

Is it time to say Goodbye?

A psychodynamic exploration of premature endings

Patricia Neary

Student number: 10313898

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Supervisor: Heather Moore

*“What we call the beginning is often the end
And to make an end is to make a beginning.
The end is where we start from”*

T.S. Eliot

From Little Gidding

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Abstract

Is it time to say goodbye? Goodbye to professional bodies that regulate psychotherapy in favour of an umbrella state regulation. Goodbye to a client after as few as six sessions? Goodbye to our idea of the therapeutic alliance as being a fundamentally positive relationship? Goodbye to a relationship that provides either the therapist or the client with fulfilment? From Freud's scepticism of short term therapy to a societal expectation that today's therapist facilitate therapeutic change with short term psychotherapy, what are the considerations for trainee psychotherapists as they start on the journey of facilitating growth and change in their client while experiencing personal satisfaction in their profession?

Premature endings in short-term psychotherapy can be limited by three essential elements. Firstly, by understanding the relational nature of the therapeutic relationship. Secondly, by accepting that the therapist is also a human being and needs to have her own support in the form of personal therapy, supervision and peer group. And thirdly, by clearly defining with the client what he hopes to gain from his therapy. However, due to the relational nature of the therapeutic setting, some endings will inevitably have a premature end. Skovholt (2005) proposed that mastery of the profession is defined by the ability to repeatedly attach and separate from clients. Herman (2015) reminds the therapist to stay aware of her own vulnerabilities and to prioritize self-care. She concludes that the therapist can experience an enrichment of her life experience through her boundaried engagement with her clients (p. 153).

INTRODUCTION

In this dissertation a collection of peer reviewed published literature will be examined on the topic of premature endings in short-term psychodynamic psychotherapy. The dissertation will aim to answer questions, not only about the impact of premature endings on both therapist and client, but also on how premature termination is defined and by whom. Chapter one of this dissertation will explore what a therapeutic relationship is and expand on this by considering what it is about the relationship that can lead to therapeutic change. The core Rogerian conditions that underpin the therapeutic relationship are empathy, congruence and unconditional positive regard (Rogers, 1957/2004). Although Rogers (2004) proposed that these conditions, when fully met, are sufficient for therapeutic change, Bordin (1979) defined the therapeutic alliance as critical, stipulating that agreement on therapy goals and collaboration on tasks are also essential to the change process. The working alliance will be tested many times during therapy. However, ruptures explored in a safe and secure environment, can be healed. It is essential that the therapist has undergone her own extensive personal therapy in order to provide a safe base for the client (Balint, 1950; Freud, 1914).

The second chapter will outline a consideration of what constitutes a healthy ending in short term psychodynamic psychotherapy for today's society. In a western society of an increasingly informed and critical population, who are requesting psychotherapy ever more frequently, psychotherapists face new challenges (Henson, 2017; Montgomery, 2015). The potential gap between client and therapist expectations can be explored at the start of therapy by clearly defining goals. Research suggests that

clients can experience significant positive change after as few as 6 sessions (Assay & Lambert, 2000). Clients who report that their therapy finished on time are most satisfied both with the outcome and the process of their therapy (Roe, 2017). Psychoeducation at the start of therapy can protect against alliance ruptures that lead to premature termination of therapy (Swift & Callahan 2011).

Chapter three will highlight both societal and human vulnerabilities that can lead to premature endings, which create an enhanced feeling of loss. The process of confronting and healing ruptures throughout therapy, but importantly, at the termination phase can be very helpful to clients as ruptures and endings are often denied and ignored in one's daily life (Eubanks, Muran & Safran, 2018). The therapist herself may be particularly impacted by loss (Sussman, 2000). Cumulative loss experiences can impact therapists who are unaware of its negative impact (Viorst, 1982). According to Viorst (1982), these losses are not always fully processed due to the isolated nature of the therapist's profession. The therapist has a duty of care to the client but also to herself, she must know her own vulnerabilities (Herman, 2015 p.15; Younggen & Gottlieb, 2008).

