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Research

THE COMPLEXITY OF LOSS DURING A FORCED TERMINATION: A CASE ILLUSTRATION

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The end of a therapeutic relationship is experienced in a unique way by each patient and triggers complex feelings relating to early attachment issues, losses and traumas. It is an immense rupture: a process of attachment and separation, intimacy and loss that is an emotionally intense experience for both participants. This case illustration provides insight into the difficulties experienced during the process of forced termination in an analytic community-training clinic. Following a 2-year treatment, Peter, a patient who had been severely traumatized in youth, had to tolerate the pain of another loss; having to say goodbye to a therapist. We describe the therapist's initiation and engagement of the termination phase. A series of measurements of patient personality, therapist attachment, and change in alliance and outcomes provide information on the impact of Peter's history and the therapeutic relationship. Clinical illustrations highlight different parts of the decision-making process in terms of the patient's sensitivity to loss, as well as the therapist's uncertainty around self-disclosure. We suggest ways therapists may facilitate endings by addressing positive and negative feelings, providing a good-enough attachment experience, and stimulating an internalization of the therapeutic relationship. Implications for clinical practice, research and supervision are discussed.

KEY WORDS: FORCED TERMINATION, TRAINING CLINIC, PSYCHODYNAMIC THERAPY, CASE STUDY, SELF-DISCLOSURE

Given that termination is part and parcel of the psychotherapeutic process, no matter what modality, there is surprisingly minimal empirical research and clinical discussion on termination in the literature (Hilsenroth, 2017). Many theoretical perspectives see termination as an essential part of the psychotherapy process. Most prominently, psychoanalytic and existential approaches, with their focus on separation, loss and death, view treatment termination as a potentially powerful therapeutic experience and unique opportunity for growth. Although therapists and patients can use

collaborative strategies in preparing for psychotherapy termination, setting treatment goals and addressing expectations throughout the treatment (Goode *et al*., 2017), the termination phase itself can be particularly therapeutic. The termination phase may, for example, allow for consolidation of therapeutic work, with patient and therapist sharing the joy, pride and pleasure of the accomplishments achieved (Roe *et al*., 2006), as well as allow for a unique opportunity to work through issues of separation and loss (Zilberstein, 2008). Importantly, this sense of loss does not only involve the loss of the therapist, but also of the hopes the patient had for personal transformation. The wished-for goals that were not realized and the patient's idealized selves that were not actualized usher in a period of mourning about what has not been achieved.

According to Bowlby's attachment theory in psychotherapy, the main role of the therapist is 'to provide the patient with a temporary attachment figure' (1975, p. 191). The therapist and the therapeutic context function as a secure base where the patient can (re-)experience traumatic responses triggered by the loss and separation (e.g. sadness, anger, anxiety, and fear of abandonment) in an attuned therapeutic relationship.

In other words, we ask of our patients a kind of attachment and trust that they will allow for the unfolding of a deep connection (Levy, 2013). We provide a space where vulnerability, quiet hopes and desperate longings may be brought, while knowing from the beginning that the relationship will end. Attachment theory and recent developments in neuroscience help explain how therapists may be able to facilitate endings that address patients' underlying relational needs, foster engagement, and may be able to facilitate a new relational experience that can be transformative for patients (Marmarosh, 2017). At its best, the therapeutic relationship offers a new attachment experience that is imbued with meaning and empathic connection, and contributes to positive treatment outcome [see Lilliengren *et al*. (2015) for an empirical example of the positive effect of patient attachment to the therapist on alliance and treatment outcome]. Successfully working through termination entails a transformation process in which patients internalize the therapeutic relationship, and ultimately develop new ways to view themselves and others. When therapists provide a rich relational experience in the here-and-now that patients can take with them, the rupture of termination can be worked through, repaired and transformed into a generative ending (Novick & Novick, 2006).

