client is the main focus of therapeutic work and the therapist is seen as working to keep this focus on the therapeutic agenda:

Good psychodynamic therapists have endings in mind, they’re not afraid to address it, um, they try and explore with the patient what that means, what that would be like etceteras…they expect that it will have an impact and they try to predict and understand what that impact might be. 1; 790-793 (Female therapist)

Preparation for ending is regarded as a process that allows for both transference feelings and those associated with the impending loss of the real relationship to be identified and expressed. During this phase, therapists may be seen as increasing their focus on and intensifying their interventions with respect to the transference:
I suppose I might be a bit more pressing towards er kind of transference comments um, you know, trying to tie in the, the ending with how they might be feeling um, feeling about me or wondering how they think I'm feeling about losing them. 6; 437-440 (Female therapist)

Furthermore, it can be argued that this aspect of preparation also distinguishes the ending of therapy from the experience of endings in life. This is because it is not usual in life for the person one is losing to be available to help the individual process the psychological phenomena that the forthcoming ending has thrown up:

It's the I think rather unusual constellation of being helped in one's mourning by the object one's losing. 4; 473-474 (Male therapist)

Through interpretation of the transference, the end of therapy can therefore be seen as providing the potential for a corrective emotional experience whereby the client may be assisted in developing a new perspective:

So my understanding of endings is, was, like just that they were to be avoided, my well-travelled path was avoid, avoid at all costs whereas my therapist taught me to think differently, don't avoid it, you know, try and understand why you get so upset. 5; 390-392 (Female client)

However, despite the importance of attention towards the transference, a focus on the meaning of the loss of the relationship with the therapist is also seen as crucial. Thus, it can be argued that achieving a balance between focus on the transference and the forthcoming end to the 'real' relationship is seen as the ideal of preparation:

If you spend too much time on these kind of historical, genetic interpretations then you're in danger of missing the here and now experience of actually, you know,
we’ve come to an end and we’re saying goodbye so um, you know, I, I’d be cautious about becoming too heavily interpretative. 2; 601-604 (Male therapist)

In addition to this ‘ideal’ focus, the nature of the relationship between client and therapist may be seen as undergoing a shift as the ending approaches, towards a more equal relationship:

Trying to maybe shift a little bit out of the therapist-patient relationship and more towards a more kind of people, just people together. 6; 95-96 (Female therapist)

This section has demonstrated the ways in which the ending of therapy is planned and prepared for within psychoanalytic therapy and how aspects of this process are storied as distinguishing the ending of the therapeutic relationship from other relationship endings that occur in life. In this way, the ending of psychoanalytic therapy is seen as providing a psychological experience over and above the experience of endings in life. It is regarded as a process that encourages the client to negotiate and exercise control and which facilitates the transition of ending and cushions the client, thereby encouraging a more positive experience, and in some cases providing the opportunity for a corrective emotional experience. This is seen as not often being possible in life.

However, as it will be argued in the following sections, even when the ending of therapy is seen as being planned and prepared for by one or other of the client and therapist or both, the inherent complexities of ending mean that difficulties are still experienced. It is thus argued that the construction of ending described within the present section represents an ideal notion of how the ending may transpire.
3.4. Powerlessness and the lack of opportunity for negotiation

As it has been argued in the previous section, therapists can be understood as encouraging clients to take responsibility for their ending and thus position themselves as ‘enablers’. This would ideally involve the client being proactive in the process of identifying an appropriate date to bring therapy to an end and also in negotiating the areas that they wish to work on in the closing stages. This emphasis along with a working through of the emotional concomitants of ending, via the ‘sign-posting’ of the therapist, allows the process of ending to be seen as offering the potential for a new or corrective experience.

Furthermore, this potential for reparation within the psychoanalytic relationship is seen as being over and above that which can be offered by other forms of therapy, or by the ending of relationships in life. Hence, therapy is at times storied as a jointly negotiated process towards the end. However, the following account contradicts this notion:

I think she made the suggestion of, you know, and um I went along with that, and apart from the asking if I could have a trial period I don’t think I had a lot of input into it really, I might, I don’t think I did. 5; 609-612 (Female client)

Thus, clients may be seen as feeling denied of any opportunity to negotiate how and when their therapy comes to an end. Within the real relationship, it is therefore not always the case that clients are given the opportunity, or indeed feel able, to exercise control and negotiate with the therapist when and how their therapy should end. The following account exemplifies how such a lack of opportunity to change the course of
therapy ending can lead to the re-enactment of a traumatic separation that has occurred in the client’s life:

Even though intellectually I could see it one way I think in here it was very much like home's left me again, you know. And I couldn’t protest, I probably couldn’t, didn’t protest so...it was devastating I suppose, do you know what I mean, frightened. So I think my experience of ending my first therapy was very much a repeat for me of leaving home or not leaving home as the case may be. 8; 181-185 (Female therapist)

It may be that under these conditions, feelings of grief are more likely to be re-invoked, associated with the experience of powerlessness:

I felt I wasn’t ready to go or I didn’t want to go and I felt pushed out, I think I really was in a state of grief and it took me along time to recover. I know I got good things from that therapy but I went through, I really did experience a loss, as a loss. 8; 670-673 (Female therapist)

Hence, in cases where the ending of therapy provokes a re-experiencing of a traumatic separation and the client thus feels forced out of therapy, the resultant feelings can continue to impact on the client in negative ways long after therapy has come to an end.

Crucially, therapists may also be seen as acknowledging an inherent discrepancy of power within the therapeutic relationship so that attempts to encourage the client to become proactive in the process of ending therapy are actually understood as deceptive:
CHAPTER 3

Often I, I’ll ask the patient to set a date and I think there’s a bit of slight of hand in that because it feels as though it gives them the impression that they’ve got some control over it when actually the power lies with me, and I suppose it always does. 7; 430-433 (Male therapist)

Indeed, within the present research the processes of initiating and bringing therapy to an end are predominantly storied by clients as therapist dominated areas:

But I think, yeah, it would be a therapist sort of area really. 5; 633-634 (Female client)

Thus, despite the notion expressed by therapists that clients can be facilitated to take control of the process of bringing therapy to an end, and that therapists have a preference for this, this section has argued that the reality for clients (including therapists in the position of clients) may be markedly different from this ideal. Indeed, as has been demonstrated, therapists may at times acknowledge that their attempts to empower clients to this end are unrealistic. As the following sections seek to argue, when the end of therapy is initially raised, and perhaps particularly when mooted by the therapist, a set of interconnected struggles may be understood as being set in motion.
3.5. The struggle of ending

An earlier section demonstrated the importance of discourses of preparation for ending, within the psychoanalytic model of therapy. However, a focus on preparation of the client for ending and attempted facilitation of the client to be proactive within this process may not necessarily pre-empt the psychological obstacles that can make ending difficult for the client. The following account illustrates this notion:

In a way I don't think you can prepare it because it's false, because even when you work towards it things happen, go wrong. 8; 746-747 (Female therapist)

Thus, despite the emphasis on preparation within the analytic approach, the ending of therapy is likely to be a difficult process for various reasons. In the following extract the difficulties that may occur are accounted for via the notion that the way in which the ending of therapy is experienced is inextricably linked to the experience of endings in life. Hence, because endings in life are complex then the ending of therapy can also be understood as a process characterised by complexities:

I don't think there's any such thing as a simple ending, in life, forget therapy, there's no such thing as a simple ending, is there, no I'm sure there's not. So there's no way it can't be struggled with in therapy. 8; 411-413 (Female therapist)

Many issues may be understood as contributing to the complexity and the 'struggle' of bringing therapy to a close, once ending has been introduced into the therapeutic agenda. One such issue may be the feelings generated through the client's understanding that they are faced with becoming independent of the therapist and the
therapeutic process. This may be a particular issue for long-term therapy such as psychoanalytic therapy often is.
3.5.1. Struggles of independence/dependence

When the idea of ending therapy is initially raised by the therapist, as in the following account, this can be seen as coming as a shock to the client. This reaction can be seen as arising from an understanding of therapy as a process that has provided stability and which the client is reluctant to leave:

We were just over a year and half and he’d mentioned, you know, how it would feel er, if, you know, if he said to start to think about ending therapy. I thought, “ooh”, it was like um, I suppose like taking the stabilisers off your bike really. 9; 87-90 (Male client)

The therapy experience is thus storied as having fulfilled the function of a safety net for the client. It can therefore be argued that clients are likely to feel extremely vulnerable if ending is introduced into the relationship by the therapist, particularly if the client understands that they are not ready to leave. Hence, the client may be seen as feeling forced out of therapy. This is illustrated within the following account:

I thought oh I’ve run out of the resource for me, I’ve used it all up and um and I’m not ready. 5; 590-591 (Female client)

Thus, clients may be seen as feeling that they do not have a choice about the therapy coming to an end and, as in the previous account they may attribute this to a limited availability of resources. However, when the ending of therapy is brought onto the agenda, clients may be storied as becoming uncomfortably aware of the dependence on therapy that they may see themselves as having developed:
CHAPTER 3

It was the dependency that worried me, yes. I mean its not something that you can go through life with anyway, going and continually doing that ... that dependency is like a need and it shows a weakness. 5; 170-171; 176 (Female client)

Indeed, as in the following account, clients may be storied as having developed a dichotomous view of themselves whereby being in therapy is seen as being indicative of a weakness and being independent of therapy is associated with feelings of being in control and of being ‘strong’:

It’s difficult to explain because it was kind of a mental picture that couldn’t really be drawn but there’d be like two of me, the one who goes to therapy and the one who doesn’t, the difference being that one person goes to therapy every week, and I think that other woman who didn’t go to therapy every week, you know, I regarded her as sort of different, kind of perhaps stronger or in control in a way, you know, and I would...in some ways I would be looking forward to being able to try to be that woman that I saw as being stronger and able to cope with life and what it throws at you. 5; 443-450 (Female client)

It can therefore be argued that the dependence which is likely to develop within a long-term therapy relationship may be understood eventually as undermining a person’s own coping resources as they look to the external support of therapy and the relationship with the therapist to assist them. Thus, the client’s understanding may be that they would never reach a point where they felt ready or ‘strong enough’ to end the therapy themselves:

I can’t envisage for me sort of reaching a point where I felt strong enough to say hey you know let’s end this, so I can’t sort of envisage it in others if you like. 5; 632-633 (Female client)
Indeed, the therapist may be understood by the client as raising the issue of ending precisely because the client is seen as being dependent on the therapist and therapeutic process:

"I could suggest that she thought I was becoming dependent and that the best solution to that was to end. 5; 196-197 (Female client)"

It can thus be argued that when the therapist’s actions are understood in this way then the client is likely to feel vulnerable and powerless. Hence, when the end of therapy is constructed as the end of a dependency relationship from which they are being forced out, then understandably what happens after therapy has ended becomes something of an unknown. The client is therefore likely to feel ambivalent and afraid.
3.5.2. Struggles around the unknown of ending

Thus, a further issue that is seen as contributing to the struggle of ending is the unpredictability of how the client may feel and cope after therapy comes to an end:

I think it's a step into the unknown. 1; 837-838 (Female therapist)

Thus, the ending of therapy can be seen as provoking feelings of uncertainty around the client's understanding that they are unable to predict how they will feel and how they will cope without the support of the therapist and the therapeutic process. Therefore, awareness on the client's part that they have become dependent on the process of therapy and on the relationship with the therapist means that the ending of their therapy presents them with an unknown:

But I wasn't sort of thinking ooh I'm gonna be happy to manage on my own, it was like stepping into the water and I wasn't quite sure what it was going to be like, whether I would cope or not. 5; 106-108 (Female client)

Hence, because of the unknown aspects of ending, clients can be seen as feeling fearful and unconfident about their ability to be independent of therapy. Therapists may also be understood as concurring with these fears through their constructions of their lived experiences of being a client within personal therapy:

Being, being scared or apprehensive I think would be a, a feature really for me, I'd imagine for others as well, how am I going to cope, will things actually be any different, what if I feel I need therapy again, those sorts of questions. 1; 817-820 (Female therapist)
These accounts have implications for the understanding that clients can be facilitated to take control of when and how their therapy comes to an end. The ending of therapy can be seen as provoking significant fears for clients about how they will manage their lives without therapy. Furthermore, it can be argued that particularly in those instances where the therapist has initiated the ending, this action may heighten the client's awareness of the dependency they have developed on the therapist and the therapeutic process. As a consequence they may then feel vulnerable and under pressure to go along with whatever the therapist suggests.

The fear that is provoked by the uncertainties that the ending raises, arising from a perceived dependency on the therapeutic relationship, may therefore mean that clients are not able to be proactive in the termination process. However, as illustrated in an earlier section, therapists are seen as having a preference for client initiation and negotiation of the ending. It can be argued that this notion may not be realistic given the significant fears expressed by clients in their constructions of experiences of ending therapy, and indeed it may be more likely that the client will attempt to avoid the ending.
3.5.3. The conscious and unconscious avoidance of the ending

The previous sections have demonstrated how clients are at times seen as harbouring feelings of loss, fear, powerlessness and uncertainty about the ending of their therapy. As the following account illustrates, such feelings can be seen as leading to an attempted psychological avoidance of the ending whereby the client can be understood as actively striving to keep the thought of ending from their mind:

I did avoid it like the plague I must be honest, I didn’t like to think about it because it just filled me, I was just scared, before, in the run up to it. 5; 113-114 (Female client)

The client may also be storied as engaging in other forms of avoidance. In the following account, a focus on preparation of the client for ending by the therapist, through discussion of previous endings and how these have been experienced allows the client to avoid expressing their fears about the ‘real’ relationship ending:

We did talk about endings and how I experience them and this ending and how I felt about it, you know, it wasn’t like not discussed at all...and again I think there’s that, talking to her about that meant that I didn’t have to talk about the fact that I didn’t actually want it to end. 5; 378-381 (Female client)

Thus, under certain circumstances such attempts at avoidance and the fear that is likely to be fundamental to this avoidance may not be verbalised by the client. This may be particularly the case in instances where the therapist initially brought the issue of ending onto the agenda. It can thus be argued that clients may understand that they should suppress their fears, as expressing them will not alter the fact that their therapy is coming to an end. However, in cases where the client has been able to raise the
ending themselves and have felt confident enough to do so, then they are more likely to feel they have control over the pace of the ending. This may pre-empt the need for avoidance and the suppression of one’s emotions. This view is supported in the following account:

I think because I’ve had quite a lot of say in that you see, I think if he had said to me, you know, a few years ago ‘right well you know we’ve got to think about ending it’ I think I’d probably be saying something rather different, you know, it’s on the agenda because I’ve been putting it there, not my therapist, um. 2; 441-444 (Male therapist)

Hence, the fears and subtle avoidance manoeuvres may go unrecognised by the therapist. However, unconscious attempts to avoid the ending are understood as being expressed in the form of ‘symptoms’. This is a form of avoidance that is seen as being well recognised by therapists, as the following account illustrates:

Some people, as soon as termination is raised will discover new symptoms that they have or new areas that need to be talked about and er, that is understandable and I think is one of the avoidance mechanisms. 4; 212-214 (Male therapist)

Avoidance of the ending of therapy can also be seen as an issue that confronts therapists:

We’re all human too aren’t we so we get attached to people and that’s, that’s normal, you get close to people and you don’t want to say goodbye. 2; 533-535 (Male therapist)

It is therefore acknowledged that avoidance by therapists also occurs and as in the previous account, one way of understanding this is that it is an attempt to avoid the
pain of loss, as is seen to be the case for clients. Thus, as in the following account, therapists may understand that they have formed emotional attachments to particular clients and this realisation on the part of the therapist may lead them to suggest working towards the ending to counteract their own potential avoidance:

When I start looking forward to a session I usually take that as a sign that we need to think about ending because uh, although I hope that therapy will help people to make better relationships or more rewarding relationships I think these need to be made outside therapy, not in therapy. 4; 170-173 (Male therapist)

However, other forms of avoidance are seen as being more commonplace for the therapist in the construction of therapist experience:

I think what’s probably more common is avoiding the ending in order to avoid the feeling of limitation of therapy, and this is about I don’t know whether someone’s actually better off or they’re not as much better off as I have hoped or they had hoped. 4; 175-178 (Male therapist)

Thus, therapists may at times be seen as prolonging therapy as a means of avoiding the realisation that therapy has not had the desired effect, in terms of helping the client to change.