Factors leading to alliance rupture are often linked to unresolved dependency needs. The therapist is not immune to these needs, which can negatively impact the therapeutic alliance (Sussman, 2000). In chapter four this dissertation will consider how a therapist can thrive in our current "client is king" culture. Finding a balance between societal and governmental demands, plus our human resistance to change is key (Brown, 2000; Montgomery, 2015). Making use of newly developed, empirically designed scales and assessment forms can help the therapist stay alerted to how and

why ruptures occur and when to address them in order to facilitate an end to therapy which empowers the client and satisfies the therapist (Larsson, Björkman, Nilsson, Falkenströ & Holmqvist, 2019). However, a balance will need to be struck to cultivate a widespread acceptance that psychotherapy is in essence about relationships, which are inherently unpredictable and messy at times. Doran (2016) questions the therapeutic alliance as an invariably positive construct in the literature. She encourages the therapist to see the benefits considering the alliance as a variable, which can also be negative. Thus, Doran (2016) highlights the benefits of working through disagreements and conflicts.

In this dissertation, for the sake of clarity, the therapist is referred to using feminine pronouns and the client using masculine pronouns. References to psychotherapy in this dissertation refer to short-term psychodynamic psychotherapy unless otherwise stated.

1. THE MEANING OF THE THERAPEUTIC ALLIANCE IN PSYCHODYNAMIC PSYCHOTHERAPY

The therapeutic alliance is the adult-to-adult working bond, which is created between a client and therapist. The client needs to develop trust and confidence that therapy can help him navigate and, in the end, alleviate his problems. The therapist is also human with her own problems but has the necessary training in order to be fully present with the client (Jacobs, 2017).

The therapeutic alliance is underpinned by the therapist-client relationship. Six core conditions were originally laid out and extensively studied by Carl Rogers (1957/2004) to understand what constitutes a therapeutic relationship. The fundamentals of the core conditions are unconditional positive regard, congruence and empathy (Rogers, 1957/2004). A therapeutic relationship is established when these conditions are met. Initially, and critically, first by the therapist alone and as the relationship builds, the client discovers his own authentic self and can find the courage to change and grow within this relationship.

In an article published in 1950, Michael Balint considered what happens in the therapeutic relationship when it culminates in a successful ending of analysis (Balint, 1950). He proposed that if the client has experienced the “unconditional expectation of being loved without being under the obligation to give anything in return...”, then consequently, the client is able to feel a sense of security from which he can be “re-born” into his new freer life (Balint, 1950, p.196). Balint, a British object relations

psychotherapist, questioned what constitutes a truly finished psychoanalysis. He asked the question of whether mental health is extremely rare and links this to the “empirical fundamental rule that no one shall analyse who has not been analysed himself” (Balint, 1950, p.196). This rule was also stated explicitly by Sigmund Freud (1914) “everyone who wishes to carry out analyses on other people shall first himself undergo analysis” (p.116).

A strong therapeutic alliance, when established, provides the experience of a safe and secure environment. The feeling of being loved unconditionally is fundamental to secure attachment. This was first explored and demonstrated by John Bowlby using “The strange situation” baby observation experiments (as cited in Gomez, 1997, pp.159-163). The client ideally experiences unconditional regard and empathy in the therapeutic relationship. According to Bordin (1979), it is from this secure base that a safe working alliance is built. The alliance is defined by three factors, agreement on therapy goals, collaboration on tasks to promote positive change and the development of a strong relational bond between client and therapist (Bordin, 1979). When these factors are met, the client can safely and securely examine aspects of himself that he resists and defends against (Jacobs, 2017, pp.87-99). Insights gained can guide the client in making life changes to alleviate his suffering. The therapeutic alliance can act as the template for relationships outside the therapeutic setting.

Jeremy Holmes (2000) suggests that once a secure base is established, the therapy can be drawn to a safe end. He emphasizes that the less secure the client is at the start of therapy, the longer it will take to get to this point. He also emphasizes that insecure attachment in the therapist can lead to a therapist’s ambivalence about endings. The

therapist who is insecure in her own attachment risks ending the therapy too soon or dragging it out for too long (Holmes, 2006, pp.139-143; Talia, Muzi, Lingiardi and Taubner, 2018; Viorst, 1982), hence the requirement for the trainee therapist to engage in her own therapy.

