

Supportive–Expressive Interventions in Working Through Treatment Termination

Aviv Nof, Liat Leibovich, and Sigal Zilcha-Mano
University of Haifa

Supportive–expressive (SE) psychodynamic treatment has been receiving much empirical support. It is based on conceptualizing and working through the patients' Core Conflictual Relationship Theme, which includes their main wish (W) in the context of an interpersonal relationship, an actual or anticipated subjective response from the other (RO) in relation to the W, and the subsequent emotional and behavioral response from the self (RS) to the RO. Studies suggest that the RO and RS components show the greatest change as a result of effective SE treatment. Clinical experience, however, suggests that in the last phase of treatment, when termination is anticipated, at least some patients regress to their original RS. This process is part of a separation conflict, which includes unconsciously renouncing their RS gains. In the present article we make recommendations regarding the timing and manner of initiating the termination discussion (the "clock-like reminder" and the "symbolic listening to termination cues"), integrating both supportive and expressive techniques. The article contains practice-based guidelines on how to work through the potential RS regression. We pay specific attention to what to do and not to do in the very last session and use examples from the pilot phase of a randomized controlled trial to demonstrate each recommended technique. Lastly, we suggest paths for future research to examine the proposed framework for working through termination.

Keywords: termination, CCRT, regression in RS, separation individuation

Supportive–expressive (SE) psychodynamic treatment has been receiving much empirical support lately (Leichsenring, Leweke, Klein, & Steinert, 2015). It is time-limited, manualized, dynamic therapy that includes supportive elements, such as enhancing the alliance and emphasizing adaptive aspects, and expressive elements designed to work on the patient's Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1998). It is based on conceptualizing and working through the patients' CCRT, which includes their main wish (W) in the context of an interpersonal relationship, an actual or anticipated subjective response from the other (RO) in relation to the W, and the subsequent emotional and behavioral response from the self (RS) to the RO. Empirical studies indicate that the RS and RO show the greatest change as a result of effective SE treatment (Leichsenring & Leibing, 2007).

The termination phase of SE is placed schematically at Sessions 13 to 16 (Book, 1998). It plays a unique role in the process of achieving the main SE purpose, which is helping the patient assimilate the CCRT changes and become adjustably self-regulating individual. But because of the conflictual and stressful meaning, termination at times activates emotional reactions, resulting in regression of the RS. RS regression characterizes some patients, but not necessarily all.

We suggest that the meaning of termination triggers the RS regression because the separation from the therapist resonates with past separation conflicts (Bauer & Kobos, 1987; Mann, 1973). Therefore, self-doubts about autonomy increase with possible expressions of separation anxiety. In response, the RS of some patients temporarily regresses to the old, pretreatment pattern, to protect itself from the disappointing RO, which is experienced as abandoning the patient. Book (1998) explains: *The patient experiences the therapist's behavior as the RO and automatically responds with his or her old RS* (p. 149). Thus, whereas during the working-through phase the RS repertoire expands, at termination phase there is a temporary RS regression. If the regression is handled effectively, the RS recovers in the end, and its quality improves.

We suggest that at least for some patients, RS regression at termination is a developmental therapeutic challenge to survive and thrive. Note that normative RS regression, which we describe here, is an expected and transitory phenomenon that occurs in the service of the ego. Developmental challenge, such as separation, requires adjustments to be made at the cost of temporary regression. The therapist's goal is to contain and stabilize the normative RS regression, so that the patient ends the therapy successfully. We propose ways of understanding and techniques to handle successfully normative RS regression in SE therapy, and use a case study to demonstrate the suggested techniques.

The case study is part of the pilot phase of therapists' training for a randomized controlled trial (RCT) on SE for major depression disorder (MDD). The clinical vignettes were taken from the last two sessions of the treatment of a 25-year-old single female patient, who was diagnosed with MDD. The patient answered an ad published at a university asking people who suffer from depression to participate in

Aviv Nof, Liat Leibovich, and Sigal Zilcha-Mano, Department of Psychology, University of Haifa.

The writing of this paper was supported by the Israel Science Foundation (ISF).