Thus, as this section has argued, avoidance may be an issue that confronts both clients and therapists. Client avoidance, either conscious or unconscious in the form of ‘symptoms’ may be seen as resulting from either feelings of loss, fear of therapy ending or powerlessness, or a combination of all of these. When avoidance is storied in this way then it can be seen as a passive resistance by the client to the therapy ending.
Therapist avoidance is accounted for by feelings of loss or more usually by a wish to avoid the realisation that the therapist and therapeutic process have not achieved the desired effect. Thus, the avoidance of ending when it occurs is also likely to complicate the process of ending.
3.6. Feelings of responsibility for the therapist

In addition to the occurrence of avoidance, continuing fears about ending may be suppressed within the therapy and therefore not verbalised to the therapist because of the client’s feelings of responsibility for the therapist:

I was quite scared and I didn’t want to tell her because, you know, I think I felt like I was, if I didn’t go, well if I didn’t stop going and then start to manage on my own my therapist had failed. 5; 117-119 (Female client)

Thus, clients may be seen as suppressing their fears about ending because they wish to avoid disappointing the therapist by verbalising them. Indeed, clients may understand that by placing what they perceive to be the needs of the therapist above their own then the final stages of the ending process may be of little therapeutic value to themselves:

It was almost as if the last two or three sessions were, were er, not particularly valuable to me in terms of dealing with the specific issues ... it just felt to me that, you know, they were fifty minute periods of er, of um questioned, questionable value really, mainly because I was concerned about drawing things to an end properly for, for my therapist really more than for me I think. 3; 377-379; 380-383 (Male client)

It can therefore be argued that when a client understands that they feel a responsibility towards the therapist then they may simply go along with the therapist’s suggestions regarding the ending and thus remain largely passive in the process of bringing therapy to an end. However, this would mean that the internal struggles of the client that are provoked by the forthcoming end to their therapy do not get expressed.
3.7. **Internalization**

When therapy comes to an end, therapists may be understood as anticipating that clients have absorbed important aspects of the therapeutic process. In addition, it is anticipated that representations of the therapeutic relationship, and of the person of the therapist may become internal to the client:

I suppose from a theoretical point of view you'd be hoping for some kind of internalisation of that relationship to take place um, and for someone to be able to sustain that, to own that, to kind of have some identification with. 2; 806-808 *(Male therapist)*

What becomes internalized is seen as being provided by the therapist via the process of therapy. However, what was once externally proffered is understood as having become transformed into an internal resource that the client can utilize. This view is exemplified within the following account:

They continue to draw on something the therapist has given them but perhaps even more importantly that that becomes part of themselves. 1; 770-771 *(Female therapist)*

Thus, the client is described as adopting and assimilating something that has been given to them by their therapist. Furthermore, the ending phase of psychoanalytic therapy can be seen as an important prerequisite for internalization to occur. The variety of feelings and reactions provoked by the ending are seen as being addressed within the termination phase and, hence, the client is understood as having worked through their grief prior to the occurrence of ending. As such, by the time the ending arrives the client is understood as having reached the stage whereby they are able to
become aware of an internal representation of a 'good object' that the therapist is seen as having modelled for the client:

The fact that we allow a termination phase to take place gives the patient time to work through the issues of loss before the loss occurs, and, you know, the ideal ending of bereavement is to re-discover the good object, internally, that you've lost externally, 7; 520-523 (Male therapist)

In addition, the internalized 'good therapist' may be understood as fulfilling different functions for the client once their therapy has ended. As in the following extract, an internalized image of one's therapist may be seen as a comfort or as an internal aide:

Its become less precise now I think, my therapist is in there somewhere but its not, she's not so clearly defined but there was, there was a period when I actually thought of her and, you know, had a kind of sense of her benign presence, you know, at times when I've been quite self attacking and that sort of thing there'd be this benign presence there which would be, you know, comforting. 7; 510-514 (Male therapist)

Perhaps the most important function of the internalized therapist and the internalized therapeutic process is to facilitate the client to tackle the obstacles that they may face in life as they were tackled within therapy with the therapist:

In some ways when I was trying to work something out I would think of her, because the way I was working something out would be the way that um, you know, I'd learned to do that with her. 5; 667-669 (Female client)

Thus, what is seen as becoming internal to the client which is understood as being derived from the experience of therapy, and from the interpersonal relationship with the therapist, is seen as a crucial resource to be drawn on at times of difficulty in the client's life. However, as previous sections have argued, clients may see their needs as
having been compromised within the latter stage of their therapy so that they remained largely passive in the run up to the ending. Hence, it can be argued that what therapists may see as potentially the internalisation of an uncomplicated *good therapist* and *good therapy* may actually be something more ambivalent and conflicted. Indeed, in the case of clients who see themselves as not having been given the opportunity to actively negotiate and contribute towards the process of termination, or those who have remained largely passive throughout this period then the residual feeling may be that the process is incomplete. Arguably, such lack of resolution for the client may mean that the process anticipated by therapists of the internalisation of a positive framework might not quite have worked.
3.8. Unfinished business

Previous sections have argued that the preparation of the client for ending that is seen to take place cannot pre-empt all the potentially complicating factors that may mean that clients are unable to take an active part in the process of ending therapy. It has also been demonstrated that clients are sometimes denied this opportunity by the therapist, although the expressed view is that clients should always be encouraged to be proactive in their own ending.

Whatever the contributing issues are, it has been demonstrated that the client’s feelings are sometimes not expressed and worked through prior to the ending of therapy. As is illustrated in the following account, therapists construct such instances of unfinished business as a negative way in which to end one’s therapy:

There are bad endings that can occur where it looks as though a piece of work’s been done but something hasn’t been completed. 7; 127-128 (Male therapist)

Indeed, it may be recognized that the ending of therapy was planned and time was given to working towards it however, the client may understand that certain issues were left outstanding:

When I think about it maybe it wasn’t such a, a good ending, I mean it was good, it was planned, er, yeah, but I don’t think it was, I don’t think I probably had worked through what I needed to. 6; 254-256 (Female therapist)
Thus, awareness that specific issues were left outstanding following the completion of
the therapy can be seen as contributing towards a negative construction of the therapy
experience. As in the following account, these can be issues of extreme personal
significance to the client:

There was if I am honest, there were feelings of being slightly let down, you know,
there were some issues around how I felt about losing my son and so on that we just
didn’t address really. 3; 481-483 (Male client)

Clients may therefore understand that they have been left with residual feelings that
there was no resolution to the end of the therapy experience:

It just seemed to me that closure wasn’t quite closure really when things could
actually be up in the air at the end of therapy. 3; 211-212 (Male client)

Feelings that arise from the idea that therapy is incomplete and that there is unfinished
business can also be understood as troubling clients before the actual end of therapy
has arrived. Clients may be seen as becoming aware prior to the ending that the
remaining time will not allow for adequate working through of the residual issues.
Hence, this may lead to a passive disengagement from the therapeutic process:

Not getting as deeply involved in talking, discussing like deeply emotional things was
to do with realising that I couldn’t resolve things because there wasn’t time, so like
you couldn’t discuss those things. 5; 460-463 (Female client)

Therefore, as this section has argued, clients may sometimes be seen as feeling that
they have unfinished business with respect to their experience of therapy. Hence, it
may be difficult for the client to ‘rediscover the good object’, as is hoped by the therapist, as they are likely to have a mixture of positive and negative thoughts and emotions towards their therapist and the therapy. Thus, the process of continuing gains that is anticipated by therapists to be undergone by clients, following the end of their therapy (by way of what has been internalised of the therapeutic process and the relationship), may actually be complicated by a more ambivalent view. Indeed, as has been demonstrated, clients report a mixture of thoughts and feelings about their therapy once it has come to an end.
4. Analysis 2

4.0. Overview of chapter

This chapter seeks to return to a selection of the narratives presented in chapter three in order to provisionally theorise the function of the discourses contained within the talk of therapists included in this study. This chapter then seeks to illustrate the hypothesised effects of the latter discourses by re-representing some of the narratives through which clients constructed their experience of termination. The critical discursive analysis contained within this chapter is predicated on the argument that the narratives set out in chapter three are more than just the way clients and therapist’s speak about their experiences of psychoanalytic therapy and termination. Thus, the focus of the following analysis is on how these narratives are played out as social practices and therefore how different ways of talking about psychoanalytic therapy and termination sustain some patterns of social action whilst excluding others.

It is therefore anticipated that a deeper level of analysis will expose some of the realities these narratives privilege and maintain (e.g. ending is always an experience of loss), and which they close down (e.g. ending as a new beginning may be the predominant perception of some clients). Put another way, it is anticipated that a discursive analysis will expose the dimensions of power contained within the talk of clients and therapists, pertaining to the experience of termination from long-term psychoanalytic therapy in a local NHS psychotherapy service.
Particular attention is given to the ideological effects these narratives have and, thus, the ways in which these narratives support and maintain particular institutions, namely, the psychoanalytic establishment. Ultimately then, this analysis seeks to illuminate the junctures where an explicit acknowledgement and discussion around the operation of power would update and improve the practice of traditional and therefore unmediated frameworks of psychoanalytic psychotherapy, and to the process of termination.

4.1. Discursive analysis of themes

4.1.1. Discourses constructing the importance of the relationship

As has been demonstrated, a prominent theme within the present study in the narratives of, in particular, therapists, is the centrality of the therapeutic relationship within psychoanalytic therapy. The relationship is seen as mediating insight and change in all phases of the therapeutic enterprise, including the process of bringing therapy to an end.

Within therapist narratives, the therapeutic relationship is constructed as containing intimate connections to the client’s relationships outside of therapy, via the transference. Hence, the client’s reactions and behaviour are seen as mirroring those originating in the context of other relationships. In particular, the primary relationship with the mother is seen as providing the themes of interpersonal life and is therefore seen as a crucial determinant of an individual’s psychological life. The following account illustrates this construction:
I see very early relations as laying down a sort of template um, and then later childhood relationships sort of adjust that template slightly um, but I think people do come into their adult relationships including their relationship with a therapist with that template so um, how they relate to you including how they experience the ending is going to be informed by that. 1; 508-513 (Female therapist)

Hence, the client-therapist relationship is typically seen as predicated primarily on the client’s early relationships with parents. The immediate relationship is thus privileged within the therapy because of the way in which it is constructed as a permeable membrane through which the internal conflicts deriving from the client’s significant early relationships flow, and are projected onto a ‘neutral’ therapist. It can be argued that such narratives have several characteristics, functions and consequences. One consequence is that such narratives have the effect of suggesting an absolute existence for such theoretical constructs as an internal template for relationships, as opposed to emphasising this view as potentially one of many ways of conceptualising a person’s experience. It is henceforth argued that psychoanalytic therapy, as practised in certain current contexts continues to behave powerfully in subscribing to specific ‘truths’ and thus closing down other possible ways of storying a person’s experience.

The idea of an internal template for relationships, like many of the structures that are theorised within psychoanalytic theory can implicate the person in the creation of their distress and can therefore function, it is argued, to locate responsibility for the latter within the client. Such narratives therefore potentially emphasise the role of the individual in the creation and reduction of their distress and can simultaneously de-emphasise the role of community and the co-construction of distress within the social realm.
In addition, an understanding of the relationship template tends to be predicated on the narrow assumption of a nuclear family and early interactions, both fantasised and real, with parental figures. Thus, such narratives may function to privilege certain types of experiences and in doing so may also simultaneously exclude other experiences or relationships which might have been equally, if not more important, in shaping a person’s experiences. For example, the role of structural issues that situate clients within society is likely to be obscured within analytic therapy when traditional theoretical structures such as the one under discussion predominate. Thus, issues such as the meaning of the person’s class, race and gender are rendered on the margins of the central core of the analytic model, that is, the primary relationship between parent and child. Therefore, as practised in certain contexts, psychoanalytic therapy continues to operate in a powerful manner by privileging certain kinds of experiences above others, namely, those originating within the primary caregiver relationship.