1.1 How important is the therapeutic alliance?

In the introduction to their book “The heart and soul of change” Hubble, Duncan and Miller (2000) remind the reader of the many studies conducted in the 1980’s and 1990’s that highlight extensively two aspects concerning all psychotherapy modalities. Firstly, that there is no significant difference between the various schools of therapy and secondly, that therapy does work (Hubble, Duncan & Miller, 2000, pp.5-6). The question they try to answer is: What is it that makes therapy work? Following a meta-analysis of peer related published work Assay and Lambert (2000) identify four major common factors and their influence on change: Extratherapeutic change 40%, Techniques 15%, Expectancy 15% and Therapeutic relationship 30%.

More recent empirical investigations into the common factors that influence successful treatment outcomes have shown that the therapeutic alliance is an essential factor in successful outcome. Of the sixteen factors explored by Stamoulos and colleagues (2016), twenty-one expert Canadian psychologists rated the therapeutic alliance as the most important factor. The researchers defined “the expert psychologist” by the following criteria; holding a doctorate in psychology, a minimum of ten years’ experience and providing current individual psychotherapy to adults (Stamoulos et al., 2016).

The question as to why therapy can end prematurely was explored by Hunsley et al. in 1999. They identified a subset of clients, those from minority groups or those who had lower socio-economic status, who were most likely to terminate early (Hunsley et al., 1999). However, a recent further study published by Anderson, Bautista and Hope (2018), although identifying this same subset of clients as vulnerable, identified a stronger predictor of premature termination, which is a weak therapeutic alliance. Bhatia and Gelco (2017) found that from a therapist's point of view a better alliance relationship at the termination phase of therapy is strongly correlated with better outcomes for both the end phase and for the therapy as a whole.

2. THE IDEAL DURATION OF PSYCHODYNAMIC PSYCHOTHERAPY

2.2 How long can it take to see improvements from psychotherapy?

In a paper entitled *Analysis Terminable and Interminable* Freud (1939) considered what the duration of therapy needs to be. He criticized his colleague Rank for offering short-term psychotherapy. This he considered as being a symptom of American haste. However, he admitted to the success he himself had had with a patient to whom he gave a time limit to finish an analysis. He stressed that this treatment, although successful, must be the exception in psychoanalysis (Freud, 1939, pp.216-253).

Eight decades later the demand for short-term psychotherapy seems to be continuously increasing. Although statistics have not yet been generated in Ireland, a UK report conducted by Pollecoff (2016) on trends in psychotherapy identifies this increasing demand for psychotherapeutic services. These trends include a demand for brief interventions with fast solutions from increasingly well-informed clients (Pollecoff, 2016). In 2012 a report published by Mellor-Clark and colleagues found that of the employees (28,476 clients) from the Employee Assistance Professionals Association (EAP) UK who attended counselling for problems including anxiety, depression and relationship problems, 70% reported recovery or significant improvement after just six sessions (Mellor-Clarke, Twigg, Farrell & Kinder, 2012).

This contrasts with the findings of Wolgast, Lambert and Puschner, who in 2003, using a population of college students, found significant improvement in 51% of the students after 14 sessions. The discrepancy could be due to more complex presentations in the college population (who were dysfunctional) compared to the employees who, although distressed, were all functioning in their work environment. An alternative explanation for this discrepancy is proposed by Michael Montgomery (2015) who questions “the more for less” policy of state organizations like EAP who, in his eyes, commodify psychotherapy.

Similar to Wolgast and colleagues (2003) investigations, Asay and Lambert (2000) suggest that clients can often fall into two groups. Those with problems that can be resolved within 5 to 10 sessions (50% of clients) and those with more complex problems who will need more than 25 sessions (20-30% of clients). Additionally, they warn that clients are not “inoculated” against recurring problems in their future (Assay & Lambert, 2000, pp.42-43). This poses the question as to how much can be expected from short-term psychotherapy. It contrasts with the hope of a deep psychological change of Freud’s psychoanalysis where repetitive patterns of behaviour are identified that have origins in the distant past, “the patient yields to the compulsion to repeat, which now replaces the impulsion to remember, not only in his personal attitude to the doctor but also in every other activity and relationship which may occupy his life at the time” (Freud, 1914, p.151). Extensive research in the US has shown that how positively a client responds to therapy in the first few weeks is highly predictive of the eventual outcome of his treatment (Brown, Dreis and Nace, 2000, p.390).

