

## ABSTRACT

Title of Dissertation: THE TERMINATION PHASE: THERAPISTS'  
PERSPECTIVE ON THE THERAPEUTIC  
RELATIONSHIP AND OUTCOME

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The termination phase of treatment is recognized as a significant aspect of the therapy process and yet remains vastly understudied in psychotherapy literature. In the present study, therapists' perspectives were used to examine how three elements of the therapy relationship (working alliance, real relationship and transference) during the termination phase relate to perceived client sensitivity to loss, termination phase evaluation and overall treatment outcome. Self-report data was gathered from 233 therapists, recruited from two Divisions of the American Psychological Association. Therapists completed measures for their work with a client with whom they could identify a termination phase of treatment. Results revealed that the working alliance and real relationship during the termination phase related positively to termination phase evaluation and overall treatment outcome, whereas negative transference

during the termination phase related negatively to overall treatment outcome. Therapists' perceptions of client sensitivity to loss related positively to both negative and positive transference during the termination phase. Post-hoc analyses revealed only the working alliance during the termination phase uniquely predicted overall treatment outcome in a model with the three therapy relationship elements examined together. On the other hand, all three therapy relationship variables during the termination phase uniquely predicted termination phase evaluation, when examined together. Limitations and implications of these findings are discussed, and recommendations for future study are suggested.

THE TERMINATION PHASE: THERAPISTS' PERSPECTIVE ON THE  
THERAPEUTIC RELATIONSHIP AND OUTCOME

by

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## Dedication

My research is guided by my interest in meaningful relationships. I dedicate my dissertation to my grandmothers, Dadi and Nani, who were among the first to help me understand the power of relationships.

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## Table of Contents

Dedication .....	ii
Acknowledgements .....	iii
Table of Contents .....	v
List of Tables .....	vii
Chapter 1: Introduction .....	1
The Termination Phase of Psychotherapy .....	1
The Therapeutic Relationship .....	6
The Development of Hypotheses .....	8
Chapter 2: Method .....	17
Participants .....	17
Measures .....	18
Termination Phase of Treatment .....	18
Working Alliance Inventory–Short Form (WAI-S) .....	20
Real Relationship Inventory Therapist Form-Shortened (RRI-T; Gelso et al. 2005) .....	21
Therapy Session Checklist- Transference Items (TSC-TI) .....	22
Perceived Client Sensitivity to Loss .....	23
Outcome measures .....	24
Procedure .....	26
Chapter 3: Results .....	30
Preliminary Analysis .....	30
Missing data .....	30
Reliability indices and descriptive data .....	30
Tests for normality .....	32
Time since termination .....	32
Termination phase sessions .....	33
Outcome measures .....	34
Tests of Hypotheses .....	34
Additional Analyses .....	43
Chapter 4: Discussion .....	47
The Termination Phase of Treatment .....	47
The Therapy Relationship during the Termination Phase .....	50
Termination and Client Sensitivity to Loss .....	56
Limitations and Conclusions .....	58
Appendix A: Review of Literature .....	62
The Termination of Psychotherapy .....	63
Theoretical perspectives on termination .....	64
Termination phase .....	65
Related research on termination .....	67
The Therapy Relationship .....	71
The Working Alliance .....	74

History and definition.....	74
Measuring the alliance.....	75
The working alliance and outcome.....	76
The working alliance at the end of treatment.....	77
The Real Relationship.....	79
History and definition.....	79
Measuring the real relationship.....	81
The real relationship and outcome.....	82
The real relationship at the end of treatment.....	83
Transference.....	84
History and definition.....	84
Measuring transference.....	85
Transference in non-analytic therapies.....	86
Transference and outcome.....	87
Transference at the end of treatment.....	89
The Present Study.....	90
Appendix B: Demographic Questionnaire for Therapists.....	92
Appendix C: Working Alliance Inventory-Short Form.....	94
Appendix D: The Real Relationship Inventory—Therapist Form.....	96
Appendix E: Transference Scale.....	97
Appendix F: Perceived Client Sensitivity to Loss.....	98
Appendix G: Session Evaluation Scale.....	99
Appendix H: Counseling Outcome Questionnaire.....	100
Appendix I: Letter to Therapists: First letter to therapists.....	101
Appendix J: First Reminder Letter.....	102
Appendix K: Second Reminder Letter.....	103
References.....	104

## List of Tables

Table 1: Descriptive Statistics and Correlations among Study Variables.....	31
Table 2: Hierarchical Regression Analyses for Negative Transference, Termination Phase Evaluation and Overall Treatment Outcome.....	36
Table 3: Hierarchical Regression Analyses for Perceived Client Sensitivity to Loss, Real Relationship and Termination Phase Evaluation.....	39
Table 4: Hierarchical Regression Analyses for Perceived Client Sensitivity to Loss, Working Alliance and Termination Phase Evaluation.....	40
Table 5: Simultaneous Regression Model for the Components of the Therapy Relationship and Termination Phase Evaluation.....	44
Table 6: Simultaneous Regression Model for the Components of the Therapy Relationship and Overall Treatment Outcome.....	45

## Chapter 1: Introduction

All forms of psychotherapy have a beginning and an ending. The final or termination phase of treatment is thought to be associated with psychotherapy process and outcome variables such as consolidation of treatment gains, strong feelings on part of both the therapist and the client, and preparation of the client for continued growth (Gelso & Woodhouse, 2002). Despite both theoretical and empirical recognition of the importance of termination, surprisingly little empirical attention has been directed towards the ending phase of therapy. A deeper understanding of the termination phase may facilitate greater effectiveness of therapeutic work.

The termination of therapy reflects the ending of the therapeutic relationship. Thus, an important consideration in the study of the termination phase of treatment is the dynamics of the relationship between the therapist and the client during this last phase of treatment. The general purpose of the present study was to examine therapists' perspectives on certain aspects of the therapeutic relationship during the termination phase of treatment (namely, the working alliance, real relationship and transference). In this study, we sought to understand how therapists' perceptions of the aforementioned components of the therapeutic relationship relate to their perceptions of client sensitivity to loss, termination phase evaluation, and treatment outcome.

### *The Termination Phase of Psychotherapy*

Part of the problem in studying termination has been the complexity inherent in defining termination. For instance, psychotherapy can be terminated for a number of different reasons. The ending of psychotherapy can be therapist-initiated, client-

initiated, mutually agreed upon by the therapist and client, or forced (involving a pre-determined number of sessions). Moreover, the termination phase can encompass a wide range of sessions depending on the length of treatment and the salience of termination-related themes during the course of treatment. Gelso and Woodhouse (2002) offered a useful conceptualization of termination phase, defining it as the “*last phase of counseling, during which the therapist and client consciously or unconsciously work toward bringing the treatment to an end*” (p.346). According to this definition, the termination phase can occur in treatments that have ended in varying ways (e.g. therapist-initiated, client-initiated, mutual, forced) and have encompassed any number of sessions. In the present study, the definition of the termination phase offered by Gelso and Woodhouse was used to study therapists’ perspective on the termination phase.

Another issue in the study of the termination phase pertains to the differing theoretical conceptualizations about the termination of treatment. A common theoretical notion emerging from the psychodynamic perspective is that clients experience the end of therapy as a significant loss (Dewald, 1969; Mann, 1973; Strupp & Binder, 1984; Ward, 1984). According to this perspective, successfully working through the loss of the therapeutic relationship can provide significant developmental opportunities for the client (Quintana, 1993; Strupp & Binder, 1984). In a qualitative study examining clients’ perspective on termination, Knox, Adrians, Everson, Hess, Hill and Crook-Lyon (2011) found that clients acknowledged grieving the loss of their therapists in cases where termination was described in positive and affirming terms. In another study focusing on termination and loss, Boyer and

Hoffman (1993) found that therapists' own experiences of loss significantly predicted therapist anxiety and depression at the end of therapy. In the same study, therapists' perceptions of client sensitivity to loss predicted therapist anxiety during the process of termination. Fortune (1987) interviewed experienced social workers and found that more than half of the therapists alluded to feelings of sadness and loss during termination in half or more of their cases. Along similar lines, Baum (2005) surveyed 132 social workers and found that, from the therapist's perspective, clients experiencing forced termination (therapist-initiated or institution-initiated) manifested greater loss experiences than clients who self-initiated termination. Thus, there seems to be some evidence pointing towards the importance of both therapist and client variables related to loss during the termination process.

In contrast to the termination as loss model, Quintana (1993) described the role of termination in terms of client transformation. Quintana pointed out that the termination phase transforms the therapeutic relationship by offering clients new ways to view themselves and their relationship with the therapist, and by promoting therapeutic internalizations. In line with Quintana's propositions, the current empirical literature on termination indicates more positive reactions on part of the therapist and client than those predicted by the termination-as-loss model. Marx and Gelso (1987) asked clients at a counseling center about the termination process. Results of the study indicated that half or more of the clients reported positive feelings about ending therapy (e.g. cooperative, calm, good, healthy). Quintana and Holahan (1992) surveyed counselors at a counseling center and asked them about the termination process with one successful and one unsuccessful client. Results of the

Quintana and Holahan study strongly resembled Marx and Gelso's results; therapists reported successful clients' reactions being positive during termination. In the study by Fortune (1987) on the reactions of 59 social workers during termination, results indicated that termination reactions tend to include positive feelings more often than negative feelings. Providing further evidence for the termination as transformation point of view, Rabu, Haavind and Binder (2013) interviewed clients post therapy and reported positive metaphors used by clients to describe their experience at the end of treatment.

Taken together, the literature on termination suggests the following. First, studies on termination, including both therapist and client perspectives, suggest the presence of positive feelings, as well as sad feelings, associated with end of therapy. Thus, there is some support for both, termination as transformation and termination as loss perspectives. It seems likely that clients' past experiences pertaining to loss might be associated with certain aspects of the termination phase of treatment. In line with the termination as loss model, we specifically examined how therapist perceptions of client sensitivity to loss relate to certain components of the therapy relationship and termination phase evaluation, from the therapist's perspective.

Second, the literature on the termination of psychotherapy seems to highlight differences in positive versus negative termination experiences, and successful versus unsuccessful treatment. As an example, in the Quintana and Holahan (1992) study, results indicated that therapists were less likely to engage in looking back on the course of treatment, bring closure to the therapeutic relationship, and process the client's feelings about the ending of treatment in cases they classified as less

successful as compared to those classified as more successful. In a recent book on termination, Joyce, Piper, Ogrodniczuk and Klien (2007) posit that termination phase outcomes specifically include accomplishments associated with the last phase of treatment, and differ from overall treatment outcome. In line with these findings and inferences, our aim in the present study was to explore how the effectiveness of the termination phase of treatment relates to certain therapy relationship components and treatment outcome in the eyes of the therapist.

Third, existing research and theoretical formulations on termination emphasize the importance of the therapy relationship during the termination phase. Knox et al. (2011) found that clients reported negative and positive aspects of the relationship in both positive and problematic termination experiences. In another qualitative study examining the experience of termination from psychodynamic and psychoanalytic therapists' perspective, Fragkiadaki and Strauss (2012) found that therapists specified the therapeutic relationship to be a meaningful determiner of the experience of termination.

The extant literature on termination of psychotherapy has examined both client and therapist perspectives on termination, and findings indicate that termination seems to be a meaningful aspect of treatment for therapists as well as clients. Studies on termination examining the therapist's point of view have focused on specific termination reactions, behaviors and feelings to shed light on how treatment ends, the client's experience of ending, and reasons for termination (e.g. Baum, 2006; Quintana & Holahan, 1992; Roe, Dekel, Harel, Fennig, & Fennig 2006; Fortune, Pearlingi & Rochelle, 1992). In spite of the recognition of the therapeutic relationship as a critical

aspect of the termination process, there has been no study to date that has focused specifically on therapists' perceptions of the therapeutic relationship during the termination phase of treatment. In efforts to add to the literature on termination, our goal in the present study was to examine therapists' views on certain elements of the therapeutic relationship during the termination phase of treatment in the context of both the effectiveness of the termination phase, as well as the overall treatment outcome.

### *The Therapeutic Relationship*

Based on Greenson's (1967) work on the therapeutic relationship in classical psychoanalysis, Gelso and Carter (1985, 1994) proposed the working alliance, real relationship and transference-configuration (including both transference and countertransference) to be key elements of the relationship between the therapist and client in all approaches to psychotherapy. Gelso and Samstag (2008) later proposed the term 'Tripartite Model' to define a model of the therapy relationship comprising of the aforementioned elements. The following components of this tripartite model were studied in the present study; the working alliance, the real relationship and client transference.

The first component, the working alliance, is the most researched component of the tripartite model. A widely used definition of the working alliance (Bordin, 1979) focuses on an agreement on tasks and goals of therapy and the working bond between the therapist and the client as key components of the working alliance in therapeutic work. Gelso (2011) distinguished between the working bond and a more personal bond between the therapist and client. He talked about this personal bond as

the real relationship (the second component), defined in terms of the extent to which the therapist and client are genuine with one another and perceive each other realistically. The third component of relevance in the present study is transference, originating from psychodynamic literature. In general, transference is conceptualized as reflecting the client's past relationship patterns as they play out in the therapeutic relationship. The notion of transference has been subject to various controversies and definitions over the years. Conceptions of transference range from a more restrictive classical definition, which theorizes transference to include client reactions to the therapist originating in the Oedipal phase of development, to a more totalistic definition, which conceptualizes transference as all of the client's reactions to the therapist (Gelso, 2014). In efforts to integrate these perspectives, Gelso and Bhatia (2012) defined transference as "the patient's experience and perceptions of the therapist that are shaped by the patient's own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (p. 385).

Though the working alliance, real relationship and transference all have their roots in psychodynamic theory, they are now viewed by many as being present in heterogeneous forms of therapy (see Gelso, 2014). A number of studies have also indicated that these components are linked to both treatment and session outcome to varying extents. There is some evidence that the components of the therapeutic relationship change across the course of therapy, indicating that they might be different at the end of treatment as compared to other times in treatment (e.g.

Horvath, Del Re, Flukiger, & Symonds, 2011; Fuertes, Gelso, Owen & Cheng, 2013; Gullo, LoCoco & Gelso, 2012; Gelso, Kivlighan, Wine, Jones & Friedman, 1997).

### *The Development of Hypotheses*

The first set of hypotheses in the present study pertain to how the working alliance, real relationship and transference during the termination phase of treatment relate to termination phase evaluation and treatment outcome in the eyes of the therapist. In order to clarify the bases for our hypotheses we refer to the literature focusing on a) studies that examine the relationship between these components of the tripartite model and session/treatment outcome, and b) studies that examine the unfolding of the relationship, and inform us about the working alliance, real relationship and transference during the last stage of treatment.