However, although the therapeutic relationship is storied as embodying the person’s formative relationships, the value of this relationship within certain psychoanalytic psychotherapies is constructed as lying in its simultaneous abstraction from other relationships. Therefore, the relationship in the following account is a de-contextualised one:

The therapeutic relationship is quite unique it’s, yeah I think probably prototypical, it is like other relationships but it is highlighted, abstracted, and therefore can be thought about almost kind of in a pure form. 4; 483-485 (Male therapist)

Hence, it can be argued that this particular emphasis with regards to the construction of the therapeutic relationship may reflect a tendency within certain psychoanalytic
therapies to construct contexts that are isolated and artificial. Such constructs, as demonstrated within the literature review, tend to be associated with more orthodox models of psychoanalysis such as those that have closely adhered to the Freudian scheme and the more traditional forms of object relations therapy. Thus, some specific psychoanalytic discourses, as in the extract shown above, may operate to distil out the therapeutic relationship and theorise it as if it exists outside of culture. An important consequence of a continued rigid adherence to such discourses, within certain approaches to psychoanalytic therapy, is that the material reality and socio-political context of client's lives will tend to be eclipsed from the work of therapy. Hence, it is argued that the de-contextualised relationship still reified within some contexts in which psychoanalytic psychotherapy is practiced, and evidenced in the previous extract, ignores the real-world contexts that give human action and distress their meaning.

Furthermore, discourses such as that exemplified within the previous extract, which reify the significance of events occurring within isolated contexts, such as within the therapeutic relationship and transference, may at times and in specific contexts (e.g. psychotherapy offered within the NHS), allow the institution of psychoanalytic psychotherapy to maintain territorial control over the boundaries of its work with clients. Indeed, as the following account illustrates, through emphasising that the therapeutic relationship is the central therapeutic device, psychoanalytic psychotherapy can be privileged over other approaches to therapy:

"It's just an opportunity that's too good to miss and that might, I suppose for me other therapies do miss it. 7; 281-282 (Male therapist)"
It is argued that because the relationship between client and therapist is central to psychoanalytic psychotherapy and because this focus is established in the previous account as peculiar to the latter, psychoanalytic psychotherapists are able to demarcate the therapy they practice from that of other therapists. This activity was identified in numerous accounts of which the following is an additional example. In this case, however, the typically longer time period through which psychoanalytic therapy takes place is utilised as a differentiating practice:

I guess because psychodynamic psychotherapy tends to be longer than other forms of therapy often then there’s more chance of that deeper relationship developing perhaps. 1; 218-220 (Female therapist)

Hence, it can be argued that through subordinating adjacent approaches to psychotherapy, the effects of such discourses are to justify the existence of the psychoanalytic psychotherapies, and to justify their value to clients. Ultimately then it is argued that such narratives function to preserve and extend the access that psychoanalytic psychotherapists have to their clientele.

4.1.2. The hierarchical construction of the therapeutic relationship

Within the following account the hierarchical structure characteristic of more traditional forms of psychoanalytic psychotherapy is invoked in order to construct the ending as a significant and unique experience:

But I think it’s the ending in therapy is particularly different, significant, whatever because um, well like a parental relationship it’s a relationship where you um are
Discourses offer subject positions and in the case of this account the therapeutic relationship invoked is one delimited by the complementary yet hierarchical positions of 'help-seeking' and 'help-providing'. Within this account the therapist adopts an authoritarian position of 'expert' and thus simultaneously positions the client in the role of naïve, help-seeker. Thus, the asymmetry implicit in this discourse produces practices with varying contents of inequality and non-reciprocity. The discourse contained here therefore functions in this case to reinforce the powerful position of the therapist as one who has the ability and knowledge to assist the client and perhaps 'cure' them of their symptoms. It is thus argued that if this inherent power differential contained within such taken-for-granted constructions of the therapeutic relationship is overlooked, and not exposed within therapy, then there are likely to be consequences for the client in terms of perhaps feeling disenfranchised and powerless.

4.1.3. The construction of termination as a unique phase of analytic therapy

Termination is storied as a relatively technical phase of therapy within therapist narratives. Also, discourses of termination found within the narratives constructed by therapists characterise it as a time of increased therapeutic activity, particularly on the part of the therapist. Indeed, these themes mirror those found in the literature reviewed for this study. The activity of the therapist is constructed as a necessary response to the reactions the ending provokes in the client, such as the re-emergence of previously experienced symptoms and conflicts, an increase in transference activities whereby
the client makes their final attempts to have their infantile wishes gratified, and the re-
experiencing of previous losses.

In particular, narratives of termination emphasise the experience of loss as central to
this phase of therapy and therefore as an expected and, hence, invited reaction.
Further, the experience of loss associated with termination from psychoanalytic
psychotherapy is elaborated within these narratives so that the loss is constructed as
occurring at different levels of experience such as within the transference, and as a
reaction to the ending of the *real* relationship with the therapist. The following
account exemplifies this construction of differentiated loss:

> Oh I think there's many levels, I mean I think, and hopefully you'll touch on the
> many levels. 8; 465-466 *(Female therapist)*

Because the experience of loss within termination is constructed in this way then it
follows that the activities of the therapist are storied as specialised and differentiated.
Indeed, this construction filtered through the narratives of therapists when they
discussed the importance and nature of preparation for termination (see section 3.3).
The following sections therefore seek to illustrate the nature and effects of the
discourses of termination contained within the psychoanalytic literature and the
narratives of the therapists and clients included in this study.
4.1.4. The construction of termination as an experience of loss

As exemplified within the following account, discourses of termination construct the ending of psychoanalytic psychotherapy as a definitive experience of loss:

It would be surprising if an ending didn’t have overtones of separation, or loss, um after all that’s what it is. 4; 388-389 (Male therapist)

In constructing the ending as a definitive loss experience, this account therefore provides an example of the ways in which psychoanalytic discourses make powerful claims to truth, and as a result other stories of possibility may be eclipsed from consideration within the therapy. Furthermore, psychoanalytic theory is specifically predicated on the experience of loss within the primary relationship(s). As such, the ending of the therapeutic relationship, in emulating the conflicts that are theorised as arising within the latter relationship(s), is constructed as a process that particularly inspires feelings of loss within the transference:

I do think that it, it brings back very early experiences of er, of attachment, dependency and loss and um that these get reawakened um at, you know, more or less conscious levels. 2; 493-495 (Male therapist)

Such discourses have several effects and consequences. Thus, the theoretical dictate that the client’s current distress is derived from early relationships is privileged within the termination phase. The current and perhaps more important social and political context of the client may therefore be eclipsed. This is not to say that for some clients, conflicts that may have arisen within early relationship(s) may be the crucial factors to be addressed in the termination phase. Arguably however, this is not the only story of
possibility and analytic theory and therapy, applied in certain ways, behaves in an oppressive way in presenting these ideas as the ‘truth’ of a person’s experience.

Furthermore, because the experience of loss is privileged within the termination phase, in this case loss occurring in connection with the transference, then the within-therapy focus of psychoanalytic psychotherapy is maintained. The theory-constructed context is therefore emphasised and the wider social context that situates the therapy is overlooked. Thus, it is argued that the deployment of such discourses function to reproduce the material basis of psychoanalytic theory and reinforce the utility of theoretical structures such as the transference.

It is therefore argued, as illustrated in the following account, that because the construction of termination as an experience of loss is privileged, then the client is invited to experience feelings of loss and to enter a grieving period at the end of therapy:

Maybe I am going through a grieving process, it's funny I feel very different to the ending of my first therapy where I clearly felt distressed and missed going and, and I haven’t felt that ... but its still an ending and it must be in there somewhere, I don’t know what I’ve done with it really. 8; 720-722; 725-726 (Female therapist)

Thus, discourses of termination invite the individual to doubt the possibility of other experiences besides that of loss and grief. It can therefore be argued that this illustrates the powerfulness of the loss discourse within psychoanalytic psychotherapy in that it closes down opportunities to experience and express feelings other than loss.

One consequence of this, suggested by the previous account, can be that clients may
undermine their more obvious feelings in favour of believing that at some level they must be going through a process of grief. Indeed, a variety of examples of other experiences besides that of loss are provided in the accounts of the clients and therapists interviewed for this study, such as positive feelings of new beginnings, feelings of responsibility for the therapist and a sense of powerlessness (e.g. see sections 3.4 & 3.6).

Factors within the client’s social environment or within that of the therapist, or both, may in some cases be more important to be considered in relation to the ending. However, discourses that construct termination as an experience of loss ensure that the focus of client and therapist is ‘inward-looking’. Thus, narratives of transference loss may at times actually close down a focus on what is important about the ending. Once again, it is argued that these ideas are only one story of possibility and by focusing on these events taking place within an isolated context, important events and feelings associated with the real relationship and its social context may be missed. Indeed, the following account provides such an example:

We did talk about endings and how I experience them and this ending and how I felt about it, you know, it wasn’t like not discussed at all…and again I think there’s that, talking to her about that meant that I didn’t have to talk about the fact that I didn’t actually want it to end. 5; 378-381 (Female client)

Thus, in this case, by privileging discourses of loss and transference within the termination, an important and very real issue was overlooked by the therapist, that is that the client did not feel ready to end their therapy. It is therefore argued that the dominant position held by these narratives within certain psychoanalytic frameworks
may obscure the complexity of experience and militate against clients’ feeling able to express the important issues for them. In addition, a potentially harmful consequence of the way in which psychoanalytic discourses construct termination as a definitive experience of loss is illustrated in the following account:

If it didn’t relate to any other losses or separations I would become seriously concerned about, among other, people’s capacity for dissociation. 4; 389-391

(Male therapist)

Hence, it is argued that clients may be pathologised for not exhibiting the reactions proscribed by dominant discourses of loss.

As mentioned previously, the construction of termination loss as a complex and differentiated experience, deriving in particular from very early relationships with parental figures, may be seen as inviting the development of specialised interventions to be carried out by the therapist. The following account illustrates this notion:

The things that get re-worked in that termination are often from very early on and, you know, our memory fails us around those very early separations. 7; 388-389 (Male therapist)

Hence, because the experiences associated with termination are storied as originating within the primary relationship(s), the client is constructed as unable to identify and interpret these for themselves. Therefore, these discourses actively construct a crucial role for the therapist and suggest that they are the only ones that can assist the client in bringing these conflicts into consciousness. Thus, because the termination is storied as recreating early separations and therefore inspiring an experience of loss, a necessity
for particular interventions on the part of the therapist is constructed. Hence, discourses of loss sustain a view that the termination phase is significant and that it requires particular focused intervention. Indeed, in a similar way to that in which psychoanalytic discourses appropriate the therapeutic relationship as defining of the analytic approach, so do they also, it is argued, construct and appropriate the termination phase as something that differentiates the analytic approach from other therapeutic approaches. Such discourses therefore play a crucial role in actively constructing a model of therapy that can then set itself apart from other models of therapy as offering a unique way of working to clients.

4.1.5. The construction of the importance of preparation for termination

As has been argued in the previous section, discourses that construct the prevalence and differentiated nature of the experience of loss within the termination justify the existence of a defined termination phase and also active, termination-specific interventions by a therapist. However, according to therapist narratives, prior to the onset of termination a decision is reached about whether the criteria for ending have been met and when therapy will come to an end. As was illustrated in the literature review, planned endings are often storied as synonymous with mutually agreed endings and the narratives of the therapists interviewed for this study mirrored this notion. The following therapist narrative thus provides one such example:

My experience of it is not that there’s an end-point of the therapy that the client gets informed about but rather there is a time when an ending becomes thinkable, and after it’s become thinkable it becomes discuss-able, and then when it’s discussed then we agree on an ending date, and in a sense I don’t know about that any more than my patient does in advance until we’ve agreed on one. 4; 490-494 (Male therapist)
This account constructs the process of arriving at a date for the ending of therapy as characterised by mutuality. However, arriving at a mutually agreed decision typically follows a period of debate and therefore the movement of power between parties, whereas the above account constructs the process of reaching a decision about ending as one where the operations of power are suspended. In contrast, the following account constructs the same process of deciding when therapy should come to an end as one of active negotiation between the client and therapist:

It's negotiated you know, it gets negotiated really. 6; 214 (Female therapist)

Taken together, the previous accounts belie the storying into being of the concept of mutual endings. However, both accounts construct the process of reaching a decision about ending as one of mutuality and therefore a process within which power is equally distributed between client and therapist or, if not equally distributed, a process in which the client has some power to negotiate. It is argued however that discourses that construct the ending as a mutual and/or negotiated process contradict the discourses embedded within psychoanalysis that construct analytic therapy as an ‘expert’ therapy. The latter narratives position clients as ‘non-expert’ and as needing the expert guidance of the knowledgeable therapist. Simultaneously, the therapist is storied as having the means to interpret and repair the client’s internal world.

This narrative therefore implies that clients would not be able to judge for themselves when they would be ready to end their therapy. Furthermore, because clients are positioned as non-expert by these powerful narratives, it follows that they would not
have the means or the opportunity to take the control necessary to negotiate the ending with the therapist:

I think she made the suggestion of, you know, and um I went along with that, and apart from the asking if I could have a trial period I don’t think I had a lot of input into it really. 5; 609-611 (Female client)

Thus, despite the construction found in the accounts of therapists that the process of deciding when to bring therapy to an end provides opportunities for the client to actively negotiate this was found not to be the case in many client accounts. Furthermore, in some cases, the experiences evoked by the ending reproduced the same power dynamic associated with earlier traumatic experiences:

I couldn’t protest, I probably couldn’t, didn’t protest so... it was devastating I suppose, do you know what I mean, frightened. So I think my experience of ending my first therapy was very much a repeat for me of leaving home or not leaving home as the case may be. 8; 182-185 (Female therapist)

However, rather than acknowledging that negative experiences such as these are produced within a social context and therefore within the context of a relationship and the social circumstances that situate that relationship, psychoanalytic discourses locate the source of such experiences within the individual:

If you’re only going to hear what you expect to hear or see, you’ll repeat it for yourself, you’ll find it, you know, you’ll cause it, you’ll look for it, the repeat bit. 8; 509-511 (Female therapist)
In this way, the person’s distress is located discursively within the individual and, thus, the social context within which these feelings have arisen and indeed been invited through the construction of a hierarchical relationship is hidden. The person’s agency in the creation of their distress is therefore emphasised. Simultaneously, the therapist’s role in the co-construction of these experiences is subjugated from view. Such narratives can thus be seen as supportive of wider societal discourses of individualisation, through their reproduction within the context of analytic psychotherapy. A consequence of such individualistic constructions is that an emphasis on the differences between client and therapist is maintained whereby the therapist is positioned as ‘mentally healthy’ and the client as ‘damaged’. It is therefore argued that such accounts are reproductive of notions of pathology, however the way in which accounts such as these operate is hidden from view by dominant discourses that define the goal of therapy as the reduction of individual distress.