Correspondence concerning this article should be addressed to Sigal Zilcha-Mano, Department of Psychology, University of Haifa, Mount Carmel, Haifa 31905, Israel. E-mail: sigalzil@gmail.com

short-term therapy as part of a study. She met the criteria for MDD as well as other inclusion criteria to participate in the study. Her presenting symptoms were depressed mood, recurring skin disease, and headaches. She was preoccupied with themes of death and suicide. Socially, she felt lonely and not understood. She had a stable job but missed many work days because of depression. The psychologist was a woman with 18 years of clinical experience. To protect the confidentiality of patient and therapist in the following clinical vignettes, we disguised the background details. The participants gave both written and oral permission in advance.

The patient's CCRT formulation, based on Book's (1998) model, was as follows: It seems that you want your deep feeling and thoughts to be accepted and understood as a whole, including both your positive and negative feelings (W), but you feel that people do not want to get involved in your sadness and are reluctant to get close to you, so they stay away from you and remain occupied with themselves (RO); therefore you get lonely, offended, and avoid becoming emotionally close to people (RS). The SE therapy focused on breaking the vicious circle of repetition compulsion in the patient's life by working through her CCRT. Therapist and patient focused on understanding that the patient's avoidant behaviors (RS) and her low expectations from people (RO) prevented her from getting close (W). As shown in Table 1, at the end of treatment, the patient showed improvement in her depressive symptoms as well as on other process and outcome measures.

Initiating and Conducting the Discussion of Termination

Theoretical Basis and Proposed Mechanism of Change

Handling the RS regression effectively requires working through the personal meaning of termination from the start of

treatment. The therapist should rely on two main techniques to initiate the discussion of termination; we call these the "clock-like reminder" and the "symbolic listening to termination cues." As part of the clock-like reminder, the therapist declares reminders of the end date of the treatment at fixed time points in the course of the treatment, inviting the patient to conduct a dialog about it. In the first three sessions, the therapist should state the termination date, adding that the patient will be reminded of this fact several times in subsequent sessions. The next opportunity to use the clock-like reminder is in the last five sessions, as the countdown to the end begins: "we have five more session to the end." The purpose of the repetition is to keep in mind the short time, and use it as a leverage to enhance goals-achieving and to work through the termination themes.

Some of the patients react to the clock-like reminder with an explicit response about termination (e.g., "It's frustrating that we have such a short time"). We propose handling the patient's explicit response in a supportive manner. The therapist should first validate the emotional tone and the short time left. Second, the therapist should emphasize the *joint* effort needed to produce a change, using the pronoun "we" ("we are together in this effort to make a change, and we will talk and think about how we do that"). Lastly, it is important to explore the personal meaning of termination ("I wonder if you could tell me some more about your feelings about it").

The second way of initiating termination discussion is by symbolic listening to unconscious termination cues. Because the end of treatment may activate unconscious emotional themes of bereavement and separation (Joyce, Piper, Ogrodniczuk, & Klien, 2007), the therapist should listen and look for such unconscious projections or representations. Based on Mahler's Separation-Individuation model (Mahler & Pine, 1975), and on clinical experience, we suggest three main categories of symbolic meaning of

Table 1
Patient Process and Outcome Measures Across the Active Phase of Treatment

Session number	Hamilton	BDI	WAI	ECR-Avoidance	ECR-Anxiety	OQ
1	16	20	5.83	3.17	1.5	1.33
2	22	13	5.83	2.17	1.33	1.3
3	15	15	6.75	2	1.17	1.17
4	20	17	6.17	2	2.17	1.23
5	14	11	7	1.5	1.17	1.07
6	14	6	6.5	1.83	1.5	.63
7	16	11	6.92	1.33	2.33	.73
8	24	23	6.42	1.5	1.33	1.3
9	24	23	7	1	1.33	1.57
10	9	9	6.58	1.67	2.5	.77
11	23	27	6.25	1.5	1.83	1.5
12	17	22	7	1.5	1.5	1.2
13	5	9	6.58	1.5	1.5	.5
14	7	4	6.83	1.5	1.5	.4
15	10	9	6.75	1.5	1.5	.8
16	8	10	6.92	1.33	1	.77
Clinical sample, Means (SD)	16.97 (5.17) ^a	22.36 (11.92) ^b	5.02 (.89) ^c	—	—	1.85 (.46) ^d
Nonclinical sample, Means (SD)	3.39 (3.23) ^a	8.36 (7.16) ^e	N/A	N/A	N/A	1.05 (.47) ^d

Note. Hamilton = Hamilton Rating Scale for Depression (Hamilton, 1967); BDI = Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); WAI = Working Alliance Inventory (Horvath & Greenberg, 1989); ECR = Experiences in Close Relationships Scale, answered concerning the therapist as an attachment figure (Brennan, Clark, & Shaver, 1998); OQ30 = Outcome Questionnaire (Lambert, Vermeersch, & Brown, 2004).