The working alliance is the most studied component of the tripartite model. There is substantial evidence of the relationship between the working alliance and outcome, affirmed by a recent meta-analysis of the working alliance and outcome in individual therapy (Horvath et al., 2011). Horvath et al. (2011) found that the working alliance accounted for approximately 7.5 percent of the variance in treatment outcome. We expected that therapists perceiving a strong working relationship with the client at the end of treatment are also likely to believe that the termination phase work is successful with the client. Thus, we hypothesized that that *therapists' ratings of working alliance during the termination phase of treatment will relate positively to therapists' ratings of termination phase evaluation.*

The unfolding of the working alliance has been studied in terms of characteristic patterns of the alliance. These patterns are based on varying strength of

the working alliance over the course of treatment. Safran and Muran and their collaborators (e.g., Safran & Muran, 1996, 2000; Safran, Muran & Eubanks-Carter, 2011; Samstag, Muran & Safran, 2004) have explored ruptures and repairs of the working alliance in treatment. Ruptures reflect a tension in the working alliance, and repair occurs when the therapist and client work collaboratively to understand the rupture (Safran et al., 2011). In a similar way, Gelso and Carter (1994) proposed that an initial strong working alliance would diminish during the course of treatment as the focus on client conflicts becomes stronger. Gelso and Carter posited that the alliance would strengthen again towards the end of successful treatment, as difficulties are addressed and resolved in the therapy relationship. On the other hand, in less successful treatment the alliance would not be repaired and may weaken further at the end of treatment. There are only a few studies that have examined these patterns of the working alliance in treatment. In their review, Horvath et al. (2011) found that some fluctuations in the alliance relate to better treatment outcomes as compared to a stable alliance pattern. In general, the findings seem to indicate that a strong working alliance (either repaired after rupture(s), or strong without rupture) in the later stages of treatment relates to more successful treatment. In line with these findings, we hypothesized that *therapists' ratings of the working alliance during the termination phase of treatment will relate positively to therapists' ratings of overall treatment outcome.*

Research on the real relationship is still in its nascent stages. Measures of the real relationship have been developed only recently by Gelso and his collaborators (Gelso, Kelley, Fuertes, Marmarosh, & Costa, 2005; Kelley, Gelso, Fuertes, &

Marmarosh , & Lanier, 2010). A few studies indicate a positive relationship between the real relationship and session outcome (Bhatia & Gelso, 2013; Eugster & Wampold, 1996; Gelso et al., 2005), as well as treatment outcome (Ain & Gelso, 2008, 2011; Fuertes, Mislowack, Brown, Gur-Arie, Wilkinson & Gelso, 2007; Gelso, Kivlighan, Busa-Knepp, Speigel, Ain & Hummel, 2012; LoCoco, Gullo, Prestano, & Gelso, 2011; Marmarosh, Gelso, Markin, Majors, Mallery & Choi, 2009; Owen, Tao, Leach, & Rodolfa, 2011). These results include both client and therapist perspectives, however, there are a few differences in client and therapist perspectives in some studies (e.g. Gelso et al., 2012; LoCoco et al., 2011). In general, evidence suggests that therapists perceiving a strong real relationship are also likely to believe that session outcomes are good. Thus, we hypothesized that *therapists' ratings of the real relationship during the termination phase of treatment will relate positively to therapists' ratings of termination phase evaluation.*

In efforts to study the unfolding of the real relationship in treatment, Gelso et al. (2012) surveyed forty-two clients and their therapists about their perspective on the strength of the real relationship after every session along with treatment outcome. Results indicated differences in client and therapist perspectives at earlier points in treatment. Client ratings of the real relationship related to outcome at earlier points in treatment whereas therapist ratings of the real relationship at the same points did not relate to outcome. However, therapist ratings of the real relationship strengthened over the course of treatment, and this strengthening of the real relationship in the eyes of the therapist related to treatment outcome. Gullo, LoCoco and Gelso (2012) studied therapist and client ratings of the real relationship at different points in brief

therapy (average number of total sessions=11.58) and found that both client and therapist ratings of the real relationship at the eighth session related to treatment outcome. Fuertes, Gelso, Owen and Cheng (2013) surveyed six client therapist dyads to examine the unfolding of the real relationship in brief therapy. Fuertes and his collaborators found that the real relationship strengthened across the course of treatment, especially when the therapy was more successful. In line with the findings suggesting the presence of a stronger real relationship at the end of successful treatment, we hypothesized that *therapists' ratings of the real relationship during the termination phase of treatment will relate positively to therapists' ratings of overall treatment outcome.*

In terms of transference, a few studies indicate that the evidence is mixed in terms of the relationship between transference and outcome. In two past studies, negative transference was not found to relate to session outcome or treatment outcome. Instead, the presence of insight in therapy moderated the relationship between negative transference and session/treatment outcome (Gelso, Hill & Kivlighan, 1991; Gelso et al., 1997). Contrary to these findings, Marmarosh et al. (2009) found that negative transference related negatively to symptom change. In other studies (Bhatia & Gelso, 2013; Gelso et al., 2005; Markin, McCarthy & Barber, 2013) therapist ratings of negative transference were found to relate negatively to therapist perceptions of session smoothness and overall session outcome. It is important to note here that the correlation between transference and outcome, when found, tends to be of a small effect size. We posited that transference might have a stronger association with outcome at certain salient points in treatment. We

hypothesized that *therapists' ratings of negative transference during the termination phase of treatment will relate negatively to termination phase evaluation*. In other words, we believed therapists perceiving greater negative transference in the termination phase of treatment would be less likely to rate the termination phase as effective.

There are very few studies that have examined how transference unfolds across the course of therapy. Beach and Power (1996) coded 40 psychotherapy sessions and found that transference references increased in later sessions in both psychodynamic and cognitive behavioral therapies. In two studies (Graff & Luborsky, 1977; Patton, Kivlighan & Multon, 1997) of psychodynamic therapies, transference was found to increase in later sessions when the therapy was successful. In contrast to these results, Gelso et al. (1997) surveyed therapists for brief, heterogeneous forms of therapy and found that transference (especially negative transference) increased from the first through the third quarter of treatment followed by a sharp decline in the last quarter, for more successful cases. On the other hand, for less successful cases, therapists indicated that transference was higher in the initial sessions and continued to rise through the course of therapy. Gelso (2014) suggests that the difference in theoretical orientation (psychodynamic versus heterogeneous) might be the underlying reason for these differing results. For our present study, comprising of a sample of therapists of heterogeneous theoretical orientations, we hypothesized that *therapists' ratings of the amount of negative transference during the termination phase of treatment will relate negatively to therapists' ratings of overall treatment outcome*.

There may be a number of factors predicting the presence of negative transference during the last stage of treatment. It made sense to us that one variable bearing upon negative transference during the termination phase of treatment might be client sensitivity to loss, and thus our second set of hypotheses pertain to therapists' perceptions of client sensitivity to loss. Client sensitivity to loss has been examined in a few studies in the context of termination. In their study on client reactions during termination, Marx and Gelso (1987) found that client loss history predicted the importance clients placed on discussing their reactions during termination. Gould (1978) posited that client sensitivity to loss would relate to perceptions of more emotional turmoil and conflict at the end of treatment. We also expected clients with heightened sensitivity to loss to be more likely to have reactions to losing the therapeutic relationship, and possibly more negative transference towards the therapist. Even though therapeutic work may be focused on the resolution of loss-related issues for clients with heightened sensitivity to loss, we conjecture that for heterogeneous forms of therapies, including non-dynamic therapies, loss may not be addressed in the context of therapeutic relationship. A recent review of studies on transference in non-analytic therapies indicated that therapists of various theoretical orientations recognize the presence of negative transference in therapeutic work, although differences exist in the extent to which negative transference is addressed or dealt with in sessions depending on theoretical orientation (Gelso & Bhatia, 2012). In line with these findings and inferences, we expected the sample of theoretically heterogeneous therapists in the present study to identify negative transference when it is present, even though the emphasis of treatment may not lie on working through or

reducing negative transference. Thus, we anticipated theoretically heterogeneous therapists perceiving heightened client sensitivity to loss to be more likely to identify greater negative transference during the termination phase of treatment. Said differently we hypothesized that *therapists' perceptions of greater client sensitivity to loss will relate positively to therapists' ratings of the amount of negative transference during the termination phase.*

In another study examining the role of client loss history during treatment termination, Boyer and Hoffman (1993) found that therapists' perceptions of client sensitivity to loss predicted counselor anxiety during termination but not counselor task satisfaction during termination. With a slightly different lens, we hypothesized that the relationship between therapists' perceptions of client sensitivity to loss and termination phase evaluation will be moderated by the working alliance and the real relationship. Our reasoning here was that therapists' perceptions of client sensitivity to loss will be associated with good outcomes when there is a sound working alliance and real relationship between the therapist and the client. We theorized that a strong personal and working relationship will facilitate working through clients' loss experiences and lead to more favorable termination phase evaluation. Thus, we hypothesized that *therapists' perceptions of the working alliance and real relationship during the termination phase of treatment will moderate the relationship between therapists' ratings of client sensitivity to loss and termination phase evaluation, such that for high ratings of the real relationship and working alliance, client sensitivity to loss will be positively related with termination phase evaluation,*

*whereas for low ratings of working alliance and the real relationship, client sensitivity to loss will be negatively related to termination phase evaluation.*

Lastly, along with attempting to understand the relationship between elements of the tripartite model and outcome during the termination phase, we also conducted additional analyses pertaining to the type of termination. Clinically, there can be many different reasons to terminate treatment. A body of literature has examined client and therapist perspectives on the reasons underlying termination (e.g. Wong, Tambling, Anderson, 2013; Olivera, Braun, Penedo, Roussos, 2013; Roe et al., 2006; Renk & Dinger, 1992). There is some evidence that different types of termination relate to certain variables at the end of treatment. As an example, in Baum's (2005) study of social workers, results indicated that from the therapist's perspective, clients experiencing forced termination (therapist-initiated or institution-initiated) manifested greater loss experiences than clients who self-initiated termination. Clients in Knox et al.'s (2011) study reported that successful treatment ended because of logistical and financial reasons, and less successful treatment often involved a rupture in the therapeutic relationship. Olivera et al. (2013) interviewed 17 former psychotherapy clients in Buenos Aires and found that treatment ended due to the following reasons; therapist proposed termination, client proposed termination, disappointment with therapy or the resolution of clients' reason for consultation. In the present study, we focused on four broad categories of treatment termination; termination initiated by therapist, termination initiated by client, mutually agreed upon termination, and termination due to external factors. Using the aforementioned categories, we examined if *the type of termination relates to a) the components of the therapeutic*

*relationship surveyed in the present study, b) treatment outcome and c) termination evaluation from the perspective of the therapist.* No study to date has examined the aforementioned categories of termination in terms of how they relate to relational and outcome variables in treatment, and thus no hypotheses are posited at this time.

## Chapter 2: Method

### Participants

Participants in this study were licensed therapists in the United States, recruited based on their membership in two divisions of the American Psychological Association, the Division of Psychotherapy (Division 29) and the Division of Independent Practice (Division 42). The final sample consisted of 233 therapists identifying a termination phase in their recently ended therapy with a client.

Participants consisted of 54.5% male therapists (n=127) and 44.8% female therapists (n=104). One therapist indicated their gender as “other.” In terms of ethnic/racial background, the majority of the therapists identified as White/Caucasian (n=221, 94.8%), followed by Hispanic/Latino (n=4, 1.7%), Asian/Pacific Islander (n=4, 1.7%), African American/Black (n=2, .9%) and “Other” (n=3, 1.3%). Most therapists in this sample stated their highest educational degree to be a doctorate (n=228, 97.9%), one therapist had a Masters degree and four therapists specified their highest educational degree to be “Other” (including categories such as EdD, PsyD, JD PhD, MEd). The average age reported by therapists was found to be 62.07 (SD=11.69).

The years of clinical experience of therapists in the present sample ranged from three to 65 years. Therapists also indicated their theoretical orientation by responding to an item determining the extent to which a specific theoretical approach was representative of their work in psychotherapy, on a five-point scale (5=strongly representative, 1=not at all). Three therapists entered erroneous values (135, 60, 15) on this item and their responses were not included in calculating the means values of

theoretical orientation. Results revealed the following mean values: Humanistic/Experiential theoretical orientation=2.73, (SD=1.08, N=197), Psychodynamic/Psychoanalytic=3.53 (SD=1.28, N=210), Cognitive/Behavioral= 3.67 (SD=1.14, N=205), Systems=2.84 (SD=1.27, N=188). A number of therapists added to this list of theoretical orientations to include categories such as mindfulness, positive psychology, client-centered, multicultural-feminist, acceptance and commitment therapy and so on. The mean ratings of theoretical orientation and additional categories of theoretical orientation used by participants suggest that the current sample is highly diverse in terms of theoretical orientation.

Therapists also completed a measure on their selected client's demographics. In terms of gender, 98 therapists indicated their client to be male, 134 indicated their client to be female and one therapist indicated their client's gender to be "Other." The clients selected for the purpose of the present study were adults, with ages ranging from 18 years to 91 years. Therapists' reports indicated the majority of the selected clients to be Caucasian/White (n=201, 86.7%), nine to be African American/Black (3.9%), 10 to be Hispanic/Latino (4.3%), five to be Asian/Pacific Islander (2.1%), and five to be "Other" (Arab, Eastern Indian, European American, Multi-racial) in terms of ethnic background.

### Measures

**Termination Phase of Treatment.** Single items were used to collect information on the termination phase of treatment. Therapists were asked to indicate the total number of sessions completed with the client and an estimate of the number of sessions included in the termination phase of treatment. A number of therapists did

not state specific numbers for total number of sessions and sessions included in the termination phase, instead indicating that they had seen the client for over ten or hundreds or thousands of sessions. In such cases, the average was calculated by entering the minimum number of sessions (e.g. ten for a therapist who mentioned he/she had seen the client for more than ten sessions), and thus the average is an underestimate of the actual value. Therapists who did not indicate a session number, or responded in a way that made it impossible to approximate the number of sessions, were excluded from the analysis of mean number of sessions and sessions included in the termination phase of treatment. The average number of sessions completed in the course of the entire treatment was found to be 62.48 (SD=102.23), indicating that on average the sample comprised of therapists seeing their clients for longer-term therapy. The average number of sessions included in the termination phase of treatment was found to be 6.59 (SD=10.49), 16.82 percent of the total number of sessions.

Therapists were also requested to share the reason for termination based on an item used by Boyer (1990). Therapists were asked to indicate which of the following led to their client's termination of psychotherapy; therapist's decision, client's decision, mutual agreement, external factors, other. Most therapists reported termination to occur due to mutual agreement (N=154, 66.1%), 57 (24.5%) therapists reported termination occurred due to external factors, 16 (6.9%) reported termination occurred due to client decision, three (1.3%) indicated termination occurred due to therapist decision and three (1.3%) therapists reported other reasons for termination.

**Working Alliance Inventory–Short Form (WAI-S).** Therapists rated the working alliance with their client during the termination phase of treatment using the WAI-S. Horvath and Greenberg (1986, 1989) developed the Working Alliance Inventory (WAI) based on Bordin’s (1979) theory of the alliance. The full-length version of the WAI comprises of 36 items, and has three subscales assessing client-therapist agreement on therapeutic goals, agreement on tasks of therapeutic work and the bond between the therapist and the client. Each item is rated on a 7-point scale (1=*Never* and 7=*Always*). Tracey and Kokotovic (1989) developed the short form of the WAI, comprising of 12 items, with four items in each subscale (Tasks, Goals and Bond). The present study used the therapist version of the WAI-S proposed by Tracey and Kokotovic to measure therapist ratings of the working alliance with their client during the termination phase of treatment.

A large body of evidence exists for both the full-length version of the WAI, as well as the WAI-S. Studies have provided support for the reliability and validity of the full-length measure (e.g. review by Horvath et al., 2011; Kivlighan & Shaughnessy, 2000; Constantino, Castonguay & Schut, 2002). Tracey and Kokotovic (1989) found the WAI-S to have a factor structure similar to the full-length WAI, and the reliability coefficients for client and therapist subscales on the WAI-S to range from .83 to .98. Studies have indicated that the WAI-S relates to client termination from therapy (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1995), treatment adherence (Corris et al., 1999) and therapy outcome ratings (Kivlighan & Shaughnessy, 1995; Weerasekera, Linder, Greenberg, & Watson, 2001). Busseri and Tyler (2003) studied therapist ratings of the final session on the

WAI-S and found internal consistency coefficients to range from .86 to .96. In the present study, the internal consistency alpha was found to be .91 for the WAI-S.

**Real Relationship Inventory Therapist Form-Shortened (RRI-T; Gelso et al. 2005).** Gelso et al., (2005) developed the therapist form of the Real Relationship Inventory comprising of 24 items, with two subscales (12 items each), Realism and Genuineness. Therapists rated items pertaining to themselves, the client and their relationship on a 5-point scale (1=*strongly disagree*, 5=*strongly agree*). Gelso et al. found the alpha coefficients for the Realism and Genuineness subscale to be .79 and .83 respectively, and the alpha coefficient for the total score to be .89. A few studies have used the RRI-T since its development and provided further evidence of its reliability (e.g. Marmarosh et al., 2009; Gelso et al., 2012; Bhatia & Gelso, 2013). Studies have also indicated that the measure relates to other relational and outcome measures in theoretically predicted ways, providing evidence for the construct validity of the RRI-T. For example, the RRI-T is found to relate positively to working alliance (Gelso et al, 2005; Fuertes et al 2007), negatively to negative transference (Marmarosh et al., 2009; Bhatia & Gelso, 2005), and positively to session as well as treatment outcome (Gelso et al, 2005; Marmarosh et al, 2009; Fuertes et al, 2007).

Hill et al., (2014) used a shorted version of the RRI-T, consisting of 12 items best representing the theoretical components of the measure. Hill et al. offered support for using the shortened version of the measure by reporting the strong correlation between the shortened version of the form and the full-length form ( $r=.96$ ). We used the shortened version of the RRI-T in efforts to reduce the amount of time taken to complete the measure. In the present study, therapists were asked to

rate the real relationship with their client during the termination phase of treatment using the RRI-T shortened form. The internal consistency alpha for the RRI-T shortened form was found to be .80 in the present study.