Once a date for ending has been agreed then the termination is storied as beginning proper and the therapist’s activities may be understood as inviting a focus on the significance of this phase of the therapy:

As soon as termination’s raised, the termination phase has started, then I kind of tend to imagine a banner over the patient’s head which says ‘every interpretation will be linked to termination’. So I will try not to say anything to the patient which isn’t related to termination. 4; 202-205 (Male therapist)

In this account, the therapist constructs their actions during the ending of therapy as focusing exclusively on the termination and therefore applying the notion as a blanket concept. It is argued that this account therefore provides an example of discourses of
termination closing down other alternatives within the therapy, via the activities of the therapist. An exclusive focus on the termination and on the interpretation of the psychological phenomena arising within therapy at this time may indeed be useful for some clients, however, it may also reduce the freedom of expression of the client and close down what the client feels permitted to talk about. Furthermore, although in the case of the above account a process of exclusively focusing on the termination is identified, it is doubtful that the client is made aware of this change in process. However, some of the therapists interviewed for this study described how they routinely give clients a choice regarding what they wish to focus on in the closing stages of therapy. Nevertheless, it is argued that this falls short of offering the client meaningful choices as the embedded dichotomy of expert/non-expert that situates analytic therapy is not explicitly addressed and so simultaneously deprives the client of real power and, hence, constrains their activities.

As demonstrated in the previous account, psychoanalytic therapy illustrates a tendency to privilege particular theoretical discourses as if they were the ‘truth’ of a person’s experience. Thus, it is argued that analytic psychotherapy powerfully imposes its metaphor for understanding human behaviour and distress onto clients rather than attempting to enter the metaphors that client’s bring into therapy. It has been discussed at length how the impact of early relationships on the person’s psychology has a privileged focus in the work of psychoanalysis, however, in the case of some clients such a narrow focus may not provide an adequate way of understanding their distress:

I didn’t have a world-view really and that was a serious consequence to me and he said that therapy could do something about that, he felt. I feel however that, that very
little was done in that way and perhaps nothing could be done about that with psychotherapy. 3; 612-615 (Male client)

By not working within the client’s narratives in order to understand the client’s distress it is argued that other ways of describing the client’s experiences are effectively closed down. In the case of the above client, discourses of spirituality were of primary importance and clearly provided a situating force for the way this person viewed their self. However, the within therapy focus of analytic discourses closes itself down to a consideration of wider social and structural issues such as these and, hence, can therefore leave clients feeling like they have not really been heard or that their experience has not been validated. Furthermore, it can be argued that this account provides an example of the effects on the client of a therapy which does not situate the client’s distress within the social context and does not therefore incorporate crucial situating factors within the client’s life and experience.

It is therefore argued that in order to develop a full understanding of the client’s life and distress, psychoanalysts must extend the boundaries of psychoanalytic therapy beyond a focus on the individual into the social, political and economic context that situates the client and therapist’s lives and the therapy experience. In this case, as with any client who enters psychoanalytic therapy, the client learns about their distress, interprets their experience within the context of psychoanalytic theory, which promotes a particular version of psychological distress and its origins. However, it can be argued that the framework for understanding provided by psychoanalytic psychotherapy does not provide the client with an adequate account as it is an account
based around the individual psyche and early relationships rather than being located
within the client’s wider social context.

4.2. Summary of chapter

In summary, this section has demonstrated, through a discursive analysis of narratives,
that termination can be understood as a constructed phenomenon that functions to
differentiate analytic psychotherapy from other therapies. Hence, the construction and
elaboration of the termination within analytic discourses supports the institution of
analytic psychotherapy as an approach and ideology that is unique in specific ways
and that, hence, has something to offer clients that no other approaches can. It has
been argued that such discourses protect the boundaries of the psychoanalytic
institution.

It has also been argued that ideas of power are not well articulated within some
theories of psychoanalysis. This will inevitably extend therefore to the local
interactions taking place within the process of psychoanalytic psychotherapy. This
was indeed found to be the case in the process of analysing client and therapist
accounts of the ending within psychoanalytic psychotherapy. Discourses that
emphasise the specialist activities of therapists during termination support the
construction of analytic therapists as experts and have the effect of maintaining the
power imbalance between client and therapist as the therapist’s activities are mystified
and therefore become the sole preserve of the therapist.
5. Discussion

5.0. Overview of chapter

Initially in this final chapter, I consider my findings in relation to the aims of this study, as outlined in the introduction. In doing so I seek to demonstrate the links between the emergent discourses, arising from interviews with clients and therapists and the literature reviewed on the subject of termination. It will be argued that whilst these discourses predominantly mirror the psychoanalytic literature that is available on termination, some client and therapist narratives cannot be explained by the available literature. For example, analysis revealed narratives echoing feelings of powerlessness in the talk of clients and therapists in the position of clients. In contrast, powerlessness as an experience associated with the ending of therapy was not well articulated in the narratives contained within therapist’s talk and was absent from the termination literature reviewed.

Thereafter, this chapter seeks to outline the implications of this study for the following areas: psychoanalytic theory and therapy, research and policy. Finally, a critical evaluation of the study is provided.
5.1. Summary and overview of the study

Commensurate with the aims of this study, as outlined in the introductory chapter, a rich array of discourses and sub-discourses describing aspects of client and therapist experiences of termination were generated within the interviews. These were generated utilising qualitative methods, namely, semi-structured interviews and through the application of a method of discourse analysis. The discourses were constituted by the complexity of respondent perspectives shown in Figure 15:

**Figure 15: Respondent perspectives sought and elicited during interviews**

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>1. View on how clients understand termination</td>
</tr>
<tr>
<td></td>
<td>2. Experiences of ending therapy</td>
</tr>
<tr>
<td>Therapist</td>
<td>1. View on how therapists understand termination</td>
</tr>
<tr>
<td></td>
<td>2. View on how clients understand termination</td>
</tr>
<tr>
<td></td>
<td>3. Experiences of ending therapy in the position of client</td>
</tr>
<tr>
<td></td>
<td>4. Experiences of ending therapy in the position of therapist</td>
</tr>
</tbody>
</table>

Pervading the emergent discourses, deriving in particular from the talk of therapists interviewed for this study, was the idea that the therapeutic relationship established in
the context of object relations psychoanalytic therapy is the most crucial aspect of this approach. As demonstrated within the literature review, this is by no means a new concept within psychoanalytic theory and practice and, indeed, there is an abundant body of literature on the significance of the therapeutic relationship within psychoanalytic therapy (e.g. Nuttall, 2000; Kahn, 1997; Winnicott, 1956). However, within this study the prevalent discourse constructing the centrality of the therapeutic relationship embodied many other important sub-discourses, and therefore played a crucial part in demonstrating how aspects of the process of termination are storied into being by therapists and clients.

The relationship between client and therapist is seen to connect with the client's relationships with early caretakers and is storied as providing the conditions for a re-emergence of psychic conflicts originating from within these primary relationships. Thus, in common with much of the early object relations literature (e.g. see Fairburn, 1954), I argue that the within-therapy context, although underpinned by a 'two-person' construction, continues to be hailed as the central focus of concern within psychoanalytic therapies practised in certain contexts. That is, in the case of this study, an NHS psychotherapy service. This is despite the many revisions to psychoanalytic theory and specific psychoanalytic models of therapy, some of which were examined within the introductory chapter of this study (e.g. see Ratigan, 1995; Ellis, 1997).

Further, within the talk of clients and therapists, discourses of loss offered the dominant way of constructing the experience of termination. These narratives were prominent within the literature on termination outlined in chapter 1. In constructing termination as predominantly an experience of loss, reactions such as grief are
inevitably invited. Support for this argument was found in both client and therapist narratives. However, clients also constructed their experiences by utilising a number of alternative narratives, such as that of 'termination as a new beginning'. The latter discourse, for example, is minimally discussed within the termination literature and was found within the present study to occupy a relatively minor position in the talk of therapists, when they were discussing the client's experience of termination.

Discourses constructing the importance of preparation of the client for ending, within the narratives of therapists, naturally derived from the storying of termination as a complex experience of loss. However, the process by which client and therapist come to a decision about bringing therapy to an end was constructed in different ways within the narratives of therapists. One of these discourses constructed this as a passive process whereby the client and therapist were seen as simultaneously reaching a decision about bringing therapy to an end. An alternative way of constructing this process, pervading the narratives of therapists was one of active negotiation between client and therapist. Both of these constructions similarly emphasised mutuality within the process of deciding that therapy should be brought to an end. This storied mutuality was not however mirrored within the narratives of clients included in this study.

Rather, the narratives of clients constructed a therapist-led process with little opportunity for active negotiation over when the therapy should appropriately be brought to an end, and which issues should be the focus of the termination phase. Furthermore, the narratives of clients described a complexity of experiences pertaining to the ending of therapy. These included awareness of feelings of
dependence on the therapist and therapy, feelings of responsibility for the therapist, suppression of feelings about ending, avoidance strategies, and residual feelings that the termination had not addressed areas of importance for the client.

An additional aim at the outset of this study was to conduct a critique of psychoanalytic theory by asking questions of the discourses generated around the issue of termination. One such question derived from the finding that whilst therapists construct the therapeutic relationship as necessarily invoking the client's earliest relationships and, in doing so implicitly acknowledge the relationship within analytic therapy as authoritarian in character, a contrasting narrative stories clients as proactive in the termination phase. Arguably therefore, such constructions exclude the issue of the real power inequality that is built into the therapeutic relationship within certain models of analytic psychotherapy, and the constraining effect that this will inevitably have on what occurs in the therapy and what options are available to clients.

Thus, the study applied a critical, social constructionist lens to some of the fundamental premises of one specific framework for psychoanalytic therapy, via the discourses generated, in order to: 1) highlight the general therapeutic milieu which these construct, and 2) deconstruct this therapeutic milieu with reference to issues pertaining to power and/or a lack of power and, thus, make some of the effects of certain analytic practices more visible and open to scrutiny. However, as with any post-modern critique, my aim has not been to argue for the abandonment of psychoanalytic therapy per se, but rather to open the way for a critical inspection of the ways in which certain forms of psychoanalytic therapy are conducted, and the theoretical assumptions these approaches embody.
In casting a critical eye on the discourses around termination generated within this study some interesting and potentially valuable findings have therefore been exposed. These will be examined in the following sections with reference to the implications that these findings have for psychoanalytic theory and therapy, research and policy. Thus, the implications ensuing from this study are not only restricted to the termination but also extend to the process embodied by specific forms of psychoanalytic therapy, and the theories behind them.

5.2. Implications for psychoanalytic theory & therapy

One of the major discourses elicited from the talk of clients and therapists, especially therapists, was that which constructed the therapeutic relationship as a powerful entity. The therapeutic relationship is storied as the crucial context within which the client’s previous experience of relationships becomes apparent and gets played out with the person of the therapist (transference). In particular, the formative influence of the person’s earliest relationships is prized. Typically, British Object Relations theory privileges a pre-Oedipal focus, on the relationship between mother and child and the conflicts arising from the developmental obstacles contained therein. Orthodox psychoanalysis however, and those approaches largely based on the Freudian scheme typically favour a focus on the significance of the Oedipus complex and the three-cornered relationship of father, mother and child.

Whilst not seeking to deny the significance of early relationships with caretakers, and the implications these may have for later development, children may however have multiple relationships that have an equal potency to that of the relationship with
parents, for example, with their siblings, grandparents or babysitter. Indeed, the notion of a traditional nuclear family with defined, proper roles for men and women, on which these theories rest, would seem to be an outdated concept within current society and may not represent the experience of a significant proportion of clients. For example, a child may have been brought up within a single-parent family or in the context of a gay relationship.

Arguably therefore, the reluctance shown by certain psychoanalytic practitioners to update their practice and revise the theoretical underpinnings of the latter to accord with the changing structure of our society and relationships may reflect something of the original ideological agenda of psychoanalysis. That is, in supporting and maintaining ideas such as the nuclear family and defined roles for men and women within this structure. As argued within chapter 1, amongst others, Orbach & Eichenbaum (1982) have discussed the need for attention to the ways in which gendered subjectivities are uncritically endorsed within certain models of psychoanalytic therapy. Femininity and masculinity are ideological practices, the more effective because of the taken-for-granted nature of the assumptions about what are the male and female domains. These assumptions have been taken into psychotherapy and therefore emerge as normative statements and codes of conduct with potentially damaging effects.

Taking a particular example of working with female clients, women have been socialised into the position of being economically dependent within patriarchal structures, and then pathologised for that dependence. Historically therefore, the prominent role carved out for women, is that of emotional caretakers and nurturers of
society. Yet women are caricatured as dependent in the sense of being clinging, helpless and weak, their assigned role thus containing a contradiction and a pejorative label (Heenan, 1995). Indeed, as Warner (2001) argues, because notions of dependency are associated with women they are automatically devalued whereas the binary opposition of independence, in being associated with masculinity, is highly valued.

The relationship between economic dependence in producing personal dependence therefore needs to be made explicit within psychotherapy, alongside. The structural processes against women becoming or existing as autonomous are well internalised and may therefore frustrate and prevent women from coming to terms with their own predicament. The internalisation of these powerful societal discourses by women that invite self-deprecation and dependency are one potentially powerful site of intervention within the termination. This study therefore contends that when the discourses embedded within certain therapeutic practices instead invite and focus on the experience of loss within the termination, these oppressive forces are simply maintained and perpetuated.

Without this perspective therefore, specific frameworks for psychotherapy, with their emphasis on individual rather than structural processes, hold the danger that these dependency processes will simply be repeated in therapy to the detriment of women. Arguably, evidence for this process was vividly evoked in the talk of a female client interviewed in this study. She utilised two separate self-constructions which conveyed her feelings of dependency on the therapist and the therapy, at termination; one for the self that was in therapy (‘weak’) and one for the self that she had fantasised no longer
went to therapy ('strong') (see chapter 3, p.128). These self-constructions functioned
to convey the feelings of failure that she reported these dependency feelings had
provoked in her. Thus, one potential consequence of attending to the structural
processes that situate our clients, and perhaps for the female respondent referred to
above, would perhaps be that individuals are contextualised within their social roles
and not amputated from the consequences of them. In the case of the respondent
described above, if these situating and oppressive practices had been articulated within
therapy, space may have been opened up for her to express her feelings of dependency
to the therapist, rather than keeping them hidden as a result of self-deprecation. A
reflective space may then have been opened up where it would have been possible to
reappraise these feelings in a more positive light, for example by exploring the idea
that if she could not depend on her therapist then she could not have engaged within
the therapeutic process.

