Psychotherapy

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Online First Publication, March 23, 2020. http://dx.doi.org/10.1037/pst0000297

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ISSN: 0033-3204
http://dx.doi.org/10.1037/pst0000297

"We Can Work It Out": Working Through Termination Ruptures

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Supportive-expressive (SE) psychodynamic treatment is based on the identification of and working through the patient's signature core conflictual relationship theme. According to the SE framework, when termination is anticipated, separation conflict arises, and the actualization of the patient's interpersonal wish in the relationship with the therapist is no longer possible. The disactualization of the patient's wish in the relationship with the therapist may cause patients to regress to their maladaptive prototype responses (Nof, Leibovich, & Zilcha-Mano, 2017), which may manifest as a rupture in the therapeutic alliance. The present work integrates constructs based on the SE framework, specifically the disactualization of the patient's wish at the end of treatment, with the framework of alliance ruptures and their resolution (Safran & Muran, 2000). We propose a conceptual clinical model to guide therapists in the successful resolution of alliance ruptures, which are the result of the disactualization of the patient's interpersonal wish. We propose a two-stage process to achieve successful resolution of termination ruptures: (a) identification of termination ruptures and (b) addressing and resolving termination ruptures. For each stage, we propose practice-based guidelines and steps to follow. We demonstrate the proposed guidelines based on the case study of a patient with major depressive disorder. We used three sources of information from the case study: verbal transcripts of the therapy sessions, questionnaires, and semi-structured posttreatment interviews.

Clinical Impact Statement
Question: We ask how clinicians can effectively work with their patients when termination ruptures arise. ***Findings:*** We offer guidelines on recognizing and addressing termination ruptures. ***Meaning:*** Therapists should be attuned at termination to the manifestation of ruptures, and address them when they arise. ***Next steps:*** Further research is needed to enhance our understanding of how to address termination ruptures effectively.

Keywords: termination process, alliance ruptures, core conflict relational theme, supportive-expressive psychodynamic treatment

The patient's core conflictual relationship theme (CCRT; Luborsky & Crits-Christoph, 1998) is a conceptualization that includes the patient's 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. Supportive-expressive (SE) treatment focuses on the patient's signature CCRT. This treatment is intended to help patients gain insight about their signature CCRT to create adaptive interpersonal patterns (Luborsky, 1984). One way to assist patients in achieving adaptive patterns is to help them recognize their wish conflict and to start exploring new ways of actualizing the wish (Book, 1998). At the termination phase, the patient's wish can no longer be actualized by the therapist because of the coming separation and the associated conflicts (Book, 1998; Mann, 1973). Therefore, we may expect regression. We defined regression as a temporary relapse of the patient to dysfunctional signature CCRT patterns, which can be resolved (Nof et al., 2017).

These dysfunctional patterns of the patient's wish and RS may appear in the therapeutic context and within the rupture resolution framework as termination ruptures (TRs). TRs arise in the context of termination and echo the signature CCRT of the patient. TRs may adversely affect treatment and overshadow the patient's treatment experience. If, however, TRs are identified and addressed effectively, they can lead to growth in treatment and may have a long-lasting effect after treatment ends. Safran and Muran (2000) emphasized the importance of therapists identifying ruptures in the relationship and dealing with them effectively. An important source of information in identifying ruptures is the transference and countertransference experience (Safran & Muran, 2000). Resolution strategies differ in their level of complexity, some can be immediate, such as when the therapist takes responsibility for the rupture, whereas others focus on exploring the rupture and what underlies it with the use of metacommunication (Eubanks, Muran, & Safran, 2018).

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This work was supported by the Israeli Science Foundation (Grant 186/15).