2.3 Therapy too long, too short or just right, who decides?

A study by David Roe (2007) showed that of the 82 clients assessed after completing psychotherapy 40% found that it ended on time, 37% that it ended too soon and 23% that it ended later than it should have. The clients who reported that therapy ended on time were most satisfied and benefitted most from their therapy (Roe, 2007). Although clients enter therapy with the hope that their suffering can be relieved, premature termination of the therapy is a common and distressing problem for both clients and therapists (Fragkiadaki & Strauss, 2012; Roe, 2007).

Clients' principle reasons for terminating therapy have been identified as, goals fulfilment, client's dissatisfaction toward treatment and economic factors (Olivera, Braun, Gómez Penedo and Roussos, 2013). Managing clients' expectations with the use of psycho-education leading to an agreed number of sessions that a client can commit to decreases attrition rates (Swift & Callahan, 2011). Therapists are advised to keep a note of the client's goal and expectations of their therapy at the initial sessions to refer back to as the therapy progresses. This helps both therapist and client to assess how far the client has come in the alleviation of the presenting problem (Roe, 2007; Rothschild, 2000, p.153).

Olivera, Challú, Gómez Penedo and Roussos (2017) found that almost all of the therapist-initiated terminations (95% of their sample) were agreed upon by both client and therapist, of the client-initiated termination cases 49% were agreed upon and 51% were disagreed upon. The clients who terminated unilaterally reported being less satisfied and having a poor therapeutic relationship (Olivera, et al., 2017). Recent studies have consistently shown the value of collaboration between therapist and

client on the correct timing of termination (Bhatia & Gelco, 2017; Olivera, et al., 2017; Shaharabani, Shafran & Rafaeli, 2018).

Collaboration implies that both client and therapist agree to finish therapy even if the therapist feels that the client may not have confronted deeper aspects of the presenting problem. The therapist runs the risk of overextending therapy “better safe than sorry” attitude if she overestimates the client’s view of what constitutes a successful therapy (O’Connor, Kivlighan, Hill & Gelso, 2019). Some therapies that are termed prematurely terminated by the therapist have been found to be successful from the client’s point of view. This may bias the high dropout statistics reported for short-term psychotherapies (Roe, 2007).

3. THE EFFECTS OF TERMINATION ON THE CLIENT AND THE THERAPIST

Premature termination is the abrupt ending of treatment with no sense of closure and/or little sense of the reasons for termination before resolving the client's presenting problem (Younggren and Gottlieb 2008). The client goes into therapy to resolve his suffering but is commonly highly resistant to change his behaviour. Freud (1939) in his essay "Analysis terminable and interminable" remained very conservative in his estimation of how far a client will use insight to change maladaptive behaviour that underscores this core dilemma.

Every ending is a rupture and to some extent represents a loss that will be grieved. The unique opportunity of the therapeutic setting is that it offers a space to prepare for and explore emotions arising from the termination, not just of the therapy, but by extension to any significant relationship or life phase. This contrasts with the common experience of a denial or avoidance of endings, in Ireland colloquially known as "The Irish Goodbye".

Short-term psychotherapy lends itself to helping the client work through the universal reality of loss. After termination, the client takes over the role of internal counsellor, becoming his own therapist (Jacobs, 2017 p. 140). Similarly, for the therapist, Ronnestad and Skovholt (2001) observe that senior therapists have internalized their mentors. Does the professionalization of psychotherapy protect the therapist from

feelings of loss at the end of therapy? Is the therapist immune to the cumulative losses that are inherent in her work?

Skovholt (2005) addresses these questions and proposes that mastery of the profession is defined by the ability to optimally attach and separate from clients time and again. The therapists' task, according to Skovholt, is to repeatedly experience the world of the other without becoming overwhelmed. The therapist's own attachment history can profoundly influence her ability to stay resilient in the face of multiple therapy endings.