^a Rehm and O'Hara (1985). ^b Beck, Steer, Ball, and Ranieri (1996). ^c Hatcher and Gillaspay (2006). ^d Lampert et al. (2004). ^e Whisman, Perez, and Ramel (2000).

separation: (a) projected representations of *leaving or coming back*, including microevents mentioned in sessions that symbolize ending (e.g., “I noticed that Tom, the guard at the gym, left without saying goodbye; I wonder what happened to him”); (b) symbolic representations of separation anxiety or longing for care (e.g., “My cellular phone was off all day long, and my mom got scared and called all my friends crying”); (c) symbolic representation of overdoing things in an omnipotent excitement (e.g., “I ran into my cousin. He’s so funny; talks all the time, runs around, never sits for a second, such a happy kid. Being able to do so many things in such a short time”).

When facing the symbolic cues, the therapist should consider three techniques in sequence. We refer to these three steps of insight-oriented intervention as the Validating, Interpreting, and Personal meaning exploration (V.I.P.) steps. The therapist should begin by validating and relating empathically to the content of the story. It is crucial to stay with the explicit story, lest the interpretation is experienced as a negation, resulting in resistance. For example, “As you mentioned, taking the train to another city can be difficult. Finding yourself suddenly in a new place, new smells and sights.”

The second step is the interpretation, and it should be introduced in the form of a proposal, but without confronting the patient. We recommend doing so by selectively connecting a section of the patient’s narrative with a specific termination element, as opposed to making a complete comparison between the symbol and underlying content, which may be too difficult for the patient to accept. For example, “When you spoke about the mixed emotions of going to new places by train, it reminded me of the mixed emotions of terminating here. I wonder how you feel about the end of therapy?” (interpretation and personal meaning exploration).

Clinical Exchange Demonstrating How to Initiate and Conduct Termination

The following clinical exchange occurred at the last (16th) session of therapy.

Patient: *I finally went to see the play we’ve talked about. It was a catastrophe. (The play that the patient spoke about can be viewed as a symbolic cue of termination content. It is a symbol of encountering the outside world, which could be either wonderful or threatening.) Just wanted to have fun, but it was a really bad experience. All the horror of depression was there. I couldn’t stop crying. Awful experience, and it was really hard to for me to carry on after that.*

Therapist: *It really shocked you. It was a bad experience for you and a disappointment (the therapist used the first V.I.P. step of validating the emotional tone). But I notice that something in the play just didn’t seem to sit well with you. You didn’t like the bad experience, right? It’s like you’ve been feeling lately about finishing the therapy. You do not like being depressed anymore. In the past, when you were depressed, you looked for depressing movies and books. Now, coming to the end, you enjoy this type of thing much less. You even suffer from*

it (the second V.I.P. step of interpreting the termination themes).

Patient: *When we left the show, I felt well again. I’m stronger now.*

Therapist: *Yes you are. I wonder how it is for you to end the therapy (the last step of V.I.P. of exploring the personal meaning).*

The patient’s narrative about the play carried an unconscious symbolic meaning of separation (going out and doing new things). The therapist used the V.I.P. steps to reach an empathic insight about termination, and brought back this unconscious content into the therapy dialog using the exploration of personal meaning.

Research That Supports the Use of This Interventions

We introduced two sets of interventions. The first, described as a set of clock-like reminders, is supportive intervention aimed at addressing an explicit response to termination. Supportive interventions are common in psychotherapy and enhance the working alliance between patient and therapist (Horvath, Del Re, Flückiger, & Symonds, 2011), which, in turn, is perceived as a mechanism of change in psychotherapy (Zilcha-Mano, 2016). The second intervention was the V.I.P., a series of steps aimed at processing unconscious symbolic themes. V.I.P. is based on the integration of supportive and expressive interventions, both supported empirically (Driessen et al., 2010).