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In this article, we present an approach to TR episodes that integrates different strategies to identify and address ruptures in the final stage of treatment. Such awareness and special attunement are essential at this delicate stage, which occurs within a limited window of time and elicits complex emotions. To fully illustrate our recommendations, we use a case study from the pilot or the active phases of an ongoing randomized controlled trial involving SE therapy for depression, conducted at the University of Haifa (Zilcha-Mano, Dolev, Leibovich, & Barber, 2018). The study was approved by the ethics committee. The patients and therapists signed informed consent forms and agreed to be videotaped during the treatment. We disguised the background detail and the content of the clinical exchanges to ensure the anonymity of the patients and therapists. We based our recommendation on session transcripts, questionnaires, and a posttreatment interview. According to the measures of clinical change, the patient we present in this study showed clinically significant recovery from depression symptoms, ending the treatment with a Hamilton (Hamilton, 1967) score of 5 points (within the range of the normative population) and solid improvement on the Reliable Change Index, with a score of 10.12 (higher than 1.96; Jacobson & Truax, 1992). Our patient is a single man in his early thirties who met the criteria for major depressive disorder. His main complaints were depressive mode and struggling in romantic relationships. His signature CCRT was as follows: W = that others be attuned to his needs and desires; RO = that others do not care about his needs and desires; and RS = that others reject his needs, and therefore he remains avoidant and passive and struggles in communicating his needs.

How to Initiate or Engage in the Discussion of Psychotherapy Termination

Theoretical Basis and Proposed Mechanism of Change

In SE treatment, a short-term psychodynamic therapy, the termination and separation conflict arises from the very beginning (Mann, 1973). The literature suggests that Sessions 13 to 16 are appropriate for discussing treatment termination to enable a proper processing (Book, 1998). Consistent with the personalized treatment approach (Zilcha-Mano & Errázuriz, 2015), we suggest planning and tailoring the termination process according to the patient's unique signature CCRT. For example, patients who are especially preoccupied with themes of separation conflict, abandonment, or loss (Mahler, Pine, & Bergman, 1975) should begin the termination process earlier.

We propose addressing the setting of the final sessions by initiating a second socialization process for the termination phase of treatment, which is an extension of the original socialization taking place at the beginning of treatment (Book, 1998). The therapist should initiate the termination socialization by specifying the number of sessions that will be dedicated to termination and discuss the patient's expectations about the final phase, emphasizing why this phase is important. The options available after the end of treatment should also be discussed: Under what circumstances should the patient start another therapy, and which therapy is recommended. The possibility of adding maintenance sessions should also be mentioned. This termination socialization process has the potential to reduce the anxiety that this phase naturally arouses and to help the patient engage in the termination process (McCullough, 2003). Such termination socialization processes can be narrated as follows:

> Our active phase of treatment will be over in four weeks, but we will meet again once a month after the final session. In these meetings we could review how you're doing and see how you manage on your own. There are some things we should decide, such as what are the goals of these meetings as far as you are concerned.

Another guideline for initiating the discussion on termination is that the termination dialogue should be tailored to the individual patient–therapist dyad. Every dyad has its own way of interacting and uses its own "emotional language." Metaphors (Cummings, Hallberg, Slemon, & Martin, 1992) that are taken from treatment narrative make the conversation on termination easier; the therapist should use terms from the patient's familiar world. For example, if the patient is an architect, the therapist can use terms related to building and can talk about the foundations needed to create what they built together.

Clinical Exchange Demonstrating the Intervention

The following clinical exchange demonstrates the use of the private emotional language of the dyad. Through treatment, this patient has been using intellectualization to express his feelings through stories derived from books.

Therapist: *You know, I wonder if you thought about our treatment as a book, what would you say about it?*

Patient: *Well, I think I would say that I managed to learn from it how to articulate my needs and desires in relationships. And . . . that it was very nice and interesting to talk with someone who has the knowledge to help me.*

Therapist: *That's nice. What would you say was the chapter you liked most in our imaginary treatment book?*

Patient: *I think the one in which we talked about my struggle in romantic relationships, and you made me feel like I'm OK and that sometimes things just take time.*

In this exchange, the therapist asking questions about the book helped turn the termination dialogue into a familiar and regulated narrative.

Key Aspects of Processing the Termination and Therapeutic Relationship

Theoretical Basis and Proposed Mechanism of Change

How to identify TRs. The therapist can identify TRs by bearing in mind that TRs do not stand on their own but usually echo the patient's pretreatment signature CCRT. As a result, therapists experience the TRs together with a regression in the CCRT. The main guideline for effectively identifying TRs is to pay attention to signs of regression that manifest as tension or

disagreement. The TRs may reflect the regressed forms of RS, RO, and W with common themes that echo the unconscious separation conflict (Mahler et al., 1975) or the unfulfilled wish. There are two important sources of information about the occurrence of the TRs: overt behaviors, such as complaints about treatment setting (Eubanks, Muran, & Safran, 2015), and the countertransference experiences (Safran & Muran, 2000). Therapists should pay attention to their own emotions that arise at the termination phase, such as frustration or detached interactions, as well as difficulties expressing emotions. Therapists should pause to reflect about the history of the countertransference and recall whether they had ever had this experience previously, with this patient, as a means of identifying the current TR.

