Relational development in psychotherapy from beginning to end

Connecting structural and interpersonal aspects

Marit Råbu
Department of Psychology
University of Oslo

Series of dissertations submitted to the
Faculty of Social Sciences, University of Oslo
No. 280

ISSN 1504-3991

Cover: Inger Sandved Anfinsen.
Printed in Norway: AIT Oslo AS.

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Acknowledgements

First and foremost: Thanks to my supervisor Professor Hanne Haavind. Wanting to learn qualitative method from you was an important motivation for joining research. I often struggle to grasp the complexity of what you have to teach, but always experience it as well worth the effort. Thanks also to my co-supervisor Professor Per-Einar Binder for generously sharing your extraordinary knowledge on the best of psychotherapy theory and the best of psychotherapy research. I am grateful to both of you for your continued engagement and trust in me and your support in helping me to find my own way.

Thanks to all the clients, therapists, researchers and assistants who participate in the project "An intensive process-outcome study of the interpersonal aspects of psychotherapy" at the Department of Psychology, University of Oslo, with special mentions for initiator and leader Professor Helge Rønnestad, co-leader Professor emerita Anna von der Lippe and my close colleagues Margrethe Seeger Halvorsen and Hanne Weie Oddli. Special thanks to client "Marian" and therapist "Paul" for allowing me to use their experiences from a challenging psychotherapy process in two single case studies.

Thanks to my co-authors on the papers in this thesis, Margrethe Seeger Halvorsen, Per-Einar Binder and Hanne Haavind. Thanks also to Karsten Hytten, who was both co-author and the therapist in a pre-study to this project. I have no faith in the romantic view of the researcher as a lonely genius. What we can do together is far beyond what I could ever achieve alone, and much more fun.

Thanks to other engaged and engaging colleagues at the Department of Psychology, University of Oslo and in the Bergen group for qualitative research on mental health at the Faculty of Psychology, University of Bergen.

Thanks to Anne Siri Moe for designing useful figures and illustrations for papers and presentations.

Thanks to the Department of Psychology, University of Oslo, for letting me experience a period of great personal and intellectual freedom, joy and development. Besides learning and performing research, I have had the opportunity to travel to Vancouver, Barcelona, San Francisco, Firenze, Dundee, Washington, Bern and Bergen. I have been taking part in an inspiring milieu where I have made new and significant friendships – almost like being young again.

Last, but not least, thanks to my loving, caring family: Jens, Julian, Klara and Torje.

Oslo, 6 March 2011
Marit Råbu

Summary

With the pan-theoretical concept of the working alliance as a starting point, the aim of this thesis is to explore relational development in psychotherapy in an experience-near, clinically relevant and empirically based way. The methodological approach is qualitative and hermeneutic-phenomenological with an emphasis on researcher reflexivity. The investigation involves a combination of reflexive data from participants in psychotherapy with observational data from the therapeutic interaction. Structural elements, such as temporary interruptions and the process of ending, are strategically chosen for close inspection because they represent challenges to the therapeutic alliance and thereby developmental possibilities. Case studies are used to explore concrete relational processes of development from different perspectives (data triangulation). The data are drawn from the project "An intensive process-outcome study of the interpersonal aspects of psychotherapy" at the Department of Psychology, University of Oslo. The findings are presented in three separate articles, one of which is already published in a scientific journal and two that are currently under review. The thesis comprises two single case studies based on the same challenging therapy process which started with relational strains but developed a good alliance and ended with good outcomes. The first case study explores the relational struggles early in the process and the development of a therapeutic alliance. The second case study explores the ambiguous process of ending in the same case. The therapist took the initiative to end therapy and the patient adopted a position where she could affirm that she had grown better only by accepting that she had to end treatment. The third paper is a study of twelve processes of negotiating ending, explored in each case and across the cases. One of the main findings was that patients and therapists seemed to share an ideal of reaching a concerted decision to end. The agreement seemed to a great extent to be based on sensed affect, rather than for instance the use of arguments or metacommunication. Structural features of therapy were used as important constituents in the process of ending and seemed to serve several psychological functions. Case study methodology and the methodological grasp of combining reflexive and observational data turned out as a useful approach which put us on the track of features of therapy that would otherwise have remained unnoticed. One example is the overarching finding that implicit negotiations of the alliance seem to come out strongly opposed to the use of, for instance, metacommunication.

List of papers

Paper 1

Råbu, M., Halvorsen, M. S., & Haavind, H. (2011). Early relationship struggles: a case study of alliance formation and reparation. *Counseling and Psychotherapy Research*, *11*, 23-33.

Paper 2

Råbu, M., & Haavind, H. (submitted). Coming to an end: a case study of an ambiguous process of ending psychotherapy. [1]

Paper 3

Råbu, M., Binder, P.E., & Haavind, H. (submitted). Negotiating ending: a qualitative study of the process of ending psychotherapy.

[1] After the thesis was submitted this article was accepted for publication in *Counselling and psychotherapy research* with minor amendments.

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Introduction: challenges of the therapeutic alliance as a strategic focus

A psychotherapeutic relationship involves collaboration between patient and therapist. The two parties have to come to terms with what they shall work to achieve for the patient, and how the work shall be carried out. A psychotherapy process lasting over time will necessarily entail several temporary interruptions of the contact and it is an implicit premise from the start that the therapeutic relationship shall come to an end when the therapeutic goals are reached. Therapeutic collaboration over time usually involves a significant feeling of emotional connection and relatedness, so temporary interruptions and eventually the decision to end psychotherapy will be an experiential concern for the two participants.

The pan-theoretical concept of the working alliance configures significant relational and developmental aspects of psychotherapy. In psychotherapy research the alliance is usually defined in terms of Bordin's (1979; 1994) model which comprises three aspects of the working alliance; agreements on the therapeutic goals, consensus with respect to the tasks that make up therapy, and an emotional bond between patient and therapist.

The therapeutic alliance is described as the quintessential integrative variable and is the most often cited "common factor" of psychotherapy (Muran & Barber, 2010). As a pan-theoretical concept, the concept of the working alliance is applicable for all different kinds of psychotherapies. The alliance can be said to serve as the context in which specific interventions can take place, whatever they might be (Goldfried & Davila, 2005). The concept of the working alliance includes important interpersonal aspects of the relationship: a psychotherapeutic relationship has aspects that are instrumental (tasks) and affective (bond) and it is directed toward development (goals). These aspects are connected and the conceptualization implicitly highlights the interdependence of technical and relational factors by making it apparent that different patients will be predisposed to find different tasks and goals meaningful as a function of their unique developmental and relational histories. Further, it implies that the usefulness of an intervention is always mediated by its relational meaning and that any attempt to disentangle technical and relational dimensions is conceptually problematic. For instance, it is problematic to think of the combination of the alliance with specific interventions as additive or interactive dimensions, as has been done in studies that used statistical techniques to investigate the joint contributions of alliance and technique (Safran & Muran, 2006). Hatcher (2010) points out that technique and alliance are not at the same conceptual level. Techniques are part of the work, while alliance considers how the work is going. Still, techniques and alliance are not independent variables. We can expect effective use of a therapeutic technique to correlate with a good therapeutic alliance.

Researchers with a strong investment in a distinct therapeutic technique, whatever this may be, tend to be sceptical towards a pan-theoretical concept of a therapeutic alliance, and will tend to emphasize that it is the effect of the specific therapeutic technique effectively applied that creates the alliance. Psychoanalysts have seen the concept as just another way to describe the major technical activity of psychoanalysis, namely transference analysis. Cognitive therapists may likewise stress the primacy of their core techniques in effecting therapeutic change, and the alliance is then seen as an epiphenomenon (Hatcher, 2010; Messer & Wolitzky, 2010; Castonguay, Constantino, McAleavey & Goldfried, 2010).

The concept of the alliance implies a connection between the process and outcome of psychotherapy, and as such it has inspired a huge amount of psychotherapy research. One of the single most solid findings in the research on the therapeutic alliance is that the quality of the therapeutic alliance, especially as perceived by the patient, correlates closely with a good outcome (Barber, Khalsa & Sharpless; 2010; Castonguay, Constantino & Grosse Holtforth, 2006; Horvath & Bedi, 2002; Martin, Garske & Davis, 2000; Muran, Safran & Eubanks-Carter, 2010) and standardized measures of alliance during the third to fifth sessions have proven to be a consistent predictor of outcome (Barber et al., 1999; Gaston, Thompson, Gallagher, Cournoyer & Gagnon, 1998; Horvath & Symonds, 1991).

During recent years, the focus of research on the working alliance has moved beyond the exploration of the links between alliance and outcome of treatment to investigate the moderators and mediators affecting the relationship (Barber et al., 2010; Horvath & Bedi, 2002).

As an explanation for the continuous popularity of the concept of the alliance, Safran and Muran (2006) point to a paradigm shift in many psychotherapeutic traditions that highlight the importance of relational factors in treatment. This shift implies putting an emphasis on themes such as the mutual influence between therapist and patient, the importance of therapist flexibility and spontaneity, and the importance of the authentic aspects of the therapeutic relationship. The alliance is established and develops in the interplay between the patient's and the therapist's subjective realities and may be conceived of as co-created (Greenberg & Paivio, 1997; Stolorow & Atwood, 1992). Safran and Muran (2000; 2006) emphasize the alliance as a process of ongoing negotiation between patient and therapist to underscore that the alliance is not a static variable necessary for an intervention to work, but a constantly shifting property of the therapeutic relationship. They point to Benjamin (1990) and her conceptualization of intersubjective negotiation as an inspiration.

Ruptures and repair

Negotiation of ruptures in the therapeutic alliance is considered to be at the heart of the change process, and in Safran and Muran's (2000) view this negotiation is considered a main curative element in psychotherapy (Eubanks-Carter, Muran & Safran, 2010; Muran et al., 2009; Muran et al., 2010; Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2002). *"Patient and therapist are seen as engaged in a struggle for mutual recognition regarding their respective subjectivities – a struggle that involves ongoing power plays and inevitable hostilities, accommodations, and refusal to accommodate"* (Muran et al., 2010, p. 321). Safran and Muran (2000; 2006) define alliance ruptures broadly as problems in the quality of relatedness, deteriorations in the communicative process, breakdown of collaboration or poor quality of relatedness, and they believe that a failure to explore and work through ruptures can lead to treatment failure or dropout. Developing the ability to repair relational disjunctions can thus be considered a central therapeutic aim (Aron, 2006; Beebe & Lachmann, 1994; 2002; Benjamin, 2004; Bordin, 1979; Eubanks-Carter et al., 2010; Muran et al., 2009; Muran et al., 2010; Safran & Muran, 2000; Safran et al., 2002). Safran and Muran (2000) have developed a brief relational therapy (BRT): *"The emphasis in BRT is in helping the patient to develop a generalizable skill of awareness, or mindfulness, often through the use of metacommunication, in which the therapist explicitly draws the patient's attention to the interpersonal patterns that are emerging in the patient-therapist interaction" (Eubanks-Carter et al., 2010, p. 81).*

Safran and Muran's rupture resolution model implies an active work to recognize ruptures and invite the patient to explore them in order to understand nuances, to explore the patient's avoidance manoeuvres and their function, and to clarify underlying wishes or needs. Metacommunication with the patient about the ruptures is strongly recommended in order to repair the ruptures (Eubanks-Carter et al., 2010; Muran et al., 2010; Safran & Muran, 2000).

Interruptions and ending as ruptures

Temporary interruptions in treatment can sometimes be experienced as an alliance rupture necessitating a reparation work in the aftermath (Råbu, 2008; Råbu, Hytten, Haavind & Binder, 2010). The process of coming to an end may likewise be a period of risk regarding the therapeutic alliance (Muran et al., 2010). According to Schlesinger (2005), all therapists struggle with endings because the ending process arouses complicated and common human themes essentially connected with the existential fact that every human has to die. To end therapy commonly arouses feelings associated with loss and separation from people we are

emotionally attached to and potentially also feelings of being left and abandoned (Holmes, 2010; Muran et al., 2010; Salberg, 2010; Schlesinger, 2005) and of a tension between needs for individuation and relatedness (Benjamin, 1990; Muran et al., 2010). Safran and Muran (2000) emphasize the termination of treatment as the final end of the therapeutic alliance. They also point to the termination process as the resolution of the ultimate alliance rupture (Muran et al., 2010).

Therapeutic alliance: between experience-near and observable

Therapeutic alliance can be thought of as a concept in between being something observable and being something experience-near and phenomenological. Interaction can be observed by outsiders, and it is possible to give outer descriptions of patterns in interaction, for instance. On the basis of observations of interaction, we can form hypotheses about the qualities of a relationship, how the emotional bond is, and, for example, if the relationship is characterized by trust or mistrust. There will always be qualities in a relationship that will be impossible to understand only through observation. To come closer to these aspects, we need to use methods addressing subjective experience in combination with the observation of interactional data. The patients' and the therapists' experiences can be explored by qualitative methods addressing how the participants in the relationship interpret themselves, each other, and their work together.