**Therapy Session Checklist- Transference Items (TSC-TI).** Graff and Luborsky (1977) initially developed three single items to measure transference from the therapists' perspective in their Therapist Session Checklist. Therapists are given the following definition of transference and asked to rate transference, positive transference and negative transference using a 5-point scale (1=*none or slight* and 5=*very much*)

*Transference:* The degree to which the client is dealing with material that is overtly or covertly related to the therapist. This material must be a manifestation of or displacement from an early important relationship(s). The previous person (or transference source), however, need not be mentioned; he or she may be inferred because of, for example, the presence of distortion, strong affect, inappropriate affect, and so forth. Positive transference may be seen as positive reactions to or perceptions of the therapist that are transference based, whereas negative transference is reflected in negative reactions to or perceptions of the therapist that are transference based.

In the present study, therapists were asked to rate the amount of transference, negative transference and positive transference during the termination phase of treatment with their client. Even though problems are recognized with utilizing single item measures, the TSC-TI has been used in a number of studies examining transference (e.g. Gelso et al., 1997; Gelso et al., 2005; Marmarosh et al., 2005). Luborsky and colleagues (Graff & Luborsky, 1977; Luborsky, Crabtree, Curtis, Ruff,

& Mintz, 1975; Luborsky, Graff, Pulver, & Curtis, 1973) have reported moderate levels of interrater reliability between therapists and external raters for the TSC-TI. Gelso et al. (1997) provided further reliability evidence for these items. The authors found the alpha coefficients for the transference items for the first four sessions in their sample to be .66 for positive transference, .86 for negative transference, and .69 for the amount of transference. Gelso et al. reasoned that transference was presumed to vary in sessions and thus a very high degree of stability was not expected. Furthermore, the TSC-TI items are found to relate to a number of variables in theoretically predicted ways, supporting the construct validity of the measure. For example, Gelso et al. (1991) found transference ratings using the TSC-TI to relate to counselor intentions in ways expected by theory, and Multon, Patton and Kivlighan (1996) found the TSC-TI to relate to a multi-item measure of transference as predicted.

Some researchers have suggested combining the three transference items to yield a single score on the transference measure (Kivlighan 1995; Markin & Kivlighan, 2007). We did not follow this suggestion as we found a modest correlation between negative transference and positive transference during the termination phase, as rated by therapists in the present study ( $r=.19, p<.01$ ), indicating that the two types of transference may relate to other constructs in the study in different ways.

**Perceived Client Sensitivity to Loss.** Boyer and Hoffman (1993) constructed the perceived client sensitivity to loss scale to assess therapists' perceptions of client vulnerability to feelings of loss that might occur during termination. The scale consists of four items to be rated on a 5-point scale (1=*not at all* and 5=*to a great*

*deal*). The first item on the scale is an adaptation of that used by Marx and Gelso (1987) in their study of therapy termination. In this item, therapists are asked to rate the extent to which loss and/or separation was a significant theme in the therapeutic work. The next three items on the scale are derived from a study by Gould (1978). These items pertain to client sensitivity to loss, the extent to which the client is unable to mourn, and the degree to which termination occurred at an untimely point in the client's life. Boyer and Hoffman found the coefficient alpha for the scale to be .66 in their study. Similar to Boyer and Hoffman, in the present study, we found the coefficient alpha for the scale to be .63. Although the reliability of the measure appears modest, we decided to retain responses from the measure given its utility in obtaining ratings of client sensitivity to loss from the therapist's perspective.

**Outcome measures.** Two types of outcomes were utilized in the present study. The first concerns the extent to which the termination phase has favorable outcomes and includes therapists' ratings of the effectiveness of the termination phase of treatment. The second concerns the overall treatment outcome, i.e. the extent to which therapeutic work has favorable outcomes. We decided to use brief measures of both termination phase evaluation and treatment outcome to facilitate a higher return rate from our pool of therapists. The following measures were used to assess termination phase evaluation and overall treatment outcome.

***Session Evaluation Scale (SES; Hill & Kellems, 2002).*** The SES was initially developed by Hill and Kellems (2008) as a subscale of the Helping Skills Measure. The SES has parallel forms to assess therapist and clients' evaluation of the session. Hill and Kellems found the measure to have sound reliability ( $\alpha=.89$ ).

Validity for the measure has been demonstrated in a number of studies, which have found SES to correlate in expected ways with client ratings of session impact and aspects of the therapeutic relationship. Lent et al. (2006) studied therapist ratings of session evaluation using the SES and found alpha coefficients of the measure to range from .86 to .87. Bhatia and Gelso (2013) used therapists' ratings of the SES and results indicated that the SES correlated with the working alliance, the real relationship and negative transference in ways consistent with theory.

In the present study, the therapist scale of the SES was used to assess therapists' evaluations of the termination phase of treatment. Participants were instructed to complete items based on the termination phase of treatment with their client. Items were modified to include the 'the termination phase of treatment' instead of 'the session', e.g. "My client was glad he/she attended the termination phase of treatment"; "My client thought the termination phase of treatment was helpful". Therapists' rated the modified items using the same 5-point scale as in the original measure (1=*strongly disagree* and 5=*strongly agree*). The internal consistency (alpha) of the measure in the present study was found to be .81.

***Counseling Outcome Measure (COM; Gelso & Johnson, 1983).*** Gelso and Johnson (1983) developed the COM to assess client and therapist perceptions of the client's improvement at present, as compared to when the client began therapy. The scale consists of four items pertaining to improvement in client feelings, behaviors, self-understanding and overall, to be rated on a 7-point scale (1=*much worse* and 7=*much improved*). The COM has been used in several studies that have demonstrated evidence for its reliability and validity. Gelso and Johnson found 3-

week test-retest reliability estimates of the items to range from .63 to .82. Further reliability evidence has been indicated by a number of other studies, with alphas ranging from the high .80s to low .90s (e.g. Ain & Gelso, 2008, 2011; Fuertes et al., 2007; Gelso et al., 2012; Tracey, 1987). In terms of the scale's validity, it has been found to relate to client, counselor and independent judges' ratings of change from counseling (Gelso & Johnson, 1983), as well as to other established treatment outcome measures (Patton, Kivlighan & Multon, 1995). The COM also relates to other variables such as the real relationship (Ain & Gelso, 2008; Fuertes et al., 2007), aspects of time-limited therapy (Gelso & Johnson, 1983) and with the interaction of client negative transference and insight (Gelso et al., 1997) in theoretically expected ways, indicating support for the construct validity of the measure. In the present study, therapists were asked to evaluate client improvement at the end of treatment using the COM. The internal consistency alpha of the COM in the present study was found to be .83.

### Procedure

Participants were recruited based on their membership in two divisions of the American Psychological Association, the Division of Psychotherapy (Division 29) and the Division of Independent Practice (Division 42). The membership lists of the two divisions were obtained from [apa.org](http://apa.org), and state licensed members in the USA were selected to find members currently licensed and possibly practicing psychotherapy. Every member from this selected list with a valid email was contacted in the initial email. A total of 3508 therapists, 2139 from Division 42 and 1369 from

Division 29, were contacted via email. Two reminder emails were sent to therapists who did not respond to the previous email (reminder 1  $n=3215$ ; reminder 2  $n=2937$ ).

The email sent to participants was a personalized invitation requesting participation in the study. This email included a brief description of the study, appreciation for the therapist's possible participation and a link to an online survey. The study was described as focusing on aspects of the therapeutic relationship and the termination phase of treatment. Therapists were asked to follow the link to an online survey if they currently saw clients and had recently terminated with a client (over 18 years of age). Therapists who followed the link were requested to give consent before proceeding to the following section. Next, therapists were asked if they were able to identify one or more clients with whom they have recently terminated, meeting the following eligibility criteria: a) the client was over the age of 18 and b) the therapist and the client met for at least 10 sessions. Therapists who respond negatively at this point were directed to a page with indicating we were not able to use their responses at this time, given the purpose of our study.

Therapists responding affirmatively to the eligibility criteria were directed to an online page with the following question, "*Are you able to identify a termination phase (defined below) of treatment in your work with one or more of these clients? A termination phase is defined as a last phase of counseling, during which you and the client consciously or unconsciously worked toward bringing the treatment to an end and talked about the end of therapeutic work.*" Therapists who were able to identify a termination phase of counseling were given instructions to complete measures based on their work with the client meeting the aforementioned eligibility criteria and with

whom they most recently ended treatment and had a distinct termination phase of treatment.

Since we were unsure if therapists would identify a distinct termination phase of treatment, we created a separate pool of measures for therapists unable to identify a termination phase of treatment. These therapists were instructed to complete measures based on their work with the client meeting the eligibility criteria and with whom they most recently ended treatment. Therapists in this pool were asked to complete therapy relationship measures with the selected client in the last few sessions of therapy (approximately 15-20 percent of the total number of sessions of psychotherapy), instead of during the termination phase of treatment.

Of the 3508 therapists contacted initially, 706 emails bounced back and/or appeared invalid and 215 therapists did not meet eligibility criteria of the study for reasons such as therapists not seeing clients, pursuing only assessment practice, not working with adult clients and so on. Twenty-four therapists indicated they have had no recent termination and 197 therapists declined to participate. Three hundred and twenty therapists began participating in the survey, of which 316 therapists gave consent to participate in the study and four therapists denied consent to participate. Thirteen therapists did not participate beyond giving informed consent. Of the remaining 303 therapists, 287 therapists went on to identify a client with whom they had recently ended treatment and had met for therapy for at least 10 therapy sessions (as indicated in the eligibility criteria). Next, 263 therapists identified a client meeting the eligibility criteria with whom they could identify a distinct termination phase. Only 15 therapists completed responses for a client meeting the eligibility criteria

without a distinct termination phase. We decided to retain only cases with a distinct termination phase for analysis, given the small number of participants in the second pool of responses.

Therapists who identified a termination phase of treatment were also asked to indicate how long it has been since they ended treatment with their selected client. Twenty therapists did not respond to this item and nine therapists indicated a time period of over two years since they ended treatment. We questioned the validity of responses on the measures for treatment with a client that occurred over two years ago and thus did not include the responses of these nine therapists for further analysis in this study. In all, our final sample consisted of 233 therapists.

## Chapter 3: Results

### *Preliminary Analysis*

**Missing data.** Guidelines suggested by Schlomer, Bauman and Card (2010) are used to report missing data. Missing data ranged from 2-5% for the scales used in the study (Working Alliance Inventory; Real Relationship Inventory; Negative Transference; Positive Transference; Perceived Client Sensitivity to Loss; Session Evaluation Scale; Counseling Outcome Measure). A dummy variable with two values (missing and nonmissing) was created and independent t-tests were used to test the relation between the dummy variable and other variables of interest in the study. No statistically significant relationship was found between the dummy variable and other variables of interest in the study, thus indicating the missing data are missing completely at random. Consequently, missing data was handled by complete case analysis (i.e., listwise deletion), in which only cases with complete data were retained for analysis. A closer examination of the data indicated that no more than seven cases were lost in using complete case analysis.

**Reliability indices and descriptive data.** Descriptive data including means, standard deviations and reliability estimates of the measures used in the study are presented in Table 1. The values of means and standard deviations in this study are comparable to those found in other studies (e.g. Markin et al., 2013; Gelso et al., 2005; Bhatia & Gelso, 2013; Marmarosh et al., 2009; Fuertes et al., 2007). Reliability indices (Cronbach's alpha) for the Working Alliance Inventory, Real Relationship Inventory, Session Evaluation Scale and Counseling Outcome Measure were .80 or

Table 1

*Descriptive Statistics and Correlations among Study Variables*

	1	2	3	4	5	6	7	Item Range	Mean	SD	Skewness	Kurtosis
1. COM	1							1-7	6.53	0.51	-1.13	1.11
2. SES	0.30**	1						1-5	4.16	0.54	-0.25	-0.23
3. WAI	0.45**	0.44**	1					1-7	5.83	0.62	-0.61	0.32
4. RRI	0.29**	0.32**	0.54**	1				1-5	4.15	0.46	-0.25	0.10
5. Negative Transference	-0.13*	-0.01	-0.36**	-0.30**	1			1-5	1.41	0.70	1.896	4.51
6. Positive Transference	0.03	0.02	-0.03	0.01	0.19**	1		1-5	2.85	1.15	0.06	-0.90
7. Perceived Client Sensitivity to Loss	-0.03	0.06	-0.13*	-0.01	0.26**	0.30**	1	1-5	2.87	0.76	-0.2	-0.39

*Note.* COM = Therapist ratings on the Counseling Outcome Measure; SES = Therapist ratings on the Session Evaluation Scale, representing termination phase evaluation; WAI=Therapist ratings of the Working Alliance Inventory-Short form; RRI=Therapist ratings of the Real Relationship Inventory

over, providing support for the reliability of these measures. The reliability index of the Perceptions of Client Sensitivity to Loss Scale was found to be modest ( $\alpha=.63$ ), though consistent with a previous study ( $\alpha=.66$ ; Boyer & Hoffman, 1993).

**Tests for normality.** The distribution of responses on the measures used in the study was examined using skewness and kurtosis statistics, histograms, normal probability plots and boxplots. Although, skewness and kurtosis indicated some deviations from normality (see Table 1), a closer look at the distributions of the measures used in the study via histograms and q-plots revealed the distributions approached normality. The skewed distributions of the measures for this sample reflect how we expect therapeutic relationship and outcome variables to exist in the population. For example, a number of studies have found similar patterns of skewed distributions for the single items measuring transference (e.g. Gelso et al., 2005; Woodhouse et al., 2003). Despite the skewed distribution of the measures, the therapeutic relationship and outcome measures used in this study have been found to relate to other variables in ways that are theoretically expected in a number of studies (e.g. Gelso et al., 2005; Marmarosh et al., 2009). Given the distribution of scores approached normality and was consistent with expectations on how we expect these variables to exist in the population, scores were not transformed for the purpose of the present study.

**Time since termination.** Therapists were also asked to indicate how long it has been since they terminated treatment with their selected client. Responses for this item ranged from one day to eight years, and we decided to only retain cases with

termination occurring within the last two years. We made this decision due to concern around the validity of retroactive ratings for a period longer than two years. Since therapists did not use a standard rating scale to indicate the time passed since termination, their responses were converted to time in months to create consistency for further analysis. On average, therapists indicated the termination to have occurred in the last four months (Mean=3.90, SD=4.80). We calculated bivariate correlation coefficients to determine if therapists' reports of the time passed since termination was associated with other variables examined in this study. Results indicated only therapist ratings of positive transference during the termination phase were positively related to therapists' reports of the length of time passed since treatment had ended with their client ( $r=.17$ ,  $p<.01$ ). The length of time since treatment ended did not relate significantly to any other constructs measured in the study. Thus, further analyses were carried out without including time since termination, as this construct does not appear to be associated with most measures used in the present study.

**Termination phase sessions.** Therapists participating in the study were requested to indicate the estimated number of sessions in the termination phase of treatment, as well as the total number of sessions included in the treatment of the client. As might be expected, a correlation of strong effect size was found between the total number of sessions and the sessions included in the termination phase of treatment ( $r= .62$ ;  $p<.01$ ), indicating a positive association between these two variables. The average percentage of sessions included in the termination phase of treatment was found to be 16.82 percent of the total number of sessions.

**Outcome measures.** Two outcome measures were used in the study, the Session Evaluation Scale (SES) to assess the termination phase evaluation from therapists' perspective and the Counseling Outcome measure (COM) to assess the overall treatment outcome from therapists' point of view. A medium sized correlation between the two outcome measures ( $r=.30$ ,  $p<.01$ ) supported our rationale for utilizing both outcome measures in the analysis, rather than combining them as a composite score to yield a single outcome score.

### Tests of Hypotheses

The first set of hypotheses pertained to the relationship between therapists' ratings of the therapy relationship elements measured in the study (i.e. the working alliance, real relationship and transference) and termination phase evaluation and treatment outcome. Bivariate correlations (presented in Table 1) were calculated to test these hypotheses. Cohen's (1992) criteria were used to determine the effect sizes of the correlations (small effect size= .10; medium effect size=.30; large effect size=.50). We first hypothesized that *therapists' perceptions of the working alliance during the termination phase would relate positively to termination phase evaluation, as well as treatment outcome*. Results indicated support for these hypotheses. Therapist-rated working alliance during the termination phase of treatment was found to relate positively to termination phase evaluation ( $r=.44$ ,  $p<.01$ ) and overall treatment outcome ( $r=.45$ ,  $p<.01$ ). Similarly, we hypothesized that *therapists' ratings of the real relationship during the termination phase of treatment would relate positively to termination phase evaluation and overall treatment outcome*, and found support for these hypotheses ( $r=.32$ ,  $p<.01$ ;  $r=.29$ ,  $p<.01$ ). We expected *therapists'*

*perceptions of negative transference during the termination phase to relate negatively to therapist-rated termination phase evaluation, as well as therapist-rated treatment outcome.* Our hypothesis pertaining to negative transference and overall treatment outcome was supported as negative transference negatively related to overall treatment outcome ( $r = -.13, p < .05$ ). However, contrary to our expectations, therapist ratings of negative transference during the termination phase did not relate to therapist ratings of termination phase evaluation ( $r = -.01; p > .05$ ).

