Teach Them How to Say Goodbye: The CMRA Model for Treatment Endings

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The ending of treatment brings with it unique challenges. Traditionally, different therapeutic approaches have emphasized distinct aspects of the termination process. Insight-focused approaches emphasized the therapeutic relationship and retrospection, whereas symptom-focused approaches emphasized therapy goals and prospection. In this paper, we present an integrative model for treatment endings, which unites the different approaches' emphases and identifies four main challenges for the end phase. Specifically, we argue that as termination nears, therapists need to actively assess and address (a) the progress and consolidation of gains achieved in therapy, (b) the maintenance and generalization of those gains in the future;, (c) the celebration of the meaningful relationship alongside resolution of ruptures that may have occurred in it, and (d) the acceptance of the impending separation between therapist and patient. We argue that these four challenges map onto two axes. One axis is temporal, and helps distinguish tasks focused on reviewing or reflecting on the past from ones devoted to planning and anticipating the future. The other axis is substantive, and helps distinguish tasks focused on the therapy's goals from ones centered on the therapeutic relationship. We conclude the paper with a discussion of the model's implications for clinical practice, training, and research.

Keywords: psychotherapy termination, CMRA model, relapse prevention, rupture resolution, clinical training

In endings, things which were once active and living cease to exist. This makes most endings hard to handle, as any person who had undergone a relationship dissolution or even, more simply, had to bid someone close farewell,

knows. Here, we will consider the specific and unique complexities of endings in psychotherapy.

Gelso and Woodhouse (2002, p. 346) defined the termination phase of psychotherapy as "the last phase . . . during which the therapist and client consciously or unconsciously work toward bringing the treatment to an end," and estimated that it takes up approximately 17% of the length of therapy. As psychotherapy is both an intrapersonal growth process and an interpersonal relationship, its ending is a formidable and multifaceted task, requiring attention to both therapy goals and the therapeutic relationship. Both of these aspects are about to end—at least in their present form. With both processes in mind, the therapist and the patient will need to consider what happened during the therapy— that is, the past, but also what is to happen after

therapy ends—that is, the near and the more distant future.

In this paper, we set out to present an integrative conceptual model for the ending phase of psychotherapy and a set of pragmatic ideas for therapists approaching this phase. We propose a model which aims to capture much of what occurs in the ending phase, as well as to suggest how it can be used to ensure that therapists take an active role in attending to those things which have yet to occur.

The Importance of the End Phase of Psychotherapy

In cognitive psychology, the recency effect describes a tendency of a person to remember the last items in a series better than other items (Ebbinghaus, 1908, p. 96). This effect may very well be applicable to psychotherapy, with the end phase of treatment having a pronounced influence on the patient. Indeed, later sessions often leave a particularly strong imprint on the patient's memory, and what happens over the course of termination often colors patients' therapy experience and the way in which they perceive treatment in its entirety.

The end phase of treatment is significant not only due to its timing, but also because it is charged with unique content and intense emotions. As the psychoanalyst Martin Bergmann pointed out, "In real life, only death and hostility bring a libidinal relationship to an end. The kind of termination psychoanalysis demands is without precedent" (Bergmann, 1997, p. 163). Whether positive or negative, termination is related to intense emotions among patients (Knox et al., 2011). And just like with *recent* information, people tend to better remember *emotionally charged* information (Holland & Kensinger, 2010).

But whereas recency and emotional salience are present in any ending, the ending of psychotherapy can prove important for a third and unique reason. In contrast to most endings of relationships, in which the decision about (and the coping with) the breakup tends to occur in solitude, therapy termination can be a joint reflective (as well as emotional) process. The possibility to discuss, process, and accept the end of a therapeutic relationship in dialogue with the therapist-partner is a rare opportunity. It differs

sharply from many other endings, in which such dialogue is entirely absent or even impossible.

Existing Models for Termination

Useful guidance for handling treatment termination can be found in both symptom-oriented and insight-oriented approaches to psychotherapy. In broad brush strokes, the former can be said to emphasize processes regarding therapy goals. For example, many symptom-focused (e.g., cognitive-behavioral therapy [CBT], interpersonal psychotherapy) treatment manuals conclude with "relapse prevention" modules (e.g., Ledley, Foa, & Huppert, 2006). These modules, which offer guidance for the culminating sessions of therapy, are designed to help the patients in maintaining treatment gains (e.g., in substance abuse, Irvin, Bowers, Dunn, & Wang, 1999). Typically, therapists are encouraged to review with patients (or, more often, "clients") what has been learned in therapy, to help them set reasonable expectations, and to impart and instill coping strategies to be used in difficult future situations (Ledley et al., 2006, pp. 72–74).