Psychotherapy as it actually unfolds

Different psychotherapy theories provide guidelines for how therapists are supposed to behave in the therapy situation and values that are considered to constitute good treatment. The challenge for the therapist in practice is, however, to take part in the concrete dialogue in the changing and often unpredictable clinical situation (Levitt, Neimeyer & Williams, 2005).

A large amount of clinical literature and most case studies are based on the reflections from the therapist and how the same therapist interprets the conduct of the patient. Therefore the normative value of reflections may come to overshadow what is really going on, how it is handled through the interactional patterns, and how these two aspects combine.

The importance of knowledge about the way the psychotherapy process actually unfolds is emphasised in the Task Force on Evidence-Based Practice (2006) of the American Psychological Association (APA). A central aim in the present studies is to study relational development in psychotherapy in an experience-near, clinically relevant and empirically

based way. We are concerned with exploring challenges in the way the psychotherapy processes actually unfold and are experienced.

Testing the strategic focus through pre-studies

Against this background, combined with an experience I had as a therapist of the meaning of an abrupt temporary break (Råbu, 2008), I presumed that disruptions and difficulties in a psychotherapy process caused by temporary interruptions and subsequent reestablishment and reparation could bring about relevant and instructive experiences for both the patient and the therapist about the meaning and usefulness of therapy (Råbu, 2008; Råbu et al., 2010; Salberg, 2010).

The usefulness of such a strategic focus was tried out in two studies prior to the present studies. In one of these (Råbu, 2008), I analyzed audio-recordings (and transcripts of these) of sessions with three of my own patients. At that time I went to a psychotherapy seminar where audio-recordings were part of the arrangement. The sessions I explored were the first sessions after an unscheduled break lasting eight weeks because I suddenly fell ill. In the dialogs with my patients I found that they were initially reluctant to talk about what the break had meant to them and they were careful not to blame me. When I actively worked to explore the meaning of the break to each of the patients, they revealed that the experience of the break was loaded with meaning for each of them, according to their own life experiences, and two of them had experienced a period of great despair. Both as a therapist and as a researcher I was in danger of, for instance, underestimating or overestimating my own meaning to my patients. To be a researcher exploring my own therapies was a challenge because I was close to the material. At the same time the closeness gave me an opportunity to get to know something personal from my patients. The meaning of my absence was what I tried to explore with them in the first session after the break, and the audio-recordings provided me with some distance and a possibility to check back. The finding of the dual carefulness in this study gave figure to the significance of affective sensing and indirect communication in psychotherapy and it also gave me a clue about the significance of the substantial meaning of structural features, such as a temporary interruption.

The second study prior to the present studies implied a further testing of the strategic focus. Together with three colleagues, I explored one single case with a severely challenging 13-year long therapy process where there had been a large number of major crises and dual intense and shifting emotions, and also some significant temporary interruptions, but still a considerable development (Råbu et al., 2010). The data consisted of a 227- page case record

and open qualitative interviews with the therapist and patient which were audio-recorded and transcribed. The strategic focus here was also especially on temporary breaks and conflicts as well as resolution of conflicts and difficulties. Since this was an exceptionally challenging case, it gave the opportunity to explore rupture and repair phenomena in a relationship where they appeared in a distinct way. It was possible to explore the various structural incidents and the shifts in the emotional bond. The case study format appeared to be useful to explore the psychotherapy process because of the opportunity to obtain several different perspectives on the same concrete relational process and to explore nuances and ambiguities.

The database

To explore alliance challenges from both the "outside" and the "inside", I needed to combine reflexive data from participants in psychotherapy with observational data from therapeutic interaction. My project was performed as part of a larger project called "An intensive process-outcome study of the interpersonal aspects of psychotherapy" (Rønnestad, 2006), which involved 18 experienced therapists, 40 patients and several researchers. The therapeutic alliance is a central angle in the main project, and other researchers are investigating, for instance, the early negotiations of tasks and goals (Hanne Weie Oddli) and high change cases (Margrethe Seeger Halvorsen). The database comprises both audio-recordings of all therapy sessions and qualitative interviews with all therapists and clients after therapy ended. The data have been stored case by case. In addition to qualitative data, the database includes quantitative measures of, for instance, the working alliance. I will describe the data more thoroughly in the method section.

The database gave me an opportunity to combine observations of what went on in the therapy sessions (audio-recordings) with exploring the participants' subjective experiences (qualitative interviews), and to investigate the material case by case.

Other studies combining observation and subjective experience

The only psychotherapy studies I have found that combined investigation of subjective experience with investigation of interactional data have used a method for interviewing called interpersonal process recall (IPR). The method was developed by Kagan (1975, ref. in Rennie, 2000) and refined by Elliott (1986) and Rennie (1990; 1992; 2000). Client and interviewer listen together to an audio-recording (or look at a video-recording) of a therapy session. The recording is used to support the client's memory of what she/he experienced in the session. To come as close as possible to the client's experiences in the session, Elliott (1986) developed a

"free memory procedure". After having listened to the recordings, the client was asked to direct his/her attention to whatever he/she experienced as interesting and significant in the session. The client was encouraged to take some distance from the material and judge what he/she experienced in the session, not only to relive it. The IPR procedure has been used mainly to explore clients' subjective experiences of therapy sessions, but has recently also been used to explore both therapists' and clients' experiences of therapy sessions (Levitt & Piazza-Bonin, 2011).

Overarching aims of the studies

The aim of these studies has been to explore the way relational development proceeds in actual psychotherapies from the perspective of both patients and therapists, in addition to the perspective of researchers' observations of interaction. The concepts of the working alliance and especially the theory of alliance rupture and repair are used as a starting point and an angle into understanding relational developmental phenomena. Structural phenomena, such as temporary interruption and the process of ending psychotherapy, are chosen as strategic focuses. The study can be said to be mainly problem driven, and not driven by a specific therapy theory or methodology. The focus is first and foremost on relational process, content and context. A methodological aim has been to find ways to combine reflexive and observational data and to explore what we could learn from such a combination.

Method: an interpretive approach

We wanted to stay as close to the participant's concrete and contextually anchored experience as possible (Elliott & Shapiro, 1992; Giorgi & Giorgi, 2003; Laverty, 2003; Smith & Osborn, 2003; Smith, 2007; Smith, Flowers & Larkin, 2009; van Manen, 1990), while exploring their views of what felt significant during the periods of alliance challenges, such as at the strenuous beginning in paper 1 and the ending processes in papers 2 and 3.

We also wanted to connect the participants' experiences with what we observed in the therapy sessions, and our aim was to identify patterns of interaction. The "outside" view of therapeutic interaction was informed both by the participants' experiences as we got to know them through the interviews, and at the same time by patterns that were given meaning through our observation and vicarious introspection in a dialogical dialectic with our own preconceptions as researchers and clinicians.

Meaning is interactive and develops through relational interaction and language representations (Bruner, 1985; 1990; Haavind, 2000; 2007). We cannot understand human behavior or experience fully or once and for all. Perception is already structured by presupposition and the researcher's presupposition will always imply being both open and closed towards parts of the phenomena which are the subject matter of the research. The researcher's history, experiences and where she places herself in the field all add to the understanding of phenomena. Any new insight is a combination of the new with her expectations and the presupposition (Alvesson & Sköldberg, 2000; Finlay & Evans, 2009).

A hermeneutical-phenomenological approach was chosen for these studies (Binder, Holgersen & Nielsen, 2010; Finlay, 2003; Gadamer, 1989; Heidegger, 1962; Laverty, 2003; McLeod, 2001; Smith, 2007; Smith & Osborn, 2003; Smith et al., 2009). The hermeneutical element implies that interpretation is a necessary and unavoidable act when we attempt to understand and point out the meaning of the clients' and therapists' utterances. The phenomenological element implies a commitment to understand the concrete lived experiences of the participants as we immediately experience them pre-reflectively rather than as we conceptualize, categorize or reflect on them. Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experience, and phenomenological research is the explication of phenomena as they present themselves to consciousness. Phenomenology asks for the very nature of a phenomenon, that is, its essences (van Manen, 1990; Husserl, 1970, ref. in van Manen, 1990; Smith et al., 2009). Husserl's phenomenology uses the methodological principle that scientific knowledge begins with an unbiased description of its subject matter (Wertz, 2005). In a hermeneutically informed approach the

idea of unbiased access to the subject matter is fundamentally questioned. A hermeneutic-phenomenological approach recognises that *"there is a phenomenon ready to shine forth, but detective work is required by the researcher to facilitate the coming forth, and then to make sense of it once it has happened"* (Smith et al., 2009, p. 35).

Reflexivity: making the research transparent

We have tried to remain open towards the material and the subjective lived experiences of the participants by approaching the material without too much formal psychotherapy theory, even if we do not believe that a "bracketing" (Giorgi & Giorgi, 2003) of our presuppositions is possible or desirable (Laverty, 2003; Smith et al., 2009). Instead, we have actively used hermeneutic reflexion and a continuous dialog with the material in our attempt to understand the participants' subjective experiences. Through the finding parts of all three papers we have summed up descriptively the meanings of the participants' statements, and in addition brought our own reflections about the possible meaning of the statements to contribute to transparency. Understanding the world of others will always be a fusion of horizons where one's own interests and preconceptions also will play a role (Alvesson & Sköldberg, 2000; Finlay, 2003; Finlay & Evans, 2009). Finlay (2003) defines reflexivity as *"the process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes"* (Finlay, 2003, p. 108).

The concept of reflexivity comprises an epistemological stance allowing for subjectivity and recognition of the existence of an objective reality which it is possible to explore only through subjective interpretation. Hoffman (1998) labels the position where one tries to navigate between nihilism on the one side and naive realism on the other side as dialectical-constructivism. Even though we attempt to stay as close as possible to the informants' own descriptions, in addition to avoiding theoretical concepts, both the formulation of research questions and the reading of the data was necessarily affected by the experiential horizon of each researcher (Finlay & Evans, 2009; Gadamer, 1989; Smith, 2007). Finlay (2003) refers to Gadamer and points out that the understanding of "otherness" occurs through a process where one is striving to make oneself transparent*: "New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process…"* (Finlay, 2003, p. 208). We are using our own subjectivity on our way to understanding others. Reflexivity is thus both a necessary step in the process of understanding otherness, and it requires that the researcher clearly

places herself in the field, reflects on her own position, interests, assumptions and limitations in dialog with the subjects of research. A dilemma considering reflexivity is that dealing too much with the researcher's own reflexion, feelings and motives can move the focus away from the "outside world" and the subjects of our research, and give the voice of the researcher disproportionately much space. Researchers have to strike a balance between self-awareness and navel-gazing.

In line with the ideal of a reflexive methodology, we have throughout the studies tried to bring awareness of how our backgrounds both contribute to our understanding and shape our investigations of the phenomena we are studying. I am a specialist in clinical psychology with 13-14 years of experience of working in psychotherapy. I am interested in relational psychotherapy theories and in psychotherapy integration and I believe motivation is sometimes unconscious; we do not always know why we think or talk the way we do, and motivation can be conflicted and ambiguous. This will be reflected in the way I understand the data, and it contributes to my recognition that it is impossible to acquire this kind of knowledge once and for all. For instance, my experience and orientation contribute to how I approach research, how research questions are formulated, or how I plan and carry out interviews, and my interests may make me more sensitive to discovering relational themes in the material. This probably represents both openness toward the material of research, and at the same time the therapist- and relational- "bias" can probably make me overlook themes. Throughout the studies I have collaborated closely with my two supervisors and also in the work with paper 1 with a research fellow (MSH). All the researchers combine doing research with practicing psychotherapy, and our diverse backgrounds are briefly described in the papers. During the analysis of the data, I prepared the material for discussions and used my collaborators as critics and "editors" of my interpretations and suggestions on how to give configuration to the meanings in the material. These discussions were performed repeatedly over a period of time in each of the studies.

I acknowledged late in the course of the present studies how these studies parallel both thematically and methodologically the study I, together with a then fellow student, conducted for my postgraduate thesis (Høye & Råbu, 1996). We studied 2-4 year old children in everyday situations in a kindergarten and how they established contact and collaboration with each other. Methodologically we combined video-recordings of the interaction (observational data) and interviews with nursery nurses and parents (experiential data) to explore the phenomena and we presented our findings as "thick descriptions". Our starting point was an interest in the development of empathy. Reading research literature about strange experiments

set up to explore empathy development in small children, we wanted to expand the scope of our study and to look for the small children's collaborative moves as relational phenomena in the context of everyday situations. So some themes and tendencies in my approach to research seem to be rather consistent over time, and this previous work also represented a useful experience to build on.