Gelso (2014) pointed out that the relationship of negative transference with outcome might be better appreciated in the context of interaction effects and moderating variables. We were surprised by the nonsignificant relationship between negative transference during the termination phase and termination phase evaluation, and wondered instead if the interaction of these two constructs bears upon overall treatment outcome. We carried out an additional regression analysis to examine the role of termination phase evaluation as a moderator in the relationship between negative transference and overall treatment outcome (presented in Table 2). Negative transference was entered in the first step, termination phase evaluation was entered in the second step, and the interaction between negative transference and termination phase evaluation was entered in the third step of a hierarchical regression analysis, with overall treatment outcome as the outcome variable. The scores were centered around the mean to prevent multicollinearity. Results indicated that Model 1 (including negative transference) significantly predicted overall treatment outcome ( $\text{Adj } R^2 = .01; p < .05$ ). Model 2 (including negative transference and termination phase evaluation) significantly predicted overall treatment outcome ( $\text{Adj } R^2 = .11;$

Table 2.

*Hierarchical Regression Analyses for Negative Transference, Termination Phase Evaluation and Overall Treatment Outcome*

	<i>B</i>	<i>SEB</i>	<i>b</i>	<i>t</i>	<i>p</i>	<i>Total R<sup>2</sup></i>	<i>Adj. R<sup>2</sup></i>	<i>R<sup>2</sup> change</i>	<i>F</i>	<i>F change</i>	<i>p</i>
<u>Step 1</u>						.02	.01		4.15		.04
Negative Transference	-.10	0.05	-.14	-2.04	0.04						
<u>Step 2</u>						.11	.11	.10	14.23	23.89	.00
Negative Transference	-0.10	0.05	-0.13	-2.03	0.04						
Termination Phase Evaluation	0.29	0.06	0.31	4.89	0.00						
<u>Step 3</u>						.13	.12	.02	11.1	4.38	.03
Negative Transference	-0.08	0.05	-0.11	-1.72	0.09						
Termination Phase Evaluation	0.29	0.06	0.30	4.81	0.00						
Negative Transference X Termination Phase Evaluation	0.16	0.08	0.13	2.09	0.04						

*N*=223

*Note: Dependent variable= Overall Treatment outcome (Therapists' ratings on the Counseling Outcome Measure); Termination Phase Evaluation=Therapists' ratings on the Session Evaluation Scale*

$p < .01$ ) and added incremental value to Model 1 ( $R^2$  change = .10,  $F$  change (220) = 23.89,  $p < .01$ ). Finally, Model 3 (including the interaction between negative transference and termination phase evaluation) significantly predicted overall treatment outcome (Adj  $R^2 = 0.12$ ,  $p < .05$ ), and added incremental value to Model 2 ( $R^2$  change = .02,  $F$  change (219) = 4.38,  $p < .05$ ). The parameter estimate associated with the negative transference and termination phase evaluation interaction was also found to be significant ( $B = .16$ ,  $p < .05$ ), providing support for termination phase evaluation as a moderator in the relationship between negative transference during the termination phase and overall treatment outcome.

A simple slopes analysis (Frazier et al., 2004) was conducted to further understand the nature of the negative transference and termination phase evaluation interaction. Results indicated that when therapists reported better termination phase evaluations (one SD above the mean), there was no significant relationship between therapist-reported negative transference and therapist-reported overall treatment outcome ( $B = .02$ ;  $p > .05$ ). However, at lower levels of termination phase evaluations (one SD below the mean), there was a significant negative relationship between negative transference and overall treatment outcome ( $B = -.17$ ;  $p < .01$ ). These findings suggest that when therapists report better termination phase evaluations, therapist-rated negative transference during the termination phase is not related to therapist-rated overall treatment outcome. However, when therapists report poorer termination phase evaluations, therapist-rated negative transference during the termination phase is negatively related to the therapist-rated overall treatment outcome.

Our next set of hypotheses pertained to therapists' perceptions of client

sensitivity to loss. We expected *therapists' perceptions of client sensitivity to loss to relate positively to therapists' ratings of the amount of negative transference during the termination phase*, and results supported this hypothesis ( $r=.26$ ;  $p<.01$ ). We also hypothesized that *therapists' perceptions of the working alliance and real relationship during the termination phase of treatment will moderate the relationship between therapists' ratings of client sensitivity to loss and termination phase evaluation*. Hierarchical regression analyses were used to test these hypotheses. To test the real relationship as a moderator, we entered therapist scores of perceived client sensitivity to loss in the first step, real relationship during the termination phase in the second step and the interaction term (perceived client sensitivity to loss X real relationship) score in the third step of the hierarchical regression analyses. Results (presented in Table 3) indicated that Model 1, including therapists' perceptions of client sensitivity to loss, did not significantly predict termination phase evaluation (Adj.  $R^2=0.00$ ,  $p>.05$ ). Although Model 2 (including therapist perceptions of client sensitivity to loss and the real relationship during the termination phase) significantly predicted termination phase evaluation (Adj  $R^2=0.10$ ,  $p<.01$ ), Model 3 (including the interaction between perceived client sensitivity to loss and the real relationship) did not predict termination phase evaluation and did not add any incremental value to Model 2 (Adj  $R^2=0.10$ ,  $p>.05$ ;  $R^2$  change= .00, F change (220) =.04,  $p>.05$ ), thus indicating our moderation hypothesis was not supported.

Analyses examining therapist-rated working alliance during the termination phase as a moderator of the relationship between therapists' perceptions of client

Table 3.

*Hierarchical Regression Analyses for Perceived Client Sensitivity to Loss, Real Relationship and Termination Phase Evaluation*

	<i>B</i>	<i>SEB</i>	<i>b</i>	<i>t</i>	<i>p</i>	<i>Total R<sup>2</sup></i>	<i>Adj. R<sup>2</sup></i>	<i>R<sup>2</sup> change</i>	<i>F</i>	<i>F change</i>	<i>p</i>
<u>Step 1</u>						.00	.00		.73		.40
Client Sensitivity to Loss	0.04	0.05	0.06	0.86	0.39						
<u>Step 2</u>						.11	.10	.11	13.78	26.74	.00
Client Sensitivity to Loss	0.05	0.05	0.07	1.02	0.31						
RRI	0.39	0.08	0.33	5.17	0.00						
<u>Step 3</u>						.11	.10	.00	9.16	.04	.85
Client Sensitivity to Loss	0.05	0.05	0.07	1.01	0.31						
RRI	0.39	0.08	0.33	5.16	0.00						
Client Sensitivity to Loss X RRI	-0.02	0.11	-0.01	-0.19	0.85						

*N*=221

*Note: Dependent variable= Termination phase evaluation (Therapists' ratings on the Session Evaluation Scale); RRI= Therapists' ratings on the Real Relationship Inventory; Client Sensitivity to Loss = Therapists' ratings on the Perceived Client Sensitivity to Loss Measure.*

Table 4.

*Hierarchical Regression Analyses for Perceived Client Sensitivity to Loss, Working Alliance and Termination Phase Evaluation*

	<i>B</i>	<i>SEB</i>	<i>b</i>	<i>t</i>	<i>p</i>	<i>Total R<sup>2</sup></i>	<i>Adj. R<sup>2</sup></i>	<i>R<sup>2</sup> change</i>	<i>F</i>	<i>F change</i>	<i>p</i>
<u>Step 1</u>						.00	.00		.64		.42
Client Sensitivity to Loss	0.04	0.05	0.05	0.80	0.43						
<u>Step 2</u>						.21	.20	.21	29.19	57.57	.00
Client Sensitivity to Loss	0.08	0.04	0.12	1.90	0.06						
WAI	0.41	0.05	0.46	7.59	0.00						
<u>Step 3</u>						.21	.20	.00	19.37	.00	.99
Client Sensitivity to Loss	0.08	0.04	0.12	1.88	0.06						
WAI	0.41	0.05	0.46	7.57	0.00						
Client Sensitivity to Loss X WAI	0.00	0.07	0.00	0.01	0.99						

*N*=222

*Note: Dependent variable= Termination phase evaluation (Therapists' ratings on the Session Evaluation Scale); WAI= Therapists' ratings on the Working Alliance Inventory; Client Sensitivity to Loss = Therapists' ratings on the Perceived Client Sensitivity to Loss Measure.*

sensitivity to loss and termination phase evaluation yielded similar findings (presented in Table 4). In a hierarchical regression analysis, Model 1 (including therapists' perceptions of client sensitivity to loss) did not significantly predict termination phase evaluation (Adj.  $R^2=0.00$ ,  $p>.05$ ); Model 2 (including therapists' perceptions of client sensitivity to loss and therapists' ratings of the working alliance during the termination phase) did predict termination phase evaluation (Adj  $R^2=0.20$ ,  $p<.01$ ); and Model 3 (including the interaction between perceived client sensitivity to loss and the working alliance) did not predict termination phase evaluation and did not add any incremental value to Model 2 (Adj  $R^2=0.20$ ,  $p>.05$ ;  $R^2$  change=  $.00$ ,  $F$  change (221) =  $.00$ ,  $p>.05$ ), thereby indicating that the interaction of therapists' perceptions of client sensitivity to loss and therapist-rated working alliance during the termination phase was not statistically significant in predicting therapists' perceptions of termination phase evaluation.

Multivariate analyses were used to study our research questions on whether the reason for termination identified by therapists (therapist decision, client decision, mutual agreement and external factors) related to therapists' perceptions of a) the components of the therapeutic relationship surveyed in the present study, and b) treatment outcome and termination evaluation. Therapists were asked to indicate if termination of treatment occurred as a result of therapist decision, client decision, mutual agreement, external factors or other reasons. Three therapists identified termination to occur due to "therapist decision", 16 therapists identified treatment ended due to "client decision", 154 therapists indicated treatment ended due to "mutual agreement", 57 reported end of treatment due to "external factors" and three

therapists identified “other reasons” for termination of treatment. The assumptions of multivariate analyses were tested (including sample size, normality, outliers, linearity, homogeneity of regression, multicollinearity and homogeneity of variance-covariance matrices) before conducting a MANOVA. Given the number of cases were lower than recommended (Tabachnick & Fidell, 2007) to meet the sample size assumption for MANOVA in certain conditions (“therapist decision” and “other reasons”), only three types of termination with sufficient number of observations were included for further analyses (i.e. client decision, mutual agreement and external factors). A one-way MANOVA analysis was carried out with therapy relationship elements as the first set of dependent variables, with three levels of the reason for termination (client decision, mutual agreement and external factors) as the independent variable. No statistically significant difference was found in therapist perceptions of the elements of the therapeutic relationship based on the three reasons of termination identified by therapists ( $F(6, 420) = .93, p > .05$ ; Wilk’s  $\Lambda = .97$ ).

One-way MANOVA analysis was also used to assess differences on termination phase evaluation and treatment outcome between the three types of termination identified by therapists. In this case, termination phase evaluation and treatment outcome were the dependent variables and the three reasons for termination (client decision, mutual agreement and external factors) were the three levels of the independent variable. Results indicated no statistically significant difference in outcome based on the three types of termination ( $F(4, 432) = 1.30, p > .05$ ; Wilk’s  $\Lambda = .98$ ). Thus, results from the MANOVA analyses indicated that therapist ratings of the therapeutic relationship during the termination phases and therapist ratings of

outcome did not differ based on the reason for termination.

### Additional Analyses

The present study is the first to examine the working alliance, real relationship and negative transference during the termination phase of treatment from the therapist's perspective. In efforts to further understand how these three components during the termination phase relate to outcome, two simultaneous regression analyses were conducted to examine how these three therapist-rated therapy relationship variables during the termination phase together account for the variance in a) termination phase evaluation and b) treatment outcome. In the first regression analysis, therapist ratings of the working alliance, real relationship and negative transference during the termination phase were entered together in the first step, with therapist ratings of termination phase evaluation as the outcome variable. Results indicated that the three relational components accounted for 22 percent of the variance in termination phase evaluation (Adjusted  $R^2=.22$ ,  $F(3, 216)=22$ ,  $p<.01$ ). A closer examination of the data (Table 5) indicated that all three components of the therapy relationship, the working alliance, real relationship and negative transference during the termination phase significantly predicted the evaluation of the termination phase of treatment (WAI:  $B=.38$ ,  $p<.01$ ; Negative Transference:  $B=.15$ ,  $p<.01$ ; RRI:  $B=.17$ ,  $p=.05$ ).

The positive relationship between negative transference and termination phase evaluation was puzzling given the nonsignificant bivariate correlation between negative transference and termination phase evaluation mentioned earlier. The role of the working alliance as a suppressor variable in this simultaneous regression model

Table 5.

*Simultaneous Regression Model for the Components of the Therapy Relationship and Termination Phase Evaluation*

	<i>B</i>	<i>SEB</i>	<i>b</i>	<i>t</i>	<i>p</i>	<i>Total R<sup>2</sup></i>	<i>Adj. R<sup>2</sup></i>	<i>F</i>	<i>p</i>
<u>Step 1</u>						.23	.22	22	.000
Constant	1.04	0.40		2.58	0.01				
WAI	0.38	0.06	0.44	5.96	0.00				
RRI	0.17	0.09	0.14	1.96	0.05				
Neg_Transference	0.15	0.05	0.19	2.90	0.00				

*N*=220

*Note: Dependent variable= Termination phase evaluation (Therapists' ratings on the Session Evaluation Scale); WAI= Therapists' ratings on the Working Alliance Inventory; RRI= Therapists' ratings on the Real Relationship Inventory; Neg\_Transference= Therapists' ratings on the single item for negative transference.*

Table 6.

*Simultaneous Regression Model for the Components of the Therapy Relationship and Overall Treatment Outcome*

	<i>B</i>	<i>SEB</i>	<i>b</i>	<i>t</i>	<i>p</i>	<i>Total R<sup>2</sup></i>	<i>Adj. R<sup>2</sup></i>	<i>F</i>	<i>p</i>
<u>Step 1</u>						.21	.19	18.67	.000
Constant	4.07	0.39		10.54	0.00				
WAI	0.35	0.06	0.42	5.70	0.00				
RRI	0.09	0.08	0.08	1.10	0.27				
Neg_Transference	0.04	0.05	0.05	0.80	0.42				

*N*=220

*Note: Dependent variable= Overall treatment outcome (Therapists' ratings on the Counseling Outcome Measure); WAI= Therapists' ratings on the Working Alliance Inventory; RRI= Therapists' ratings on the Real Relationship Inventory; Neg\_Transference= Therapists' ratings on the single item for negative transference.*

can explain these findings. A suppressor variable enhances the relationship between an independent variable and dependent variable and can improve the predictive power of the overall model (Pandey & Elliott, 2010). It appears that, in the presence of the working alliance, negative transference relates positively to termination phase evaluation.

Results of the second simultaneous regression analysis, with therapist ratings of the three relational components during the termination phase entered simultaneously in the regression analysis with therapist ratings on the Counseling Outcome Measure (reflecting therapists' perceptions of overall treatment outcome) as the outcome variable (Table 6), revealed that the three relational components together predicted 19 percent of the variance in overall treatment outcome (Adjusted  $R^2=.21$ ,  $F(3, 216)=18.67$ ,  $p<.01$ ). In the case of overall treatment outcome however, only therapist-rated working alliance at the end of treatment significantly predicted treatment outcome ( $B=.35$ ,  $p<.01$ ), whereas the real relationship and negative transference during the termination phase did not significantly predict overall treatment outcome (RRI:  $B=.09$ ,  $p>.05$ ; Negative Transference:  $B=.04$ ,  $p>.05$ ).

## Chapter 4: Discussion

A number of therapists in our study could identify the presence of a termination phase in their therapeutic work with a client. From the therapist's point of view, a successful termination phase seems to be associated with better overall treatment outcomes. The present study is the first to examine how the working alliance, real relationship and transference during the termination phase of treatment relate to termination phase evaluation and overall treatment outcome, from the perspective of the therapist. A stronger working alliance and real relationship during the termination phase of treatment are associated with more effective termination phase evaluations and better overall treatment outcomes. On the other hand, therapists' perceptions of negative transference during the termination phase are associated with poorer overall treatment outcomes. There also appears to be a relationship between therapists' perceptions of client sensitivity to loss and transference during the termination phase, which provides some support for the termination as loss model.