As discussed previously, the experience of loss was found to be the dominant way
through which the ending of therapy was discursively constructed. Within the
narratives of therapists, termination is storied as a unique and critical phase of the
therapeutic relationship and the work of therapy. This accords with the termination
literature pertaining to psychoanalytic therapy (e.g. see Frank, 1999). Termination is
thus seen to hold a special significance for the client within the narratives of
therapists, and, typically, these narratives were constructed with reference to
discourses of loss and grief occurring at different levels of consciousness and
therefore deriving from different psychic sources. Loss is thus described as being
experienced at the level of the immediate client-therapist relationship, in the
experienced repetition of previous losses occurring within the transference, and as a
consequence of the client renouncing their desire to have their transference wishes gratified. The latter are predominantly seen as infantile wishes for fulfilment of one kind or another, usually by a parent figure. Once again these findings resonate with the literature on termination (e.g. see Blum, 1989; Levinson, 1977).

However, within the narratives of therapists and also within the literature on termination (e.g. see Dewald, 1982), a distinction is made between prior losses in the client’s life re-experienced within the transference and the loss of the therapist as a real person. These were differentiated on the basis that the latter experience of loss within termination typically arises from the psychological maturation of the client. Within this construction, the client is therefore storied as leaving the therapist rather than the client being left (e.g. see chapter 3, p.107-108), as is seen to be typically the case with the experience of loss outside of this context. Therapist’s also talked about their preferences for client-initiated ending and their attempts to facilitate this activity on the part of clients. Furthermore, as was argued within the previous chapter, the process of arriving at a decision of when therapy will be brought to an end is characterised within therapist discourses in contrasting ways. These portrayals were referred to respectively as ‘passive’ and ‘active’ and both of these constructions loosely correspond to the classification utilised in the literature of a ‘mutual’ or ‘planned’ ending (e.g. Dewald, 1982). Therapist narratives that construct the process of arriving at a decision of working towards an ending therefore contradict those of expert/non-expert as they storied this process as predominantly mutual.

All of the therapist discourses described here thus imply either that clients feel in control of the ending or that the process is a predominantly mutual one. However,
taking into account the powerful position of the therapist from the outset, this study contends that it may be disingenuous to talk about mutual endings or endings where clients feel they are in control of the process when arguably there is no mutual relationship in the first place. It therefore becomes contentious that clients would be able to determine for themselves when they are ready to end their therapy, or indeed to take any proactive role. These therapist discourses were indeed contradicted by those of clients who discussed a variety of experiences associated with termination including the perception that the latter was therapist-led, that they felt powerless to forestall this process and unable to express their real fears about ending.

An individual’s role within the therapeutic process is not absolute, however, therapist discourses and the literature on termination clearly fail to represent the moments in therapy when the power shifts or is negotiated. It may therefore be safe to assume that operations of power are not explicitly addressed within the therapy, despite the fact that an understanding of the ways in which power is enacted within therapy may be crucial for understanding the process and emotional reactions of clients and therapists.

To exemplify this point, in the case of therapists initially mooting the idea of ending, as was found to be the case in the context of client narratives contained herein, clients did not perceive that any explicit discussion about how this had felt for them had taken place. Rather, the perception was that they just had to get on with the process as it emerged and the real lived experience of the client of not having a choice at that point in the therapy was not set at issue.
The client's experience of vulnerability was evoked through one interviewee's use of a powerful metaphor that constructed an image of the stabilisers being taken off his bike when the therapist had initially raised the idea of therapy being brought to an end (see chapter 3, p. 127). It is therefore argued that once the end of therapy has been raised by a therapist, despite encouragement of the client to become proactive within that process, it may be very difficult for the client to recover from a position of vulnerability and express what they may be experiencing. Furthermore, as was illustrated in chapter three, when the therapist initially brings the ending onto the agenda, clients may construct a variety of explanations to account for the therapist's actions. One example of such accounting was the use of the widely available discourse regarding the stretched resources of the NHS and the management of long waiting lists (see Chapter 3, p. 127). Thus, when such ways of accounting are utilised it is very unlikely that client's would attempt to challenge the view of the therapist and express, for example, the view that they did not feel ready to end their therapy. However, if the therapist were to explicitly discuss power relationships throughout the whole process of therapy then it is likely to result, it is argued, in the client becoming more powerful.

In contrast to the therapist discourses described above that were found to construct termination as a typically mutual process, or one where the balance of power is in the client's favour, other therapist discourses construct the termination as a relatively 'technical' phase of psychoanalytic therapy. This view is echoed in the literature (e.g. Kohut, 1977 cited in Novick, 1997). Thus, heightened activity on the part of the therapist in the form of transference interpretations is both invited and justified. As such, psychological activity during this phase, in the context of the transference, is storied as frenzied. The complex and multidimensional phenomena that are described
as manifest within the ending phase therefore justify certain interventions and tasks that psychoanalytic therapists perform. Thus, one of the primary tasks of the termination phase is seen as the ‘working through’ of the client’s inevitable grief and resolution of the various reactions that separation from, and loss of, the relationship with the therapist stimulate (e.g. see Dewald, 1982).

As argued in the previous chapter, discourses that construct the specialised knowledge of the psychoanalytic therapist (and other therapists), such as that required for termination, simultaneously create the basis for professional prestige and social distance between the therapist and the client. This is because the client, by definition, is excluded from the esoteric knowledge of psychoanalytic theory. The client is therefore invited, it is argued, to experience a sense of dependency on the therapist who is constructed by these dominant narratives as holding the key to the client’s mental health.

Under these circumstances, when clients construct their experiences by utilising available narratives of powerlessness and impotence, as in the case of this study, their only option for forestalling the ending may be attempted conscious or unconscious avoidance. The emergence of avoidance as a theme both within the talk of clients and therapists concurred with the literature on termination (e.g. see Blum, 1989). However, a sub-narrative of the discourse of avoidance poses an interesting question for the therapist discourses described above, and for the literature describing the importance of preparation of the client for ending. As has been discussed at length, the view represented by the literature and echoed by the therapists included in this study is that termination evokes previous losses and separations and, hence, transference loss
is generally deemed to be the primary focus for the therapist’s interventions during this phase. However, one of the narratives that emerged from the analysis demonstrated how feelings of not wanting the therapy and the ‘real’ relationship to end were avoided through collusion with the therapist’s interventions pertaining to the transference (see chapter 3, p.132). Thus, as this study has endeavoured to do and as Larner (1999) advocates, ‘when it [therapy] seeks its own power and position as an exercise of technology, it [therapy] requires deconstructing’ (1999: 49).

A prevalent discourse amongst the therapists interviewed in this study was the idea of the relationship becoming more equal as the end approaches. This narrative therefore implicitly conveyed the idea that the balance of power within the therapeutic relationship naturally shifts in the client’s favour towards the end of therapy. There are however differences of opinion within the termination literature around this issue. As Lipton (1961, cited in Firestein, 1978) argues, the fundamental rules that have governed the therapeutic milieu should continue up until the last hour. To alter the situation, it is argued, would provide transference or counter-transference gratification. Other authors, like a majority of the therapists interviewed here, believe that the development of a more companionate relationship towards the end of therapy can be more beneficial for both client and therapist (e.g. Shane & Shane, 1984). It can be argued that the latter idea perhaps reflects a more humanistic revision of the austere implementation of the traditional neutrality of the therapist.

However, this study contends that whilst the discourses that speak of increasing equality within the therapeutic relationship towards the end of therapy reflect the well-intentioned, humanistic grounding of therapists, they are likely to be naively
conceived as they overlook the inequalities that are fundamental to the theoretical underpinnings of the model, and the unseen ways in which these are enacted.

Indeed, traditional approaches to psychoanalytic theory and therapy, such as the object relations model, are predicated upon notions of hierarchy such as expert/non-expert and parent/child. Thus, the relationship established between client and therapist is essentially a hierarchical one from the outset. This appears to be an unseen aspect within some modes of psychoanalysis, as the implications of this hierarchical relationship were not espoused in the talk of therapists, and are not articulated within the literature. Indeed, as has been demonstrated, therapist discourses operate to deny the asymmetries on which the therapeutic relationship is built, albeit perhaps unintentionally.

As has been argued earlier in this chapter, it was predominantly within therapist narratives that termination was discursively predicated on the experience of loss. Arguably therefore, loss feelings are likely privileged within therapy. As a result, the potential experiences that can be raised and talked about within termination are delimited by the discourses governing this phase of the therapy and additional areas of importance are excluded from view and may therefore be effectively silenced. However, whereas the therapists interviewed within this study almost exclusively defined termination in terms of discourses of loss, client narratives offered alternative ways of constructing termination. For example, clients articulated feelings of responsibility for their therapists. They also articulated feelings of powerlessness from a number of different contexts, for example, in their perceived lack of opportunity for negotiation over when therapy would come to an end, and in the perception that they had to leave because their therapy had exceeded an unspoken period of time.
Conversely, within this study, therapists did not articulate notions of powerlessness when describing the client’s experience of ending although one reference was made to the power differential that exists between the client and therapist in psychoanalytic therapy. As Pilgrim (1997) argues, “given the humanistic mandate associated with psychoanalytic psychotherapy and psychotherapies in general and a genuine central concern of therapists to listen to and empathise with the experience of clients, it is easy to see how the question of power is overlooked”.

Another prominent narrative within the discourses constructed by clients and therapists in the position of clients was the perception that important issues had been left outstanding. A variety of sub-discourses were in evidence within the major discourse of ‘unfinished business’. These were: failure to address important specific events that had occurred within client’s lives that were deemed to be relevant to the experience of ending; unfinished business deriving from the client’s perceived powerlessness to negotiate over the ending; a perceived lack of resolution at the end of therapy. Although the experience of ‘unfinished business’ is sometimes discussed within the literature on termination, although typically this phenomenon is linked to forced endings (e.g. see McRoy, Freeman & Logan, 1986), it is argued that the richness and variety of experience which is evident within the themes in chapter three is not represented. Thus, it is argued that the process of internalisation which is prevalent within the literature (e.g. see Kauff, 1977), and which was a theme within therapist’s talk, may actually be more conflicted than is anticipated.

A further theme that arose in the analysis was the construction of termination as a new beginning. As was demonstrated in chapter 1, and in common with the therapists interviewed in this study, the psychoanalytic literature predominantly characterises the
ending of therapy as a loss experience and, hence, many psychoanalytic authors see a process of mourning as an inevitable and essential feature of termination. However, within the talk of the clients interviewed for this study, the theme of ending being understood as a new beginning figured prominently. Positive reactions resonating within client narratives included excitement, pride, a sense of autonomy and maturity. However, the psychoanalytic literature (e.g. Shane & Shane, 1984), and indeed, some of the therapist narratives represented in chapter three typically mention the positive experiences evoked by termination in the context of an ambivalence about ending. Thus, the more positive aspects of ending are typically hidden from view within the literature and within the talk of therapists in favour of the dominant narrative of loss.

Crucially, as evidenced within the narratives obtained in this study, despite the many important developments that have taken place within psychoanalytic theory within recent years, a focus on the internal world of clients still predominates in particular contexts where psychotherapy is offered. Within these frameworks for therapy, the presence of Oedipal and/or pre-Oedipal conflict is understood as a necessary condition of psychological disturbance. Naturally therefore, everything that occurs within the termination and throughout the therapy in its entirety will typically be related back to the client's early relationships with parental figures. However, as Pilgrim (1997) argues, ideas of phenomenology and theory-based strategies may help therapists understand their clients but they do not enable therapists to understand their own practice in a socio-political context. Indeed, as it was argued in the introductory chapter of this study, in isolation these metaphors and their associated therapeutic strategies limit the focus of the psychoanalytic model of psychotherapy (and other models of therapy) to a consideration of the individual within a theory-constructed
context. Thus, this system of thought naturally excludes consideration of the social context within which the therapy is enacted. It is therefore argued that this constitutes a form of psychological reductionism, as the salience of the wider social context of these phenomena tends to be either ignored or, perhaps more traditionally, actively rejected.

A consequence of this unmediated adherence to these theoretical frames is that interpersonal and structural processes occurring within the client's current social context are seen as important only in so far as they augment either the underlying conflicts or the ego's ability to deal with them (e.g. Masson, 1992). This point has also been argued extensively elsewhere (see, for example, Pilgrim, 1997; Burr & Butt, 2000). Arguably therefore, psychoanalytic therapy offered within specific settings, in neglecting the limitations placed by social structures, will likely fail to acknowledge the events in client's social worlds that contextualise their current and past lives and which may set limits on possibilities for individual change.

A potential consequence of ignoring the social context of clients can be the trivialisation or exclusion of the circumstantial events and/or material reality of their life. This may be irresponsible and indeed dangerous as with the example of sexual abuse. Traditionally, psychoanalysts acted with complicity with this phenomenon, with the client's purported fantasies justifying a form of victim blaming (Warner, 2001). It can therefore be argued that that some analytic therapies have been used to explain away oppressive practices. Historically, there has also been reluctance on the part of the psychoanalytic establishment to address the objective power differentials that exist between various social groups in society. Arguably, for example, child abuse
is a function of the power discrepancies that exist in society, in this case between adults and children.

However, as demonstrated within the introductory chapter, psychoanalysis can also be used to reveal how social structures are internalised and regulate people (e.g. Chodorow, 1978; Heenan, 1998). Within ‘post-modern’ approaches to psychoanalytic therapy (e.g. Ellis, 1997), the focus is on connecting up the client’s reported personal experience and the socio-political context in which they are embedded. ‘Problems’ are understood as deriving at least in part from the social and cultural context of the person, rather than as properties of pathological personalities and there is a desire to work with people in ways that will facilitate challenges to oppression (e.g. Timimi, 1996). ‘Problems’ are therefore located within wider social and cultural practices and are seen as arising at least in part from the positions opened up for people within discourses operating in the culture of which they are a part.