Although terminations are likely to be therapeutic when they are planned and chosen, a forced termination process can bring additional challenges (Wong, Tambling & Anderson, 2013). In this paper, we investigate the complexity of the process of a forced treatment termination with reference to a clinical case. After a brief overview of the existing literature on forced termination as well as the main clinical guidelines that have achieved consensus, we attempt to discern the complex meanings that emerged for both patient and therapist during a forced termination. The first author saw Peter, a patient in his mid-thirties, for a 2-year, weekly psychodynamic psychotherapy in a low-fee training clinic. We evaluated the termination phase – for our purposes, the last 15 sessions of the treatment – by reporting on relevant outcome measurements, and highlighting themes of attachment, separation,

intimacy, and loss as they emerged in excerpted clinical material. Following a discussion of the complexity of clinical decision making in Peter's termination phase, we suggest possible implications for clinical practice, training and research.

FORCED TERMINATION

A forced termination, when the decision to terminate is determined by external factors rather than by choice, can offer a major therapeutic challenge for both patient and therapist (Wachtel, 2002).[1] The limited empirical literature on forced termination suggests that it is not only difficult for both patient and therapist, but also that such endings are likely *not* to be beneficial for our patients and may have a negative effect on the therapeutic relationship and treatment outcome (Wong, Tambling & Anderson, 2013). Moreover, forced terminations are common and unavoidable, a critical problem that every therapist in a training clinic inevitably confronts.

In contrast to a chosen termination, where the patient and the therapist are in an active position (both parties agree that drawing the treatment to a close is a sensible thing to do), a forced termination is a more passive experience for both patient and therapist. Therefore, they may, consciously or unconsciously, try to convert their sense of powerlessness into one of active mastery by turning passive into active (i.e. the patient stopping attendance before the termination date; the therapist disclosing in an unusual way, without thinking through the consequences), and thus regaining an illusory sense of agency (Corradi, 2007).

For some patients, termination may not feel particularly impactful, whereas for others, forced endings can be very challenging. Patients tend to experience forced termination (therapist initiated or institution initiated) as a greater loss than when they initiate termination (Baum, 2007). Forced termination may trigger patients' feelings of being dismissed, discarded, betrayed and abandoned, as if everything the therapist had explicitly or implicitly promised (i.e. security, safety, consistency, trust) has now been destroyed (Sherby, 2013). This can be problematic when a patient's anger makes internalization of the positive aspects of the therapeutic relationship difficult, leading to an even greater sense of loss.

Especially for patients with histories of painful losses or trauma (a hallmark of disorganized attachment), the loss of the therapist may feel too great because it represents the unmourned, ungrieved, unresolved abandonments and separations previously suffered by the patient (Salberg, 2009). Despite therapeutic gains, these patients are likely once again to feel overwhelmed by intolerable helplessness and inability to self-regulate (annihilation anxiety) that is triggered by the re-experience of loss (Winnicott, 1980) during termination. On the other hand, the forced termination process may offer a unique perspective into the patient's new capacities with respect to attachment: in the best case, they may now be able to understand the loss in terms of increasingly coherent narratives of their own painful histories, reflecting the achievement of earned security (Diamond & Kernberg, 2008). The unique way each patient processes the loss of the therapist adds to the complexity of forced termination.

Another factor that adds to the complexity is that the therapist, too, suffers a loss (Sherby, 2013). For novice therapists, early on in their career, forced terminations tend to be the norm, as they move through various internships, residencies, and therapeutic settings. Therapists must leave a person they have come to know intimately over many months or years, and who has gratified them in their role as a helper. Therapists are confronted with the reality of their own limitations and the limitations of the therapeutic relationship, and might feel anxious about letting go. Therapists tend to feel anxious during the forced termination process, especially when they perceive their patients to be sensitive to loss (Boyer & Hoffman, 1993). Also, a therapist's guilt about leave-taking might result in withdrawal and avoidance of the termination topic or an overemphasis of the termination in a way that does not match the patient's experience. Either reaction could make connection with the patient more difficult, and might leave the patient feeling alone and left before the actual date of termination. In addition, therapists may have identified with the needing, longing, wanting parts of their patients and, in giving to them, may have nurtured themselves as well (Sherby, 2013).