Data: the "intensive-process outcome study of the interpersonal aspects of psychotherapy"

The data in this thesis are drawn from a research project called "An intensive process-outcome study of the interpersonal aspects of psychotherapy" conducted by the Department of Psychology, University of Oslo (Rønnestad, 2006).

The participants

The project involves 18 therapists, 40 patients and several researchers. All the patients and therapists live in or near Oslo. The participating therapists are highly experienced and work as therapy teachers in addition to practicing psychotherapy. Concerning theoretical affiliations, they were asked to place themselves on a scale from zero (not at all) to five (very much) in terms of how much they based their therapeutic work on the following theories: psychodynamic, behavioral, cognitive, humanistic, systemic or other. All the therapists in the sample I used based their work on several theories and a broad spectrum of affiliations, but placed different emphasis on the different theories. The treatment in this project can be characterized as "therapy as usual" and the length of therapy was not pre-determined. The participants in the case studies and in the sample used in paper 3 are described in further detail in the papers.

Qualitative data

All the therapy sessions were audio-recorded, which gave the opportunity to observe the therapy process over a period of time. After every session patients and therapists separately wrote a small reflective note in which they answered the question: "What was the most important aspect of this session and why?" These notes gave an experience-based description of what occurred in the sessions and the possibility of strategic thematic searching within the database.

After the end of therapy, both patients and therapists were given open semi-structured interviews about their experiences and retrospective reflections concerning the therapy. Some

of the interviews were carried out by me, the others by two other researchers in the project (Hanne Weie Oddli and Margrethe Seeger Halvorsen). The interview guide was developed collectively in the project and was organized around the experiences of the therapeutic process and helpful as well as challenging aspects of treatment. The qualitative data were the main data source used in my studies and the way they were used is thoroughly described below.

Quantitative data

In addition to qualitative material, the database contains quantitative measures from standardized scales measuring therapeutic alliance (WAI; Hatcher, 2010; Hatcher & Gillaspy, 2006; Horvath, 1994a, 1994b; Horvath & Greenberg, 1989; Tracey & Kokotovic, 1989), which comprise Bordin's (1979; 1994) three aspects of the working alliance. It also contains measures of outcome (OQ64; Lambert & Burlingame, 2004 and IIP-C; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988) and pathology (SCID). The WAI scores were used to select the single case that is explored in depth in papers 1 and 2, and WAI scores were used as a source to judge the therapeutic alliance in addition to the qualitative sources. Every case is "a case of" something (McLeod, 2010), and we used the quantitative data (OQ64, WAI and SCID), in addition to the qualitative data, to describe and contextualize both the single case and the sample of cases we investigated.

Discussion of inquiries and interviews

The format of an inquiry necessarily lays down frames on what kind of information it is possible to gather, for example, if you invite someone to talk about the relationship with their therapist and provide a Likert scale (as, for instance, with WAI). Diagnostic interviews (such as SCID) take as granted that people have insight, overview and motivation to provide enough information about their own condition, characteristics and tendencies.

Also when we invite people to talk openly about their experiences in their own words, as we did in the open semi-structured post-therapy interviews, they can find it hard to both recognize and express subjective experience. They may even have conscious or unconscious motives for holding back or hiding information. In building and performing qualitative interviews, it is a challenge for the interviewer to facilitate information that is as valid as possible, that is, to ask questions that are both open and yet sufficiently leading to get the information you are interested in. Qualitative data are not simply lying about on the surface ready to be gathered up or picked like apples from a tree (Finlay & Evans, 2009; McLeod,

2001; Polkinghorne, 2005), cf. the earlier mentioned need for researcher reflexivity. The researcher is required to dig below the surface to bring up experiential accounts. The skills needed to perform research interviewing overlap with the skills involved in doing psychotherapy (Finlay & Evans, 2009; Kvale, 1996). Both practices require an ability to form an accepting relationship, a skill in active listening, and a focus on the other's experiential world. The researcher performing an interview tries, just like a therapist, to understand what goes on in an ongoing and developing relationship. One difference is that a therapist has a more explicit incentive to intervene and contribute to the patient's change and development, while the researcher is more motivated to find out or understand something. However, when I interview patients and therapists, I am a therapist interviewing a patient in the first case, and in the second case I am a therapist interviewing a colleague. These different relations probably have an impact on what the participants tell me, and how I am able to recognize what they tell.

In one of the studies prior to the present studies, I tried out a slightly different way to get as much as possible of the informants' reflection in interviews (Råbu et al., 2010). I sent the participants open questions beforehand and asked them to reflect on them and then conducted the interviews as open dialogs based on what they had been thinking. An important ethical element was that the questions sent beforehand gave the participants some information they could use to be in control of the situation and maintain control over their own story, so they could avoid being taken aback or being overwhelmed in the interview situation. This was also motivated by knowledge that the patient in this study was particularly vulnerable. I was inspired by a book consisting of stories based on interviews with holocaust survivors (Lothe & Storeide, 2006). This book disseminates war experiences through deeply moving stories told in a bearable form for both the teller and the reader. I supposed that getting some questions or guidelines beforehand might help the teller to feel safe, to recall more, and perhaps to be able to reveal more material, also of a vulnerable kind. Still, it is always a challenge for the interviewer to create and perform every time an interview both targeted enough and safe enough to make it possible to have a dialog with the other about substantial matters that can provide the basis for valid knowledge.

A relational approach to case studies

Case-based evidence represents a form of practice-based evidence that has been central to the development of knowledge in psychotherapy from early on. A central feature of what practitioners do is case-by-case problem solving. Case studies have some distinct scientific advantages for quality control on the complex, nuanced, context-responsive aspects of psychotherapy and they are often experienced as useful by clinicians. A case study comprises a large number of observations from one case. Case studies are narrative accounts of psychological phenomena and processes and such accounts can offer narrative knowledge which is an important part of psychological knowledge. A story consists of a sequence of events that allows the person to organize experience in a way that reflects human purpose and intentionality, and also to evaluate it. Human nature is sense-making and meaning-making, and stories are needed to create involvement, communicate knowledge and to help us remember the knowledge (Flyvbjerg, 2006; McLeod; 2010; Miller, 2004; Stiles, 2006). As Bruner (1985; 1990) has pointed out, psychology has tended to ignore narrative knowledge in favor of knowledge based on paradigmatic knowledge and abstract rules. A balanced approach to scientific and professional psychological knowledge requires a combination of both paradigmatic and narrative knowing. Narrative cognition configures elements of a particular action into a whole. Hearing a storied description of a person's experiences can touch us and evoke emotions. Case studies can provide narrative knowledge that can be used to complement knowledge of a more abstract or paradigmatic nature (Bruner, 1985; 1990; McLeod, 2010; McLeod & Elliott, 2011; Polkinghorne, 1995). A case study can offer knowledge that is readily assimilated into the clinicians' pre-existing "action schemas" so it can be used to guide their practice with clients (McLeod & Elliott, 2011). Stiles and Goldsmith (2010) recommend qualitative case studies as a useful methodology to explore and assimilate the multiple and varied theoretical observations of a complex theoretical concept such as the therapeutic alliance.

Psychotherapy case studies are mainly carried out and written up by therapists reporting on their own cases. They are told and written by the therapist in retrospect, based on his or her memory and notes and used as an anecdote to illustrate a theoretical and/or clinical point, or to tell an important story to other clinicians. Freud's case studies are comprehensive and famous examples. Even if such case studies tend to fit a previously articulated theory, they also seem to add or modify details, extend and enrich the theory, rather than merely illustrating it (Stiles, 2006). A few case studies have also been carried out by clients, and by external researchers (McLeod, 2010).

The case studies in this thesis are made by us as "external researchers" and they are not performed to illustrate a specific theory or to fully understand the case, but to develop hypotheses about and models of development in psychotherapy.

In most case studies, it is the patient only who is thought to be the case. However, case studies also have an advantage in the possibility of getting different subjective perspectives on the same therapy process. There are a few interesting examples of case studies exploring therapy as relational phenomena. The most comprehensive example I have found is a case study made by Etherington (2000). With a strong element of researcher reflexivity and with the use of several data sources, for instance, diary notes, interviews, letters and drawings, she tells the 340-page story of two adult brothers who survived child sexual abuse. The narration of the therapy process is triangulated and presented from the perspectives of the two clients, two different therapists and the researchers. A variant on this is a book by Yalom (1974), written together with his patient Ginny Elkin (pseudonym). Yalom and Elkin separately wrote a couple of pages after every session about the experiences in the session. This gives the reader a complementary view of every session told from the two different perspectives of the therapist and the patient. At times their stories are concerted and at other times their experiences differ significantly. For instance, the reader is able to see misunderstandings left unnoted by the therapeutic dyad at the time of writing. This has also been done in a similar way by Eva Axelsen (1991) together with her patient Sissel Bakke (pseudonym). These twice-told therapies present almost un-edited diary notes, however, and lack the analysis and perspective of a researcher.

During recent years, case study methodology has had a revival, and there is a growing interest in case studies (Fishman, 2005; McLeod, 2010; McLeod & Elliott, 2011). Books on case study methodology have been published (Loewenthal, 2007; McLeod, 2010; Yin, 2009). The journal *Counselling and Psychotherapy Research* has recently published a special issue on case studies (McLeod & Elliott, 2011). The University of Abertay, Dundee, Scotland has arranged a series of international case study conferences and in the aftermath of these conferences an international case study network for researchers is being established. At the Department of Psychology, University of Oslo, we have during the last couple of years run an ongoing research seminar on single case studies. Fishman (2005) has established an electronic journal named *Pragmatic Case Studies in Psychotherapy,* with the ambitious intention of building a database over time consisting of case studies useable for meta-analysis. In the first paper of the journal, Fishman (2005) presented an extensive and rigorous template for how case studies should be performed, attempting to include almost "everything". One of my main

objections to Fishman's project is the hubris in the standardizing and the rigorous instructions, as if it were possible to perform a complete case study. His template may have the effect of limiting other researchers' creativity in conducting case studies. Still, after five years, few case studies have been published in the journal, so the building of the database for meta-analysis is progressing slowly. Another basic objection to Fishman's project is that "the case" in this journal, even if much information about the therapist is requested, still seems to be basically the patient. In my view, individual psychotherapy always consists of two important subjectivities, and is best studied from the perspective of both parties' subjective stories. These stories are complementary and highly relevant when we want to understand the psychotherapy process through a case.

An interesting experience in performing case studies has been how much of the material one necessarily has to leave out, even in a case study. First we had to make a strategic selection of material according to the research questions. Then there was a process by which we had to make tough choices to present a story short enough to report in a paper. One cannot avoid the necessity of in some way reducing and simplifying findings to mediate them. This must necessarily apply to research in general, not least in quantitative research with a large N. Still, reviewing and grouping case studies from different contexts can be used to enhance findings into a larger picture (McLeod, 2010; Smith et al., 2009).

Analysis: combining reflexive data with observational data

The database gave us the opportunity to explore therapy processes both case by case and across cases. The research questions were explored from the point of view of both patients' and therapists' accounts in combination with observation of their actual interaction during sessions. We avoided theoretical conceptions in the analysis to be able to explore the experiences of the participants as openly as possible.

We used the different data sources to complement each other to explore how the interaction in sessions and the post-therapy reflexions were connected. Comparisons between patient, therapist and observer perspectives have often shown great discrepancy and are often judged as "error" (Caskey, Barker & Elliott, 1984; Elliott & Shapiro, 1992). In this project we are concerned with coherence or discrepancy between patients, therapists and observers as interesting phenomena in their own right, and not "error". We try to understand and integrate such findings in a perspective on how relational qualities are handled in a way that may change the relationship and promote development.

By interviewing therapists and patients, we gathered information about the subjective experiences, judgements and interpretation of the two different subjects who were participants in the therapy sessions. In the process of analyzing, we started with the reflexive data and used these to guide us into the interactional data. Starting with the reflexive data seemed like a suitable approach to the observation of subjects being able to reflect on and interpret themselves, the other part of the therapeutic dyad and their interaction together. The reflexion notes and the interviews were used both for the selection of cases, and for a strategic sampling of important sessions to explore in depth so as to understand the course of the therapy processes.

Audio-recordings allowing for observations of the dialog according to the chronology of the therapy sessions were combined with the interviews. We looked for connections between the subjective aspects of the relation and the observable aspects of the interaction. One challenge was to judge whether the sources were connected in a way that was specific enough to say that they are all about the same. Is there accordance between the researchers' reflection on the interaction and the reflection of the therapist and the patient?