Post-modern approaches to psychoanalytic psychotherapy thus provide some ways of attempting to grapple with issues of power and structural difference. This need not mean the abandonment of psychoanalytic metaphors such as the Oedipus complex but simply the acknowledgement and examination of the impact of structuring forces that maintain people in underprivileged positions. This stance also allows for recognition that whatever happened in the past only has relevance if it is maintained in the present and, thus, is not just internal to the person. It is therefore argued that if the more traditional forms of psychoanalytic psychotherapy, that are still evidently applied within the NHS, were to import some of these ideas into their practice then the applicability to the lived realities of people’s lives may be greatly improved.
5.3. Implications for research

An implication of this study for future research relates to the utility of the adoption of a social constructionist framework and qualitative methods for data collection and analysis. Thus, within the introductory chapter it was argued that in privileging the ‘expert’ view of therapists the body of literature on termination does not represent the social constitution of therapy. In devaluing the views of clients the literature therefore inevitably bypasses much of the complexity of ending and the multiplicity of experience. A social constructionist perspective presupposes multiple realities surrounding any one area of experience and, hence, this study wished to draw on these multiple realities rather than repeating the tradition of only seeking the views of therapists, in the hope that the ‘truth’ of termination would be discovered.

Arguably then, the findings of this study have revealed some of the plurality and complexity of experiences of termination, in that the process has been shown to clearly resist being represented via simple theoretical terms, i.e. the distinction within the literature of mutual, unplanned and forced endings. Thus, analysis of client and therapist narratives revealed a complex array of perceived feelings and experiences derived from the ending phase of analytic psychotherapy. The adoption of a realist ontology would necessarily have placed restrictions on the range of responses available to clients and therapists, therefore suppressing variability. It is therefore argued that it is through the adoption of a social constructionist framework and the use of qualitative methods of data collection and analysis that this complexity was allowed to emerge. In addition, because language and, crucially, the effects of the ways that language is constructed are taken as the focus of social constructionist research then it
has a direct relevance to therapeutic work. Thus, in drawing upon bodies of knowledge outside of psychology like that of social constructionism, psychoanalytic research would be likely to generate findings that would have a resonance for therapists and which they could apply to their therapeutic practice. Also, this would increase the likelihood of psychotherapy as a social practice being illuminated and reinforced.

5.4. Implications for policy

In addition to having implications for direct therapeutic work, it is argued that certain implications for policy arise from the findings of this study. This study has highlighted how traditional psychoanalytic frameworks continue to influence, and perhaps dominate, the way in which psychoanalytic therapy is applied within one local NHS psychotherapy service. It is argued that in unmodified form, these frameworks delineate the ways in which the therapeutic relationship is established and, henceforth, the therapeutic relationship becomes established within a hierarchical structure of asymmetries of power. Indeed, because of the way in which the primacy of the relationship with parents gets prefigured within the therapeutic model, the effect is that other things of potential importance to the client cannot be talked about with equal relevance. It therefore becomes crucial for all practitioners to become more reflexive and to examine the implicit assumptions and effects of the theory on which their practice is based.

I would suggest therefore that both specialist psychotherapy training courses and clinical psychology training courses need to establish parts of the curriculum that are
more political. By this I mean that training therapists could be encouraged to examine social and political forces that structure the lives of clients who come to therapy. This could perhaps be encouraged in the forms of case presentations whereby theoretical structures are abandoned and the focus becomes the social, i.e. the client and therapist’s worlds outside of therapy and how these may be impacting on their interaction and what limits these powerful structures may set on potential change. As this study has endeavoured to demonstrate, there is danger in the taken-for-granted notion that because the motivation to become a therapist tends to be an altruistic one that psychotherapy is necessarily beneficial to clients. Through the incorporation of deconstructive practices into applied psychology and psychotherapy training, involving a certain critical questioning of therapeutic practice, technocracy and the consolidation of the therapist’s power may be avoided, which are naturally to the detriment of the client.

In terms of implications for research policy it is argued that in planning and evaluating the impact and effectiveness of therapeutic services this should always include users of services, in addition to those who manage and deliver services. In doing so, genuine respect is communicated to user groups/people who are referred to therapeutic services. This is because attempts are being made to enter into the social and linguistic world of users of services, as opposed to expecting them to enter into our often theoretically based frames of reference. As this study has argued, these theoretical structures separate and elevate the status of health professionals in relation to the people they are employed to help. This can be a mystifying and disempowering experience for those who seek or are referred for therapy.
CHAPTER 5

Research that includes user perspectives is not however new as, for example, planning around the recently implemented National Service Frameworks demonstrates.

Established frameworks such as the mental health NSF (September, 1999) have been developed with the assistance of external reference groups, which bring together health professionals and service users, amongst others. I would argue however that the use of epistemological and methodological frameworks, such as those framing this study, should become standard practice in canvassing the views of services users in the development of services.

5.5. Critical evaluation of the study

The following section seeks to critically appraise this study, initially with reference to further issues of reflexivity (initially addressed in section 2.2.1. & 2.2.2) and then by examining issues of research quality.

5.5.1. Reflexive section

A valuable part of the evaluation of qualitative research is considered to be the attention to and explicit inclusion of a reflexive process. Winter (1989, cited in Stevenson & Cooper, 1987) has suggested that research methods should be used in a reflexive fashion rather than just being routinely applied. Undertaking research in a reflexive way, forces the consideration of both the philosophical aspects of research and the researcher’s own assumptions about the world. To this end, the researcher’s epistemology, questions and assumptions in undertaking this study were discussed in an earlier chapter (see chapter 2, section 2.2). Reflexivity requires the researcher
actively to consider whether his or her involvement has enhanced or detracted from
the ‘findings’. However, the extent to which researchers can identify all of the values,
experiences and assumptions that have influenced their engagement with the area
being researched is questionable. This said however, engagement with a reflexive
process is considered complementary to this study as it draws attention to the
contextual factors that may have influenced my arrival at certain constructions and the
various ways in which the process of research has impacted on and changed me.

Firstly, my selection of research topic was inevitably informed both by my
experiences as a therapist and those as a client. Hence, these experiences suggested
that researching the ending of therapy would be of personal significance and would, it
was anticipated, have implications for my therapeutic practice. In particular, the
experience of the ending of my first therapy is acknowledged as shaping the study in
that I was very much a passive bystander within this process. Indeed, the client
narratives that were privileged were those that highlighted the effects for the client of
the inequities of power upon which the therapeutic relationship within certain analytic
therapies is constructed. Thus, my analysis and interpretation of the interview data
may have looked quite different if I did not have this experience of termination to
draw on. However, although I acknowledge that these experiences shaped the
questions I asked respondents, I did not include any questions explicitly designed to
provoke issues to do with experiences of having power or powerlessness. Yet clearly
this was a discourse extensively utilised by both clients and therapists in the position
of clients. Arguably however, my interrogation of how the decision to terminate is
reached utilised words such as ‘mutual’, which inevitably invokes notions of power
and powerlessness.
The process of conducting this study has also had an enormous effect on my values and therapeutic practice. I have become much more aware of issues to do with how power is enacted and negotiated with my relationships with clients and this drew me towards the ideas embodied within community psychology approaches. Indeed, I am now employed within a child & adolescent service which takes the community psychology model as its guiding framework.

The community psychology framework differs fundamentally from mental health models, in terms of philosophy, theoretical underpinnings and therapeutic approaches. Working with children and adolescents, normal psychological development is key to the way in which we work. Community psychology aims to be accessible to families by operating within the child health services, thereby minimising any issues of stigma and labelling. This allows the service to reach families that would otherwise not have been seen, such as African-Caribbean and Asian families. Furthermore, as a service we do not expect clients to travel to centralised clinics and as far as possible we see people in their local communities.

Clearly, certain groups find it difficult to access traditional psychology services, including specialist psychotherapy services, as they typically offer ways of working that are inaccessible for certain sections of the community. This may be due to issues such as economic and emotional poverty, the grind of everyday life, the lack of social support systems or the lack of an effective and cheap public transport system. Hence, obstacles such as these often render such services as exclusive. Community psychology therefore emphasises the understanding of the interplay between the person and their environment.
Therefore, I certainly feel that a reflexive process has been set in motion through conducting this research, which, in my opinion, can only improve my approach to working with families in distress. I realised throughout the process of conducting the research that I was guilty of the things that I was critiquing, that is, overlooking the social structures of which the person is part and which may put limits on achievable change. Community psychology is a very different way of working from the practice of psychotherapy on which this study has concentrated and my work with families is sometimes more closely affiliated with advocacy. However, I do not view this negatively as, in my experience, this is one way in which families are helped to feel more powerful.

In terms of bringing ‘therapy’ to an end I have become much more oriented towards encouraging children and their families to set goals for our work together. This gives the person or family some control over the process and I encourage people as far as they are able to keep track of where we are at and what there is still left to do in order to achieve these goals. Families and children are therefore aware that there will be an end point to our meetings. However, the rules of ending are not rigidly applied as a department and once a period of contact reaches its end, families are encouraged to telephone us if they either need some advice or support over the phone or if they wish to resume contact. Like many other members of our department I have also begun to operate a ‘book-in’ system. This is a system whereby one clinic monthly is left open for clients to book themselves into if they so wish. Clients ring the secretary directly who has the information regarding which slots are available and the person chooses a time to suit them. We have found that this system gives families more control over
when they come to see us and, perhaps as a result of the knowledge that they have the availability of this safety net, these clinics are currently under-used.

5.5.2. Critique of the study

This study sought to draw on the different perspectives and ways of understanding the process of termination from long-term psychoanalytic therapy that were made available in interviewing both clients and therapists. As highlighted within the introductory chapter, this included the intention to draw on the therapist’s understanding of termination when speaking from a position of having been a client. It could therefore potentially be argued that the study failed to do justice to one of the initial aims of seeking to draw on therapist experiences of termination from personal therapy. However, as intended, some of the similarities and differences between narratives employed by clients and therapists, in constructing the experience of termination, have indeed been highlighted and interrogated. Indeed, the opportunity to juxtapose client and therapist narratives revealed some interesting findings. But whilst I was able to draw on these different perspectives associated with therapists, clients and therapists in the position of clients, the study did not explore in any detail the potential similarities and differences between the latter two perspectives. It is however anticipated that a comparison study of the ways in which clients and therapists as clients construct experiences of termination would make an interesting study in the future.

A point I would like to make is that, overall, I do not think a qualitative project of this size is practicable within the time constraints of clinical training. In the first place,
CHAPTER 5

given the nature of the analytic process I feel that I conducted too many interviews. In turn this meant that there was a huge amount of transcription material to sort through. As a consequence, the preparation and categorisation of the data and subsequent analysis was extremely labour intensive. Thus, at times the process felt extremely directionless from which a sense of hopelessness often emerged about whether anything useful would emerge from the data. On reflection I think the struggle I encountered can be explained on the one hand by my inexperience as a discourse analyst and the tendency to slip back into reflecting on hypothesised underlying social and psychological realities, and on the other, the lack of guidance available on a method for conducting a discourse analysis. Thus, some of the findings presented in chapters three and four pertain to the ways in which the accounts are constructed and some to the psychological effects of these discourses (mainly the effects that therapist constructions may have on the experience of clients).

Finally I want to acknowledge that the findings reported in this study are understood to be provisional and situated, hence, it is difficult to generalise the findings beyond this research project. They are context and time-specific. The study concentrated on a localised service and the way in which psychoanalytic therapy is enacted within this service may not be representative of other services within Great Britain and beyond.
CHAPTER 5

5.6. Conclusions

The aim of this study was to explore client and therapist narratives regarding their experiences of termination from psychoanalytic psychotherapy. An additional aim of this study was to utilise these narratives as the basis for a critical analysis of the psychoanalytic model of psychotherapy. This study has therefore attempted to provide some context to what is ordinarily de-contextualised. This study has therefore critiqued the normative assumptions to which specific models of psychoanalytic theory and therapy still adhere. For example, in privileging early relationships within the therapeutic relationship, individuals are invited to focus on very localised relationships and therefore the lived realities of people’s lives are rendered on the margins of the work of psychotherapy. Thus, the relevance of the impact of social and political structuring forces on the distress of the person to do with being, for example, a man, woman, black and/or gay, is closed down.

The findings of this research therefore highlight the need for therapists to think about theory in conjunction with the social context of clients. This is not a revolutionary idea and as was demonstrated in the introductory chapter, for example in the work of Ellis (1997), it is possible to open out the boundaries of psychoanalytic theorising in order to engage with issues of direct relevance to the society in which people live, and the social structures of which they are a part. Thus, as far as can be reasonably established, given this study’s circumscribed focus, the many important advances that have occurred within psychoanalytic theory and certain therapies in recent decades, have failed to permeate the ways in which termination is theorised and worked with in everyday clinical practice in certain contexts. Further, the literature that addresses this
phase of the psychoanalytic enterprise has also failed to engage with these important
debates and developments, as this study has highlighted.

Thus, in arguing for an updated and expanded practice within specific frameworks for
psychoanalytic psychotherapy, in this case British Object Relations, it is this study's
contention that the aim of the latter should be to seek a greater understanding of stasis
and change in the lives of distressed people, which includes, but is not limited to, the
processes existing inside the therapeutic sessions.


References


References


References


References


References


References


Appendices

Appendix 1

Reply from Southern Derbyshire Ethics Committee
Dear Ms Cowen

SDEC REF: 9905/56
CLIENT AND THERAPIST CONSTRUCTIONS OF THEIR EXPERIENCES OF TERMINATION FROM LONG-TERM PSYCHOLOGICAL THERAPY

The Southern Derbyshire Ethics Committee considered the above protocol on 20 July 1999. Whilst members were supportive of the principle they did not feel able to give approval without considerable further work being done on the study, as follows:

- It considered that '4/5' is much too small a number of recruits for the study to be valid.

- The participant information sheet, as well as the laypersons' summary, make reference to the fact that 'as part of my course I am required to do a study'. This gives the impression that the study has been devised to fulfil a course requirement rather than to gain new knowledge. Nowhere in the proposal does it discuss how the information gleaned from this study might translate into changes in clinical practice or what the mechanism for this translation would be.

- The participant information sheet should therefore be rewritten with more clarity about the motivational forces behind 'doing the research'.

- Consideration should be given to inclusion of subjects involved in counselling and therapy who have not had good outcomes, to make the research more effective.

If you wish to resubmit the study, with a larger pilot group, and taking into account the comments made above, we will be happy to reconsider it.

Please quote the SDEC reference number (shown above) in all future correspondence on this study.

Yours sincerely

A W A Crossley
Chairman
Southern Derbyshire Ethics Committee
Appendix 2

*Answer to Southern Derbyshire Ethics Committee*
Dear SDEC REF: 9905/56

CLIENT AND THERAPIST CONSTRUCTIONS OF THEIR EXPERIENCES OF TERMINATION FROM LONG-TERM PSYCHOLOGICAL THERAPY.