We illustrate these guidelines with our case, discussed earlier. When the termination phase arrived, the patient complained about the short duration of treatment, which did not synchronize with his deepest wish for a close and lasting relationship with his therapist (disactualization of the patient's wish). The patient temporarily regressed (RS and wish regression) and could not directly verbalize his needs and wish to the therapist (e.g., "What's the point now to keep talking about my difficulties. We don't have much time left to deal with them, do we?"). This was the first sign of TR, and the therapist, who felt the countertransference experience of hopelessness, followed the recommended guideline: She paused and reflected upon her countertransference feelings and tried to understand whether these feelings were familiar to her from previous sessions. She recalled that a few sessions earlier, she had felt frustrated when she could not emotionally communicate with the patient and understood that a TR was taking place. Following this guideline helped the therapist maintain her therapeutic stance, without being drawn into the patient's vicious cycle of the maladaptive pretreatment CCRT (e.g., responding in an avoidant and frustrated manner).

How should we address the TRs? To address the TRs, we suggest a three-step intervention model: declaration, acknowledgment, and integration. The first step is to point out and declare the existence of the TR, making an objective statement, without attaching any labels or interpretations to it. The TR declaration should be articulated as part of CCRT formulation, with emphasis on the wish that was heard and can be actualized (e.g., "I think you wanted to tell me that you feel bored today"), rather than reflection on the dysfunctional regressed RS and its nonfulfillment aspect (e.g., "I can see that it is hard for you to express what you want"). The second step is to supportively acknowledge the patient's experience and to validate it. The validation of the TR opens a unique opportunity for translating the maladaptive rupture communication into a communication effort of the patient that is received and understood by the therapist (Safran & Muran, 2000). The third step, integration, is carried out by presenting the development of the CCRT over the course of treatment. The therapist should present both the regressed and progressed CCRT schemas, as they are reflected in the TR. The latter should be done by pointing out concrete times when the patient acted based on new and adaptive RS, as opposed to the current regressed TR and RS, and by discussing the meaning of the changes the ruptures and resolutions underwent as treatment progressed (e.g., "You are angry with me about being silent. I can recall the session you were frustrated with my tendency to be silent, and it was so meaningful that we could talk about it. Do you know what helped you bring up this issue back then?"). This step helps strengthen the patient's mentalization ability by deepening the awareness to inner mental states (Allen & Fonagy, 2006), which may also empower patients by enhancing their sense of ownership of the changes they achieved during treatment. Moreover, through this step, the therapist and the patient are collaboratively rewriting their story, strengthening and consolidating both the narrative of their relationship and the change in the CCRT (Luborsky & Crits-Christoph, 1998; McCullough, 2003).

Clinical Exchange Demonstrating This Intervention

The following posttreatment interview, which demonstrates the three-step intervention and reflects the occurrence of the TR and its repair from the patient's perspective. This exchange provides a vivid example of the long-lasting effect of the TR and its repair.

Interviewer: *Were there any moments when you felt distance from your therapist?*

Patient: *Yes, there was that time toward the end of treatment when the therapist asked me to say more about some issue and I didn't know what to say. She tried to push me harder, but I had really nothing to say. Then she told me that she feels like something happened between us, that I became silent and that it seems like we are having a hard time.* [Declaration] *At the next session she told me she was sad about pushing me too hard, that she understood that I felt forced to talk,* [acknowledgment] *and that it is important to understand what happened between us.*

Interviewer: *And how was it for you?*

Patient: *I think it was good. We talked about the times in treatment when I succeeded to assert myself before her. I remembered correcting her about the number of brothers I have, and this was meaningful because usually I would remain silent* [integration upon the rupture].

This clinical exchange demonstrates the patient's reflection and integration on the TR as part of the changing CCRT. The integrative dialog about the rupture helped the patient to gain greater insights into the desired changes he underwent and to consolidate them.