The first step of the VIP, validation, finds support in the work of some theoreticians and researchers but not of others. Some approaches to psychotherapy conceive supportiveness as unnecessary or even nontherapeutic (Crown, 1988). Supportiveness does not fit what Appelbaum (1994) termed the “growth-by-insight” model of classical psychoanalysis, which emphasizes interpretation as the curative element. For example, Kernberg (1984) suggested that pathological defenses weaken the ego and only persistent interpretation can bring structural change.

In contrast to these approaches, other orientations within psychodynamic writing suggest that validation, or support in general, may attenuate anxiety and help create a comfortable atmosphere for further exploration. Appelbaum (1994) suggested that interpretations offered in the absence of explicit or implicit “supportiveness” are ineffective or demonstrably noxious. Wachtel (2011) explained that support should not be understood as processes of “covering over” unconscious material, but as a basic feature of relationships that makes exploration possible (Wachtel, 2011). Empathic experience is crucial in the therapy process because people need to feel understood and appreciated before they are ready for changes (De Jonghe, Rijnierse, & Janssen, 1994). Supportive therapy has been shown to be effective for patients with varying diagnoses, and to effectively complement existing treatment (Carsky, 2013; de Maat et al., 2008).

Key Aspects of Processing the Termination

Theoretical Basis and Proposed Mechanism of Change

The CCRT and its subcomponents are described to the patient as a schema or as a narrative. Clinically, it is convenient to think of

the RS regression as a specific narrative with particular features. The regressed RS is often a *one-sided narrative* (e.g., “I feel strong now and don’t need anyone near me anymore”), which is neither coherent nor integrative. The one-sided narrative refers either to the old pretreatment RS, or the new RS, but not to the synthesis of the two.

The therapist’s goal is to rephrase the one-sided RS narrative into a coherent one, using a technique we called the “*combing into a whole*,” which combines disparate elements into a whole and contains both sides of the RS. First, the response should be supportive in a way that affirms the feeling of the articulated one-sided RS (e.g., “It’s wonderful to feel that strong”). The next step is to formulate an *abstraction metaphor* summarizing the RS-regression tone (e.g., “It’s like finding a treasure that gives you strength”). The purpose of the abstraction is to create a space for observation on the one-sided RS experience. After being stated, the abstraction metaphor serves as a bridge to an interpretation based on the technique of combining into a whole. The therapist can offer a suggestion or use an exploratory question, aiming to capture both the old and the new RS. We demonstrate here the combining into a whole technique in response to a patient’s enactment of devaluing transference (the old RS of becoming offended): “You’re not a sensitive psychologist, are you? I was talking about my dog, and you never picked up on it, always ignoring me . . .”). The therapist may respond as follows: “It’s good that you can tell me about it. I understand how frustrating it can be to get no response about important things” (a supportive element that mirrors the one-sided RS); “It’s like being left alone along the way when you need something” (the abstract bridging metaphor); “Perhaps you’re angry at me because soon we’ll be wrapping up our therapy here. Lots of issues won’t be addressed after we finish. However, you spoke earlier about feeling good, and I guess you feel both good and angry” (the technique of combining into a whole). Note that the therapist tries to describe a narrative that changes and demonstrates progress.

Clinical Exchange Demonstrating Key Aspects of Processing the Termination

This clinical exchange took place at the start of the 16th (last) session of the treatment.

Therapist: *We’re at our final session.*

Patient: *Yes, I’m not bothered by it; it was a great success for me (the one-sided regressed RS).*

Therapist: *You feel it’s going to be OK for you (supportive affirmation of the emotional RS tone). It’s like the feeling after climbing this really high mountain together and now we can rest and watch the beautiful view (the abstract metaphor). I wonder if maybe there were not only good things here (the technique of combining both sides of RS into the whole)?*

Patient: *I guess I’m not sure how deeply I’ve changed. It has crossed my mind that one cannot be totally changed. But . . . there is a but . . .*

Therapist: *A human being remains a human being; our nature cannot be radically changed (the technique of combining into a whole).*

This exchange demonstrates the integration of RS using the technique of combining into a whole. The abstract metaphor (climbing a high mountain) is intended to convey an empathic understanding and implicitly to emphasize the one-sided quality of it.

Research That Supports the Use of This Interventions

The idea of “wholeness” can be referred to as a *coherence* feature of a narrative (Adler, Harmeling, & Walder-Biesanz, 2013). Coherence is a thoroughly studied feature of narratives, which has been found to be related to several desired outcomes in psychotherapy. For example, Adler et al. (2013) found that coherence and processing are specific features of narratives that are associated with sudden gains in psychotherapy. Qualitative investigation of narratives showed that patients high in ego development tend to describe a coherent story of growth. The ability to contain a coherent story about experiences is regarded as a foundational element of narratives, associated with improved well-being (Adler, Skalina, & McAdams, 2008).