When termination occurs, the therapist's subjectivity inevitably moves to the foreground (Siebold, 2007), issues of ongoing connection become paramount and patients often express curiosity and interest in the therapist him or herself (Bonovitz, 2007). It often stimulates the patient's curiosity and motivates attempts to understand the therapist's experience of their relationship. The patient finds himself asking, 'What do I mean to you?' and 'Will you remember me?' Therapists often feel an increased (un-)conscious pull to self-disclose (i.e. reveal personal and factual details about their life to patients) even if they might not intend to or understand the meaning of their self-disclosure until later (Bonovitz, 2007). The termination phase raises questions around the extent to which the therapist shares her/his experience of the patient 'in the moment' versus reveals outside experiences, life events or other extra-therapeutic aspects of the therapist's life. A critical part of termination is the way in which the therapist participates in the ending, particularly whether he or she allows the patient access to the therapist's own experience of the treatment and its personal impact. These shared, intimate moments help to open up the opportunity for the patient to internalize the therapeutic relationship. As with any intimate relationship, if the ending is marked by emotional honesty, validated feelings and a gentleness that speaks to the vulnerability of the moment, the relationship can be jointly grieved, remembered and relied upon in future (Gurevich, 2008).

TERMINATION IN CLINICAL PRACTICE

How might therapists help the patient to transform this forced termination process into a growth-enhancing experience? Given its importance and complexity, it is surprising that very few overall clinical pointers have been formulated to guide the therapist through this treatment phase (Frank, 1999; Hilsenroth, 2017). Three main guidelines appear to have achieved consensus in the empirical and clinical literature

on termination more generally, and are applicable to our discussion of the forced termination process.

1. *Preparing for termination*. Although arguably one can never fully prepare for it (Silverman, 2010), a termination experience where both the patient and the therapist take an active position, discussing the feelings around termination and the post-termination plans before the termination occurs, contributes to a better therapeutic alliance and ultimately to a better treatment outcome (Knox *et al*., 2011).
2. *Positive and negative feelings around termination.* Acknowledging patients' positive feelings, including pride, independence, accomplishment and self-respect, can help ease the termination experience (Baum, 2007; Wachtel, 2002). Besides patients' positive feelings, it is also important to validate the patients' negative feelings around termination and take responsibility for the limitations of the therapeutic relationship. Therapists should be attuned to patients' previous attachment experiences, loss and trauma, and the anxiety, anger and sense of abandonment that the termination might arouse. In this way, therapists create an experience of absence in the presence of another ('absence tenderness'; Gurevich, 2008).
3. *An internalized secure attachment*. In order for patients to internalize a new attachment experience they need to develop a representation of the therapist as a secure attachment figure that they can draw upon to solve problems and gain support, even after termination (Novick & Novick, 2006). A secure attachment to the therapist might, for example, be indicated when a patient wishes to remain in contact with the therapist (Siebold, 2007). The therapeutic attachment experience is not only helpful in itself, but might also help patients establish other similarly secure relationships (Levy, 2013).

CLINICAL CASE

In this clinical vignette, we describe the case of Peter,[2] a fragile-looking man in his late thirties who was seen by the therapist (the first author), a 34-year-old female postdoctoral psychology trainee. The entire treatment – a supervised, weekly psychodynamic psychotherapy that spanned 2 years in a low-fee training clinic – ended through a forced, planned termination when the trainee's tenure at the training clinic was completed. Although the therapist always knew she would be leaving the clinic, she had previously hoped to take this patient with her to private practice. For Peter, this meant that the termination from the clinic was expected but the termination of the relationship with the therapist was not definite.

Peter had never been in therapy before but was pushed by his girlfriend to seek treatment for his depression and alcohol use as it had started to impact their relationship. He described many traumatic experiences in his childhood, including boundary violations, intrusions, sexual abuse and parental neglect. During his childhood, the family moved from home to home, depending on which short-term boyfriend his drug-addicted mother had at the time. His father had been largely absent, ever since Peter turned 1 year old. In Peter's view, people could not be relied upon and his only reliable attachment was with alcohol. He was worried about losing his girlfriend,

'the only good thing' that had happened to him. During the initial therapy phase, Peter described his strong sense of responsibility, his fears of abandonment and rejection and not feeling good enough, and had started to process his anger and disappointment with his parents. Although the limits of a training clinic and its predicted therapy ending had been raised earlier in his 2-year treatment, in this paper, we describe the termination phase during the last 15 sessions, session 71–86.