Parallel with how therapy sessions and qualitative interviews have similarities and differences, the data sources, consisting of qualitative interviews and therapy sessions, are both similar and different. One way the sources are similar is that they consist of audio-recordings of dialogs between two people, either therapist/interviewer or patient/interviewer in the interviews or patient/therapist in the therapy sessions. One way sessions and interviews may be different is that sessions are more "naturalistic" data, while interviews are more "meta". If a therapy process is double-hermeneutic, which means that a therapist is trying to understand a patient who is trying to understand her/himself (Smith & Osborn, 2003; Smith et al., 2009), an interview can be said to be multiple hermeneutic. The interviewed subjects try to create meaning, and the researcher tries to create meaning from the subjects' attempts to create meaning. To analyze interviews may be thought of as an attempt to understand the subjects' attempts to understand their own experience.

We explored audio-recordings of interviews and therapy sessions and transcripts of the same audio-recordings. Audio-recordings of interaction in therapy sessions can be thought of as behavioral data. They are recordings of the therapeutic interaction as it took place in real time. Audio-recordings are interactive and allow for the possibility of returning to the material and deepening the first impression, and for different researchers to observe the same material.

We attempted to understand the alliance formation and reparation and the processes of negotiating endings and had to select material accordingly. The selection was performed with

the use of a hermeneutically modified method for systematic text condensation (Malterud, 1993; 2001; 2003) and inspired by McLeod & Balamoutsou's (2001) qualitative narrative analysis of psychotherapy transcripts. The text condensation has similarities with the defining of "meaning units" to discern the psychological essence in a phenomenological analysis (Giorgi & Giorgi, 2003). The analysis was carried out with the assistance of Nvivo 8 software (QSR, 2008).

In the work with all the three papers the analysis started with me listening to and transcribing verbatim the recordings of the post-therapy interviews first, and later the strategically selected sessions (in the work with paper 1 this part of the work was shared between Margrethe Seeger Halvorsen and me, and a few of the transcripts for paper 3 were made by a research assistant). The exploration started with the reflexive material in the interviews and the procedures for selection of therapy sessions were different for the different papers and are described in each of them.

In the next stage of analysis all the authors read through the written material separately to obtain a basic sense of the meaning of the dialogs in interviews and sessions. We then met to discuss the material and suggested and elaborated possible analytical grasps. We discussed the material together in several meetings over a period of time and identified structural features as well as the substantial content of the therapy relationships under investigation and looked for connections between what we observed in the sessions and how they were experienced and reflected upon by the participants in the subsequent interviews. Meaningful domains were selected through dialog both with the material and between the researchers, and refined and compressed to configurations of findings. In the end examples and quotes were selected to illustrate the findings. We chose a presentation style of "thick descriptions" (Denzin, 1989; Geertz, 1973) to exemplify the meaning for readers, and to enhance the transparency of our interpretative process.

Short presentation of the three papers

I chose to explore in depth a therapy relationship where the alliance was judged as poor for several sessions and then was turned into a good one, and to explore ending processes as a phase of the therapy process where the working alliance will be at stake (Gabbard, 2009; Muran et al., 2010; Salberg, 2010). In therapies where the length of therapy is not set at the beginning and where there are no pre-decided criteria considering when to stop, the question of when therapy should come to an end is a matter of negotiation and affective regulation. This was explored in a series of twelve cases and through an in-depth analysis of a deviant and exceptionally ambiguous case. The understanding of the meaning of structural elements was used as an angle into the material. The papers consist of two single case studies based on different aspects of the same therapy process and one case-by-case study with a search for features both in each case and across cases.

Paper 1

Paper 1 is called "Early relationship struggles: a case study of alliance formation and reparation". It is a single case study of an exceptional case where both patient and therapist regarded the alliance as being poor for an extended period (the first 15 sessions), yet still managed to develop a solid and stable alliance and reached a successful completion of therapy. This is contrary to the solid finding in empirical psychotherapy research that an early good alliance is a good predictor for a good outcome. The aim in this paper was to give a close inspection of the process of establishing a good alliance after all. Ratings on the Working Alliance Inventory (WAI) were used to guide the strategic selection of a case in which a depressed woman in her thirties sought help from an experienced senior male psychotherapist. A detailed analysis of the therapeutic dialog brought forth what the parties expected from each other and how they responded to explicit and implicit expressions about how to proceed. Post-termination interviews revealed their subjective configurations of events in therapy and their corresponding reflections. Important steps and hallmarks of the alliance formation and reparation were identified: (i) Early in the process, incompatible expectations about what the relationship could achieve led to repeated struggles. (ii) Their conflicting notions came forward in a more open dialog about two specific issues, her medication and sick leave. (iii) Through the recognition of different viewpoints they were able to expand on their interactional pattern and develop playful ways to explore her decision-making in everyday life. (iv) Temporary breaks seemed to consolidate her autonomy. (v) Late in the course of therapy, the therapist introduced a literary metaphor that seemed to further

consolidate the alliance. The paper is published in a *Counseling and Psychotherapy Research* special issue on case studies, in which it also got an extensive editorial review (McLeod & Elliott, 2011).

Paper 2

Paper two is called "Coming to an end: a case study of an ambiguous process of ending psychotherapy". When the duration of therapy is not preset and the outcome is a matter of negotiation, the decision to end psychotherapy will be an experiential concern for the two participants. This case study brings attention to how ambiguities may be settled in a process where ending was initiated by the therapist and resisted by the patient. The case was strategically selected as exceptional due to a combination of circumstances: the patient and the therapist had developed a "good enough" alliance (WAI) and reached a "good enough" outcome (OQ-45), and still the patient felt she was far from finished. A close inspection of interactional data in sessions, together with both patients' and therapists' reflections in post-therapy interviews, brought forth both substantial and structural aspects of this complicated process of ending. Analytical questions were: When and how was the theme of ending introduced and how did the others respond? How was the decision postponed, and what arguments made the theme recur? Ending was explored as a chronology and as a narrative. The discrepancy between therapist and client was not addressed, rather postponed and actualized again later. The theme of ending was negotiated back and forth, and the underlying notion was that they were searching for an agreement. Some ambiguities were addressed, and others were covered and twisted. Difficult emotional reactions seemed to be smoothened indirectly as well as addressed in a direct way. Structural elements like preparations for a break due to a vacation and reduction of frequency were used to test experiential qualities like how the patient managed life without therapy. Carefully preserving a "good enough" emotional bond through the negotiations seemed important to both parties. Substantial elements were interpreted as the final proof of improvement, and the patient came to a point where she could affirm that she had grown better only by accepting that treatment was coming to an end.

Paper 3

Paper 3 is called “Negotiating ending: a qualitative study of the process of ending psychotherapy” and is an investigation of twelve processes of ending which are explored case by case and across cases. The case in paper 1 and 2 is included. When the length of therapy is not agreed at the outset, the question of when it should end is a matter for negotiation. The aim of this paper was to present a model based on both content and process of ending to explain how psychotherapies may come to “good enough” endings. We found that exchanges between clients and therapists about when to end therapy seem to rest on a shared ideal of a concerted decision, regardless of who initiates the ending process. To be in harmony and content about ending seems to be more important than having reached therapeutic goals or criteria for recovery. The agreement seems to a great extent to be based on sensed affect, rather than, for instance, the use of arguments or metacommunication. Both parties appeared to sense that discussing the theme of ending contains a potential challenge to the working alliance. They seem to anchor the decision to end both in progress in life outside therapy and progress in therapy. In the end, they refer to successes rather than failures and the focus is mainly on gains and positive aspects. Towards the end, the focus of the therapeutic dialog becomes increasingly future-oriented in terms of what might happen later in therapy and after therapy is concluded. Structural elements, such as changes in schedule, temporary breaks, tapering of sessions and an agreement to eventually resume therapy later were actively used to serve several psychological functions, such as disconfirming abandonment and non-competence (mutually), testing and consolidating the client’s autonomy, reducing her loneliness and helping her to deal with grief. Therapy without a pre-determined end seems to stop when patient and therapist find a way to resolve basic ambivalences so the therapy can end and the emotional bond can continue.

Discussion: connecting structural and interpersonal aspects

In line with Stiles (2006), I find it appropriate to think of development of scientific knowledge in terms of a metaphor of diffusion rather than a metaphor of a brick wall. New insight can be integrated with previous knowledge and used to change, nuance and refine the relevant field of knowledge. Interpretive research does not aim at reaching a once and for all truth about the phenomena of study. Yet findings from these studies may imply theoretical generalizations and can contribute to a broader discussion of how to explore psychotherapy processes and point out clinically relevant themes.

A central aim in this thesis has been to establish knowledge that is more specific about concrete and experience-near features of psychotherapy for the research to be clinically relevant. The concept of the therapeutic alliance has been a starting point and interruptions and ending processes have been strategic focuses. The challenges of the therapeutic alliance are a theme throughout this thesis, studied from various perspectives, such as the establishing and repair of a therapeutic alliance when it is complicated and the coming to a closure of therapy with an intact "good enough" emotional bond. We have adopted Safran and Muran's (2000) concept of the alliance as a process of ongoing negotiation in the constantly shifting property of the therapeutic relationship. Safran and Muran (2000) emphasize that the termination of treatment is the final end of the therapeutic alliance. This can be said to count for the tasks and goals of treatment, which are distinctively in-treatment concepts (even if the patient carries on with her/his life goals and life tasks). However, we found that the careful preservation of an emotional bond that will last beyond the end of treatment seems to be an important concern for the participants in psychotherapy. This fits with a view recently suggested by Barber et al. (2010), that the therapeutic alliance can be viewed as an outcome in its own right, rather than as a prerequisite for treatment.

The three papers all comprise findings and discussion parts, which I will not repeat here. Instead I will briefly sum up the meaning of the structural elements in the three papers and draw some lines considering overarching findings, especially the finding about the implicit and careful negotiation of the therapeutic alliance and the contributions of the combination of the interactional and reflexive data. I will then review the scientific status of this kind of research, and comment on ethics and limitations, before I conclude with some implications of the findings.

The meaning of structural elements

As I described initially, the work with two pre-studies put me on the track of temporary interruptions as a structural element of therapy with a distinct personal and interpersonal meaning to the participants (Råbu, 2008; Råbu et al., 2010). At the outset, my attention was first and foremost directed towards temporary interruptions as possible alliance ruptures. This might be due to the fact that the break in the first study was abrupt and unprepared, and therefore probably more of a traumatic experience to the patients than a well prepared vacation, and the patient in the second study was a particularly troubled one. Through the present studies we have included additional structural aspects of therapy and we have extended the understanding of the multiple possible meanings of temporary interruptions as well as other structural elements of psychotherapy.

In the case study in paper 1 the therapist points to the vacation breaks as a consolidation of the changes in therapy. The temporary breaks seem to have been a task for testing a central therapeutic goal: the client's independence and autonomy. Thus breaks seem to have functioned as a way to highlight and consolidate the therapeutic alliance. The therapist says in the interview that he thinks the vacations marked the client's mastering of her own life, that it contributed to her self-esteem and consolidated the alliance. The client returned after vacations and reported that she had tried out new strategies they had worked on in therapy. In the sessions after vacations the dialog focused more explicitly on the tasks and goals of therapy.

In the case study in paper 2 the therapist used an upcoming Christmas vacation as an opportunity to introduce the theme of ending and he used the long series of sessions they had had as an argument for planning to end. The client answered by pointing to the long difficult beginning of the therapy, and that she had only recently become able to use the therapy. She negotiated in answer to the therapist's statement of the series row of sessions: the first part should not be counted. In the further negotiation, the therapist effectively divided the ending into smaller parts. They reduced session frequency and later in the course the therapist used a new upcoming summer vacation as an introduction of the definitive end. Again they postponed the final ending to use the vacation as sort of a final test of how the ending would be.

In the study of twelve processes of ending we found that the therapeutic dyads used several structural elements to prepare for the end. Structural elements seemed to be actively used to regulate affects and fulfil psychological needs. They used changes in schedule, such as vacation breaks and tapering of sessions, and they used the possibility of resuming therapy

later. These structural elements seemed to represent a variety of meanings and affect-regulating functions, such as offering safety for the patient, disconfirming abandonment and non-competence (mutually), testing and consolidating the patient's autonomy, reducing the patient's loneliness and helping her to deal with grief.