Key Aspects of the Process During the Final Session

Theoretical Basis and Proposed Mechanism of Change

How to identify TRs. If treatment was effective before the termination phase, and if the TRs were effectively resolved, only minor TRs are likely to be evident in the final session. We define minor TRs as small tensions or disagreements that reflect the patient's regressed signature CCRT in an implied or mild manner. Common themes are regressed CCRTs themes that reappear, particularly as RS regression. Slight devaluations and reactions of withdrawal are possible. We propose that before the last session,

therapists should invest effort into mentalizing and simulating scenarios of possible RS regression in advance. These actions promote the attunement needed to identify minor TRs. In addition, the therapist and the patient should prepare together for the final session. They can reflect upon both the desired aspects and the possible ruptures in the final session. The mutual reflection about possible obstacles or ruptures can strengthen the alliance and promote the patient's curiosity about the progress they have made.

Clinical exchange demonstrating this intervention. The following clinical exchange demonstrates the identification of a minor TR at this final session. Although the patient reported on improved mood, a minor TR occurred. The therapist could have missed it if she had not prepared in advance, using the mentalization procedure of simulating signs of RS regression corresponding to the signature CCRT.

Patient: *A friend of mine told me we can't go hiking together next weekend.*

Therapist: *Oh, that must've been frustrating . . .*

Patient: *Yes, well . . . being frustrated won't help me now, what can I do . . .*

Therapist: *How do you feel about it?*

Patient: *I don't know . . . doesn't matter.* [The therapist identified the minor TR]

In this clinical exchange, the minor TR of becoming demonstratively laconic was the regressed RS reaction. The therapist, who had mentalized ahead of session the possible minor TRs of withdrawal and brief answers, was efficient in identifying it.

How should we address the TRs. Therapists should address the minor TRs by using minimal intervention, which we define as delicate references to previous successful RS reactions. The main goal of the minimal intervention is to strengthen and illuminate the adaptive RS changes, focusing on closing and summarizing the treatment narrative rather than opening and exploring new themes. We suggest using our previous three-step intervention, with several adjustments. Our first two steps, declaration and acknowledgment of the TR, should be used as mentioned earlier, with emphasis that this is the final session. At the third step of integration, the therapist should focus mainly on the RS integration (rather than on other CCRT components) and make a quick reference to previous adaptive RS reactions.

Another guideline is to apply an intervention we called "preparation for the day after". The therapist should reframe the CCRT insights into practical day-to-day guidelines. For example, the therapist may point out that the development achieved through treatment is dynamic and that some normative regression is anticipated. The therapist should help the patient recognize with whom and when the achieved CCRT change is possible (e.g., "You know, in the future you will meet all kinds of people. Some may be very sensitive to you and some may be less attentive. Let's think together how you can manage in both situations, bearing in mind the insights you gained here about your emotional needs"). This intervention resembles the cognitive-behavioral treatment relapse prevention strategies, which emphasize the importance of recognizing, identifying and preparing to handle high-risk situations effectively (Marlatt & Donovan, 2005) and communicate the therapist's sincere faith in the patient's capability to use the deep insights gained in treatment.

Clinical exchange demonstrating this intervention. The following clinical exchange demonstrates how to handle minor TRs in the final session using minimal RS integration and preparing for the day after intervention.

Patient: I feel sad. It feels like "What's the point," like I have not made a change here.

Therapist: It must be tough and sad to experience these feelings, and it's important to discuss it. I guess it's even harder to feel this way at the final session. [acknowledgment with reference to termination].

Patient: *Well, that's exactly how I feel, exactly.*

Therapist: *Sometimes you may feel that things don't quite change easily. However, there were times you did succeed in saying what you want. Do you remember how you managed to communicate with Miriam emotionally?* [minimal RS integration]

Patient: *Yes, when I dated Miriam I could tell her what I expect from the relationship.*

Therapist: *Yes, I remember that.*

Patient: *Well, I guess I did make some change. But how can I be sure it will last?*

Therapist: *You're right that the possibility of going back again is always frightening. I guess it's important to keep in mind that the nature of change is dynamic and doesn't always go in the same direction. Also, there will be episodes when you will need to take the risk of communicating your needs, and there's a chance of being disappointed. At other times, it may be better not to say what you think.* [preparing for the day after].