Evaluating the Termination Phase

Following standard clinic practice, the patient was not asked to complete any self-report process or outcome measures during the treatment or the termination phase. However, for her own professional learning, the therapist completed quantitative measures of patient and therapist characteristics at termination and relevant repeated measurements at 6-month intervals throughout the treatment, during the termination phase, and after the treatment's conclusion.

Patient Peter's personality style was assessed using the Shedler–Westen Assessment Procedure 200 (SWAP–200; Shedler & Westen, 2004), an assessment instrument designed to bridge the gap between the clinical and empirical traditions in personality assessment. The first author completed this assessment at the end of the treatment.

The SWAP-200 showed elevated scores on the DSM-V Personality Disorder Scale for both Depressive Features (T=57.6) and Borderline Features (T=56.6). In addition, on the SWAP Personality Syndromes scale, Peter showed elevated scores for Dependent-Victimized Personality Features (T=57.4), High-Functioning Depressive Personality Features (T=56.4), and Borderline (Emotionally Dysregulated) Personality Features (T=55.6). With an Overall Personality Health (T=49.3) score suggesting an average level of personality functioning relative to a clinical sample, the SWAP-200 depicts Peter as an individual with an average level of resources who will tend to attribute the loss of forced termination to his own deficiencies (i.e. depressive thinking), struggle to give voice to his own needs and feelings (i.e. dependent-victimized relational style), and suffer from emotional dysregulation and intense affective experience (i.e. borderline functioning) during the termination process.

Examination of individual responses to the SWAP-200 revealed certain responses suggestive of insecure attachment functioning (Bowlby, 1975). For example, the therapist rated the following items as 5 or higher (out of 7 total): 'Tends to fear s/he will be rejected or abandoned by those who are emotionally significant'; 'Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered)'; and 'Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other'. While the SWAP-200 does not directly assess attachment style, his responses suggest Peter's attachment would be classified as 'insecure'.

Therapist To assess the therapist's attachment style, the therapist completed the Experiences in Close Relationships Scale (ECR-RS; Fraley *et al*., 2006), a contextual

nine-item self-report measure of attachment. Specifically, it is designed to assess anxiety and avoidance across several distinct relationships, including relationships with parents, partners and friends. As well as overall attachment score, the ECR-RS items result in two subscale scores, one for attachment-related avoidance and the other for attachment-related anxiety, indicating attachment levels ranging from 1 (very secure) to 7 (very insecure) for different attachment figures (mother, father, romantic partner and best friend). The therapist's scores on the ECR-RS indicated low attachment anxiety (ranging from 1.33 to 2) and low avoidance (ranging from 1 to 2) for the different attachment figures and an overall secure attachment style.

Therapeutic relationship The therapist completed the Working Alliance Inventory Short Form (WAIS-SF; Tracey & Kokotovic, 1989) after 6, 12, 18 and 23 months (session 27, 50, 71 and 86 respectively). The WAI-SF comprises 12 items rated on a seven-point scale (1=never and 7=always), divided into three subscales (agreement on therapeutic goals; agreement on therapy tasks; therapist–patient bond). Peter's WAI-SF mean scores (4.5, 4.7, 5.5 and 5.6) represented an increased alliance throughout Peter's 2-year treatment.

Termination evaluation The five items of the Session Evaluation Scale, originally developed as a subscale of the Helping Skills Measure (Hill & Kellems, 2002), was adapted for the termination process ['the termination phase of treatment' instead of 'the session', in line with Bhatia and Gelso (2017); e.g. 'My patient thought the termination phase of treatment was helpful']. Like the original measure, the therapist rated the modified items on a five-point scale (1=strongly disagree and 5=strongly agree), which previously showed sufficient internal consistency ($\alpha = 0.81$; Bhatia & Gelso, 2017). The therapist completed the SES after 18 months (session 71, at the start of the termination phase) and 23 months (session 86, at termination) of treatment and reported an increase from 3.8 to 4.8.

Patient sensitivity to loss The Perceived Patient Sensitivity to Loss Measure (PPSLM; Boyer & Hoffman, 1993) assesses therapists' perceptions of patients' vulnerability to loss, previously found to relate to the therapist's anxiety at termination. The four items, with a five-point scale (1=not at all, 5=a great deal), reflect the extent to which loss and/or separation were addressed in the treatment, the patient could mourn, and the termination occurred at an untimely point in the patient's life. The therapist perceived an increase in Peter's sensitivity to loss from 2.87, 2.87 and 3.5 to 3.75 at termination.