The possibility of eventually resuming therapy

One structural feature we were unprepared for was the finding that, towards the end of therapy, all the therapeutic dyads in our sample used the opportunity of possibly resuming therapy later. We did not include questions about this when we composed the interview. However, most of the participants, especially the patients, spoke spontaneously about the importance of such an agreement. This was regardless of the therapists' theoretical orientation. In psychoanalytic education the need is emphasised to confront and work through any difficult feelings towards the end as part of the process of developing autonomy, and it is made a therapeutic point not to extend or resume therapy when the decision to end is made (Gullestad & Killingmo, 2005). The therapist in this sample who most clearly stated himself as psychoanalytically oriented is therapist John in paper 3. John did not mention in the interview that they had talked about the possibility of resuming therapy later and neither did his patient. We thought we had found a therapy-theory based exception from the other cases. However, when I listened to the recordings of the therapy sessions, the possibility of resuming therapy later was thoroughly discussed and settled as a possibility. In this case, the combination of data helped us to nuance and extend a finding based on interviews and researcher presupposition.

Turning points as consolidation rather than cause

As part of a qualitative approach to research, we should not make categories too tight beforehand and should be open to what we detect in the material. Even if we cannot unreflectively generalize the findings in a single case to count for other cases, the phenomena we find in a single case can make us reflect on themes relevant for clinical practice and for further research. One example is the finding of the "turning point" in paper 1. We were not looking especially for turning points, but in the interviews both the client and the therapist separately pointed to the introduction of a literary metaphor as an important turning point in the therapy process. When we went to the sessions to explore the interaction, we found that this happened towards the end of therapy. The participants, probably due to a recall bias, were surprised to learn this when they later read the article manuscript. This gave us the ability to

reflect on turning points, and to state that turning points might be a consolidation of a development that has already taken place during the course and over time, rather than a causal explanation for changes to happen. This would have been impossible to grasp without the combination of reflexive and interactional data.

Indirect and implicit negotiation of the therapeutic alliance

By carefully comparing interviews with patients and therapists with actual therapy dialogs, we were able to detect phenomena in the material which otherwise would have remained unnoticed. I will focus especially on the finding of the prevalent use of indirect and implicit ways of communicating.

Our paper 1 received an extensive editorial review in the special issue on case studies (McLeod & Elliott, 2011). One of the points the editors made was that our article contributes to the theoretical understanding of the therapeutic relationship by addressing the issue of the strong evidence that a good therapeutic relationship by session five is predictive of an eventual good outcome by exploring a case where there is initially a poor relationship and yet the eventual outcome is positive.

"*…The findings of this study consist of two different types of knowledge 'product'. First, the case is richly described, so that the reader can arrive at his or her own understanding of it, in a way that will potentially enrich his or her way of working when similar situations occur in their own practice. Second, the study contributes to our theoretical understanding of the nature of the therapeutic relationship. Råbu, Halvorsen and Haavind (2011) suggest that the well known model of 'alliance repair' formulated by Safran and Muran (2000) does not provide an adequate basis for interpreting what happened in this case. They then go on to propose that what is missing from existing theories of how therapeutic relationship can be repaired is sufficient attention to the possibility that the therapist and client can be playful together…"* (McLeod & Elliott, 2011, p. 4).

A conspicuous finding in all three studies was how the interaction between the experienced therapists and their clients to a large degree seemed to rely on implicit communication and affective regulation. It was the combination of data sources which made this visible. Basic emotional needs were primarily handled indirectly in the relationships, and the therapists rarely used metacommunication. This was a surprise to us, against the

background of both our own psychotherapy training, and Safran and Muran's (2000) work on rupture and repair, where they point out the importance of actively recognising ruptures and using metacommunication to repair disjunctions. I personally find the model of negotiating the therapeutic alliance (Muran et al., 2010; Safran & Muran, 2000) useful and inspiring in my work as a therapist. There seems to be significant evidence supporting the effectiveness of the brief relational therapy (BRT) developed by Safran and Muran (Eubanks-Carter et al., 2010; Muran et al., 2010; Safran, Muran, Samstag & Winston, 2005). In this therapeutic approach *"the critical task is for the therapist to recognize the rupture and invite an exploration of it... The key principle in this regard is to establish communications about the communication process, or metacommunication"* (Muran et al., 2010, p. 323). The model of BRT seems to have similarities with the interpretation of transference in psychodynamic therapy.

However, our findings point at a possibly opposite significance of being able to, sometimes, indirectly negotiate relational challenges. Similar to our findings, Aspland et al. (2008) found that most alliance ruptures arose from unmentioned disagreements about tasks and goals of therapy. Rupture resolutions occurred when the therapist shifted focus from the therapy task to issues that were more important for the patient. None of the therapists in Aspland et al.'s sample used any overt recognition and discussion of the rupture in therapy and Aspland et al. suggested a model of an indirect approach to rupture resolution.

In the presentation of their therapy model (BRT), Muran et al. (2010) emphasize affect regulation and interpersonal sensitivity as important ingredients. They point at Benjamin (1990) as an inspiration for the development of their therapeutic approach, especially the inbuilt tension between the need for independence and the need for relatedness, and the resolution of the paradox of recognition as a constant tension between recognizing the other and asserting the self. Beebe and Lachmann (1994; 2002) have built theory about the interactional process in psychotherapeutic relationships by investigating early relational development. By reviewing research on infant development and observing interaction between infants and caregivers they developed three principles of how the dyadic modes of regulation in interaction unfold. The principles are "ongoing regulation", "disruption and repair" and "heightened affective moments". The principles are thought of as hierarchically organized, each constituting the context for the next. The principle of ongoing regulation is the overarching principle, the broad pattern of interaction. The disruption and repair is a sequence where expectancies are more or less violated and ensuing efforts are made to resolve the breaches. The heightened affective moment is a moment of positively or negatively loaded

intense experience. A heightened affective moment may function as disruption or as repair. Signs of an urge to repair relational disjunctions are observed very early, for instance in 2-3 month old infants. The sequences of disruptions and repair are thought to function as organizing experiences of coping and hope. Beebe & Lachmann (1994) also point to Kohut's (1977) therapeutic concepts of "empathic failure" and "transmuting internalisation" as a parallel to the process of disruption and repair.

Early relational regulation is necessarily characterized by a large proportion of non-verbal communication, such as interpersonal timing. The negotiation of ruptures in relationships involving infants is necessarily performed without a strong element of metacommunication. Perhaps the negotiation sometimes even includes diverting attention from pains and strains.

Perhaps Safran and Muran could have used more of Beebe and Lachmann's model in their therapy model, such as the salience of also remaining an ongoing regulation, and the importance of from time to time experiencing heightened affective moments, in addition to the active work on rupture and repair through metacommunication.

I would not recommend diversion from relational ruptures as a main developmental or therapeutic principle, but once in a while it may even be constructive to divert from relational difficulties and focus on something other than the rupture, and for instance be playful about something together; cf. our finding of the playful dialogs which developed in the relationship in parallel with the unmentioned relational difficulties (Råbu, Halvorsen & Haavind, 2011). At least such a break from focusing on relational difficulties can probably contribute to saving some vital part of a relationship during phases of difficulties that are too complicated to handle at the moment. This playfulness may help to regulate unmanageable emotions sufficiently to be able to handle relational difficulties later.

We did not have an ambition of developing a normative model of how therapists should handle alliance ruptures. The therapy processes we have explored are perceived as "good enough" according to both quantitative measures and the experience of meaningfulness by the participants, but these therapies are not necessarily exemplary. Still, our findings point in the direction of the usefulness of a sensitive and not necessarily overt negotiation of ruptures to repair them. Active use of metacommunication in rupture resolution seems well documented as a useful method (Eubanks-Carter et al., 2010). Still, therapeutic competence must include sensing when overt communication is useful, and when it is better to carefully regulate feelings in a more indirect mode, or through finding other ways to communicate

which can give relational difficulties a break and perhaps also introduce more vital ways of interaction.

One example of the inexplicit negotiation of sensitive emotional themes we found in the exploration of the ending process was the clients who wanted to end therapy before their therapists judged they were ready. The clients described in their interviews a feeling of relief when the therapist finally agreed that it was okay to end. The therapists confirmed this by telling a complementary story in the interviews, that it seemed as if the client was relieved when the therapist agreed about ending. In the sessions, we looked for but did not find any mentioning of relief in the dialog. The relief they both mentioned in the interviews as substantial in the interpersonal process was something both clearly perceived, but it was sensed and handled indirectly in the dialog. For instance, when a primary goal for the process of ending psychotherapy seems to be to take care of an emotional bond and preserve what is good in the relationship for the client to use in the future, recommendations from clinical literature, for instance, on the explicit marking of goal achievements, can sometimes run contrary to this.

The group of researchers who performed these studies have backgrounds from both systemic and psychodynamic approaches that have an emphasis on relational factors as a common trait. This reasonably brought an extra focus on relationship issues into the analysis. Therefore, from our perspective it was surprising to detect the lack of explicit communication about feelings and fantasies in the patients' relationships with their therapists during the process of establishing an alliance in the first paper, and during the process of ending in the second and third paper. However, our background probably sensitized us to recognize the implicit affect regulation and possible unconscious communication in the therapeutic relationships.

Qualitative evidence?

"Ideally, the quality of craftsmanship results in products with knowledge claims that are so powerful and convincing in their own right that they, so to say, carry the validation with them, like a strong piece of art. In such cases, the research procedures would be transparent and the results evident, and the conclusions of a study intrinsically convincing as true, beautiful, and good." (Kvale, 1996, p. 252).

Still, in a less ideal world, what kind of scientific status can we claim for this case-based qualitative research? The question whether qualitative data can constitute evidence has been subject to controversies. This is partly because some of the philosophical approaches informing qualitative research are explicitly anti-positivist, anti-realistic or anti-modernistic, and yet it is from these methodological traditions that the criteria for evaluating research have been derived (Denzin & Lincoln, 1998; Manson, 2002; Morrow, 2005). Criteria for judgment of what may be called scientific evidence are problematic to the extent that they presume that research data are neutral and research results are objectively true. A logic that restricts attention to common features is likely to narrow an account of psychotherapy into oblivion or banality (Stiles, 2006).

Since the questions on criteria for evidence in qualitative research cannot be answered once and for all, reflecting on basic dilemmas concerning evidence must be included throughout the research process. Elliott et al. (1999) have, through a comprehensive consensus based work, developed a set of criteria for evaluation of qualitative research. These criteria are about, for instance, stating one's perspective explicitly, situating the sample, grounding the findings in examples, providing credibility checks, coherence and resonating with readers. McLeod (2001) recognizes the significance of reflecting on and taking steps to reach criteria for quality and he values Elliott et al.'s (1999) work, but still criticizes them for having made too rigorous a set of criteria. McLeod points to the fact that less, if any, published qualitative research actually reaches all these demands and underscores that the quality of research ultimately rests with the researcher's credibility and ability to present convincing arguments. The conflict between feasibility and being too rigorous seems to be an inescapable dilemma for the researcher to deal with.

Because the use of terms such as validity, reliability, generalizability, and even the term data have connotations drawn from their specialized use, their adoption to describe similar but different qualitative processes can lead to misunderstandings (Polkinghorne, 2005). Mason (2002) underlines the advantage of using concepts such as validity and

reliability if you do not apply them in qualitative research as if it was quantitative. Based on the ontological and epistemological position where I have placed my own research and on a qualitative way of using validity, reliability and generalizability, I will use these concepts through the further reflections.

Validity

Validity is frequently associated with the operationalising of concepts in quantitative and experimental research. Nevertheless, the concept encapsulates the idea that you need to be able to demonstrate that your concepts can be identified and observed in the way you say they can.

A common disadvantage in qualitative research is that it typically relies solely on informants' retrospective recall. Recollections are subject to recall bias and, furthermore, experiences are re-constructed as people talk about them in an interview, given that the nature of talking about an experience with another person shapes what one is able to tell (Hill, 2006). In these studies it has been a central aim to combine reflexive data with observational data. The design of the three papers allows for the possibility of data triangulation (Denzin, 1989; Stiles, 2006). Triangulation is a surveying metaphor that refers to the geometrical possibility of fixing a point in space by viewing it from two other locations. All research methods have weaknesses, and different methods omit aspects of what we want to explore. Accordance between different sources adds to validity.

In line with an ideal of dialogical validity (Kvale, 1996) and with the suggestion of resonating with the reader (Elliott et al., 1999), we presented "thick descriptions" (Denzin, 1989; Geertz, 1973) of the findings in the papers to provide the readers with quotes exemplifying the meaning of our findings, so the readers – at least to some extent – can take part in the process of analysis, make their own assessment, and judge the relevance and validity of our interpretation on the basis of their own experience. The clinic-near descriptions can also be said to add to ecological validity. Through the finding parts of all three papers we have summed up descriptively the meanings of the participants' statements, and also added our own reflections about the possible meaning of the statements to contribute to transparency.

Since this study is not loaded with too much formal therapy theory the internal validity can be said to be fairly high.