Michael Sussman (2007) expands on this topic; he proposes that the personality traits that predispose an individual to a career as a psychotherapist are also the traits that predict difficulties with individuation and separation. This would predict that not only are therapists not immune to separation loss, but that they may be particularly susceptible to it. Dependency issues also seem to play a seminal role in understanding how a therapist defines premature terminations (Van Denburg & Van Denburg, 1992). The therapist may have to accept that in an increasingly self-aware client population, expectations of therapist and client may diverge. It is up to the therapist to attend to the client's perspective (Pollecoff, 2016; Van Denburg & Van Denburg, 1992; Viorst, 1982).

An analysis of sixteen expert therapists who were interviewed by Judith Viorst (1982) brought several commonalities to the fore. Fifteen of the interviewees admitted to feelings of loss after termination of therapy. They reported feelings of anger, guilt, frustration, disappointment and sorrow at the termination stage of therapy, which

although not of traumatic proportions, is present for them at this stage (Viorst, 1982). Moreover, Viorst (1982) experienced pleasure and relief in the participants as they talked of their experiences of the termination stage of therapy. She attributes this to the isolation of the working environment of the psychotherapist.

This has implications both for continual professional development and for trainee psychotherapists. Negative affect from accumulating losses can be relieved during the therapists' own therapy. However, the therapists' therapy also will come to an end. Therapists can consider turning to other resources including collegiate support or peer groups where emotions can be normalized and/or worked through (Fragkiadaki & Strauss, 2012). Ronnestad and Skovholt (2001) report that the ability of therapists to function well is dependent on a balance being found between personal and professional lives, on personal therapy, on taking vacations and in interaction with mentors. Skovholt (2005) claims that therapist satisfaction is positively affected by balancing empathy with boundaries. He suggests that when the balance of self-care versus other-care is optimal professional attachment will be assured and the therapist will be resilient to the multiple terminations inherent in her profession.

Boundaries are further explored by Younggren and Gottlieb (2008) who distinguish between types of termination where the process for ending treatment is ethically and clinically followed and where it is not. They call therapy that is unethically terminated abandonment. Abandonment can lead to re-traumatization of the client caused by unethical therapist behaviour such as an abrupt ending to therapy by text or email, the initiation of a romantic relationship with the client or breach of confidentiality. They emphasize that a therapist has a duty of care for the client but equally must be aware

of the dangers of not terminating clients who pose a threat to them, for example by severe boundary violations like stalking or threats of violence.

In Ireland codes of conduct are written into the code of ethics by the professional bodies, for example the Irish Association of Humanistic and Integrative Psychotherapists (IAHIP, 2019).

4. HOW TO PROMOTE SUCCESSFUL ENDINGS IN PSYCHODYNAMIC PSYCHOTHERAPY

An alliance rupture is a fracture in the working alliance that is caused by any one or a combination of factors. The most common factors are; a disagreement between therapist and client, a failure to engage constructively with the agreed tasks or, more severely a violation of the code of ethics governing the therapist client working agreement (Eubanks, Muran & Safran, 2018; Younggen & Gottlieb, 2008; IAHIP code of ethics, 2019). Eubanks and colleagues (2018) have listed research-supported practices for addressing and repairing ruptures in the alliance (Appendix 1).

Factors that influence alliance rupture may be linked to the therapist's own dependency needs (Sussman, 2007). The therapist herself needs to feel secure in their attachment relationships in order to balance the intimacy of the therapeutic relationship with the acceptance of loss when the relationship ends (Holmes, 2010). Acknowledging a feeling of loss as the therapeutic relationship nears the end can help the client to accept loss as a natural part of life which, not only leads to a healthy ending of the therapy, but can also be seen as a template for negotiating life's inevitable losses (Jacobs, 2017). Interestingly, Doran (2016) comments that the construct of the therapeutic alliance, which she proposes is too focused on the positive relationship, minimizes the value of working through disagreements and conflict in a therapeutic setting. The value of working through challenging relationships is poignantly made by Herman (2015) who, in her work with healing highly traumatized people, accepts that the relationship will often be fraught with mistrust and even rage

on the side of the traumatized client (pp.138-141). Therefore, Doran (2016) cautions that high alliance ratings early in therapy could, actually be a measurement of dependency and submissiveness and so not necessarily predictive of successful therapeutic change.