### *The Termination Phase of Treatment*

There is some agreement in literature about the presence of a termination phase of treatment (see Gelso & Woodhouse, 2002; Joyce et al., 2007). In our study, 281 therapists responded to the request for participation and identified a client with whom they had recently ended treatment. Of these therapists, 263 could identify a distinct termination phase of treatment, defined as the last phase of treatment during which the client and therapist work towards ending therapy. Thus, a notable number of therapists appear to be able to identify a termination phase of treatment. Given the

intent of the present study to examine the termination phase, only the cases in which therapists were able to identify a termination phase of treatment were retained for further analysis.

The total number of sessions reported in the present study ranged from 10 to 850, and an association of strong effect size ( $r = .62$ ;  $p < .01$ ) was found between the total number of sessions and the number of sessions included in the termination phase of treatment. This association suggests that the longer the treatment, the more time devoted to termination work or bringing the treatment to an end. The average number of sessions included in the termination phase of treatment in this study was found to be approximately 17 percent of the total number of sessions. Even though the number of sessions included in a termination phase of treatment remains largely unexamined in literature, this percentage seems consistent with the review by Gelso and Woodhouse (2002). Gelso and Woodhouse reviewed theoretical and empirical literature and indicated that the time devoted to termination was around 16.67% of the total treatment, a number almost identical to that found in this study.

Part of the complexity in studying termination of psychotherapy pertains to the different reasons for ending treatment. In the present study, five categories were used to assess therapist reports of reasons for termination; therapist decision, client decision, mutual agreement, external factors or other reasons. A majority of therapists participating in this study indicated treatment ended due to mutual agreement (66.1%) and external factors (24.5%). Only a handful of therapists reported reasons for termination to be due to the therapist's decision (1.3%), client's decision (6.9%) or other reasons (1.3%). These varying percentages may reflect that termination is most

likely to occur due to mutual agreement or external factors. It is also possible that therapists identifying a termination phase of treatment are more likely to report treatment ended due to mutual agreement and external factors, than the other categories used in this study. Perhaps when treatment ends due to mutual agreement or external factors, the therapist and client are able to engage in a termination phase of treatment to bring therapy to a close. The data and design of the present study does not allow us to confirm these possibilities, and thus further research is needed to study the relationship between the reason for termination and the presence of a termination phase of treatment.

It appears that from the therapist's perspective, termination due to client decision, mutual agreement or external factors do not seem to relate to the therapy relationship components during the termination phase. These three reasons identified by therapists also don't seem to be associated with termination phase evaluations or treatment outcomes. Further research is needed before drawing conclusions from these nonsignificant results. Our findings contradict results from a small body of literature (e.g. Roe et al., 2006; Knox et al., 2011; Renk & Dinger, 2002) indicating the end of treatment due to reasons such as client-reported logistical/financial concerns (Knox et al., 2011), improvement of symptoms (Roe et al., 2006), dissatisfaction of services (Renk & Dinger, 2002) is associated with outcome. An explanation for these discrepant findings might lie in our sample of therapists selecting a client with whom they could identify a termination phase of treatment. Our sample does not include therapists' perceptions of clients who prematurely terminated or dropped out of treatment, which could be reasons associated with

elements of the therapy relationship and outcome. Another possible reason for the nonsignificant findings in the present study may pertain to our use of broad categories for reason for termination. Our broad categories do not assess more specific circumstances in terms of the reasons for ending, such as financial concerns, ruptures, improvement of symptoms, which may be contributing to outcome and elements of the therapy relationship.

In the present study, therapists rated termination phase evaluations and overall treatment outcomes, and both these constructs were found to positively correlate with each other to a moderate extent ( $r = .30$ ). This correlation indicates that greater effectiveness of the termination phase is likely to be accompanied by better overall treatment outcome, and yet there also exists a distinction between the two types of outcomes. Joyce et al. (2007) proposed that termination phase outcomes specifically include accomplishments associated with the last phase of treatment and are different from overall treatment outcome, and our finding lends support to this claim, although, again, the two types are clearly related. In addition, the positive association between termination phase evaluations and overall treatment outcomes is also in line with the literature on termination suggesting the termination phase or end of treatment work differs for successful versus unsuccessful treatment (e.g. Quintana & Holahan, 1992; Marx & Gelso, 1987; Joyce et al., 2007). A key message here seems to be for therapists to pay attention to the implications of successful versus unsuccessful termination experiences, apart from overall treatment outcomes.

#### *The Therapy Relationship during the Termination Phase*

Findings suggest that therapists perceiving a stronger working alliance during

the termination phase are also likely to view the termination phase of treatment as effective. Moreover, therapists' perceptions of a stronger working alliance during the termination phase of treatment seem to be accompanied by better overall treatment outcomes. Although studies have not specifically examined the working alliance during the termination phase of treatment, our findings are consistent with the literature confirming the positive association of the working alliance and outcome (see review by Horvath et al., 2011). A few studies have examined patterns of change in the alliance over the course of treatment (e.g., Safran & Muran, 1996, 2000; Safran, et al., 2011; Samstag et al., 2000) and, consistent with our results, have found that a stronger alliance at the end of treatment (either repaired after rupture(s), or strong without rupture) relates to more successful treatment.

Similarly, in line with our expectations, therapists' perceptions of the real relationship during the termination phase relate to better termination phase evaluations and treatment outcomes. In other words, therapists perceiving a strong personal bond, as well as a realistic and genuine relationship with clients during the termination phase of treatment, are likely to view termination work as effective and overall treatment as successful. The positive associations between real relationship and outcome from the therapists' perspective are consistent with previous findings (e.g. Gelso et al., 2005; Bhatia & Gelso, 2013; Fuertes et al., 2007; Marmarosh et al., 2009). Comparable to our results, findings from two studies (Fuertes et al., 2013; Gelso et al., 2012) suggest the real relationship strengthens over the course of treatment when treatment is successful.

We also expected negative transference during the termination phase of

treatment to be associated with termination phase evaluation and overall treatment outcome, from the perspective of the therapist. Therapist-rated negative transference during the termination phase related negatively with therapist-rated overall treatment outcome, suggesting that greater negative transference during the termination phase is likely to accompany poorer overall treatment outcomes. Contrary to our expectations, no statistically significant relationship was found between negative transference during the termination phase of treatment and termination phase evaluation.

These results on negative transference can be better comprehended in the context of previous research on negative transference and outcome. Gelso et al. (1997) studied therapists with heterogeneous theoretical orientations and found negative transference increased from the first to the last quarter of treatment when therapy was unsuccessful, consistent with our finding. Also similar to findings from the present study, results from a few studies suggest negative transference relates negatively to outcome in theoretically heterogeneous forms of therapy (e.g. Gelso et al., 1997; Bhatia & Gelso, 2013; Gelso et al., 2005; Marmarosh et al., 2009).

It is noteworthy that the correlations between transference and outcome, when found, tend to be of a small effect size. Gelso (2014) suggests the association between transference and outcome might be better understood in the presence of interaction effects. In efforts to further explore the relationship between negative transference and outcome, we used moderation analyses and found that termination phase evaluation moderates the relationship between negative transference during the termination phase and overall treatment outcome, from the perspective of the therapist. It appears that in cases with more effective termination work, or in other

words, better termination phase evaluations, negative transference and overall treatment outcome do not relate to each other. However, when termination work is less successful, negative transference negatively relates to overall treatment outcome. One possible interpretation of this finding is that the client's negative feelings rooted in past experiences and emerging during the end of the therapeutic relationship are satisfactorily addressed during successful termination work, thereby reducing the association between negative transference and treatment outcome. On the other hand, when termination work is not effective, negative transference during the termination phase may not be addressed effectively, thus contributing to diminished success of the overall treatment. Further research is needed to examine the validity of these interpretations.

In sum, individual analysis of the association between the three therapy relationship components and outcomes indicates that therapists perceiving a strong working and personal relationship during the termination phase with their clients are also likely to view the termination phase as effective and overall treatment as successful. In addition, therapists perceiving greater negative feelings displaced onto them by the client during the termination phase are more likely to view the treatment as unsuccessful. However, when therapists view termination phase as successful, they are less likely to believe negative transference during the termination phase is accompanied by poorer overall treatment outcomes.

Along with the individual analysis of each therapy relationship component with outcome, we used simultaneous regression models to understand the contributions of the three relational elements *together* on termination phase

evaluation and treatment outcome. The working alliance, real relationship and negative transference during the termination phase account for 22 percent of the variance in termination phase evaluation and 19 percent of the variance in overall treatment outcome as rated by therapists. These findings are similar to those found by Bhatia and Gelso (2013). These investigators studied therapist-rated working alliance, real relationship, negative transference and therapist countertransference for a single session and found these four components of the therapy relationship accounted for 27 percent of the variance in session outcome.

A closer examination of the simultaneous regression analyses reveals only therapists' perceptions of the working alliance during the termination phase contribute to overall treatment outcome, when all three components are examined together. The unique contribution of the working alliance during the termination phase to overall treatment outcome seems to highlight the central role of the working alliance during the termination phase. It appears that the relation of the real relationship and negative transference to overall treatment outcome disappears in the presence of the working alliance during the termination phase. Perhaps therapists perceive a relationship characterized by a strong working bond and agreement on tasks and goals during the termination phase as critical in determining the success of treatment, or indeed as part of successful treatment, more so than a strong personal connection or negative transference directed towards them during the termination phase.

On the other hand, all three elements, the working alliance, the real relationship and negative transference during the termination phase uniquely predict

termination phase evaluation when entered together in a simultaneous regression model. While we expect a strong real relationship and working alliance to relate positively to termination phase evaluation, we were surprised by the unique and positive relationship of negative transference during the termination phase and termination phase evaluation. Results from two previous studies (Woodhouse et al., 2002; Gelso et al., 1997) suggest that the association of negative transference with therapy constructs tends to be complex. Woodhouse et al. (2002) found therapist ratings of negative transference to relate positively to clients' secure attachment to therapist, contrary to their hypothesis. The authors of the study reasoned that clients with a secure attachment to their therapists are able to use the therapist to explore their negative representations. In another study, Gelso et al. (1997) found that high negative transference coupled with high insight is associated with positive treatment outcome in brief therapy. These findings highlight that the presence of negative transference is not always detrimental to treatment. Moreover, it appears that the role of negative transference can be better appreciated in the presence of other variables.

In the context of findings from the present study, perhaps clients are able to express their negative transference during the termination phase of treatment in conjunction with a strong working alliance and strong real relationship during the termination phase. Clinically, the negative transference during the termination phase captured by the simultaneous regression model may represent opportunities for valuable therapeutic work in the presence of a strong personal and working relationship during the termination phase, and thus contribute to better termination phase evaluations.

### Termination and Client Sensitivity to Loss

We examined therapists' perceptions of client sensitivity to loss to further our understanding of how this variable might relate to the therapy relationship during the termination phase. Results suggest that therapists perceiving greater client sensitivity to loss are more likely to perceive greater negative transference from their clients during the termination phase. Although we cannot make strong causal inferences based on the design of the present study, we can offer a possible interpretation for this finding. It may be that, consistent with the termination-as-loss model (Dewald, 1969; Mann, 1973; Strupp & Binder, 1985; Ward, 1984), clients with a greater history of loss view the ending of the therapy relationship as a significant loss, and thus experience negative feelings towards the therapist rightfully rooted in earlier relationships and relationship losses.

Findings also indicate that therapists perceiving greater sensitivity to loss in clients are more likely to identify stronger positive transference during the termination phase. It appears that, from the perspective of the therapist, clients with greater sensitivity to loss do not just experience negative transference towards the therapist during the termination phase, but also more positive feelings displaced onto the therapist during the termination phase. This finding is particularly interesting as it brings together two distinct theories on termination, termination as loss and termination as transformation. According to the termination as loss model, the end of therapy signifies a significant loss for the client and thus evokes negative feelings towards the therapist. On the other hand, the termination as transformation model, supported by a few studies (Marx & Gelso, 1987; Quintana & Holahan, 1992;

Fortune, 1987), emphasizes clients' positive feelings about ending therapy. Clients with greater loss experiences might view the therapy relationship during the termination phase in positive ways, even as they have unresolved transference feelings toward their therapists. Perhaps clients with greater loss experiences displace the positive feelings absent in previous relationships and past losses onto the therapist.

Significant to mention here is that therapists' perceptions of negative and positive transference during the termination phase, as well as therapists' perceptions of client sensitivity to loss, do not relate to termination phase evaluation. These nonsignificant relationships suggest that the presence of transference during the termination phase, as well as heightened loss sensitivity of the client, from the perspective of the therapist, are not necessarily adversely related to evaluations of the termination phase. Conceivably, transference reactions during the termination phase based on clients' loss experiences may represent areas of meaningful termination work. The relationship of transference during the termination phase as well as client sensitivity to loss with termination phase evaluation may be better captured in the presence of moderating variables.

We expected the working alliance and real relationship during the termination phase to moderate the relationship between perceived client sensitivity to loss and the effectiveness of the termination phase. Our rationale here was a stronger alliance and real relationship during the termination phase would allow better resolution of loss-related issues as they emerged in the termination phase of treatment, and thus contribute to more successful termination phase evaluations. Contrary to our

expectations, our moderation hypotheses with both the working alliance and the real relationship were not supported by the present data. Perhaps the working alliance and real relationship contribute to resolution of loss at other points in treatment rather than during the termination phase. It may also be that variables other than the working alliance and real relationship are involved in the resolution of loss.

### Limitations and Conclusions

Findings of this study need to be interpreted within the context of its limitations. A limitation of the study is its utilization of solely therapists' ratings. Consequences of mono-method reports can include biases in self-reports, as well as inflated correlations. However, given that termination remains seriously understudied in literature, our goal was to expand our understanding of the termination phase from the therapist's perspective, with the hope that future research can focus on client and observer perspectives to provide a more holistic view of the termination process.

A second limitation of the study pertains to the measures used in the study. First, the study utilizes single-item measures of transference. Although problems with single-item measures are recognized, there is a significant body of literature that lends support to the use of the transference measures in the present study, providing support for the reliability and validity of the measures (e.g. Markin et al., 2013; Gelso et al., 2005; Gelso et al., 1997; Woodhouse et al., 2003; Multon et al., 1991). Along similar lines, the *Perceptions of Client Sensitivity to Loss* measure has limitations in terms of its low reliability. We decided to use the measure, given that it is the only existing measure pertaining to loss themes in treatment that can be rated by therapists in the study. Still, the validity of the findings pertaining to this measure is diminished to an

unknown degree by the measure's modest reliability.

A third limitation of the study concerns the ecological validity of the study as a result of sample recruitment and demographics. Our sample demographics indicated that therapists participating in the study were predominantly White and thus our sample is not heterogeneous in terms of participants' ethnicity/race, limiting the generalizability of our findings. Furthermore, only a fraction of therapists contacted initially participated in the study (with an approximate response rate of 13 percent) and thus therapists participating in the study may represent therapists interested in termination work and the therapy relationship in treatment. We attempted to improve response rates by sending personalized invitations, using a survey program supported by a number of different browsers, providing a realistic estimate of time needed to complete the survey, communicating the purpose of the study, including the contact information of researchers and expressing appreciation for participation. Despite these efforts it is recognized that web surveys, such as the survey used in this study, are criticized for lower levels of response rates as compared to phone/mail surveys (Fan & Yan, 2010).

Lastly, the design of the present study does not allow us to make causal inferences. Our results do not add to knowledge about the direction of influence between the therapy relationship components and outcome measures used in the study. We have offered possible interpretations on the directionality of associations and future research utilizing longitudinal research and experimental design is needed to examine the validity of these interpretations.

In the present study, we specifically looked at three elements of the therapy

relationship during the termination phase in attempts to understand their relationship with client sensitivity to loss, termination phase evaluation and treatment outcome. While these elements accounted for a significant percent of the variance in termination phase evaluation and treatment outcome, we recognize there may be a number of constructs affecting the termination phase of treatment. In their review, Gelso and Woodhouse (2002) address a number of client factors, therapist factors and treatment factors that play a role in the termination process. Moving forward, it will be useful for research on termination to study comprehensively the role of the therapy relationship, as well as factors such as client diagnosis, therapist and client attachment, therapist loss, and the nature of treatment (e.g. brief versus long-term) that might further contribute to the variance in treatment evaluation and treatment outcome.