Audio-recordings are interactive and allow for the possibility of returning to the material to deepen the first impression, and for different researchers to observe the same material. Thus the audio-recordings are open to a deepening of content validity.

Reliability

Reliability involves the accuracy of the applied research methods. To critically resonate whether a particular research method or data source really sheds lights on the phenomenon you are trying to explore may well be discussed in qualitative terms.

The kind of research in this thesis may have low reliability in the sense of the ability to replicate it. However, even traditional replication studies involve alterations or extensions, so what is replicated is rather the interpretation than the observation (Stiles, 2006). This study may, however, have high reliability concerning transparency, credibility and a solid researcher community.

In the process of analyzing data in the present studies we were three researchers working together in two of the studies, and two collaborating on one study. All spent time going through the material separately and it was thoroughly discussed in the group over a period of time. The arrangement with multiple researchers can be said to enhance reliability.

Generalizability

Generalizability or external validity is about the extent to which we can make some form of wider claim on the basis of our research, if it can be used to understand more than the particular and idiosyncratic. If research did not have meaning beyond the particular or local, it would be rather worthless. However, it is a challenge to judge the range of research results. The range of the results is not necessarily embedded in the research. In quantitative research, generalizability usually involves randomized samples and statistical procedures and diversity and variation within a sample is often reduced to a mean. In qualitative research as well, the generalization is a matter of theory, but in qualitative terms. Qualitative results are usually presented as “thick-descriptions” of the phenomena under investigation and models made to understand these. Models are developed or continued on the basis of interplay between theory and empirical results (Andenæs, 2000; Polkinghorne, 1991, ref in Andenæs, 2000). Kvale (1996) points to generalization as a part of human psychological functioning: we spontaneously generalise from one situation to another. From experience with one situation or person we anticipate new instances and form expectations of what will happen in other similar situations or with similar persons. The concept “analytical generalization” comprises the idea

that generalization takes place in the mind of the reader of the research and has been described as "naturalistic generalization" or "transferability" (Kvale, 1996), or "resonance" (Finlay & Evans, 2009). The findings in all these studies are presented in a clinic-near and narrative form that will probably be experienced by clinicians as recognizable and having transfer value. McLeod (2010) underscores that every case is "a case of" something, and that case researchers have a responsibility to place their case analysis within the context of the larger population of cases from which they are drawn, whether it is diagnostic categories, therapeutic approaches, typical or deviant cases, good outcome or bad outcome, relative to the population the case is drawn from. He also recommends using, for instance, standardized measures for the same purpose. Our cases are drawn from a sample and are clearly contextualized and interpreted in relation to relevant categories, also with the use of standardized measures.

One example of a useful opportunity for theoretical generalization in this study is the mentioned finding considering therapeutic turning points.

Ethical considerations

The research project (Rønnestad, 2006) was approved by the Regional Committee for Medical and Health Research Ethics (Region South-East) and by the Norwegian Social Science Data Services. Details about participants have been changed to provide anonymity. The process of disguising the identity of participants by changing some of the facts may, especially in case studies, compromise the integrity of the data and the meaningfulness of the analysis (McLeod, 2010). In our studies we did not have to reveal too much of the clients' life story to record the therapeutic relationship and the therapy process. In the single case studies, the participants read a late draft of the papers both to give final consent and to make sure that the quality of their experience was conveyed in the analysis and presentation. We also involved the participants in the single case studies in the disguising of identity, and the patient actually had some suggestions that we used.

Case studies are ethically sensitive and may represent specific ethical challenges (McLeod & Elliott, 2011; Miller, 2004). Even if little of the client's life story is told, rich and personal material is exposed about something personal and vulnerable for the patient, and sometimes also not least for the therapist. In our way of performing case studies, the therapist might be just as vulnerable as the patient or even more vulnerable since the therapists are the one who are observed while in charge. These therapists are also presented as "highly experienced". As several of the participating therapists have mentioned in the interviews, they

sometimes felt embarrassed by the audio-recordings and that the research project at times could be a challenge to their professional self-esteem. It is brave and trusting for a therapist to let researchers perform audio-recordings in the therapy room, and it encourages empathy and sensitivity on behalf of the researchers. On this it is probably an advantage that all the involved researchers also are practicing psychotherapists and know how much easier it is to reflect upon and evaluate what goes on in the therapy room with a researcher's distance and afterthought.

Limitations

The present research contains condensed and strictly prioritized versions of some aspects drawn from a few extensive psychotherapy processes, and several elements are necessarily left out. These studies are an exploration of a limited group of clients in individual outpatient treatment with experienced therapists. A similar investigation of couple-therapy or family-therapy could have made it possible to extend the number of perspectives on the same process correspondingly and added even more to complexity. More systematic comparison between different treatment approaches, such as psychodynamic and humanistic therapies and CBT, could also point to differences between therapies giving weight to relational and emotional process issues versus therapies with a more clearly procedural focus. Exploring relational challenges in other groups of clients and other groups of therapists would probably nuance our findings, for instance, the exploration of negotiating alliance in cases where the dyads are working under tougher economic conditions with a larger pressure towards ending, or inpatient therapies or drop-out cases.

Conclusion: Implications for theory, research, and practice

Our finding in the first paper refines and nuances the accuracy of the principle that the alliance needs to be judged as good during the third to fifth sessions for the outcome to be good. As such, this case can be viewed as a "black swan". The findings in this paper contribute *"to our theoretical understanding of the nature of the therapeutic relationship"* (McLeod & Elliott, 2011, p. 4), together with the findings in paper 2 and 3.

The findings in the three papers together challenge and bring nuances to Safran and Muran's well-known model of alliance rupture and repair and the importance they place on therapeutic metacommunication. In papers 2 and 3 we found that exchanges between clients and therapists about when and how to end therapy seemed to rest on a shared ideal of a

concerted decision, regardless of who initiates the ending process. Even in the case study in paper 2, where the therapist insisted on ending when the patient still felt she had much unfinished business, an underlying ideal to be concerted about the ending seemed to be vital. Both parties appeared to sense that the process of ending contains important emotional themes and that discussing the theme of ending contains a potential challenge to the working alliance. To be in harmony and content about ending seemed to be more important than having reached therapeutic goals or criteria for recovery. The agreement seemed to a great extent to be based on sensed affect, rather than, for instance, the use of arguments or metacommunication. Ending processes are probably the phase of a therapy process where the therapeutic dyad knows each other best. Our findings on the inexplicitness and the process of careful negotiation of ending towards a concerted decision suggest that relational sensitivity and affective attunement may be more important than following a technique, such as metacommunication to repair ruptures, or a recipe on "how to end". Active metacommunication seemed to play a modest part both in the repair process in paper 1 and in the negotiation of ending in paper 2 and 3. We did not have an ambition of developing a normative model of how therapists should handle alliance ruptures, and the therapies we have investigated are not necessarily exemplary. Still, our findings point in the direction of the usefulness of a sensitive and not necessarily overt negotiation of ruptures to repair them. Active use of metacommunication in rupture resolution seems well documented as a useful method. Still, therapeutic competence must include sensing when overt communication is useful, and when it is better to carefully regulate feelings in a more indirect mode.

Important steps in the negotiations toward ending seemed to imply an active use of structural and substantial tools in order to solicit affirmative responses. An agreement to possibly resume therapy later was, for instance, actively used in all the cases presumably to serve several and diverse psychological functions, such as disconfirming abandonment and non-competence (mutually), reducing the patients' feelings of loneliness and helping the patients to deal with grief. Temporary breaks were frequently used to test autonomy and to test the patients' experience of how ending might be.

Combining reflexive and observational data seemed very useful to investigate psychotherapy process. The chronology of the cases and some mechanisms of change could only be pinpointed through a combination of the sources. This methodological grasp put us on the track of features of therapy that would have remained unnoticed and impossible to detect with the use of each of the data sources separately, for example, the reflexion on the meaning of turning-points, and that they might be a consolidation of development that has already

taken place during the course and over time, rather than a causal explanation for changes to happen. This can be used in further exploration of turning-points in psychotherapy research and in reflexion on clinical theory and practice.

Case studies have an advantage in the possibility of getting different subjective perspectives on the same therapy process. Our case studies are not performed to illustrate a specific theory or to fully understand the case, but to develop hypotheses about and models of development in psychotherapy. The case studies provide narrative knowledge that is used to challenge and complement knowledge of a more abstract or paradigmatic nature.

The findings in all the studies are presented in a clinic-near and narrative form that will probably be experienced by clinicians as recognizable and having transfer value. The rich description can potentially enrich clinicians' ways of working when similar situations occur in their own practice.

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PAPER 1

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PAPER 2

Råbu, M., & Haavind, H. (submitted). Coming to an end: a case study of an ambiguous process of ending psychotherapy.

Running head: An ambiguous process of ending

Coming to an end: a case study of an ambiguous process of ending psychotherapy

Marit Råbu and Hanne Haavind
Department of Psychology
University of Oslo, Norway

Corresponding author: Marit Råbu Email:mariraa@psykologi.uio.no

Keywords: case study, ending psychotherapy, multiple perspectives, negotiating termination, qualitative research, therapeutic dialogues, working alliance

Coming to an end: a case study of an ambiguous process of ending psychotherapy

Abstract

Aim: When the duration of therapy is not preset and the outcome is a matter for negotiation, the decision to end psychotherapy will be an experiential concern for the two participants. This case study draws attention to how ambiguities may be settled in a process where ending is initiated by the therapist and resisted by the patient.

Method and analysis: The actual case was strategically selected as exceptional owing to a combination of circumstances. The patient and the therapist had developed a 'good enough' alliance (WAI) and reached a 'good enough' outcome (OQ-45), and still the patient felt she was far from finished. A close inspection of interactional data in sessions together with both patients' and therapists' reflections in post-therapy interviews elicited both substantial and structural aspects of this complicated process of ending.

Findings and discussion: The discrepancy between therapist and client was not addressed, but rather postponed and actualized again later. Structural elements like preparations for a break for vacations and reduction of frequency were used to test experiential qualities such as how the patient managed life without therapy. Carefully preserving a 'good enough' emotional bond through the negotiations seemed important to both parties. Substantial elements were interpreted as the final proof of improvement, and the patient came to a point where she could affirm that she had grown better only by accepting that treatment was coming to an end.

Coming to an end: a case study of an ambiguous process of ending psychotherapy

When the duration of psychotherapy is not preset and the outcome is a matter of negotiation, the decision to end psychotherapy will be an experiential concern for the two participants. In clinical work, it is widely recognized that dealing with many types of difficulties related to the therapeutic alliance is essential to the course of therapy (Bordin, 1994; Orlinsky, Rønnestad, & Willutzki, 2004; Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2002). In psychotherapy research the alliance is usually defined in terms of Bordin's (1979, 1994) model which comprises three aspects of the working alliance; agreements on the therapeutic goals, consensus with respect to the tasks that make up therapy, and an emotional bond between patient and therapist. Negotiation of ruptures in the therapeutic alliance is considered to be at the heart of the change process, and in Safran and Muran's (2000) view it is a main curative element in psychotherapy (Eubanks-Carter, Muran & Safran, 2010; Safran & Muran, 2000; Safran, Muran, Samstag & Stevens, 2002; Muran et al., 2009; Muran, Safran & Eubanks-Carter, 2010). Safran and Muran (2000, 2006) define alliance ruptures broadly as problems in quality of relatedness, deteriorations in the communicative process, breakdown of collaboration or poor quality of relatedness, and they believe that failure to explore and work through ruptures can lead to treatment failure or drop-out. They also point to the termination process as the resolution of the ultimate alliance rupture, and the process of ending as a phase likely to evoke tensions between the needs for individuation and relatedness (Muran et al., 2010).

In one sense, Safran and Muran (2000) are right when they point to the conclusion of treatment as the end of the therapeutic alliance as well. This can be said to count for the tasks and goals of treatment, which are more distinctively in-treatment concepts. It may be significant to keep an emotional bond beyond the end of treatment, and the patient will go on with her/his life goals and life tasks. As in many other kinds of relationships the autonomy of each party may rest on a reliable and reciprocal emotional bond.

In this paper we present a process of ending where this inbuilt ambiguity came to our attention. In the case we are going to present there seems to be an unsettled issue as to whether the goal of increased autonomy for the patient is accomplished or enforced by the ways in which the therapeutic sessions were brought to an end.

The process of ending psychotherapy has primarily been explored in the psychodynamic tradition, where it is termed termination, with reference to Freud's (1937)

paper 'Analysis terminable and interminable'. Even in the psychodynamic tradition, the focus on the exploration of ending is sparse (Novick & Novick, 2006; Schlesinger, 2005; Wachtel, 2002). Both Schlesinger (2005) and Wachtel (2002) emphasize how the ending of treatment entails separation and powerful and sometimes negative emotions. Hoffman (1998) and Gabbard (2009) are concerned with making endings 'good enough', and address the myth of a perfect termination. *Good enough endings* is also the title of a new book edited by Salberg (2010).