Patient: *I haven't thought about it that way, but that makes sense in a way.*

This clinical exchange demonstrates how the therapist leveraged the TR to strengthen the patient, using acknowledgment, minimal RS integration, and preparation for the day after.

Key Aspects of the Termination Process at Its Very End

Theoretical Basis and Proposed Mechanism of Change

Based on our clinical experience, most treatments do not end with ruptures at the very end. Most of the patients try to end treatment in a regulated manner and express gratitude to some degree. Nevertheless, some patients, and especially those who suffer from Cluster B personality disorders, could show TRs and express their dissatisfaction or disagreement with the therapist at the very end of treatment. For example, at the last minute of the final session, a patient could say, "I feel all alone again, exactly as I felt when we started treatment." In these cases, we recommend

following an adjusted version of the minimal intervention, as presented in Section 3. First, the therapist should acknowledge the TR experience, emphasizing the short time left in the current final session (e.g., "You feel all alone now like you sometimes felt here. Unfortunately, treatment ends now, and time does not allow us much more"). Second, the therapist should make a quick reference to the adaptive RS patterns that have manifested in previous sessions and were part of the treatment narrative (e.g., "However, I remember that, although you feel lonely now, there were times when you succeeded in getting closer to me and to other important people in your life").

Clinical Exchange Demonstrating This Intervention

The following clinical exchange demonstrates how to address the rare goodbye TRs. This example involves a different patient (not the one previously mentioned).

Therapist: *We have a few moments lefts. How do you feel at the end of our treatment?*

Patient: *Overall fine . . . I admit I wondered if you are kind of pleased to have more time for your other patients* (laughing).

Therapist: (smiling) *Perhaps you feel like you've been a burden to me, and not as important as other patients, like you felt here before. Unfortunately, we don't have much time, and we should soon end the session. However, it is important for me to say that I do remember those times in treatment when you felt important to me here.* [acknowledgment of the patient's experience with reference to the final session and minimal RS integration]

Patient: *Yes, you're right. It keeps happening to me, these feelings of being a burden on others. But I do remember now what you have mentioned.*

This clinical exchange demonstrates the use of acknowledgment and minimal RS integration to address the TR.

Research Supports the Suggested Interventions

SE treatment was found to be effective and efficient (Barber, Barrett, Gallop, Rynn, & Rickels, 2012; Gibbons et al., 2012). Although the therapeutic guidelines we proposed have not been directly examined, some of the interventions they include have received empirical support. With respect to initiating the discussion on termination, the use of metaphors (Cummings et al., 1992) has been found to lead to treatment success. With respect to the termination process, an empirical meta-analysis stresses the importance of rupture resolution processes to successful treatment (Eubanks et al., 2018). Concerning identifying ruptures, the empirical literature suggests that better countertransference management, which includes higher reflection and fewer reactions, is associated with better treatment outcomes (Hayes, Gelso, Goldberg, & Kivlighan, 2018). Concerning addressing ruptures, acknowledgment has been shown to be effective as a supportive intervention (Gibbons et al., 2012). The integration of the rupture intervention, such as noting previous treatment successes and explorations, was found to contribute to the working alliance (Ackerman & Hilsenroth, 2003). The intervention preparing for the day after is supported by Norcross, Zimmerman, Greenberg, and Swift (2017), who emphasized the importance of discussing the patient's future functioning at termination.

Summary

This article proposes possible guidelines to recognize and address TRs through the course of termination process. We demonstrate the termination process guidelines based on a case study, psychodynamic theories, and the CCRT conceptualization that suggest possible regression in the subcomponents of the CCRT at the end of treatment. The guidelines are practical and focusing on not just what to say but also on how to say it (Wachtel, 2011). We suggest that further qualitative as well as quantitative research is needed to enhance our understanding on how to address TRs effectively. Future research should examine if the resolution strategies of the TRs contribute to reduction in the CCRT regression and to enhanced outcomes of treatment. The specific repair techniques, however, should be tailored further, based on clinical experience and future empirical findings.

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Received December 31, 2019
Revision received January 30, 2020
Accepted February 28, 2020 ■