Despite the limitations of the study, findings from this study contribute to our understanding of the termination phase of treatment, from the perspective of the therapist. Results suggest that clients with greater sensitivity to loss appear to have both stronger negative and stronger positive transference towards the therapist during the termination phase of treatment. Therapists' perceptions of client sensitivity to loss as well as transference during the termination phase of treatment do not relate to termination phase evaluation, suggesting that the relationship between client sensitivity to loss and transference may represent opportunities for meaningful therapeutic work and not necessarily contribute to adverse outcomes. Understanding client's transferences during the termination phase through the lens of their loss experiences may allow therapists to better understand, address or work through these

transferences in treatment.

A central message of the present study seems to be to pay attention to the working alliance, real relationship and negative transference during the termination phase of treatment, as each of these components is associated with more successful termination work. A successful and effective termination phase in turn, appears to be associated with better overall treatment outcomes. The role of the working alliance during the termination phase seems especially significant in relating to overall treatment outcomes. An implication of this result is that therapists should focus on strengthening the alliance and establishing a strong working relationship during the termination phase of therapy.

## Appendix A: Review of Literature

The termination phase of treatment has important implications for the process and outcome of psychotherapy. Despite theoretical and empirical literature suggesting the significance of the end of treatment (Gelso & Woodhouse, 2002; Joyce, Piper, Ogrodniczuk & Klein, 2007), the termination phase of treatment remains largely understudied. In the present study, the focus lies on examining the therapist's perspective on the termination phase of treatment.

The termination of treatment implies the end of the relationship between the therapist and the client. A few studies on therapy termination have found the relationship between the therapist and client to emerge as a salient aspect of termination, in both client as well as therapist reports (e.g. Knox, Adrians, Everson, Hess, Hill & Crook-Lyon, 2011; Fragkiadaki & Strauss, 2012; Quintana & Holahan, 1992). Due to the limited empirical attention directed towards therapy termination, a number of questions pertaining to the therapeutic relationship at the end of treatment remain unanswered. For example, how do therapists perceive certain aspects of the therapeutic relationship during the termination phase of treatment? How do therapists' perceptions of the relationship during the termination phase associate with outcome? These questions provide the backdrop for the present study.

The aspects of the therapeutic relationship of interest in the present study are based on Greenson's model of the therapeutic relationship (1967), refined by Gelso and Samstag (2008) as a tripartite model of the therapeutic relationship. The components of this tripartite model of the therapeutic relationship are the working alliance, the real relationship and the transference-configuration, including both client

transference and therapist countertransference. In the present study, the working alliance, real relationship and transference during the termination phase were examined from the therapist's perspective. In addition, therapist perceptions of client sensitivity to loss, treatment outcome and termination phase evaluation were also studied. In this chapter, a theoretical and empirical review of termination of psychotherapy is presented based on the goals of the current study. Next, the importance of the therapy relationship in psychotherapy is described, followed by a review of the components of the tripartite model that are a focus in the present study.

### *The Termination of Psychotherapy*

All forms of therapy eventually come to an end. Gelso and Woodhouse (2002) defined termination as, "*the permanent or temporary ending of counseling*" (p.346). Termination has been recognized as a critical component of psychotherapy in theoretical and empirical writings (e.g. Kramer, 1990; Joyce et al., 2007; Dewald, 1982; Garcia-Lawson & Lane, 1997; Quintana, 1993). Despite the presence of the notion of termination in the clinical literature, empirical work examining the termination phase in psychotherapy remains limited. The focus of empirical literature on termination has mostly been on theoretical aspects of termination, specific criteria for termination and premature termination (or drop-outs) on the part of the client. In efforts to broaden the understanding of termination in therapeutic work, the goal of the present study was to examine certain relational and outcome variables during the termination phase from the therapist's perspective.

A possible reason for the dearth of empirical literature is the complexity inherent in the termination phase of treatment. In efforts to address some of this

complexity, I begin by reviewing the different theoretical considerations of termination, followed by defining it in the context of the present study and reviewing the extant empirical literature on the termination phase of psychotherapy.

**Theoretical perspectives on termination.** The theoretical perspectives on termination can be divided into two broad categories, a) termination as loss, and b) termination as transformation. The termination as loss model emerged from psychoanalytic literature. According to this model, clients experience the ending of the therapeutic relationship during the termination of psychotherapy as a significant loss (Dewald, 1969; Mann, 1973; Strupp & Binder, 1985; Ward, 1984). In line with the termination as loss model, termination in psychotherapy provides a unique opportunity for clients to work through ending a significant relationship in ways that may provide developmental opportunities for the client. According to this model, termination work entails attending to transference and countertransference associated with the loss of relationships, addressing unconscious conflicts, and working with client responses to abandonment and separation (Ward, 1984; Wachtel, 2002; Curtis, 2002).

In more recent years, the focus has shifted from psychodynamic notions of termination as loss to termination as a transformative experience in psychotherapy. Quintana (1993) was one of the first to redirect attention to more positive aspects of termination. Quintana drew attention to how the end of treatment can offer client new ways to perceive themselves and the therapeutic relationships, in ways that are positive and help transform the client. Consistent with Quintana's position, in a recent paper Maples and Walker (2014) suggest replacing the term 'termination' with

‘consolidation’ in order to reflect the transformative nature of the end of therapy. The extant evidence offers support for both the termination as loss model and termination as transformation position (e.g. Boyer & Hoffman, 1993; Marx & Gelso, 1987; Fortune, 1987; Quintana & Holahan, 1992).

The extent to which termination is viewed as loss versus transformation may also depend on factors such as the theoretical orientation of the therapeutic work. Theorists differ on what they consider to be critical aspects of termination work at the end of treatment. For example, Mann (1973) highlights the need for an explicit focus on termination to deal with the separation and ending of psychotherapy in the last third of short-term therapy. Other approaches direct attention towards the consolidation of gains in the last phase of treatment rather than issues of separation and loss. As an example, Goldfried (2002) emphasizes the importance of discussion of treatment goals and coping strategies at the end of cognitive-behavioral treatment, rather than focusing on the loss of the therapeutic relationship. In sum, it appears that there are differences accorded to certain aspects of termination depending on theoretical orientation of treatment. Despite these differences, however, many theorists agree that the termination phase itself is a significant aspect of therapeutic treatment.

**Termination phase.** There seems to be some sort of agreement in the literature that psychotherapy entails a termination phase at the end of treatment. Theoretically, there is also agreement that the last phase of treatment focuses on addressing therapeutic work that has been accomplished, talking about the client’s future, and bringing closure to the therapeutic relationship (Lamb, 1985; Ward,

1984). Gelso and Woodhouse (2002) offered a definition of the termination phase of treatment as “*last phase of counseling, during which therapist and client consciously or unconsciously work toward bringing the treatment to an end*” (p.346). According to this definition, the termination phase can include a varying number of sessions and termination can be therapist-initiated, client-initiated, mutual or forced.

In other efforts to expand on the notion of the termination phase, Joyce et al. (2007) have drawn on theoretical writings along with empirical studies to present a termination phase model. In this model, the authors present the objectives, tasks and outcomes associated with the termination phase. Particularly useful and relevant to the purpose of the present study is the description of the outcome of the termination phase of treatment as being different from the overall treatment outcome. The authors clarify that termination phase outcomes pertain specifically to the end of treatment and differ from overall treatment outcome. According to the model, the outcomes of the termination phase are defined in terms of the extent to which the following are accomplished during the termination phase: looking back at the course of treatment, processing the therapeutic relationship, and internalizing aspects of the therapy process and relationship to prepare the client for healthy functioning outside of therapy. At present, no measure exists to specifically study termination phase outcome based on the three outcomes highlighted by Joyce et al. However, in line with the recommendations of the authors, outcomes of the termination phase were studied as separate from overall treatment outcomes in the present study. Indeed, there is some evidence that suggests important implications of successful versus

unsuccessful termination experiences. The empirical literature on the termination phase of treatment is reviewed in the next section.

**Related research on termination.** The current review of the literature on termination focuses on findings relevant to present study, namely those pertaining to successful versus unsuccessful termination experiences, client sensitivity to loss during termination, therapist versus client-initiated termination, and the therapeutic relationship during the termination phase of treatment. It is recognized that termination has been studied in other realms, for example, premature termination, differences in theoretical orientation, reasons for client termination and so on. These studies will not be reviewed in the present section, as they do not relate to the purpose of the present study.

What does the empirical literature say about what occurs during the termination phase? Two studies conducted at university counseling centers (Marx & Gelso, 1987; Quintana & Holahan, 1992) found that, as suggested by theory, the termination phase of brief therapy typically involves setting a final date for the last session, summarizing the therapeutic work, addressing the client's future plans and working on ending the therapeutic relationship.

In terms of the research on theoretical models of termination, there is some evidence suggesting the relevance of client and therapist variables related to loss during the termination phase of treatment (Boyer & Hoffman, 1993; Marx & Gelso, 1987). In a study of former university counseling center clients, Marx and Gelso (1987) found that client loss history predicted the importance clients placed on discussing their reactions during termination. Boyer and Hoffman (1993) surveyed

117 licensed therapists in efforts to study termination within the context of therapist loss history and therapists' perceptions of client sensitivity to loss. In this study, therapists' perceptions of client sensitivity to loss were found to predict therapist anxiety, after the effect of therapist loss history was partialled out. Therapist loss history predicted both, therapist anxiety and depression during the termination phase of treatment. In another study, Baum (2005) surveyed 132 social workers and found that, from the therapist's perspective, clients experiencing forced termination (therapist-initiated or institution-initiated) manifested greater loss experiences than clients who self-initiated termination. In the present study, therapist perceptions of client sensitivity to loss were studied in relation to aspects of the therapeutic relationship, as well as outcome.

Although there is some evidence, albeit limited, supporting the termination as loss model, a number of studies have found that the termination phase of treatment involves more positive reactions than predicted by the loss model. Marx and Gelso (1987) surveyed 72 former counseling center clients and found that clients typically reported positive feelings at the end of treatment. Quintana and Holahan (1992) reported similar findings in their study of therapists from different counseling centers; therapists reported more positive feelings than negative about termination. Another study by Fortune (1987) of the reactions of 59 social workers during termination indicated that although therapists report negative reactions (e.g. feelings of loss and sadness) at the end of treatment, termination reactions tend to include positive feelings more often than negative feelings. Rabu, Haavind and Binder (2013)

interviewed clients post therapy and found that clients used positive metaphors to describe their experience at the end of treatment.

Although the literature indicates that overall, both the client and the therapist report more positive feelings than negative feelings, a more nuanced look at the findings also suggests that feelings at the end of treatment depend on other factors during the termination process. For example, in two studies (Baum, 2005; Baum 2007), social workers indicated that positive feelings (of both therapists and clients) were associated with factors such as less abrupt termination, more control over the termination process, a more central therapeutic relationship and attainment of therapeutic goals.

Another finding in the termination literature pertains to successful versus unsuccessful termination phase and treatment outcome. Knox et al. (2011) interviewed 12 clients about their experiences during therapy termination. Data was analyzed using consensual qualitative research (Hill et al., 2005) and results indicated that clients talked about grieving the loss of their therapists in successful termination cases. Clients also talked about feeling confident, moved and sad in cases with successful termination experiences. In contrast, clients with less successful and problematic termination experiences reported feeling disappointed during the termination process. From the therapists' perspective, Quintana and Holahan (1992) found that therapists were less likely to engage in looking back on the course of treatment, bring closure to the therapeutic relationship, and process the client's feelings about the ending of treatment in less successful cases as compared to more successful cases.

The success of treatment and termination phase has also been found to relate to reasons for termination. Roe et al. (2006) studied retrospective reports of 84 clients and found that clients more satisfied with treatment were likely to report positive reasons for termination (e.g. improvement), whereas those dissatisfied with psychotherapy were more likely to report negative reasons for termination. Similarly, in the Knox et al. study (2011) the reasons for termination for successful therapy often tended to pertain to logistical and financial reasons. In contrast, in less successful and problematic termination cases, the reasons for termination often entailed a rupture in the therapeutic relationship that was not resolved. Renk and Dinger (2002) surveyed graduate students therapists and found that large number of clients terminated therapy because of dissatisfaction of services. In another study, Wong et al. (2013) used archival data from a university-based counseling center and found significant differences in the relationship between who initiated termination (therapist, client or mutually-initiated) and treatment success; clients had the highest success rate when treatment was mutually terminated by the therapist and client.

Lastly, the empirical literature on termination highlights the importance of the therapeutic relationship during the termination phase of treatment. In studying client perspectives on the termination phase of treatment, Knox et al. (2011) found that clients often referred to the therapeutic relationship and described both negative and positive aspects of relationship during termination experiences. In studies of the reactions of both clients and therapists during termination, results indicate that a critical component of termination is closure in the client-therapist relationship (Marx & Gelso, 1987; Quintana & Holahan, 1992). In a recent study, Fragkiadaki and

Strauss (2012) used grounded theory to study 10 psychodynamic and psychoanalytic therapists' experience of termination. The authors concluded that all therapists indicated the therapeutic relationship to be a significant determinant of the experience of termination. Although the therapeutic relationship appears in a number of studies on termination of psychotherapy, no study to date has focused on examining specific components of the client-therapist relationship from the perspective of the therapist during the termination phase of treatment. In the present study, efforts are made to address gaps in the literature on termination by studying the termination phase from the therapist's perspective.

### *The Therapy Relationship*

The significance of the relationship between the therapist and the client in psychotherapy has been addressed in theoretical as well as empirical literature. Norcross (2002, 2011) has presented efforts of the American Psychological Association's (APA) task force (Divisions 12 & 29) on evidence-based therapy relationships and pointed out the importance of the therapeutic relationship in psychotherapy by tracing its history, examining the extant literature on the relationship, and recommending future directions for the study of the therapeutic relationship.

Historically, humanistic and psychoanalytic writings have implicated the relationship between the therapist and the client to be a vital component of psychotherapy. The humanistic approach typically focuses on therapist-related variables, such as therapist's empathy, genuineness, and positive regard toward the client (Rogers, 1951). Psychoanalytic conceptions of the therapeutic relationship

usually concern therapist as well as client-related variables. As an example, psychoanalytic literature has focused on constructs such as client transference, therapist countertransference and the working alliance between the client and the therapist as key aspects of the therapy relationship (Greenson, 1967; Shedler, 2010; Gelso, Nutt Williams & Fretz, 2014).

Despite the humanistic and psychoanalytic roots of the therapeutic relationship, in recent years the significance of the therapy relationship is being recognized across a number of theoretical approaches. Two editions of Norcross' (2002, 2011) book on the therapy relationship highlight findings on the therapy relationship. A substantial body of research has implicated the relationship between the therapist and client to be a significant contributor to therapy outcome (e.g. Norcross & Lambert, 2011; Wampold & Brown, 2005; Lambert & Barley, 2002) in various forms of psychotherapy. The extant literature suggests that the therapeutic relationship has a vital role in various forms of treatment, although differences exist in the extent to and the way in which the relationship is addressed.

Gelso and Carter (1985) theorized that certain aspects of the therapy relationship exist in all psychotherapy relationships, regardless of theoretical positions. Gelso and Carter extended Greenson's (1967) theory on the therapeutic relationship in analysis, by positing that a working alliance, a transference configuration (including client transference and therapist countertransference), and a real relationship exist in all client and therapist relationships. Gelso and Samstag (2008) further refined these ideas and proposed a tripartite model comprised of the aforementioned components of the client-therapist relationship. In the present study,

the working alliance, real relationship and transference during the termination phase were studied from the therapist's perspective. Since the present study will utilize solely therapist ratings, countertransference is excluded to avoid issues pertaining to biases in self-reports of countertransference during a critical phase of treatment. In line with the variables being examined in the present study, the following review will focus on the working alliance, real relationship and transference components of the tripartite model.

In recent years, an increasing body of research on the components of the tripartite model has focused on, a) the presence of these components in heterogeneous forms of therapy, b) the relationship of the components with session as well as treatment outcome, and c) the relationship of the components with each other (e.g. Horvath et al., 2011; Kivlighan, Hill, Gelso & Bauman, 2016; Horvath, Del Re, Flukiger, & Symonds, 2011; Zilcha-Mano, McCarthy, Dinger & Barber, 2014; Markin et al., 2014; Markin et al., 2013; Gelso, 2014; Gelso et al., 2012; Gelso et al., 2005; Marmarosh et al., 2009; Fuertes et al., 2014; Fuertes et al., 2007; Bhatia & Gelso, 2013). Recent studies have also looked at how these components of the therapy relationship unfold across the course of treatment (e.g. Fuertes et al., 2013; Gelso et al., 2012; Gelso et al., 1997). Relevant to the present study, some evidence has indicated that the working alliance, real relationship and transference exist in varying amounts at different points in treatment from the perspective of both the therapist and the client. There is no study to date that has examined the therapist's perspective of these relational components during the termination phase of treatment. Furthermore, the association among the relationship components in the last phase of treatment and

the success of the termination phase and treatment outcome, in the eyes of the therapist, remains largely unexamined.