Schlesinger (2005) thinks therapists often have too high expectations that processes of ending should be more streamlined than they often are. This could be a consequence of the fact that the literature on ending is usually based on clinical accounts by therapists. The experienced clinician will present case vignettes and create therapeutic recommendations that relate to the theory to which he or she adheres. The way in which ending is dealt with however, is something that is going on in interactions, and as such can be accessible to outside observers. In addition, ending is comprised of a dual set of personal experiences, and can be described from the vantage point not only of the therapist but of the patient as well. The interactional as well as the experiential mode of configuring and representing processes of ending can be explored through qualitative, interpretative methods. In this case study we combined both patients' and therapists' reflections with interactional data in ways that made room for a combination of different perspectives on the same therapy process.

The selection of the actual case is a strategic choice owing to the fact that the therapist wanted to end treatment when the patient felt she was far from finished. We already knew from a wider selection of cases that this case was exceptional. Approaching an end is potentially a vulnerable phase of psychotherapy (Schlesinger, 2005; Wachtel, 2002), where difficult feelings of separation and abandonment might arise, and the alliance might be put to new tests. Clients and therapists seem to share an ideal of a concerted decision (anonymous ref.). In this case negotiations about when and how to end continued across thirteen sessions in a way which brought forward several issues that could be addressed as relevant for the decision as well as issues that were left out of the dialogue and which the two parties therefore kept to themselves.

The exploration of the case has been guided by the following research questions:

- When and how is the theme of ending introduced?
- How was the other's response?
- How was the decision postponed and what arguments made the theme reoccur?

Method and design

The case was selected from a larger psychotherapy research project called 'An intensive process-outcome study of the interpersonal aspects of psychotherapy' (Rønnestad, 2006) at the Department of Psychology, University of Oslo, Norway. The project includes eighteen highly experienced therapists and 40 patients. The database contains both quantitative and qualitative data, and the material was stored case by case.

All sessions were audio recorded, allowing for observations of the dialogue according to the chronology from beginning to end. Both patient and therapist were interviewed after the end, and asked for their subjective configuration of the events in therapy and their corresponding reflections. The alliance was measured with the Working Alliance Inventory (WAI; Hatcher & Gillapsy, 2006; Horvath, 1994a, 1994b; Horvath & Greenberg, 1989) and outcome was measured with the Outcome Questionnaire 45 (OQ-45; Lambert & Burlingame, 2004). These procedures for data collection were independent of the present case.

Subjects

The patient. Marian is a 35-year-old woman who was referred to a psychotherapist after two hospitalizations a few years earlier. The hospitalizations were owed to severe depression accompanied by suicidal thoughts (the first time) and psychosis (the second time). When she started therapy, she was diagnosed with Bipolar I disorder, currently moderately depressive, and used anti-depressant and mood stabilizing medication. Marian has an artistic profession and started therapy while on sick leave, though she gradually started working again during the process of treatment.

The therapist. Paul is a 54-year-old man, who works in a public outpatient clinic. He has worked as a clinical psychologist for many years, and he is also an experienced teacher and supervisor in psychology. His psychotherapeutic orientation may be defined as eclectic and integrative, with input from psychodynamic, systemic and cognitive thinking.

The therapy. The therapy was conducted in an outpatient setting, and the patient paid a low standard fee for the consultations. There was no predefined time limit for the treatment. The therapy lasted for nineteen months and a total of 43 sessions. The frequency was one session per week the first year, and one session every second week for the last six months.

Figure 1

Analysing interactions and reflections (therapy sessions and post-termination interviews)

We have previously described how the patient and therapist in the present case struggled with severe difficulties in finding common ground on which to work together in the initial phase of this therapy, and how they managed to create a meaningful therapy process with a good outcome after all (anonymous ref.). The case in this study is the relationship between the patient and the therapist. When the issue of coming to an end was introduced it was in a relationship where the struggle had led to a strong alliance with a mutual belief that the client was actually helped by the therapist.

Our design allows for the possibility of data triangulation (Denzin, 1989), i.e. interviews with the patient and the therapist asking for their subjective configuration of the events in therapy and their corresponding reflections, in combination with audio recordings allowing for observations of the dialogue according to the chronology of the therapy sessions. We could therefore explore how ending evolved as a chronology and was configured into two complementary narratives, with a special focus on negotiations as well as experiential concerns.

To explore the first-person perspective on the termination process, a combined hermeneutical-phenomenological approach was chosen (Binder, Holgersen & Nielsen, 2010; Finlay, 2003; Gadamer, 1989; Heidegger, 1962; Laverty, 2003; McLeod, 2001; Smith, 2007; Smith & Osborn, 2003). We wanted to stay as close to the informants' concrete and contextually anchored experience as possible, while exploring their views of what felt significant in the therapeutic process (Elliott & Shapiro, 1992; Giorgi & Giorgi, 2003; Smith & Osborn, 2003; Smith, 2007). We also wanted to connect their experiences with what we observed in the therapy sessions, and our aim was to identify patterns of interaction as well as how the theme of ending occurred in the dialogue.

Even though we tried to stay as close as possible to the informants' own descriptions, in addition avoiding theoretical concepts, both the formulation of research questions and the reading of the data will necessarily be affected by the specific experiential horizon of each researcher (Gadamer, 1989; Smith, 2007). In accordance with reflexive methodology, we used dialogue with the participants' views in order to explore and reflect on our own pre-understanding (Alvesson & Sköldberg, 2000; Finlay, 2003).

We marked and selected material from sessions as well as from interviews that could provide some answers to the analytical questions about initiations/recurrences and the subsequent responses. Further, we paid attention to the issues that were brought out – or kept

hidden – in the negotiations and in the narratives about ending or continuing. We also produced a systematic overview of structural changes in the scheduling of sessions and the ways in which they were addressed and experienced. The following set of selected material was reduced and condensed with the use of a hermeneutically modified method for systematic text condensation (Malterud, 1993, 2001) and inspired by McLeod and Balamoutsou's (2001) qualitative narrative analysis of psychotherapy transcripts. The analysis was carried out on a technical basis with the assistance of Nvivo 8 software (QSR, 2008). The data analysis proceeded as follows: (i) the first author listened to and transcribed verbatim the recordings of the interviews and the therapy sessions; (ii) both authors read through the written material separately several times the better to obtain a basic sense of the negotiations about ending in the relationship between patient and therapist; (iii) we discussed the material together and identified units of meaning which represented different aspects of what had taken place both in the sessions and in terms of the informants' experiences, and looked for connections between what we observed in the sessions and how it was experienced and reflected upon by the participants in the aftermath; (iv) we then selected examples and quotes from the transcripts to illustrate various aspects in the presentation. The narrative dimension is important for structuring and interpreting the data (McLeod, 2001; McLeod & Balamoutsou, 2001; McLeod, 2010) so we chose a chronological presentation of the course of therapy.

The researchers

Both authors are psychologists and both combine working with psychotherapy, teaching psychotherapy and doing research. The first author has thirteen years of clinical experience and has an interest in relational psychodynamic approaches and in psychotherapy integration. The second author has more than 30 years of clinical experience, and her therapeutic work is theoretically informed by developmental and interpersonal psychology.

Ethics

This study (Rønnestad, 2006) was approved by the Regional Committee for Medical and Health Research Ethics (Region South-East) and by the Norwegian Social Science Data Services. Details about the informants have been changed to provide anonymity. The informants read a late draft of the paper both to give final consent and to contribute to the validity of the study by ensuring that the quality of their experience was faithfully conveyed in the analysis and presentation.

Findings

In the last session, Marian concluded by saying: 'I think this is a good timing. I feel ready now'. Before this, extensive negotiation had taken place. Even if Marian finished by stating that she was ready, doubt still exists whether she really felt that it was a good time to end.

When Paul, the therapist, first took the initiative to end treatment, the patient Marian resisted. Marian responded by saying that she was not finished yet and she wanted to continue therapy. Paul was willing to postpone the end, but he still stood firm in his decision despite the patient's repeated dissent. This ambiguity between handling their conflicting views and reaching a conjoint decision endured for the last thirteen sessions.

Session 31 was the one in which Paul introduced the theme of ending therapy. This was the last session before the Christmas vacation, and the quote is taken from the end of the session.

Session 31

Paul: After this vacation I think we should consider deciding a date, either to end therapy, or to meet more seldom?

Marian: That sounds fine. But I very much want to continue for a while. I feel like the sting is still not out.

Paul: But we have managed to meet for a long series of sessions now.

Marian: Absolutely. But I feel that I have only recently been able to use this therapy.

Paul used the long series of sessions as an argument for planning to end and he used the forthcoming vacation as an opportunity to make a proposal they could consider after the vacation. Marian pointed to the long difficult beginning, and that she had only recently been able to use the therapy. She negotiated as an answer to his statement about the long series of sessions: the first part of therapy should not be counted.

Session 32 – the first session after the Christmas vacation

Marian: It has been a while. Just before Christmas we summed up some. Where are we heading?

Paul: We agreed that we should make plans with the perspective that we are approaching the end. It is important that we find a tempo that suits you.

Marian: I am glad to hear that. I sort of don't want to stop next week. As I've said, I used so much time just to be able to use this therapy.

Paul: I think we could manage to finish rather soon. And if we agree that we are approaching the end, we don't need to decide a date today. But at some point it will be appropriate to do it, so this can get a proper ending.

Marian: It will be quite a change when I'm on my own.

In this session Paul made a further move toward ending. He referred back to the last conversation as if the agreement was more solid than it really was. He said 'We agreed' and Marian responded by restating that she had only recently become able to use the therapy. In general, Paul's lines seemed to have two parts; he invited her to join in the decision and he marked his own decision. He said that 'It is important that we find a tempo that suits you', and immediately he modified it by saying that they could manage to finish quite soon. He negotiated by saying '…if we agree that we are approaching the end, we don't need to decide a date today'. Paul effectively divided the ending into smaller parts.

The next illustration was ten sessions later, and the frequency was then reduced to every second week.

Session 42 – the last session before the summer vacation

Marian: Last session before summer?

Paul: Mhm.

Marian: I feel I am not done yet. There are so much more to work on. I feel some anxiety almost always. Or not always. But when I wake up every morning, all my worries torment me. I worry about my mother, the economy, whatever. I long for safety and I need control.

Paul: So it's far from strange that you feel you aren't finished here. There is always much to worry about, if you want to spend your time that way.

…

Paul: I suggest we have three more sessions after the summer, and then it's the end.

Marian: Now you are strict.

Paul: But it seems to me that you see the point. And this safety you are hunting for to feel able to stop treatment, you will never find. That isn't life, it's just an idea.

Marian disapproved of Paul's eagerness to stop treatment and she pointed to her worries. Paul used his firmer experiences with Marian when he said *'There is always much to worry about, if you want to spend your time that way'.* This was far from an independent report, and pointed back to their process together. Paul interpreted Marian's worries and hesitations instead, for instance, of exploring them.

Session 43, the last session, after two months' summer vacation

Paul: Now it's been two months, and we planned this to be the last session, didn't we?

Marian: Did we really plan that? I think you said it, not we. And I thought, okay, that remains to happen. Perhaps three more sessions, I thought.

Paul: (laughs): But in fact you have had two good months since I said that. So if we are to take that response seriously it seems to be a good timing.

Marian: Actually I think it's a good timing. I feel ready now.

Paul used the temporary interruption because of the summer vacation and he repeatedly used the word *we*, seemingly to make earlier ambiguous agreements about ending more solid. He seemed to have forgotten the suggestion of having three more sessions after the summer. Marian, though, remembered, and gently suggested that there was a difference between their points of view. She finished by stating that the timing was good, and that she was ready. She both disagreed with the therapist and she complied.

In the sessions, Paul repeatedly stated that the termination was significant in terms of Marian's main area of difficulty, her autonomy. In his view, she had to realize that she had to live with much of her difficulty and trust her ability to handle her concerns on her own. Marian however stated both that it was appropriate to end and that she wanted to continue treatment. She consented to the idea, but wanted to postpone the point of time. In the dialogues she typically started out by agreeing with Paul's point of view, then she hesitated, and finally she agreed with Paul. It is still unclear whether Marian was unable to get her message through and gave up or whether she really felt some relief because she was able to be part of a conjoint decision to end treatment. In one sense she was talked into it, and she felt she had no choice. In another sense the proof of a successful therapy in this case showed as the capacity to move on with her life and experience a reduction in her somewhat pointless worries and tendencies to hang on to unresolved issues.