4.1 How can the therapist facilitate successful endings?

Shaharabani, Shafran & Rafaeli (2018) propose a four-factor model which therapists can follow in order to help their clients Consolidate and Maintain the gains of therapy while also Resolving any alliance ruptures and Accepting the separation (CMRA model). Is it possible to develop a model, for example the CMRA, to create a reliable and valid short-term psychotherapy?

Where psychotherapy is conceived of as a commodity in a “client is king” culture, can psychotherapy be reduced to a more precise form whereby the end result is both reliable and quantifiable? Montgomery (2015) calls this phenomenon the “McDonaldization of Psychotherapy”. He warns of the increasing demands of state legislative bodies, which, he believes, deny the reality of the authentic therapeutic alliance. This relationship, as with all relationships, is inherently unpredictable and messy. His concern is shared by Reeves and Mollon (2009), who warn that psychotherapists in Ireland may not be fully cognizant of the implications of state regularization with its evidence-based demands on a profession that celebrates the uniqueness of each person.

The increasing demands of professionalization could force the societal expectations of efficiency, validity and control in a time limited setting onto the profession of

psychotherapy. This could have negative consequences for the psychotherapeutic domain (Henson, 2017; Montgomery, 2015; Reeves & Mollon, 2009). Ultimately, Henson (2017) questions the value of state legislation in Ireland based on his experiences in the UK. We now live in a risk-adverse litigious culture. This is supported by Montgomery (2016), in his interviews with six expert therapists he found that they reported being increasingly risk-adverse as the clients have become more litigious. The therapists admitted to fears of being criticized or sued and were likely to refer clients to their general medical practitioner faster than in the past. The state requirement for therapy to be empirically based and formulaic is a contradiction to the human condition. However, transparency and openness on empirical factors that improve therapy outcome can also empower and inform the therapist (Brown et al., 2000 p. 402).

Life is intrinsically incalculable. The illusion could be created that following a set of guidelines will ensure a tidy, defined path bringing therapist and client from the start to the finish of their journey. It is important to distinguish life goals from therapy goals. The therapist may have to accept that sometimes her ambitions for her client may be higher than those that the client has for himself. The therapist may need to be aware that the goals she holds for her client could represent the lack or missed opportunities she herself missed out on during her own therapy (Viorst, 1982).

Hubble and colleagues (2000) highlight that at the end of the day it is the client who pays for their own therapy. Some clients may feel empowered by transparency on empirical outcomes showing what works well and what does not seem to work in the psychotherapeutic arena. This psycho-educational factor could encourage the client's

active participation on his journey to change. This could, according to Hubble and colleagues (2000, p.408) strengthen the all-important working alliance.

Recent studies are indicating that repeated measurements of within session alliance and alliance ruptures can be reliably measured (Larsson, Björkman, Nilsson, Falkenströ & Holmqvist, 2019). Larsson and colleagues (2019) have developed the Alliance and Rupture Observation Scale (AROS), which measures client rated alliance and alliance ruptures. This could be an interesting tool for trainee psychotherapists to use and so better understand how ruptures develop in the therapeutic setting. Essentially, the researchers have not yet been able to determine if AROS scores predict positive therapy outcome (Larsson et al., 2019).

Alliance ruptures can never be avoided and nor should they if we consider that the therapeutic setting is ideally a safe and secure micro-world in which the client confronts his suffering and works through painful experiences. Therapists can prepare themselves for ruptures during the termination stage of therapy by taking account of the client's loss experiences. Notably, clients with significant loss experiences may need more time to work through negative transference in order to maintain and strengthen the therapeutic alliance through to the end of therapy (Bhatia and Gelso, 2017).

CONCLUSION

This dissertation reviewed published literature on endings in the therapeutic relationship. It particularly focused on premature endings, which can have a negative impact on both client and therapist. It posed the question as to what exactly constitutes a premature ending as it examined endings from a client, a therapist and governmental prospective.