Thank you for your feedback which I have considered and discussed with my supervisors, _________ and _________. I hope the following points will answer your concerns and clarify some of the methodological queries raised in the feedback I received.

1. The actual number of participants to be included in the study is 10. This number will comprise 4 clients, 4 therapists and 1 client and therapist to pilot the interview schedule. This confusion may have arisen because the number of participants stated in the ethics form represented only the number of clients who will be involved, as therapists had already consented in principle to be interviewed. The same ethical procedures will be utilised for both clients and therapists. This number of participants is in accordance with the requirements of a qualitative study of this nature and represents a realistic number of interviews for the methodology of discourse analysis. To illustrate this point further, J. Potter & M. Wetherall (1987) write, “Discourse analysis is an extremely labour-intensive approach.....if one is interested in discursive forms, 10 interviews might provide as much valid information as several hundred responses to a structured opinion poll. Because one is interested in language use rather than the people generating the language and because a large number of linguistic patterns are likely to emerge from a few people, small samples or a few interviews are generally quite adequate for investigating an interesting and practically important range of phenomena. For discourse analysts the success of a study is not in the least dependent on sample size.....more interviews can often simply add to the labour involved without adding anything to the analysis”. I would be happy to provide additional information to the committee regarding qualitative methodologies if further clarification is required.

2. Thank you for your feedback on the clarification of motivational forces behind the research. I have duly amended the participant information sheet to include an emphasis on the clinical impetus of the research. Copies of this are enclosed with this letter for your attention.

3. To clarify the motivational forces, it is anticipated that the findings of the study will contribute to a wider understanding of the therapeutic process and particularly with reference to the ending of therapy. By representing the client’s voice and client constructions of the process of termination it is hoped that therapists who practice psychotherapy, both locally to the study and nationally (following publication), will be alerted to the view of the client when approaching termination. However, given the exploratory nature of the study it would be difficult, and to some extent counter-intuitive in accordance with the methodology, to attempt to pre-empt possible findings and the way in which these may be utilised in the therapeutic arena.
4. The ethical committee make a valid query about whether it would be helpful to include clients who had not had good outcomes. This point had been discussed in some length in the initial stages of planning with my field supervisor, __________. Since receiving your feedback I have discussed this point further with both supervisors and I hope the following points will explain why this would not be appropriate for this particular study.

- As explained in the research proposal and layperson’s summary, the existing knowledge base on the area of termination from psychotherapy does not include representation of the client’s voice. Thus, the main aim of the study is to try to tap into client understandings of endings which are perceived by their therapists to have been good endings, whilst understanding the diversity which will be inherent within client accounts. To include clients who have experienced “bad” endings at this early stage of investigation into client understandings would confound the original question of the study.

- Interviewing people who have experienced bad endings would potentially cause the client some distress and perhaps re-invoke painful feelings. It is for this reason that therapists would be reticent about such clients being approached.

- In addition, drawing on the results of postal questionnaire research which has endeavoured to discover from clients the reasons for therapy drop-out, and which have been subject to very low rates of returns, it is unlikely that clients who have experienced bad endings would consent to be interviewed.

Thank you again for your feedback and I hope the preceding discussion clarifies the queries raised by the committee. If it is deemed necessary I would be happy to discuss these points further or to provide more information. Both __________ and __________ would be happy to be contacted should you wish to do so.

Given the tight deadline within which I am required to complete and submit this study (January, 2000) I would greatly appreciate a prompt reply. If it is necessary to contact me to discuss further concerns could you please telephone me on the following number: ________.

Thank you for your consideration

Kate Cowen
Clinical Psychologist in Training.
Appendices

Appendix 3

Lay Person’s Summary
The idea for this study originated from my own clinical experience of therapeutic contact with individuals, which has taken place throughout my clinical psychology training. I have developed an interest in psychotherapy process and in the mechanisms of change within psychotherapy. The focus chosen for this study is people’s experiences of therapy, and in particular the ending of therapy. It is anticipated that the information gained from this study will contribute to a broader understanding of the therapeutic process and will therefore contribute towards a better service for future clients.

A lot has been written about the process of ending therapeutic contact and much of this focuses on the emotional and behavioural reaction of clients and the different kinds of endings which can occur, e.g. a mutual agreement between the therapist and client that therapy should come to an end. What has been written about therapeutic endings has been written by the therapists who are typically psychiatrists, counsellors, clinical psychologists, social workers and the like. Thus, the literature base which exists concerning therapeutic endings is the therapist’s perspective of what the client experiences as therapy is coming to an end. In addition, the language and terminology used to represent and explain these processes is that of the therapist and not that of the client who has undergone therapy.

This study thus aims to begin to bridge the gap in available knowledge by exploring the perceptions of individuals who have encountered psychotherapy as the client in that relationship. Individuals who agree to be interviewed will be asked to talk about their experience of the ending of their therapy and how they continue to represent the experience of psychotherapy in their everyday lives. The latter area pertains to the notion that therapy experiences may carry on even after therapy has ended, perhaps in the form of remembered conversations or images. A number of therapists based at the Psychotherapy Unit in Derby have also agreed to be interviewed about their experience as the client in their own previous therapy.

The study intends to examine the experiences and perceptions of a small number of individuals in great depth. Clearly the ending of therapy is a complex process and by using a qualitative approach to the analysis of interviews then this complexity will be fully represented. It is anticipated that the findings of this study will provide the reader with a better understanding of how clients and therapists perceive and understand the ending of therapy. The findings may also raise awareness about those aspects of therapy which are
considered most beneficial and those considered unhelpful. Such knowledge would be of significance to psychological therapists.
Appendices

Appendix 4

Participant Information Sheet (Clients)
Dear [Name],

I am a post-graduate university student and am studying to become a clinical psychologist. Clinical Psychologists are people who work in the health service and help people who are experiencing difficulties in their lives, often by talking through problems. I am currently conducting a study into people’s experiences of therapy, particularly with reference to the process of ending therapy and it is for this reason that your previous therapist has been asked to make contact with you. It is hoped that the information gained from this study will contribute to a greater understanding of the therapeutic process and will therefore contribute to a better service for future individuals undergoing therapy.

In order to carry out this study I will be asking both clients and therapists who are willing to be involved to meet with me and talk about their experiences of the ending of therapy. This does not mean that participants will be asked to discuss issues which they may feel are private, such as the reasons for initially seeking therapy or the content of their therapy. Participants will also be free to withdraw from involvement in the study at any stage.

I would like to interview both clients and therapists because I think that everyone’s opinion is important. I would like to interview each participant for about 30 to 45 minutes. I will be asking everyone the same questions and there are no right or wrong answers as I am simply interested in everyone’s opinion. Information obtained from these interviews will be kept strictly confidential and will not be shared with therapists. I would also like to audio-tape the conversation to enable me to get as full a picture as possible and to make sure that I do not miss anything that is said. The tapes will only be used by me to write out a word for word transcript which will not have your name on it. The tape will then be destroyed. I shall write up my work but will make completely certain that no names are mentioned or that anything discussed can be traced back to participants.

I would therefore like to ask you if you would be interested in participating in this study. Participation in this study is purely voluntary. You are under no obligation to participate if you do not wish to, however, if you feel you would have something to contribute to this study or if you feel you would like to take the opportunity to discuss your experience of the ending of therapy, your participation would be greatly appreciated. Your contribution may also help to improve therapeutic services by making them more sensitive to the views of the people who use them.

If you are interested, please fill out the enclosed consent form and return it in the envelope provided and I will contact you to arrange a convenient time. If you would like any further information about the study I can be contacted at the following address:

Kate Cowen  
Department of Clinical Psychology  
Centre for Applied Psychology  
University of Leicester  
University Road, Leicester. LE1 7RH.

Thank you for your consideration.
Appendix 5

Opting In Form
Opt-In Form

I would like to participate in this study about endings of therapy. I understand that my participation is completely voluntary and that the information I give will be kept strictly confidential.

Name: ..........................................................
(block capitals)

Date: ..................................................

Telephone number: .................................
(or address if not on the phone)

Signature: ............................................

Thank you for your consideration.
Appendix 6

Letter to Therapists (First Contact)
Dear 

I was given your name by _______ as someone who may be interested in being interviewed for the piece of research which I am conducting as part of the requirements for the Clinical Psychology training course which I am due to complete this year. I have enclosed a participant information sheet for you to read to enable you to consider whether you wish to be interviewed on the subject of termination from psychoanalytic psychotherapy. The information sheet also carries a section for written consent to be involved. Should you decide that you are willing to be interviewed and you sign the consent you will of course be free to withdraw your involvement at any stage in the research process. If you do decide that you wish to be involved could you please pass the completed consent section to _______ by the 4th June, who will then post it back to me. Your willingness to be involved will be greatly appreciated and will contribute towards what I hope will be an interesting piece of research.

The research project is of a qualitative nature and based on interviews with individuals. This dictates that the numbers of people I intend to interview will be quite small. I am hoping to interview 4/5 therapists and 4/5 clients who have undergone time unlimited psychotherapy. For this reason if each therapist approached agrees to be involved then it will be necessary for me to select participants but I would like to thank you for your interest in advance should you agree to be involved. If you agree to be involved in this research I would like to ask that you begin to think of one or two previous clients who underwent time unlimited psychoanalytic therapy and who you would deem suitable to be approached and possibly interviewed. and I have discussed the concept of ‘suitability’ and we agreed that therapists would perhaps feel more inclined to volunteer those who they feel have experienced a good termination. This judgement will of course be necessarily subjective however it may be important for therapists to feel that the process of interview will not pose a significant risk to the client.

Once again I would like to thank you for your interest and should you decide that you are willing to be interviewed then I will contact you initially by telephone on receiving the consent form and if you prefer, we can perhaps agree a time to meet at a place convenient for yourself to discuss the research in more detail. Alternatively, if you feel you have all the information you need then we could arrange the time and place of interview on the telephone.

Thank you for your consideration.

Yours Sincerely

Kate Cowen.
Clinical Psychologist in Training.
Appendix 7

Participant Information Sheet (Therapists)
Participant Information Sheet (Therapists)

I am a post-graduate university student and am studying to become a clinical psychologist. I am conducting a study which focuses on people’s experiences of therapy, particularly with reference to the process of ending therapy. In order to do this I will be asking both clients and therapists who are willing to be involved in the study to meet with me and talk about their experiences of the ending of therapy. This does not mean that participants will be asked to discuss issues which they may feel are private. Participants will also be free to withdraw from involvement in the study at any stage.

I would like to interview both clients and therapists because I think that everyone’s opinion is important. I would like to interview each participant for about 30 to 45 minutes. I will be asking everyone the same questions and there are no right or wrong answers as I am simply interested in everyone’s opinion. Information obtained from these interviews will be kept strictly confidential and will not be shared with clients or other therapists. I would also like to audio-tape the conversation to enable me to get a full picture as possible and to make sure that I do not miss anything that is said. The tapes will only be used by me to write out a word for word transcript which will not have your name on it. The tape will then be destroyed. I shall write up my work but will make completely certain that no names are mentioned or that anything discussed can be traced back to participants.

I would therefore like to ask you if you would be interested in participating in this study. Participation in this study is purely voluntary. You are under no obligation to participate if you do not wish to, however, if you feel you would have something to contribute to this study or if you feel you would like to take the opportunity to discuss your experiences of the ending of therapy, your participation would be greatly appreciated. If you are interested, please indicate your consent to participate below.

I would like to participate in this study about endings of therapy. I understand that my participation is completely voluntary and that the information I give will be kept strictly confidential.

Name: ................................
Date: ...........................
Signature: ............................

If you would like any further information about the study I can be contacted at the following address:

Kate Cowen
Department of Clinical Psychology
Centre for Applied Psychology
University of Leicester
University road, Leicester. LE1 7RH.

Thank you for your consideration.
Appendices

Appendix 8

Draft Interview Schedule (Clients)
Interview Schedule (Clients).

- Remind participant of who I am and why I am conducting this study.

- Thank participant for volunteering to be interviewed.

- Give the participant the choice of looking over the information sheet again or of having it read to them.

Does the participant consent for the interview to be tape-recorded? Give consent form.

- The discussion should last between 45 minutes and 1 hour.

- I am interested in the varied perspectives of different people so there are no right or wrong answers. I am trying to get as wide an understanding as possible which is why I am interviewing both therapists and individuals who have been clients.

- I am interested in your opinion in this discussion and I recognise that you may be drawing on one experience of therapy, however, that does not mean that you will not have an opinion and that opinion is just as valid as anyone who has perhaps been in therapy five times or has worked as a therapist for years.

- Inform the participant that if they are not sure what I mean at any stage or if they do not understand something they are asked, then they are encouraged to ask for clarification.

- Are there any questions which the participant would like to ask before I switch the tape on.
**Context setting.**

1. Why do you think people enter therapy/ for what reasons?.
   - **(Why did you enter therapy?)**
   - Do you think people enter therapy voluntarily or do you think it is suggested to them by others?; if suggested by others, who might suggest this?
   - Are you aware of any other types of therapy besides the type (psychoanalytic) which you experienced?; if not aware of others provide a brief overview of models such as cognitive therapy
   - Why do you think people come for psychoanalytic therapy as opposed to other approaches?; **(why did you come for this kind of therapy?)**

2. How do you think people find the experience of therapy?.
   - **(How did you find it?)**

3. Do you think people benefit from psychotherapy?.
   - In what ways do you think people might benefit?
   - **(Do you feel that you have benefited/changed as a result of your therapy?; if so, in what ways?)**

**Signposts for discussion.**

1. How do you think the ending of therapy is experienced by clients who have been in psychoanalytic therapy?
   - Do you think the ending of therapy would generally be a good/bad/indifferent experience?
   - What kind of things do you think make the ending of therapy a good experience?
   - What kind of things make the ending of therapy a bad experience?
   - What do you think clients feel, what do they think, how do they behave, what kinds of things do you think they talk about, do you think they begin to talk about different issues in their therapy after ending is raised
   - What do you think therapists would say about this?
   - Do you think clients begin to think differently about the therapy and/or therapist, do you think they begin to think differently about themselves?
   - How do you think ending is experienced by therapists?
   - What do you think clients experience when ending therapy is initially raised?
   - **(What did you experience?)**
   - What do you think clients experience in the time prior to ending?
   - **(What did you experience?)**
- What do you think clients experience at the time of ending?
- (What did you experience?)
- Do you think these experiences are different for therapists?