Support can also be found in the literature for our suggestion to use an abstract metaphor. Martin, Cummings, and Hallberg (1992) demonstrated the effect of the use of metaphors in psychotherapy. Patients tended to recall therapists’ metaphors approximately two thirds of the time, especially when these were developed collaboratively and repetitively. Patients rated therapy sessions in which they recalled metaphors as more helpful than sessions in which they did not.

Key Aspects of the Process Occurring in the Final Treatment Session

Theoretical Basis for the Proposed Mechanism of Change

The final session should not be dramatically different from the other termination phase sessions. Some clinicians carefully plan how to act and which techniques to use in the final session to make sure that the patient is not overwhelmed. The main technique we recommend is *regulating the dynamics* at termination. The therapist can help the patient summarize and talk about the therapy and termination in a supportive, regulated manner. We suggest that defenses be handled with a supportive attitude, which takes into account their adaptive role (rather than interpreting them in the last minute of treatment). We recommend adopting a supportive attitude, and repeating already established insights and the narrative of the CCRT change. We suggest using two techniques to stabilize the RS regression in the last session: the goodbye letter and the summarizing question.

The goodbye letter. Lemma, Target, and Fonagy (2013) suggested giving the patient a goodbye letter that contains the central understandings of the therapy, a description of the process, and thoughts about the work that can be done in the future. We add that the therapist should consider including in the letter a narrative of the change that has taken place in the CCRT and the new RS

repertoire gained during treatment. We also suggest that patient and therapist can write a letter to each other, talking about the process itself of writing the letters, and celebrating the end of treatment by giving and receiving these letters.

Summarizing question. Marx and Gelso (1987) described termination as consisting of three objectives: looking back, saying goodbye, and looking ahead. We suggest building on these objectives and asking the patient the following three questions with regard to the change in the CCRT: What do you take away from therapy? What have you learned about being in relationships (CCRT focus)? How do you feel about finishing here?

Clinical Exchange Demonstrating Key Aspects of Processing the Termination

- Patient: *I wrote you letter, as we agreed.*
- Therapist: *Wow, I'm excited (reading silently)! Now I'll read for the cameras:*
"With this document I declare my psychologist to be the best one ever on earth, as attentive, understanding, a genius and super-analyzer as one could ever be. She has restored the dignity of all clinical psychologists and redeemed them forever" I'm so excited . . . This is wonderful. I'll keep it, and if anyone ever doubts me, I'll just show it to them (they laugh together) (supportive self-disclosure and affirmation of the emotional tone).
- Patient: *How did it pass so quickly? 16 sessions? That's incredible . . .*
- Therapist: (Looking again at the letter): *I can barely hold back my tears.*
- Patient: *In this case, I was successful with the letter. I hope you like the card. I chose it especially for you when I was on the trip last month.*

The exchange demonstrates the RS regression and the affect regulation maintained by the therapist. The letter reflects an idealizing transference ("I declare my psychologist to be the best . . .") and an intellectualized response (framing the letter as a document of excellence). It may reflect a specific form of pretreatment RS transference enactment, in which the patient is emotionally reluctant and distanced. The therapist chose not to confront the defenses nor to interpret them. She enjoyed the gratitude and thanked the patient for it, disclosing her highly emotional reaction. But the therapist did not follow the omnipotent transference tone, and thus she regulated the dyadic atmosphere and helped the patient stabilize the RS.

Research That Supports the Use of This Interventions

Grecucci, Theuninck, Frederickson, and Job (2015) emphasized the role of emotion regulation in psychotherapy and stressed that it should be considered as a key goal. It has also been found that verbally sharing emotions with another person helps regulate emotions (Zaki & Williams, 2013). Finally, patients tend to accept goodbye letters from their therapists positively (Gelman, McKay, & Marks, 2010).

The therapist's comment about holding back her tears was a self-disclosure. Although classical psychoanalysis stresses the properties of anonymity, neutrality, and abstinence as necessary features for the success of treatment, contemporary relational and intersubjective approaches suggest that self-disclosure is an important and even necessary process in therapy (Goldstein, 1997; Ziv-Beiman, 2013). Self-disclosure contributes also to better perception of therapy as a deeper process (Myers & Hayes, 2006).