The dissertation started with an overview of the core Rogerian conditions of empathy congruence and unconditional positive regard that underpin the therapeutic relationship in psychodynamic psychotherapy (Rogers, 2004). Bordin (1979) proposed that the therapeutic alliance is critical to the therapeutic change process. He defined the factors of agreement on therapy goals and collaboration on tasks as essential in this process. The alliance ruptures that inevitably occur during this alliance must be confronted and healed as they occur. To provide a safe and secure environment the therapist must herself have participated in extensive personal therapy (Balint, 1950; Freud, 1914; Herman, 2005; Talia et al, 2018; Younggen & Gottlieb, 2008).

The dissertation continued by highlighting that today's therapists face new challenges. The demand for short-term psychotherapy, in an increasingly informed public, is rapidly and continuously expanding (Pollecoff, 2016). As professional bodies are being taken over by governmental bodies, Henson (2017) and Montgomery (2015) highlight the potential difficulties of incorporating biomedical governmental

expectations on the essentially relational model of psychodynamic psychotherapy. However, the therapist can profit from empirical research that can inform her own growth in clinical practice (Shaharabani et al, 2018; Larsson et al, 2019).

In contrast to Freud's sceptical view of short-term psychotherapy, Hubble and colleagues (2000) showed that short-term psychotherapy does work. The therapist needs to remain congruent to her own expectations versus the expectations of the client and needs to collaborate with her client on therapy goals (Bhatia & Gelco, 2017; Olivera, et al., 2017; Shaharabani et al, 2018).

Relationship ruptures and endings are themes that are often ignored in daily life. This dissertation proposed that psychotherapy provides a unique opportunity to work through these ubiquitous problems. It supported this idea by citing Doran's (2016) observation that the therapeutic alliance is often portrayed as overly positive and so can deny the reality of working through these difficulties.

This dissertation concludes that premature endings in short-term psychotherapy can be limited by three factors. Firstly, by understanding the relational nature of the relationship; secondly, by accepting that the therapist is also a human being who needs to have her own support in the form of personal therapy, supervision and peer group. And thirdly, by clearly defining with the client what he hopes to gain from his therapy. However, it acknowledges that, due to the relational nature of the therapeutic setting, some endings will inevitably have a premature end. Skovholt (2005) proposed that mastery of the profession is defined by the ability to repeatedly attach and separate from clients. Herman (2015) reminds the therapist to stay aware of her own

vulnerabilities and to prioritize self-care; she concludes that the therapist can experience an enrichment of her life experience through her bounded engagement with her clients (p. 153).

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APPENDIX

Research-supported practices for addressing and repairing ruptures in the alliance (Eubanks, Muran & Safran, 2018).

- Be attuned to indications of ruptures in the therapeutic relationship. Be alert to the presence of markers of confrontation markers, in which patients express dissatisfaction or hostility, as well as more subtle markers of withdrawal, which may take the form of patients evading or appeasing the therapist in an effort to move away from the therapist or the work of therapy.
- Acknowledge the rupture directly, and openly and nondefensively invite patients to explore their experience of the rupture, or if direct exploration would take the focus away from a therapeutic task that needs to be prioritized to alleviate painful symptoms, then address ruptures in an indirect, immediate manner, by responsively changing the tasks or goals of therapy in the direction of the patient's concerns.
- Empathize with patients' expression of negative feelings about the therapist or the therapy. Validate them for broaching a difficult and potentially divisive topic in the session.
- Accept responsibility for one's own participation in the rupture, and do not blame patients for misunderstanding or failing to comply with the therapist's wishes.
- Consider linking ruptures in session to interpersonal patterns in the patient's life outside of sessions to engage a patient who is withdrawing from a focus on the rupture. At the same time, be alert to the possibility that you- and your

patients- may feel pulled to link the rupture to other relationships to escape a painful exploration of how the therapist is disappointing the patient.

- Anticipate that ruptures can evoke feelings of confusion, ambivalence, incompetence, and guilt in some therapists. Develop your abilities to recognize, tolerate, validate, and empathically explore your own negative feelings so that you can do the same for your patients.