In the following sections of the literature review, descriptions of the working alliance, transference and the real relationship in psychotherapy are presented. Each component is addressed in terms of their definitions, brief history and measures. Next, given the focus of the present study, the review draws on two lines of research, a) studies that examine the relationship between these components of the tripartite model and session/treatment outcome, and b) studies that examine the unfolding of the components, and specifically focus on the components in the last stage of treatment.

### *The Working Alliance*

**History and definition.** As with other components of the tripartite model, historically the working alliance emerged from psychoanalytic literature. Although Freud emphasized the reality-based collaboration between the therapist and the client in the early 1900s, it wasn't until Sterba, Zetzel and Greenson's efforts that the alliance appeared as a defined construct in therapeutic work (Horvath, Del Re, Flückiger, & Symonds, 2011). Sterba (1934) used the term ego alliance to describe the ego-observing process of the client. In 1956, Zetzel coined the term therapeutic alliance, defining it as the client's alignment of the healthy ego with the analyst. Greenson (1965, 1967) further refined the concept of alliance, defining the working alliance in terms of the client's alignment with therapeutic tasks.

The notion of the working alliance was not limited to analytic work. The work of Luborsky (1976) and Bordin (1975, 1989, 1994) was critical in broadening the

description of the working alliance to be applicable to non-analytic therapy approaches. Based on more recent work, conceptualizations of the working alliance focus on an active collaboration between the therapist and client (Bordin, 1980; Hatcher, Barends, Hansell & Gutfreund, 1995; Luborsky, 1976). Bordin (1980) defined the alliance in terms of three key features; agreement on therapeutic goals, agreement on therapeutic tasks and a bond between the therapist and client. Bordin's definition is perhaps remains the most widely used definition of the alliance today, and has been utilized successfully to develop instruments to measure the working alliance in treatment.

**Measuring the alliance.** The working alliance has been studied rigorously in recent years, most likely because of the presence of well-validated and reliable measures of the working alliance. In their review, Horvath et al., (2011) identified over thirty alliance measures, and highlighted four core measures through a meta-analysis. These four measures are as follows, California Psychotherapy Alliance Scale (CALPAS, Gaston & Marmar, 1994), Helping Alliance Questionnaires (HAQ, Alexander & Luborsky, 1986), Vanderbilt Psychotherapy Process Scale (VPSS, O'Mally, Suh & Stupp, 1983) and Working Alliance Inventory (WAI, Horvath & Greenberg, 1986). The aforementioned four measures have been used for over two decades and have considerable evidence to support their reliability and validity. The WAI (Horvath & Greenberg, 1986) has been used in a number of studies in recent years that have examined the relationship of the alliance with treatment/session outcome as well as other components of the tripartite model of the therapeutic relationship (e.g. Gelso et al., 2005; Fuertes et al., 2007; Marmarosh et al., 2009;

Bhatia & Gelso, 2013). In the present study, we used therapists' ratings of the WAI-Short form (WAI-S) for the termination phase. The WAI-S conceptualization of the working alliance and ease of use made it the most fitting measure in terms of the purpose of the present study.

**The working alliance and outcome.** The relationship of the working alliance with treatment as well as session outcome has been studied extensively over the past three decades. Horvath et al., (2011) conducted a comprehensive meta-analysis and found the working alliance-treatment outcome relationship to be moderate and reliable ( $r = .275$ ,  $p < .00001$ ). The results of the Horvath et al. meta-analysis are in line with the findings of previous meta-analyses (Horvath & Bedi, 2002,  $r = .21$ ,  $k = 100$ ; Horvath & Symonds, 1991,  $r = .26$ ,  $k = 26$ ; Martin, Garske, & Davis, 2000,  $r = .22$ ,  $k = 79$ ). Evidence points towards a robust relationship between the alliance and outcome in individual therapy. The alliance typically accounts for approximately 7.5 percent of the variance in treatment outcome (Horvath et al., 2011). More recently, Kivlighan and his colleagues (Kivlighan, Marmarosh & Hilsenroth, 2014; Kivlighan et al., 2016; Kivlighan, 2007) have used the actor-partner interdependence model (Ledermann & Kenny, 2012) to study the contributions of both therapist and clients alliance ratings on outcome. These studies have added to our knowledge on how therapist and client ratings of the alliance relate to each other in terms of predicting outcome. For example, findings by Kivlighan et al. (2014) suggest that client ratings of the alliance relate positively to their therapist's ratings of session depth.

In the present study, only therapist-ratings of the working alliance during the termination phase of treatment were utilized. Inherent within the notion of the

working alliance is the extent to which there is an agreement and collaboration between the client and the therapist. Thus, the alliance is an interpersonal construct implicating both therapist and client-level variables. The working alliance has been traditionally examined from both the therapist and client perspectives. What does the research say about client and therapist ratings of the alliance? It seems as though clients and therapist views of the working alliance hold both similarities and dissimilarities. Results of a meta-analysis (Tyron, Blackwell & Hammel, 2007) of 32 studies indicated that the correlation between therapist and client ratings of the alliance was .32, implying that there is some degree of convergence along with dissimilarities between client and therapist perspectives. Bachelor (2013) sought to understand client and therapist views of the alliance in terms of similarities, dissimilarities and relationship to outcome. Bachelor surveyed 176 clients and 61 therapists and found that therapists and clients emphasized different aspects of the alliance. The study also indicated that the alliance, from both the therapist and the client perspective, related to outcome. These studies provide support for examining the therapists' perspective of alliance and outcome in efforts to add to our understanding of therapeutic work. In sum, the body of research on the alliance and outcome suggests a moderate relationship between the two, from both the therapist and client perspective. Furthermore, evidence exists supporting the relationship between the alliance and treatment outcome as well as session outcome.

**The working alliance at the end of treatment.** Not much is known about therapists' perceptions of the alliance during the therapist-identified termination phase of treatment. In the present study, termination phase refers to the work in

treatment to bring therapy to an end. There is some literature, however, on how the working alliance unfolds during the course of treatment, and how it exists at the end of treatment.

Gelso and Carter (1994) posited that a strong working alliance during the initial phases of treatment will weaken as therapeutic work progresses and client conflicts become the focus of treatment. According to Gelso and Carter, at the end of successful treatment, the alliance would strengthen again as a result of resolution of client difficulties. However, in less successful treatment, the alliance will likely weaken further at the end of treatment. A study by Kivlighan and Shaughnessy (2000) provided support for this proposition. Kivlighan and Shaughnessy found three patterns of alliance development; stable alliance, linear alliance growth and quadratic alliance growth. The quadratic growth pattern in this study was reflective of the high-low-high pattern of the alliance as proposed by Gelso and Carter. In the Kivlighan and Shaughnessy study, the quadratic growth pattern of the alliance was associated with good treatment outcome. Other studies, however failed to replicate the high-low-high pattern found by Kivlighan and Shaughnessy. Instead, a growing body of research by Safran, Muran and their colleagues has focused on rupture and repair sequences of the alliance in treatment. Results of a meta-analysis of three studies (Safran et al., 2011) indicated that there is a moderate relationship between rupture-repair sequences and therapeutic outcome. In another review by Horvath et al. (2011), some fluctuations in the alliance were found to relate to better treatment outcomes as compared to a stable alliance pattern. In reviewing the literature on rupture and repair of the alliance, Gelso (2014) concluded that for theoretically

diverse treatments, training in repairing ruptures was moderately related to treatment outcome. It seems significant to emphasize here that better treatment outcomes are associated with *repair* of the ruptures. Thus, taken together the literature seems to suggest that a strong working alliance at the end of treatment is associated with successful treatment outcome.

### *The Real Relationship*

**History and definition.** The real relationship has had a somewhat elusive presence in the writings of earlier psychoanalysts. Some psychoanalysts referred to the real relationship without explicitly defining the construct. For example, Freud focused on a reality element as part of the therapeutic relationship in his work with the Wolf-man (see Gelso, 2011 for the complete example). Other analysts have differentiated between the real and transference aspects of the therapeutic relationship (e.g. Menaker, 1942). Greenson's (1965, 1967) work, however, was the first to elaborate on the concept of the real relationship. Greenson wrote about the 'real' in the real relationship as entailing two key aspects; a realistic and undistorted component, and a genuine and authentic component, in the relationship between the client and therapist. It is noteworthy to point out that historical attention to more real aspects of the therapeutic relationship is not limited to psychoanalytic work. Therapist genuineness in therapeutic work is a key component in humanistic therapies, included in Rogers (1957) necessary and sufficient conditions for change to occur.

Although the real relationship received some attention after it appeared in Greenson's writings, it has been refined as a well-defined and vital component of therapeutic work only in recent years through the work of Gelso and his colleagues

(e.g. Kivlighan et al., 2016; Kivlighan et al., 2015; Markin et al., 2014; Gelso, 2014; Fuertes et al., 2013; Gelso et al., 2012; Ain & Gelso, 2011; Gelso, 2011; Marmarosh et al., 2009, Fuertes et al., 2007, LoCoco et al., 2011; Bhatia & Gelso, 2013; Kelley et al., 2010; LoCoco et al., 2011). Gelso (2011) has defined the real relationship as “the personal relationship existing between two or more persons as reflected in the degree to which each is genuine with the other and perceives the other in ways that benefit the other” (p.6). Gelso conceptualizes the real relationship as consisting of two elements, a) genuineness, defined in terms of being authentic in the therapeutic relationship, and b) realism, referring to perceiving the other in ways that benefit the other. Gelso proposed two additional concepts to refine the real relationship construct. The first is the magnitude of the real relationship and refers to how much of the real relationship exists at any given point in treatment. The second, valence, indicates the extent to which the thoughts and feelings about the real relationship are positive or negative.

As a construct, the notion of the real relationship has been subject to some controversy. A key concern with its conception is whether the real relationship exists as a distinct variable in psychotherapy, as opposed to being an extension or part of the working alliance. Theoretically, Gelso (2014) posits that the real relationship acts as the foundation of the therapeutic relationship, whereas the working alliance functions as the catalyst in facilitating therapeutic work. In terms of empirical evidence, findings suggest that working alliance and the real relationship tend to be moderately correlated, and each uniquely predicts treatment/session outcome in the eyes of the therapist (e.g. Gelso, 2014; Bhatia & Gelso, 2013; Fuertes et al., 2007; Gelso et al.,

2005; LoCoco et al., 2011; Marmarosh et al., 2009). In summarizing the literature, it appears that the real relationship and the working alliance are closely related, and also separate from one another (Gelso, 2014).

**Measuring the real relationship.** Eugster and Wampold (1996) were the first to develop a measure of the real relationship. The real relationship measure developed by Eugster and Wampold was part of a battery of measures and included eight items to be rated by the therapist and client. The measure was found to be marginally reliable (patient ratings Cronbach's  $\alpha = .66$ , therapist ratings Cronbach's  $\alpha = .72$ ). Gelso (2011) pointed out that the items in the Eugster and Wampold measure tended to be reflective of the genuineness component of the real relationship and lacked focus on the realism component. In 2005, Gelso and his colleagues developed a therapist version of the Real Relationship Inventory (RRI-T). This measure was based on the theoretical conceptions of the real relationship offered by Greenson (1967), Gelso and Carter (1985, 1994), and Gelso and Hayes (1998). Following the RRI-T, Kelley et al., (2010) developed a client version of the Real Relationship Inventory (RRI-C). Both the therapist and client versions of the Real Relationship Inventory (RRI-T and RRI-C) consist of 24 items (12 items each in two subscales; Genuineness and Realism). There is satisfactory reliability and validity evidence for the measures (Gelso et al., 2005; Kelley et al., 2010). Furthermore, the measures have been used successfully to study associations between therapist and client perceptions of the real relationship and other therapy process and outcome measures (e.g. Marmarosh et al., 2009; Gelso et al., 2012; Fuertes et al., 2013; Ain & Gelso, 2012). In a number of studies, the real relationship as measured by the RRI-T and RRI-C has

been found to relate to components of the therapy relationship and outcome in theoretically expected ways.

In the present study, a shorter form of the RRI-T, created by Hill et al. (2014), was used to study therapists' perspective on the real relationship with a client during the termination phase of treatment. Hill and her collaborators reported a strong correlation between this shorter form and the full length measure ( $r=.96$ ). We used the shorter form in the present study in efforts to reduce the amount of time spent on completing measures.

**The real relationship and outcome.** A number of studies in the last decade have focused on the relationship between the real relationship and treatment progress and outcome. Eugster and Wampold studied client and therapist ratings of the real relationship and found that perceptions of a better real relationship by therapists and clients were related to better evaluations of a psychotherapy session by both therapists and clients. Several studies since have indicated a positive relationship between the real relationship and session outcome (e.g. Gelso et al., 2005; Bhatia & Gelso, 2013; Markin et al., 2014), as well as treatment progress and outcome (Fuertes et al., 2007; Ain & Gelso, 2008, 2011; Gelso et al., 2012; LoCoco et al., 2011; Marmarosh et al., 2009; Owen et al., 2011). There are however, some discrepancies in these findings. For example, LoCoco et al. (2011) and Gelso et al. (2012) found no significant relationship between therapist ratings of the real relationship and treatment outcome. After further analysis however, Gelso et al. found that an increase in the strength of therapist-rated real relationship over time did relate to treatment outcome. Taken together, there seems to be considerable support for the real relationship to relate

positively to outcome, despite some conflicting findings. A possibility to account for some of the conflicting findings is that the real relationship may be salient at certain points in treatment and thereby more likely to relate to outcome during those instances. In the next section, studies examining how the real relationship unfolds or appears across the course of treatment, especially during the termination phase of treatment, are reviewed.

**The real relationship at the end of treatment.** Gelso and Carter (1994) proposed that the real relationship deepens as therapy progresses. Results of three studies have lent some support to this claim. Gelso et al. (2012) studied the perspective of forty-two therapy dyads on the real relationship after every session. The authors found that client ratings of the real relationship in the initial stage of therapy related to treatment outcome, whereas therapist ratings of the real relationship during the initial stage of treatment did not relate to treatment outcome. Instead, therapists perceived the real relationship to strengthen as treatment progressed, and this strengthening of the real relationship related to treatment outcome. In another study (Fuertes et al., 2013) of six therapy dyads, the real relationship strengthened across the course of therapy when treatment was more successful. Lastly, Gullo et al. (2012) found a positive relationship between client and therapist ratings of the real relationship at the eighth session and treatment outcome in brief therapy (average number of total sessions=11.58). Taken together, this small body of literature suggests that a stronger real relationship during the final stages treatment is likely to be associated with better therapeutic outcomes, in the perspective of both the therapist and client.

## Transference

**History and definition.** Since its initial appearance in the psychoanalytic literature, there have been a number of controversies in defining transference (Gelso, 2014). Some of the sources of controversy around transference pertain to the extent to which transference includes co-construction between the therapist and the client, and the extent to which transference involves a distortion of the therapist. Researchers and theoreticians have presented varying definitions of transference, reflective of differences around the co-construction and distortion elements of transference.

Freud (1912) talked about transference as being a universal phenomenon and a central mechanism of change in therapeutic work. Classical Freudian theory conceptualized transference as a transfer of client material rooted in the Oedipal stage onto the therapist (Singer, 1970). This classical analytic definition was broadened in later years by interpersonal theorists (e.g. Sullivan, 1954; Fromm-Reichman, 1950) to include not just a transfer of Oedipal material, rather a displacement of client's feelings, attitudes and behaviors rooted in earlier significant relationships onto the therapist. Both the classical and interpersonal theorists emphasized the role of distortion of the therapist in their definition of transference. More recently, Gelso and Bhatia (2012) defined transference as, "the patient's experience and perceptions of the therapist that are shaped by the patient's own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships" (p. 385). According to Gelso and Bhatia, transference involves co-construction, as the person

of the therapist contributes to transference reaction, as well as distortion, as the transference response emerges from the client's earlier experiences.