Crying, as a self-disclosure act, has not been studied much, empirically or theoretically. Case studies suggest that crying may confront clinicians with a conflict and hesitations about breaching professional standards or hesitations about harming the client (Blume-Marcovici, Stolberg, & Khademi, 2013). Nevertheless, in their study of crying, Blume-Marcovici et al. (2013) reported that 72% of therapists had cried in therapy and that it helped deepen an already strong and positive rapport. According to Blume-Marcovici et al. (2013), these findings about the generality of crying may serve as a "de-shaming for those who have cried or will cry in therapy to know that they are not alone (i.e., they are in the 72% majority)" (p. 232).

The Very End of the Final Session

Theoretical Basis and General Guidelines

The act of saying goodbye at the end of the last session is a natural gesture, and yet a complicated and often embarrassing one. The best way to handle the last goodbye may be to talk in advance about it and explore its personal meaning, with adherence to the ethics code. For example, the therapist may say: "The end of the session is here. Some people find it convenient to talk about the very last goodbye to clarify it. What are your thoughts about it?"

We recommend the following guidelines for handling the ending of the final session:

- a. *Be flexibly attuned* and follow the patient's dynamics.

In general, during the entire SE treatment, therapists are encouraged to take an active stance in the process of working through the patient's CCRT (Leibovich & Zilcha-Mano, 2016). During the last session, however, and mainly at its very end, we recommend following the patient's lead, and not being as active as before. This means that the therapist should adapt to the tempo and the unique emotional expression of the patient (e.g., happiness of celebrating the success should meet with a similar rhythm and emotional tone from the therapist, whereas hesitation about the future should be met with validation of it).

- b. *Maintain a regulated atmosphere:*

- i. *Continue in a supportive mode* (as opposed to offering new interpretations). The therapist should help the patient feel understood and feel that his or her ideas and emotional reaction are normal and contained. It is important to empower the patient's ego strengths and validate adjustment coping efforts.

- ii. *Cope with peak moments.* It is the therapist's role to recognize emotionally overloaded dynamics and to help the patient regulate it. One way of handling the peak

moment at the very end is to first validate the emotional tone and next to share with the patient empathically the dilemma of not opening a new topic because of lack of time (e.g., “You mentioned your separation from your beloved aunt, and it’s very sad to hear about it. I wish we could talk more about it. It’s not easy for either of us not to be able to deal with it, but the time is not on our side”). Another way of regulating the last minutes is to use structured-open-questions, such as “what is the best way for you to end here?” or “How will your weeks look without our meetings?” This type of reappraisal thinking has been shown to activate a regulation process, in which the prefrontal cortex down-regulates the emotional experience of the limbic system (Goldin, McRae, Ramel, & Gross, 2008; Gross, 2002).

- iii. *Handle intense countertransference emotional reactions.* Last-minute events can evoke an intense countertransference reaction (e.g., in response to the patient giving a present or as a reaction of the therapist to his own history of separation). We recommend using a brief adaption of the three *Ws* of (*Wait, Watch, and Wonder*) as a guideline, which we adopted from parent–child psychotherapy (Cohen et al., 1999; Muir, 1992). The *Wait, Watch, and Wonder* steps can help the therapist reflect upon the event and his or her possible therapeutic reaction, and wonder internally or as part of a dialog about what has happened. The three *Ws* can help mentalize the meaning of patient signals and needs in the last minutes. In this way, the final separation can be meaningful, emotional, and at the same time contained and understood.

The very last interpersonal exchanges can vary along a wide spectrum of behaviors and emotional tones. The variations stem from the versatile cultural norms, tendency for emotional reactivity, interpersonal distance attributes, and personality tendencies. Some dyads choose to shake hands, others to hug, say goodbye, make a light comment (“See you around . . .”), or say nothing. The therapist should be receptive, use the three *Ws*, be flexible within the boundaries of his or her own tendencies, and remain within ethical limits.