The dialogues in the last phase of this therapy share some patterns with the difficulties we observed in the sessions in the beginning of this therapy (anonymous ref.). In the interview, Marian said that in the beginning she experienced the therapist as being arrogant, authoritarian and lacking empathy. Paul said in the interview that at the beginning he experienced Marian as a somewhat defensive person who was passively waiting to receive help. His therapeutic goals were more in the direction of challenging her, thereby helping her to develop agency and autonomy. Marian and Paul started out with differing expectations of what therapy should be like and how each of them was supposed to behave. Both parties acted according to their own expectations and wishes. The patient wanted support and the therapist wanted to challenge the patient. They met for about fifteen sessions before a sufficient balance was reached and they established common ground on how to work together.

In the sessions in the late phase, Marian gave reasons for not ending therapy yet by repeatedly pointing to the experience in the early phase; that she needed a long time before

she was able to use the therapy. Paul's criterion of recovery was mainly autonomy, and this was perhaps what Marian ended up consenting to. There were, however, important differences between the early and the late dialogues. For instance, both Marian and Paul reported the alliance to be good in the end. The dialogues in the late phase after all also seem to reflect a more equal relationship where the patient seemed more capable of asserting herself.

Reflections from the post-therapy interviews

Both participants stated in the interviews that the process of ending had been a challenge.

Marian: The first time Paul introduced ending I was scared. I didn't feel ready. After a while I felt more secure about continuing on my own even though I felt there still were topics to work on in therapy. After all, the ending went well. It feels like a security that Paul gave me the opportunity to call him.

She said that she resolved the ambivalence and it went well: they still have a connection, an emotional bond in terms of the working alliance, and she can call him.

Paul: We had to spend some time on ending. It was the same central theme of autonomy. I wanted to make it soft, but finally I had to say, okay, this ending is for real. And then we agreed that it was time. But I had to mark it clearly and crisply.

Their stories about ending can be seen as complementary. Marian was scared to be pushed. In the interview she also said that from time to time she felt really bewildered after ending. She mentioned that Paul gave her the opportunity to call him after the end of therapy as an extra security. Paul felt that he both needed to be soft and needed to hold to the decision to end treatment. He also came out with the ambiguous statement that they agreed that it was time, but he had to state the decision clearly and crisply. Paul also revealed some of his general thoughts about ending in the post-therapy interview about this therapy.

Paul: One shouldn't use therapy to resolve all one's troubles; the client should go on with her life. It is also a matter of capacity and priorities in this outpatient clinic, so here it is often the therapist who decides the end. It is in and by itself such a good thing to have someone to talk with about your difficulties in life. The end is a farewell, with all the anxiety and separation anxiety that means, but also a kind of recognition that I think she is able to make it on her own. So there is potentially support in suggesting an ending. And I see it as a good point to be able to handle farewells that are sad, but still possible to endure. And sometimes I say that it may be a way to think of it, that we have finished a piece of work, and we don't have sessions anymore, but I am not

dead, I work here, and it is possible to call me, for instance, if that feels meaningful. Perhaps only thinking it is possible is enough?

Paul explained his reasons for initiating the ending both in externals, such as capacity and priorities at the clinic, and in internals, such as the potential support and affirmation his attitude might bring about. He also utilized the possibility of later contact as a way to stimulate the patient to make constructive use of her image of the therapist and the relationship after the therapy had ended.

The informants' reflections on this paper

Both participants read a late draft of this paper to ensure that the quality of their experience was conveyed in the analysis and presentation. Marian felt the paper provided a good analysis of the process of ending. She felt that Paul confronted her with a fait accompli which she felt powerless about. She remembered that she concentrated on ways to look positively and constructively upon the ending when she had to end in any case. Paul stated that he felt the paper gave a valid picture of their process of ending. He remembered struggling with this ending, and reflected upon his own tendency to become impatient if leave-takings last too long. He raised the question whether therapists who are used to attaching emotionally to patients may be vulnerable during the process of detachment and therefore in danger of becoming less empathic?

Discussion

Ending has been explored as a chronology and as a narrative. This dual approach has brought attention to some of the constituents that make the decision to end consensual and allow the qualities of the alliance to bear on the suffering derived from separation. The theme of ending was negotiated back and forth between the participants, and the underlying notion was that they were searching for an agreement. Difficult emotional reactions can be smoothed indirectly – even by forgetfulness – as well as addressed in a direct way. Structural matters, such as breaks because of vacations and meeting again after vacations, are important constituents in the decision to end. When the process of ending was initiated by the therapist, he was actually preparing for a vacation and seemed to use this opportunity to introduce ending as a somewhat analogous experience.

Such breaks were further used to test how Marian managed life without her therapist. Paul presented ending as the final proof of improvement and as a future promise. The therapeutic dyad reached an agreement that it was time to end treatment. Ending was also an

important experiential concern for the participants. When the participants reflected on it in retrospect, the therapist was satisfied with the decision and the patient was left with traces of doubt. When the relationship appears to have some unfinished business, the improvement in the direction of autonomy may continue. Marian's doubts and bewilderment are ambiguous. It may be a sign that the decision to end treatment was somewhat forced, and that the therapist tricked her into it. To complain and say so, however, could be a sign that she was going back to her earlier habits of clinging and complaining, and thus had not benefited from the therapy In the last sessions Marian was in an emotional twist that mirrors important qualities of ending: solving the ambivalence and preserving an emotional bond. If she continued to protest, she would be unhealthy, alone, dependent and not emotionally affirmed. If she agreed with Paul, she affirmed that she was healthy and independent and she received his emotional support and affirmation. Paul made Marian ‘an offer she couldn’t refuse’, so to speak. Paul’s offer was tempting because it invited her to be more healthy and independent than she perhaps really felt or was. In his view, ending was a sign of autonomy and it pointed to further autonomy in the future. His stance can be said to contain a paradox or a double bind for Marian: she had to make the decision to end to show her autonomy, but he without doubt was the one who made the decision. She could affirm that she had grown better only by accepting that she had to end treatment. This emotional twist can be thought of in terms of the fundamental paradox entailed in the need for recognition, as described by Benjamin (1990): when we realize our own independent will, we are dependent upon another to recognize it.

Paul, who in the sessions and in the interview seemed mainly preoccupied with the chronology and the goal of coming to an end, revealed experiential concerns considering detachment and vulnerability when reflecting upon our configuration of the process of ending in this paper.

In this therapy, as well as in other cases where the end is not decided in the beginning, there is no right time to end treatment and no set of obvious right criteria. Ending therapy seems to be a matter of constructing agreement through interpersonal negotiation in a way that both parties can tolerate in the experiential mode. In this sense it was a concerted decision; some ambiguities may have been addressed, and others were covered and twisted. To resolve the ‘rupture’ of disagreement on when to end and to be able to negotiate the ending process in a way that brought Paul and Marian to a concerted decision seems to be an important therapeutic achievement in its own right. They were able to maintain a therapeutic alliance throughout the difficulties. This fits with a view recently suggested by Barber, Khalsa

and Sharpless (2010), that is, the therapeutic alliance can be viewed as an outcome in its own right, rather than as a prerequisite for treatment.

The power to define when it is time to end eventually rests with the therapist. Such a definition of what is appropriate will however have to be worked through as implicit and explicit negotiations. The point seems to be to utilize structural and substantial constituents in order to solicit affirmative responses from the other. In this case Marian herself was ready to say yes at a point in time when saying no did not any longer make sense. Saying yes was the best way to sustain what had been accomplished during therapy. An answer to when therapy stops may be this: therapy stops when patient and therapist find a 'good enough' way to resolve the basic ambivalence concerning ending. Then they can reach a concerted decision that the therapy should end and the emotional bond continue.

Figure 2

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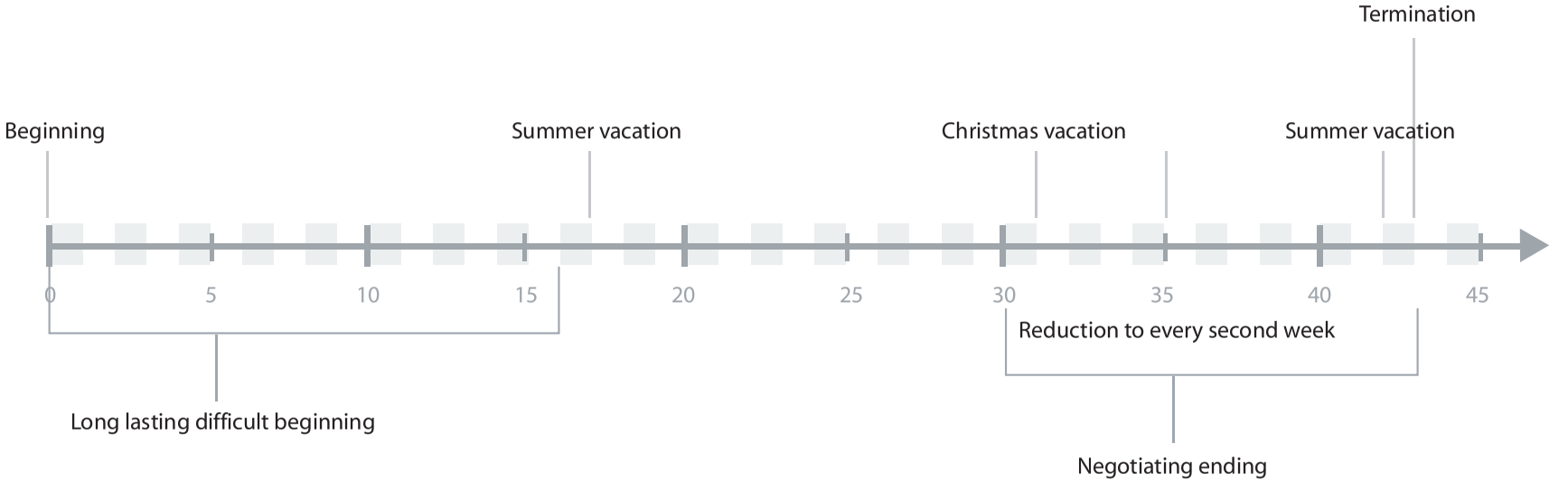
TIMELINE


Termination
Beginning
Summer vacation
Christmas vacation
Summer vacation
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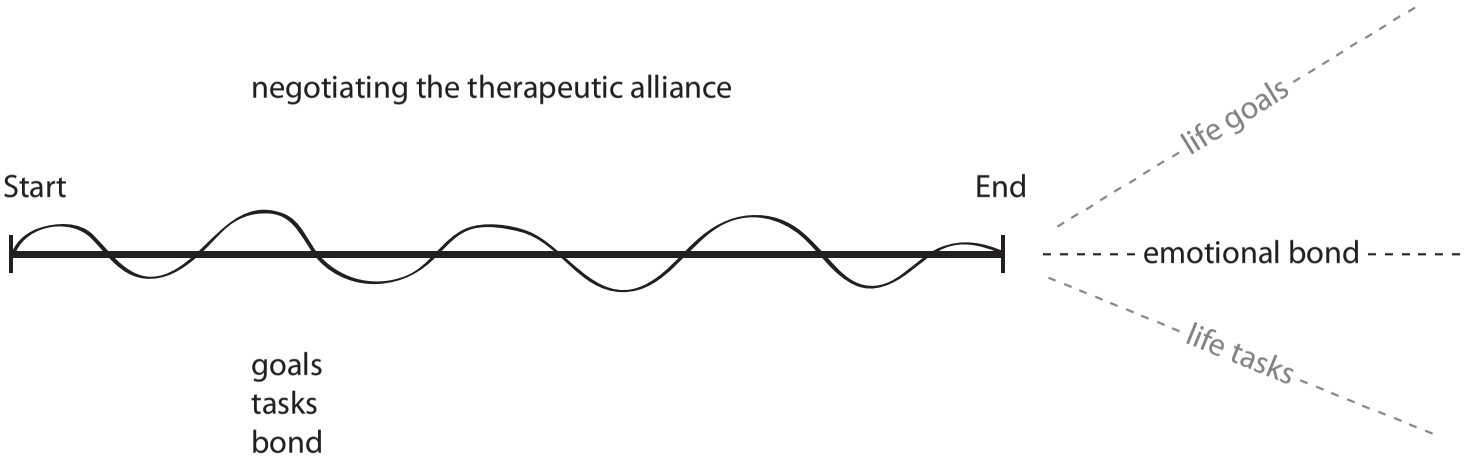
5
10
15
20
25
30
35
40
45
Reduction to every second week
Long lasting difficult beginning
Negotiating ending

Ending psychotherapy



PAPER 3

Råbu, M., Binder, P.E., & Haavind, H. (submitted). Negotiating ending: a qualitative study of the process of ending psychotherapy.