**Measuring transference.** Measures of transference can be categorized into three broad groups (Gelso & Samstag, 2008), a) observer-rated, b) client-rated and c) therapist-rated. Given the differing conceptualizations of transference, there are varying approaches to measure transference in therapeutic work.

Two commonly used observer-ratings of transference are the Plan Formulation Method (PFM; Curtis & Silberschatz, Weiss & Sampson, 1994), and the Core Conflictual Relationship Theme method (CCRT Luborsky & Crits-Cristoph, 1998). Both these methods of measuring transference rely on ratings of the client's characteristic pattern in relationships. This relationship pattern is deciphered based upon clients' descriptions of their interpersonal interactions. The relationship pattern acts as a proxy of transference emerging in therapeutic work (Gelso & Samstag, 2008). While an advantage of the CCRT and PFM is that they address the complexity inherent in the notion of transference, a disadvantage is that they do not lead to a score indicating the degree of transference present in the interactions. There is an absence of a clear transference score needed for certain quantitative analyses. Furthermore, Gelso and Samstag (2008) point out that these methods can be challenging to use as they involve substantial observer learning and can limit generalizability.

Transference can also be measured through client ratings. Barber, Foltz and Weinryb (1998) developed the Central Relationship Questionnaire (CRQ) to measure characteristic interaction patterns with significant others through self-reported items.

Self-report measures are easy to use and result in a transference score that can be utilized in quantitative analyses. However, the CRQ and client-reported transference measures are criticized for not being able to capture distortions that may be unconscious to the client and an essential component of transference (Gelso & Samstag, 2008).

Lastly, instruments exist to measure transference from the therapist's perspective. The Missouri Transference Scale (MITS; Multon, Patton, & Kivlighan, 1996) and Graff and Luborsky's (1977) Therapy Session Checklist- Transference items are examples of therapist-rated transference measures. The MITS is a multi-item measure whereas the TSC-TI includes three single items assessing the general amount of transference, positive transference and negative transference present in a session. Therapist-ratings of the two measures are found to relate to one another (e.g. Woodhouse et al., 2003), and there is satisfactory reliability and validity evidence for both the measures indicated by a number of studies (e.g. Woodhouse et al., 2003; Gelso et al., 2005; Markin, et al., 2013). Limitations of therapist-ratings of client transference are recognized as including therapist biases in reporting and detecting transference. Despite these limitations, the utility of these measures lies in their easy use. Furthermore, there is evidence supporting the use of the measures to study therapy process and outcome variables. The TSC-TI was used in the present study to examine therapists' perspective on transference during the termination phase of treatment.

**Transference in non-analytic therapies.** Before reviewing the literature on transference and outcome, it seems essential to address the presence of transference in

non-analytic therapies, given its strong ties to psychoanalytic theory. Gelso and Bhatia (2012) reviewed the empirical literature on transference in non-analytic therapies and found 16 empirical studies to have examined the existence of transference in a number of forms of therapy (e.g. Arachtingi & Lichtenberg, 1999; Beach & Power, 1996; Connolly, Crits- Christoph, Demorest, Azarian, Muenz, & Chittams, 1996; Horowitz & Moller, 2009; Gelso, Hill & Kivlighan, 1991; Gelso, et al., 2005). Gelso and Bhatia also noted that transference has been addressed in the writings of a number of non-analytic theorists (e.g. Rogers, 1951; Perls, 1969; Brown, 1994; Kelly & Greene, 2010). In essence, a body of theoretical and empirical literature indicates that therapists recognize the presence of transference in therapeutic work (e.g. Gelso et al., 2005; Marmarosh et al., 2000; Bhatia & Gelso, 2013) regardless of theoretical orientation, although differences exist in terms of how transference is dealt with in session. In the present study, a sample of therapists with varying theoretical orientations were surveyed for their perceptions of transference during the termination phase of treatment.

**Transference and outcome.** How does transference relate to session or treatment outcome in heterogeneous forms of therapy? Results of a few studies that have sought to answer this question indicate that the evidence is mixed (Gelso, 2014). In four studies, the relationship between negative transference and session outcome (Bhatia & Gelso, 2013; Gelso et al., 2005; Markin et al., 2013), as well as treatment outcome (Marmarosh et al., 2009) was found to be negative. Bhatia and Gelso (2013), Marmarosh et al. (2009) and Gelso et al. (2005) surveyed therapists of varying theoretical orientations, whereas Markin et al. (2013) studied the perspective of

psychodynamic therapists. These findings suggest that both psychodynamic and non-analytic therapists perceiving high amounts of negative transference are also likely to believe that the session/treatment outcome is poorer.

Results of two other studies, however, do not support the aforementioned findings (Gelso, Hill & Kivlighan, 1991; Gelso et al., 1997). Gelso et al., (1991) studied the perceptions of 38 therapists and found that insight moderated the relationship between negative transference and session quality. Gelso et al. (1997) found similar results in a study of 33 therapists' perceptions of negative transference and treatment outcome. In both studies insight moderated the relationship between negative transference and outcome, such that when insight was low, negative transference was less likely to relate to session quality (Gelso et al., 1991) and treatment outcome (Gelso et al., 1997), whereas when insight was high, negative transference related positively to session quality and treatment outcome. Thus, low insight and high negative transference resulted in the poorest outcomes. In both studies insight was defined as follows, "*Extent to which client displays accurate understanding of material being explored. Understanding may be of the relationship, client's functioning outside of counseling, or aspects of the client's dynamics and behavior*" (Gelso, et al., 1991, p. 3). This replicated interaction effect suggests that effects of transference on outcome may depend on certain other moderating variables. It is relevant to mention here that the main effects that have been found between transference and outcome tend to be of small effect sizes (e.g. Marmarosh et al., 2009; Gelso et al., 2005; Markin et al., 2013; Bhatia & Gelso, 2013). Gelso (2014) reviews the literature on transference and outcome and concludes that the modest

main effects of transference on outcome are likely better understood in the context of interaction effects. In line with this position, transference may have a stronger main effect on outcome at certain points in treatment. Studies on transference at the end of treatment are reviewed to shed some light on this issue.

**Transference at the end of treatment.** Only a few studies have examined how transference unfolds during the course of therapy. In a study of 40 psychotherapy sessions (Beach & Power, 1996), references to transference increased in later sessions in both CBT and psychodynamic therapies. Graff and Luborsky (1977) examined transference over the course of psychoanalytic treatment and found that transference increased in later sessions when therapy was successful. Another study of psychodynamic therapies (Patton et al., 1997) found similar results, transference increased during the course of successful therapies. However, in a study of therapists adhering to differing theoretical orientations (Gelso et al., 1997), transference ratings by therapists were found to increase from the first to third quarter of treatment, followed by a decline in the last quarter, when therapy was successful. Gelso (2014) points out that theoretical orientation may be an underlying reason for how transference unfolds during the course of therapy. In psychodynamic treatment, the focus often lies on working through the transference by encouraging transference to emerge in therapeutic settings, and thus transference may increase through the course of therapy from the therapist's perspective. Other forms of therapy may not necessarily have the same focus, and transference may be more likely to decrease over the course of successful non-analytic treatments. Given these findings, and our rather nebulous knowledge of transference at the end of therapy, an aim of the present

study was to examine transference from the perspective of the therapist during the termination phase of therapy.

### *The Present Study*

To summarize, it appears that a growing body of research has implicated the therapeutic relationship to be an important contributor of therapeutic outcome. Within this broader literature, certain components of a tripartite model (working alliance, real relationship, transference) have been studied in terms of how they relate to session/treatment outcome, and how they unfold during the course of treatment. Results have indicated that the working alliance, real relationship and transference relate to outcome (either directly or indirectly through the presence of moderators) and tend to vary across the course of treatment.

In another line of literature on the therapeutic endeavor, the termination phase of therapy is indicated to be a significant phase in treatment in the eyes of both the therapist and client. The literature also suggests that the therapeutic relationship has a salient role during the termination of psychotherapy. No study to date has focused on the working alliance, real relationship and transference during the termination phase of treatment in order to understand their relationship with termination phase evaluation and treatment outcome. A goal of the present study was to examine therapists' perceptions of the working alliance, real relationship and transference during the termination phase and therapists' views on termination phase evaluation and treatment outcome to study the relationships among the aforementioned components. A second goal of the study was to address the termination as loss model by examining therapists' perceptions of client sensitivity to loss in order to a)

understand the relationship between client sensitivity to loss and transference b)  
examine the role of the working alliance and real relationship as moderators in the  
relationship between therapist perceptions of client sensitivity to loss and outcome. In  
addition to these goals, further analyses were conducted to examine if the type of  
termination relates to the aforementioned therapy relationship components and  
outcome in the eyes of the therapist.

## Appendix B: Demographic Questionnaire for Therapists

FORM A:

Please answer the following questions about yourself:

1. Gender

2. Age

3. Ethnic Background

- African American/Black
- Caucasian/White
- Asian/Pacific Islander
- Hispanic/Latino
- Other (Specify)

2. Most Advanced degree

- BA/BS
- MA/MS
- PhD
- Other (specify)

3. Your Theoretical Approach

Please write the number that best indicates how representative each of the following approaches is of your work in psychotherapy

<b>Strongly Representative</b>	<b>Moderately</b>	<b>Neutral</b>	<b>Just a Little</b>	<b>Not at all</b>
<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>

- Humanistic/Experiential
- Psychodynamic/Psychoanalytic
- Cognitive/Behavioral
- Systems
- Other

4. Years of clinical experience: To your best estimate, please write how many years you have been providing therapy (post graduate degree)

FORM B:

Please answer the following questions about the client with whom you have most recently terminated meeting the following criteria:

- The client is over the age of 18
- You and the client met for at least 10 sessions
- The end of treatment included a last phase of counseling, during which you and the client consciously or unconsciously worked toward bringing the treatment to an end and talked about the end of therapeutic work.

5. Client's Gender

6. Client's Age

7. Client's Ethnic Background

- African American/Black
- Caucasian/White
- Asian/Pacific Islander
- Hispanic/Latino
- Other (Specify \_\_\_\_\_)

8. Approximate number of sessions with the client (your best estimate).

9. Approximate number of sessions included in the termination phase of treatment.

10. Which of the following led to your client's termination of psychotherapy?

- Your Decision
- Client's Decision
- Mutual Agreement
- External factors
- Other (Describe) \_\_\_\_\_

11. How long has it been since you terminated with this client?

## Appendix C: Working Alliance Inventory-Short Form

### Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of \_\_\_\_\_ in the text.

Below each statement inside there is a seven-point scale:

---

\_\_\_\_\_

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes. Please complete the items below in terms of your relationship with **the selected client during the termination phase of psychotherapy.**

---

1. \_\_\_\_\_ and I agreed about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

2. \_\_\_\_\_ and I both felt confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

3. I believed \_\_\_\_\_ liked me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

4. I had doubts about what we were trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

5. I was confident in my ability to help \_\_\_\_\_.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

6. We were working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

7. I appreciated \_\_\_\_\_ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

8. We agreed on what was important for \_\_\_\_\_ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

9. \_\_\_\_\_ and I had built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

10. \_\_\_\_\_ and I had different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

11. We had established a good understanding between us of the kind of changes that would be good for \_\_\_\_\_.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

12. \_\_\_\_\_ believed the way we were working with her/his problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

---

## Appendix D: The Real Relationship Inventory—Therapist Form

Please complete the items below in terms of your relationship with **your selected client in the termination phase of psychotherapy**. Use the following 1–5 scale in rating each item.

<b>Strongly Agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>

- \_\_\_ 2. My client and I were able to be genuine in our relationship.
- \_\_\_ 3. My client felt liking for the “real me.”
- \_\_\_ 7. I felt there was a “real” relationship between us aside from the professional relationship.
- \_\_\_ 8. My client and I were honest in our relationship.
- \_\_\_ 11. My client held back significant parts of him/herself.
- \_\_\_ 13. There was no genuinely positive connection between us.
- \_\_\_ 14. My client’s feelings toward me seem to fit who I am as a person.
- \_\_\_ 15. I did not like my client as a person.
- \_\_\_ 18. It was difficult for me to express what I truly felt about my client.
- \_\_\_ 19. My client had unrealistic perceptions of me.
- \_\_\_ 20. My client and I had difficulty accepting each other as we really are.
- \_\_\_ 23. My client shared with me the most vulnerable parts of him/herself.

## Appendix E: Transference Scale

Evaluate the items below with respect **to the termination phase of psychotherapy with your selected client**. Use the following definitions:

*Amount of transference* is the degree to which the client was dealing with material that was overtly or covertly related to the therapist. This material must be a manifestation of or a displacement from an early important relationship(s). The previous person (or transference source), however, need not be mentioned; he or she may be inferred because of, for example, the presence of distortion, strong affect, inappropriate affect and so forth.

*Positive transference* may be seen as positive reactions to or perceptions of the therapist that are transference based.

*Negative transference* may be seen as negative reactions to or perceptions of the therapist that are transference based.

Transference:	1 None or slight	2 Some	3 Moderate	4 Much	5 Very much
Amount					
Positive					
Negative					

## Appendix F: Perceived Client Sensitivity to Loss

Please complete the following items about your selected client using this 5-point rating scale.

1	2	3	4	5
Not at all	Not Very much	Somewhat	A Fair Amount	A Great Deal

1. To what extent was loss and/or separation (other than separation due to termination) an important theme in the content of your work with this client
2. To what degree was your client sensitive to loss
3. To what extent did your client lack the capacity to mourn
4. To what degree did this termination come at an inopportune moment in your client's life



## Appendix H: Counseling Outcome Questionnaire

*Instructions:* Please complete the four questions below by circling the number that best fits your view about the selected client.

Compared to when your client began counseling

1	2	3	4	5	6	7
Much Worse	Moderately Worse	Slightly Worse	About the same	Slightly Improved	Moderately Improved	Much Improved

---

1. How did this client feel at the end of therapy?
2. To what extent did this client show change in behavior at the end of therapy?
3. To what extent did this client understand him/herself at the end of therapy?
4. Rate this client's overall change in therapy

## Appendix I: Letter to Therapists: First letter to therapists

Dear \_\_\_\_\_,

As a practicing therapist, how do you perceive the relationship with your client at the end of treatment? What do you notice about your client and the therapeutic work accomplished at the end of treatment? We believe your perspective on these questions can provide valuable insight into an important piece of psychotherapy, the therapeutic relationship during the termination phase of psychotherapy. We hope that you will be willing to help us in our efforts to understand this important aspect of psychotherapy. If you are not currently seeing clients or patients, please respond to this email letting us know and we will not contact you further. If you do currently see clients or patients for individual psychotherapy, please read on.

Your participation would be incredibly helpful and appreciated. This research would involve approximately 20 minutes of your time to complete some measures. We are aware that your time is extremely important, but believe that the nature of this research will make your participation worthwhile. All participants will receive a summary of our findings and be notified of any publications that result from this study.

We request you to follow the link attached in this email if you are agreeable to participating in this study and have recently terminated psychotherapy with a client (over 18 years of age). At this point, we would be happy to discuss the study further and answer any questions you might have.

This study has received IRB approval from The University of Maryland. If you are willing to participate please follow the link below. For any questions regarding this study, please contact Avantika Bhatia at [abhatia6@umd.edu](mailto:abhatia6@umd.edu) or [240-264-9681](tel:240-264-9681).

Link: [https://umdsurvey.umd.edu/SE/?SID=SV\\_6x14lhweVOy2N25](https://umdsurvey.umd.edu/SE/?SID=SV_6x14lhweVOy2N25)

Sincerely,

Avantika Bhatia, M.A.  
Charles J. Gelso, PhD

University of Maryland  
Department of Psychology

## Appendix J: First Reminder Letter

Dear \_\_\_\_\_,

We recently sent you a request for your assistance in a study we are conducting. We have not heard from you and wanted to send you a reminder about your participation. We will be deeply appreciative if you will be willing to participate in the study. Included below is the request that we sent you for the study. If do not wish to participate or have already participated, please respond to this email and we will no longer contact you.

Sincerely,

Avantika Bhatia, M.A.  
Charles J. Gelso, PhD

**\*\*Body of first letter will be attached here\*\***

## Appendix K: Second Reminder Letter

Dear \_\_\_\_\_,

We are following up on my earlier requests for your assistance in a study we are conducting. We are sorry to bother you again with this email. We are trying to increase the sample size for the study and would really appreciate your help. If you do not wish to participate or have already participated, please respond to this email and let us know. This will be our last reminder email. Included below is the request that we sent you for the study.

Sincerely,

Avantika Bhatia, M.A.  
Charles J. Gelso, PhD

**\*\*Body of first letter will be attached here\*\***

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