Clinical Exchange Demonstrating Key Aspects of the Very End of the Last Session

- Patient: *I know we do not have much time now. I do not know what else to say.*
- Therapist: *You’re right, we are very close to the end and to saying goodbye. I can really understand that it’s not easy to choose what to talk about in the last minutes. (The therapist continues in a supportive manner and chooses not to interpret the possible passive-aggressive reaction of the patient, i.e., having nothing to say).*
- Patient: *I spoke today with my eldest sister. I am angry at her. She was always kind of a mother to me, until she got married and left home. She is so different now. All she thinks about now is her family and work.*

Therapist: (Realizing that there were 2 min left and hesitating about how to react. She feels both exited and tense because of the new topic raised close to the end, and because of her countertransference in regard to separations. The therapist uses the *Wait, Watch, and Wonder* steps, understanding that the narrative may reflect transference of being abandoned by a close caregiver. She thinks of two main ways to react: interpret it, or regulate the atmosphere and maintain a supportive manner). *Thank you for sharing this with me. I understand that your sister was a meaningful person in your life until she left home (validating). It is a painful experience when someone changes and you lose something. (Stating an abstract validating statement to normalize the feeling. Note that the therapist did not interpret the transference themes, choosing not to start on a complex issue at the end).*

Patient: *I feel like crying now. I do not want to cry.*

Therapist: *You’re sad. I can feel it too. It is really sad that we are saying goodbye, ending this journey together. (The therapist remains in supportive mode and discloses her own feeling).*

Patient: *O.K, I’ll be O.K. Let’s hug and say goodbye.*

Therapist: *OK, I understand. I guess we should end now . . . (The therapist is flexibly attunement to signals of overloaded affects and regulates them by leading the way to the end).*

The interventions we suggested to handle the act of saying goodbye, such as wondering and reflecting about it before doing it, are based on the cornerstones of psychodynamic therapy. Blagys and Hilsenroth (2000) found seven features that reliably distinguish psychodynamic therapy from other therapies. The intervention we offered to manage the goodbye gesture is based on their features of affect and expression of emotion, attempts to avoid distressing thoughts and feelings, and focus on the interpersonal and therapy relationship.

Summary

Successful therapy does not need a show of fireworks at its end, and unsuccessful therapy most of the time cannot be saved by termination maneuvers in the last minute. But because termination at times activates RS regression, it is of great importance that the therapist handle it effectively. We presented guidelines for techniques to be used in the course of the termination process. The proposed dynamics of RS and the proposed techniques we introduced should be studied empirically.

First, we recommend that future research examine the pattern of changes in the nature of RS during the different phases of SE therapy, as well as other related treatments. At the beginning of treatment, we expect the RS to show nonadaptive expressions, as part of the maladaptive pretreatment CCRT pattern. Next, we expect to find a decline in nonadaptive RS expressions during the middle phase (as opposed to the beginning baseline), when it is

being replaced by a more adaptive one. This is followed by a rise in the nonadaptive RS at the early termination phase, a normative termination reaction, as described in this paper. Finally, in a successful treatment, we expect to find a final decline in nonadaptive RS expressions at the very end. Future studies should also examine the personality tendencies that may moderate the appearance of RS regression, to determine which patients are likely to experience it and under which circumstances.

Second, future studies should also examine the utility of the specific interventions we introduced (e.g., the clock-like reminder and the V.I.P.). The studies could explore the utility of the complete set of interventions for the manualized SE treatment, or add one component at a time in a deconstructing design aimed at identifying the effects of individual treatment components.

Third, from the point of view of V.I.P., it is important to begin with a validation comment before stating an interpretation. It would be beneficial to test this approach by comparing patient reactions to two different natural conditions in treatment: patient hearing a sequence of Validation–Interpretation comments and those hearing only an Interpretation comment. Based on the literature (Appelbaum, 1994; Wachtel, 2011), it can be hypothesized that the Validation–Interpretation sequence may help the patient reflect upon the interpretation in a more relaxed, contained manner, with fewer objections.

The need for evidence-based psychodynamic treatment has been receiving increased attention nowadays. We are witnessing the first signs of the gap between practice in the field and academic research beginning to close. Clinicians have a growing need to learn how to use the clinical guidelines accompanying the evidence-based manuals of psychodynamic treatment. Practice guidelines, such as those we introduced here, can help establish a bridge between the accumulated research knowledge and clinical wisdom derived from practice. Studies that focus on specific evidence-based interventions in given domains of psychodynamic therapy, as well as in other treatments, can help us achieve the desired change.

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Received June 15, 2016

Revision received August 17, 2016

Accepted August 17, 2016 ■

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