2. Do you think there are any similarities between the ending of the therapeutic relationship and other types of relationship endings? Do you think that the ending of therapy is a distinct process from other kinds of endings?

- How do you think that the ending of therapy relates to other endings and/or separations? If you do not think the ending of therapy relates to other endings/separations, why not? What are the differences between these?
- Do you think therapists would say there are similarities or that other endings were relevant to the ending of therapy?
- Do you think that the discussion and exploration of previous relationship endings and/or separations is relevant to the ending of psychotherapy?
- What do you think therapists might say about this?
- What kinds of issues came up in your therapy, if any, in relation to previous separations or endings? Did you feel that the issues which came up were addressed in the therapy? If so, how were they addressed?
- How might your therapist see this?
- How would you explain the kinds of issues that got talked about in relation to the ending of therapy? How would you account for the kinds of issues or emotions which came up in the period prior to the end of your therapy?
- How do you think your therapist would explain this?

3. Do you think it is preferable for clients to be aware of the date of ending their therapy from the beginning or for their therapy to be open-ended (with no set date to finish) and for the ending date to be negotiated at a later point in the therapy?

- If one is viewed as more preferable, what makes the difference? Why is one approach to ending more preferable?
- Was your therapy an open-ended one from the beginning or was it time-limited?
- If open-ended, at what point in the therapy was ending raised and by whom?
- Do you think that the ending of psychotherapy is mutually decided between therapist and client or do you think that the decision to end therapy is more often made by the therapist or by the client?
- By whom do you think ending is normally initially raised, the therapist or the client?
- If it is thought that ending would normally be raised by the therapist, what are the factors/considerations which might lead the therapist to suggest this? What do you think might tell the therapist that it is the right time to raise ending as an issue?

- If it was the therapist who raised the issue of ending in your therapy did this come as a surprise?; if so, was it a welcome/unwelcome surprise?; why do you think the therapist raised it at that point, how did he/she explain their reasons for this?

- If the therapist raised the topic of ending in your therapy, was this something that you had considered prior to the therapist’s suggestion?; do you then feel that the decision to end was reached mutually or do you feel one person had more influence over this decision?

- If it is thought that ending would normally be raised by the client, what are the factors/considerations which might lead the client to feel that the therapy should come to an end?; if only external factors are offered, e.g moving house, what are the internal factors?; do you think there are any other factors which might lead the client to suggest ending their therapy (e.g. unhappy with their therapist; feeling that ending should have been raised earlier)

4. What do you think clients experience after therapy has ended in relation to the therapy and the therapist?

- Do you think aspects of the therapeutic experience continue after the client and therapist have stopped meeting?

- Do you think aspects of the relationship between the client and the therapist continue in any way?; for example, having an image of the therapist when attempting to deal with any problems.

- Do you think clients continue to benefit from their therapy after it has formally ended?; if so, in what ways?
Appendix 9

Revised Interview Schedule (Clients)
Interview Schedule (Clients).

- Remind participant of who I am and why I am conducting this study.

- Thank participant for volunteering to be interviewed.

- Give the participant the choice of looking over the information sheet again or of having it read to them.

Does the participant consent for the interview to be tape-recorded? Give consent form.

- The discussion should last between 45 minutes and 1 hour.

- I am interested in the varied perspectives of different people so there are no right or wrong answers. I am trying to get as wide an understanding as possible which is why I am interviewing both therapists and individuals who have been clients.

- I am interested in your opinion in this discussion and I recognise that you may be drawing on one experience of therapy, however, that does not mean that you will not have an opinion and that opinion is just as valid as anyone who has perhaps been in therapy five times or has worked as a therapist for years.

- Inform the participant that if they are not sure what I mean at any stage or if they do not understand something they are asked, then they are encouraged to ask for clarification.

- Are there any questions which the participant would like to ask before I switch the tape on.
Context setting.

1. Why do you think people enter therapy/for what reasons?
   - How do people enter therapy?
     - voluntarily
     - suggested by others?; who?
   - Why did you enter therapy?
   - Aware of any other types of therapy?
   - Why do people come for psychoanalytic therapy?
     - Why did you?

2. How do you think people find the experience of therapy?
   - How did you?

3. Do you think people benefit from psychotherapy?
   - How?
   - Have you benefited/changed?
   - How?
Signposts for discussion.

1. How do you think ending is experienced by clients who have been in psychoanalytic therapy?
   - Generally be a good/bad/indifferent experience? for therapists?
     - What makes it good? -- for clients; for therapists
     - What makes it bad?
     - your therapy?
   - After ending is raised -- what gets talked about?
     - talk about different issues?
     - feelings?; what do these feelings reflect?
     - thoughts?
     - behaviour?
     - your therapy?
   - Do clients begin to think differently?
     - about the therapy?
     - about therapist?
     - about themselves?
     - did you?
   - What is ending like for therapists?
   - Clients experiences when ending is initially raised?
     - prior to ending?
     - time of ending?
     - what did you experience?
     - different for therapists?
     - relevant to other therapists?
2. Do you think that the ending of therapy relates to other endings and/or separations?

- why?
- why not?
- differences?
- distinct process?

- therapists view - endings relevant to the ending of therapy?

- discussion of previous relationship endings and/or separations
  - relevant to the ending of psychotherapy?

- kinds of issues that get talked about in relation to the ending of therapy?
  - how would you account for these?
  - emotions which come up?
  - can you explain these?
  - therapist would explain this?

- in your therapy in relation to previous separations or endings?
  - issues addressed?
  - how were they addressed?
  - therapist see this?
3. When should clients know when their therapy will end?

- beginning/time-limited?
- open-ended?
  - negotiated at later point?
- why?
  - therapists agree?

- your therapy - open-ended or time-limited?
  - when raised?
  - who decided?

- Who decides generally to end – therapist?
  - client?
  - mutually?

- Who raises ending initially?
  - therapist – why would they suggest this?
    - how would they know to raise ending?
  - client – why would they suggest this?
    - how would they know to raise ending?
    - external factors
    - internal factors
    - other factors

- In your therapy?
- therapist raised ending?
  - surprise?
  - welcome/unwelcome surprise?
  - why at that point?
  - how did he/she explain reasons for this?

- therapist raised ending:
  - had you considered prior to the therapist’s suggestion?
  - decision to end reached mutually?
  - one person have more influence?
4. What do clients experience after therapy has ended?

- continuing therapeutic experience?
- relationship between the client and the therapist?
- images of therapist?
- dialogue?
- continued for you?
- how?

- do clients continue to benefit after ending?
  - why?
  - why not?
  - how?
  - have you continued to benefit?
  - do therapists benefit?

5. How are endings prepared for in therapy?

- How approached – by therapist
  - by client

- Do clients feel prepared?
  - did you feel prepared?

- Do therapists feel prepared?

Anything you wish to add that we haven’t talked about – anything important for me to think about.

How was the experience?

Thank you for your participation.
Appendices

Appendix 10

Revised Interview Schedule (Therapists)
Interview Schedule (Therapists).

- Remind participant of who I am and why I am conducting this study.

- Thank participant for volunteering to be interviewed.

- Give the participant the choice of looking over the information sheet again or of having it read to them.

Does the participant consent for the interview to be tape-recorded? Give consent form.

- The discussion should last between 45 minutes and 1 hour.

- I am interested in the varied perspectives of different people so there are no right or wrong answers. I am trying to get as wide an understanding as possible which is why I am interviewing both therapists and individuals who have been clients.

- In the following discussion can I ask you to draw on your experiences as a therapist but also on your own experiences as a client in therapy. I am not asking you to answer questions with the specific client in mind whom you have contacted although this client will inevitably constitute part of your experience as a therapist.

- Inform the participant that if they are not sure what I mean at any stage or if they do not understand something they are asked, then they are encouraged to ask for clarification.

- Are there any questions which the participant would like to ask before I switch the tape on.
Context setting.

1. Why do you think people enter therapy/ for what reasons ?.
   - How do people enter therapy ?
     - voluntarily
     - suggested by others ?; who ?
   - Why did you enter therapy ?
   - Aware of any other types of therapy ?
   - Why do people come for psychoanalytic therapy ?
     - Why did you ?

2. How do you think people find the experience of therapy ?.
   - How did you ?

3. Do you think people benefit from psychotherapy ?.
   - How ?
   - Have you benefited/changed ?
   - from your therapy ?
   - from your experience as therapist ?
   - How ?
1. How do you think ending is experienced by clients who have been in psychoanalytic therapy?

- Generally be a good/bad/indifferent experience?; for therapists?
  - What makes it good? -- for clients; for therapists
  - What makes it bad?
  - your therapy?

- After ending is raised – what gets talked about?
  - talk about different issues?
  - feelings?
  - thoughts?
  - behaviour?
  - your therapy?

- Do clients begin to think differently?
  - about the therapy?
  - about therapist?
  - about themselves?
  - did you?

- What is ending like for therapists?
  - clients say?
  - different for other therapists, e.g. cognitive?

- Clients experiences when ending is initially raised?
  - prior to ending?
  - time of ending?
  - what did you experience?
  - different for therapists?
  - relevant to other therapists?
2. Do you think that the ending of therapy relates to other endings and/or separations?

- why?
- why not?
- differences?
- distinct process?

- clients view - endings relevant to the ending of therapy?

- discussion of previous relationship endings and/or separations
  - relevant to the ending of psychotherapy?
  - clients say?

- kinds of issues that get talked about in relation to the ending of therapy?
  - how would you account for these?
  - emotions which come up?
  - can you explain these?
  - client would explain this?

- in your therapy in relation to previous separations or endings?
  - issues addressed?
  - how were they addressed?
3. When should clients know when their therapy will end?

- beginning/time-limited?
- open-ended?
- negotiated at later point?
- why?
- clients agree?

- your therapy - open-ended or time-limited?
  - when raised?
  - who decided?

- Who decides generally to end – therapist?
  - client?
  - mutually?

- Who raises ending initially?
  - therapist – why would they suggest this?
    - how would they know to raise ending?
  - client – why would they suggest this?
    - how would they know to raise ending?
    - external factors
    - internal factors
    - other factors

- In your therapy?
- therapist raised ending?
  - surprise?
  - welcome/unwelcome surprise?
  - why at that point?
  - how did he/she explain reasons for this?

- therapist raised ending:
  - had you considered prior to the therapist’s suggestion?
  - decision to end reached mutually?
  - one person have more influence?
4. What do clients experience after therapy has ended?

- continuing therapeutic experience?
- relationship between the client and the therapist?
- images of therapist?
- dialogue?
- continued for you?
- how?

- do clients continue to benefit after ending?
- why?
- why not?
- how?
- have you continued to benefit?
- do therapists benefit?

5. How are endings prepared for in therapy?

- How approached – by therapist
  - by client

- Do clients feel prepared?
  - did you feel prepared?

- Do therapists feel prepared?

*Anything you wish to add that we haven’t talked about – anything important for me to think about.*

*How was the experience?*

*Thank you for your participation.*
Appendices

Appendix 11

Consent Form
Consent Form.

I have had the nature of the research explained to me. I understand that any information I give will be fully anonymised and will not be able to be traced to me as an individual. I understand that all information discussed during the interview will be treated as confidential.

I have had the need for audio taping explained to me and I give my consent to the taping of the interview. I understand that the audio tapes will be transcribed and subsequently destroyed, and that their contents will remain confidential and used for this study only.

I understand that if I give my consent to participate at this point in time, I can change my mind and withdraw my consent at any point in the future.

I give my consent to be interviewed, and for the interview to be audio taped and transcribed.

Name (please print): ................................

Name (please sign): .............................

Date: ..............................

If you have any further questions, I can be contacted at the following address:

Kate Cowen
Department of Clinical Psychology
Centre for Applied Psychology
University of Leicester
University Road
Leicester, LE1 7RH.
Appendices

Appendix 12

Themes Generated in the Initial Stages of Analysis
Themes generated in initial stage of analysis

- Erotic transference
- Expectations of therapy
- Impact of previous relationships are ‘read’ through the transference
- “Dependent patients” need longer periods of therapy – “early developmental difficulties”
- Gratitude important to therapists
- Fears about ending
- “Part of their job” – client negation of therapist feelings of loss
- When to end – training therapy governed by different criteria
- “Running out of things to say”
- “Superficiality” of ending phase
- Enough time to prepare for ending
- Raising ending – “done all that can do”
- Unexpected endings
- “Relationship becomes more equal”
- Ending group therapy
- Context of therapy
- Feelings of responsibility – wanting therapist to be ‘okay’
- Relationship between trainee and training therapist – post-termination transformation
- Negotiation of the ending – “mutual”
- “Safe topics” discussed during termination
- Client “disconnecting”
- Resource limitations – “I thought my time was up”
- Therapists carrying on therapy to meet own needs
- Therapist preference for client raising ending
- Therapist concern to “manage the ending ....properly”
- Increased openness in run up to ending
- “Ending is explicitly worked with”
- “Some clients would prefer it if therapy never ended”
- Therapist raising ending – "diminishing returns"
- Avoiding expression of feelings in termination
- "Struggles" to leave
- Uncertainty regarding the rules of client/therapist relationship post-termination
- "Not everything was stuck down"
- Barriers to establishing therapeutic relationship
- Preference for client's raising the ending
- A "Balance" of feelings on the part of the client is crucial
- Termination as providing "corrective emotional experience"
- Uniqueness of ending of therapy versus other relationship endings
- Applicability of termination for all therapies
- Unable to express feelings
- The longer the therapy the longer the termination
- 'Time's up!'
- Process of preparation
- Negative feelings
- Ending "comes about" in the process -- passive notion
- Internalisation and internalised
- Unfinished business
- Powerlessness
- "Manic overdrive"
- Ambivalence/mixed feelings
- Ending as a 'new beginning'
- Ownership of ending
- Therapists "have their intellectual framework to fall back onto"
- Ending is an unknown
- A "natural" timescale
- Links to early experiences of dependency and loss
- Ending felt "as a kind of grief"
- Ending as separation
- Feeling "pushed out"
- "Part of a fundamental template"
- "Parallel experience to bereavement"
- Fear of being forgotten
- Separation and individuation
- Other endings
- Dependence/independence – "had to pull myself together and not need it"
- Fear of the future without therapy
- Levels of engagement
- Symptoms reappearing
- Focus on relationship – exclusive to psychoanalytic model
- Focus on transference obscuring 'real' issues
- Therapist "reluctance to accept limitations of therapy"
- Reciprocal rewards
- Relationship makes when to end a "fuzzy" process