Termination Phase with Peter

Peter's insecure attachment style, the therapist's secure attachment style, and the improved alliance over treatment are representative of many therapeutic dyads. Given Peter's increased sensitivity to loss, and rated helpfulness of the sessions at termination, Peter provides a helpful case illustration of the complexity of a forced

termination. We now provide excerpts from three sessions during the termination phase of treatment. These three excerpts were chosen in particular because they highlight the previously described dynamic themes of termination that we discuss further in the remaining sections of the paper.

Breaking the News (Session 71): Preparing for Termination

Therapist: Talking about the next few months and the change you want to make … I know we have till August together, do you have a sense of what you would like to achieve in these next few months?

Peter: For real? You'd mentioned that you might leave but now it's certain?

Therapist: Hmm

Peter: Can you take people with you?

Therapist: I am moving on, but I won't be able to take people with me.

Peter: You can't or you won't?

Therapist: I wish I could but I can't …

Peter: How can you move to another job and not being able to take people with you? That doesn't make sense.

Therapist: … it hurts.

Peter: Like you don't want me anymore. You want to get rid of me.

Therapist: It is hard to feel I might be genuine … You feel rejected?

Peter: I do, you just don't want to take me with you. Can you not tell me where you are going? Why can't you tell? Why can't you take me with you?

Therapist: I know, it is hard … I am moving out of town, but can't say much more than that, it would give away a lot of information about my personal circumstances and I think that would interfere with our relationship here.

Peter: Okay, that's a relief. That's at least something. I can live with that. I mean I never knew where my mother was, when she went out to get drugs. Well you know my ex-girlfriend. I found her in another man's bed.

Nearing the End (Session 80): Positive and Negative Feelings

Peter: Can you really not accept any presents? Even for the last session? I would love to bring you a muffin, would that be okay?

Therapist: I wonder whether you are asking me about the rules or whether you are telling me that you are thinking about us ending?

Peter: I have been thinking about when you leave, I don't want to start all over again with someone else. I really appreciate you being here.

Therapist: What do you appreciate about it?

Peter: The consistency I guess. I have not had much of that in my life. I know what to expect, you are here. You always listen and support me. You will be leaving here and will see many more people like me and I will just be a footnote. I really don't know how you see me. I don't know whether you see how bad I can be sometimes … how intense it is …

Therapist: You expect me to be angry if you show how bad you really are?

Peter: No, I can't imagine you being angry with me.

Therapist: I can imagine that it is difficult to trust that I care.

Peter: I know you care about me, even if I say I don't, I feel it. But it will be worth nothing after August.

Therapist: That makes me sad when you say it's worth nothing in August.

Peter: It makes me sad too. I won't feel this safe with someone again. I don't know you, you know me. You'll move on, see more people like me. I know you care about me now but that'll go. I don't want to leave today.

Therapist: I know.

The Termination (Session 86): An Internalized Secure Attachment

Peter: I know you have the clinic rules, but I wish I could get a hold of you, let you know that I am doing well, or when I need you. Chances are I am doing well; I have been drinking a lot less. You won't be there for me.

Therapist: It is hard to be here with me today …

Peter: It is. Why get close if you know it is only going to end?

Therapist: Our connection makes you feel vulnerable, it hurts.

Peter: Yes it does. But then again, why not? Why not get the most out of a relationship while you have it? I will think of you. I used to talk all the time and pace around, be angry or drunk, now I've come to appreciate the silences. Like all the chaos, and the mess I am in, it feels different. It feels more in my control: like I am looking at it from a distance, observing what I do, it doesn't overwhelm me.

Therapist: Thank you for sharing this journey with me these last two years. I have felt very connected to you and our work together.

Peter: I'll miss coming here … you. I appreciate the time we've had together.

Therapist: Yes, me too ...

Peter: I have never looked you up online, I wanted the experience to be here. How do I pronounce your last name?

Therapist: You wonder about my name ....

Peter: I wonder about your life really. Do you have a nice family, personal life?

Therapist: Are you asking whether you need to worry about me?

Peter: I just want you to have a good life. You are a nice person, professional and caring. It has felt safe here. How can I go from this warm bath to my feelings of scepticism about the couples' therapist?

Therapist: It is hard ...

Peter: It is. I will miss you. This goodbye feels like when I broke up with my ex-girlfriend. We had been good friends for so long, no scene, no acting out, just a conversation about how we would go our own ways.

Peter: I am going to give you a hug (he hugs the therapist and holds her tight).

Peter: Take care of yourself.

Therapist: You too. Take good care of yourself.

Reflections on Peter's Termination Phase

In our view, the therapist's understanding of the impact of Peter's experiences with previous attachments and losses on the treatment's termination phase helped him to become more connected to his feelings of pride and loss, to the therapist, and to outside relationships. Although clearly wrestling with the pain of loss in a way that is characteristic of an insecure attachment, he begins to show some signs of earned security (Diamond & Kernberg, 2008). We might, for example, view Peter's decision to commence couples therapy at the same training clinic as a new attachment to the clinic as well as an investment in his attachment to his girlfriend, both made possible by the therapeutic relationship. This is hopeful because one secure attachment relationship helps to foster future attachments (Zilberstein, 2008).

In bringing up the issue of termination, the therapist confirmed her separateness and implied that her goals differed from his. For Peter the termination from the clinic was expected but as the therapist had previously hoped to take him with her into private practice, the termination of the relationship with the therapist was not definite until the 'breaking of the news' in session 71. Implicitly, the therapist was telling him that she was interested in career advancement and that she could not be a lifelong parent. Peter's ideas about him being replaceable and forgotten but the therapist not

being replaceable indicated the vulnerability and helplessness of his position. It might have been better if the therapist had acknowledged the pain that underlies Peter's wish to reconnect after termination, and responding to his desire to maintain contact might have promoted his attachment security. However, paradoxically, this explicit separation between therapist and patient might also be the reliable and consistent response typical of a secure attachment that is helpful for Peter (Zilberstein, 2008). Indeed, research suggests that patients with hyperactivating tendencies with respect to attachment are helped by gradually increasing therapeutic distance, to the extent that the patient can tolerate it, in order to create a corrective emotional experience of growing autonomy (Mallinckrodt, Choi & Daly, 2015).

In each of these experiences with Peter, there was a shared intensity of feelings, which, while not banishing the hurt, confusion or fear itself, did succeed in diminishing the sense of aloneness. The therapist wanted to let him know that she cared about him, and that she, too, felt the urge to hold on; however, she felt ambivalent about how much of herself to disclose to him. The therapist felt afraid that breaking professional boundaries would be intrusive and would re-traumatize him. Peter's response to her reluctance to share personal information suggests that he did not quite believe this answer either because afterwards he says, 'That's at least something. I can live with that'. He then describes abandonments and betrayals by his mother and his ex-girlfriend, indicating his obvious sense of betrayal and loss. Although the therapist may have revealed more or less than some therapists might have been comfortable with, she believes that Peter felt the ambivalence and sadness that she experienced during the termination process. This place of shared identifications and mutual connection was potentially helpful for him in that it enhanced their feelings of connectedness, of importance, of significance, and that it is the internalization of these feelings that remain as they say their final goodbyes.

To cope with the pain of termination, Peter became increasingly interested in who the therapist 'really' was. Peter appeared to be saying that he imagined that he would become nothing to the therapist once she left and then says that she does not know how 'bad' – by which he possibly means angry or depressed or both – he can become. This sequence might suggest that he was feeling intense pain connected to his belief that he would end up mattering barely at all. His response also suggests a way of coping in which 'it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil' (Fairbairn, 1952, pp. 66–7). Although it is possible that he feared the therapist would be angry at him for being 'bad', maybe unconsciously the therapist was concerned about being angry with him for not wanting to be left. In hindsight, it might have been more helpful to instead address his feelings of rejection and his attempt to cope with it, in an almost Fairbairn-like process, by seeing himself as the 'bad' one. The therapist, could, for example, have said something like: 'It sounds as if my departure makes you feel that you do not matter to me'?

In line with the research by Boyer and Hoffman (1993), the therapist felt guilt over Peter's evident distress caused by the forced termination, and attempted to share her feelings with Peter in response to his sadness and pain. In hindsight, the therapist should have been more attuned to his feelings of loss, abandonment and betrayal, and

should have addressed the intensity of his pain more fully. It seems likely that the therapist's own anxiety and perceptions around Peter's increased sensitivity to loss in the termination phase were related to an identification with his expressed sadness. Also, her initiative to write this case illustration about their termination experience could be viewed as an effort to avoid termination or even refuse to give up their relationship. At the very least, the therapist felt the loss of a relationship in which the work was productive, intimate and rewarding, and through which she experienced professional and personal growth. Peter and the therapist must both come to terms with the limits of their therapeutic relationship, and after acknowledging their shared wish both to hide and to connect, the therapist must let him go, let him seek from others what they can no longer share.

CONCLUSION

Given the lack of clinical and empirical guidance on the forced termination process, further examinations of this complex treatment phase are warranted. This case illustration, although highlighting the importance of the topic, was very limited in scope, and reflects only the therapist's view of the termination process. Future studies should include process and outcome measures that are patient and observer rated as well as detailed diagnostic assessments and symptom measurements to create a more comprehensive picture of this treatment phase.

Future research would also benefit from including pre-treatment assessment measures of attachment, such as the Adult Attachment Interview (REF), that could be administered by someone other than the therapist. Also, a task analysis interview post treatment (Greenberg, 2007) might have shed more light on the patient's experience of the process. Moreover, the use of patient self-report measures of alliance, attunement and affect experiencing would have offered an interesting addition to the therapist's perspectives on the termination process reported in this paper. Rather than completing instruments after the event in an *ad hoc* manner, it might be possible in training clinics to standardize these assessment, process and outcome measures as part of training practice and in support of the termination process.

Although this case illustration describes the forced termination phase by a therapist in training, the particular clinical dilemmas described here might not be solved by clinical experience alone and could also apply to forced terminations later in a therapist's career (Siebold, 2007). This case illustration might, for example, also be relevant to other scenarios of forced termination, caused by patient factors (e.g. a move or job loss), psychotherapist factors (e.g. a move or work change, illness or retirement), institutional factors (e.g. clinic rules) and/or external factors (e.g. drops in funding). While these differently caused forced terminations may impact the unfolding of the termination process in different ways, we nevertheless feel that certain dynamic themes are likely to recur in all cases of forced termination. We might never be able to truly prepare patients for termination or offer the perfect therapy ending experience. Each treatment is a unique co-creation of the therapist and patient, and their past and current attachments, which means there is no one

'right' way to bring a psychotherapy to a close. It is nevertheless important to prepare therapists to facilitate a 'good enough' termination experience (Gabbard, 2009).

If one views termination as a significant rupture, this also implies the potential for training in repairing the inevitable alliance ruptures created by forced termination in a training clinic. Termination is not the only time in therapy that affords opportunities to work on loss (Zilberstein, 2008) and therapists should be aware of the opportunities that small losses, such as holidays, conference leave, illness etc. provide for working through loss. Also, adequate supervision, where therapist and patient's feelings are normalized, seems crucial. Supervisors in a training clinic may help junior therapists to manage the conflict between their desire to help and their desire to learn. The termination phase, with its balance between attachment and separation, intimacy and loss, warrants further reflection, training and research. Questions remain about what therapeutic techniques are best suited to manage cycles of re-traumatization brought on by the coming and going of therapists in a community training clinic. How can therapists be supported, trained and supervised to help them support their patients through the forced termination phase? While patients might be forced to end psychotherapy, therapists will continue to learn and reflect on its meaning.

NOTES

1. There are many variations on these forced terminations, ranging from unplanned forced terminations to those that pertain to a planned termination due to external circumstances (but known about from the outset), such as the therapist being on a time-limited contract. Here we describe a case of planned forced termination in which both the therapist and patient know that the clinic offers only time-limited work.
2. The patient's name, age, race, occupation, time and location of therapy have all been disguised to protect confidentiality. Further, specific historical traumatic events have been omitted, altered or combined with that of multiple patients to further protect patient confidentiality. The termination process itself remains unaltered. Verbal informed consent of the patient and the training clinic for this confidential write-up of his treatment was obtained.

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