Approaching the end phase in this manner suggests a focus on therapy goals, in which the treatment is viewed as a learning process and the termination is thought to be an opportune time for summarizing what has been learned—as well as for planning for the future. However, an exclusive focus on these goals in the end phase leaves unattended other, possibly equally important, aspects—ones tied to the therapeutic relationship.

An emphasis on the therapeutic relationship is (again, in broad brush strokes) often the domain of insight-oriented approaches to therapy. For example, psychoanalytic writers have argued that endings are inevitably experienced as interpersonal losses (for review, see Gelso & Woodhouse, 2002). According to the termination-as-loss model, clinicians should help patients who are undergoing treatment termination to experience, in full, the emotions that arise, emotions which are thought to replicate ones related to earlier experiences of interpersonal loss.

Alongside this loss, patients often experience termination as a normative or positive transition and growth process. In that sense, termination may be thought of as resonating with patients'

earlier experiences of growth and independence (e.g., rapprochement, Mahler, 1966). Notably, such termination experiences still highlight the significance of the therapeutic relationship itself. Approaching the end phase of treatment with this emphasis leads therapists to assign the therapeutic relationship a central role in therapy—and therapy termination—processes.

In practice, many experienced therapists integrate both therapy goals and therapeutic relationship aspects in the end phase. For instance, a recent study polling 65 expert therapists identified with six distinct treatment approaches, spanning the range between insight-oriented and symptom-oriented ones, found more similarity than differences in their reported termination behaviors (Norcross, Zimmerman, Greenberg, & Swift, 2017). In our view, this practice calls for a unified trans-theoretical language for the end phase of treatment. It is with such a language in mind that we present the consolidating (C) therapeutic gains, maintaining (M) them, resolving (R) therapeutic relationship issues, and accepting (A) the separation (CMRA) model, which we hope can serve as an integrative, clear, compact, and applicable model for treatment termination.

The CMRA Model

In beginning our quest to develop a common and trans-theoretical language for the end phase of therapy, we first turned to the existing, though relatively small, theoretical and empirical literature on this topic. Quite consistently, this literature (including major reviews spanning close to two decades; Barnett, MacGlashan, & Clarke, 2000; Joyce, Piper, Ogrodniczuk, & Klein, 2007; Kramer, 1990), points to three tasks that are unique to the end phase: the assessment of accomplishments, their generalization, and the resolution of issues in the therapeutic relationship.

It struck us that these three tasks can actually be mapped onto two dimensions or axes: one reflecting the temporal focus of the task, and the other reflecting its substantive domain, that is, the focus on therapy goals versus the therapeutic relationship. The temporal axis is centered on the present, and ranges from reviewing or reflecting on the past to planning and anticipating the future. The substantive axis ranges from a focus on the therapy goals and tasks to a focus

on the therapeutic relationship, that is, patient-therapist bond and alliance.

These axes provide a framework for understanding the three challenges mentioned in the literature, which we refer to as consolidation, maintenance, and resolution. Consolidation refers to work that has a past temporal orientation with a substantive focus on therapy goals (e.g., an assessment of what has been accomplished in therapy). Maintenance refers to work that has a future temporal orientation and is also focused substantively on therapy goals (e.g., reviewing ideas for the future implementation of stress-reduction skills). In contrast, resolution refers to work that is temporally oriented toward the past, but focused on the therapeutic relationship (e.g., dealing with ruptures). Importantly, when looking at the intersection of the two axes, a fourth challenge—one which has received little attention to date—emerges. Specifically, this challenge (which we term acceptance of the separation) involves work that is future-oriented with the therapeutic relationship in focus.

Consolidating therapeutic gains (C), maintaining them (M), resolving therapeutic relationship issues (R), and accepting the separation (A) are the patient's challenges and thus should serve as the focal points for the therapeutic work from the therapist's point of view. To refer to the model, we use the initials of each challenge, which together spell out CMRA (pronounced "camera"; Figure 1).

It is worthwhile to situate our model by comparing it with the aforementioned existing models of termination suggested by symptom-oriented versus insight-oriented approaches. Traditionally, symptom-oriented treatment approaches such as CBT have emphasized the therapy goals aspect, particularly the present and future, typically summarizing what was learned and preparing for relapse prevention. This suggests that much of the work conducted in the end phase of such treatments would fall under the rubric of the maintenance challenge, which borrows mainly from symptom-focused approaches and often goes unacknowledged by insight-oriented ones. In contrast, insight-oriented approaches, such as psychodynamic therapy have emphasized the therapeutic relationship aspect, and particularly the present and past, typically attending to the emotional (and usually negative) experience of the termination, and to its similarity to other, earlier, losses. This
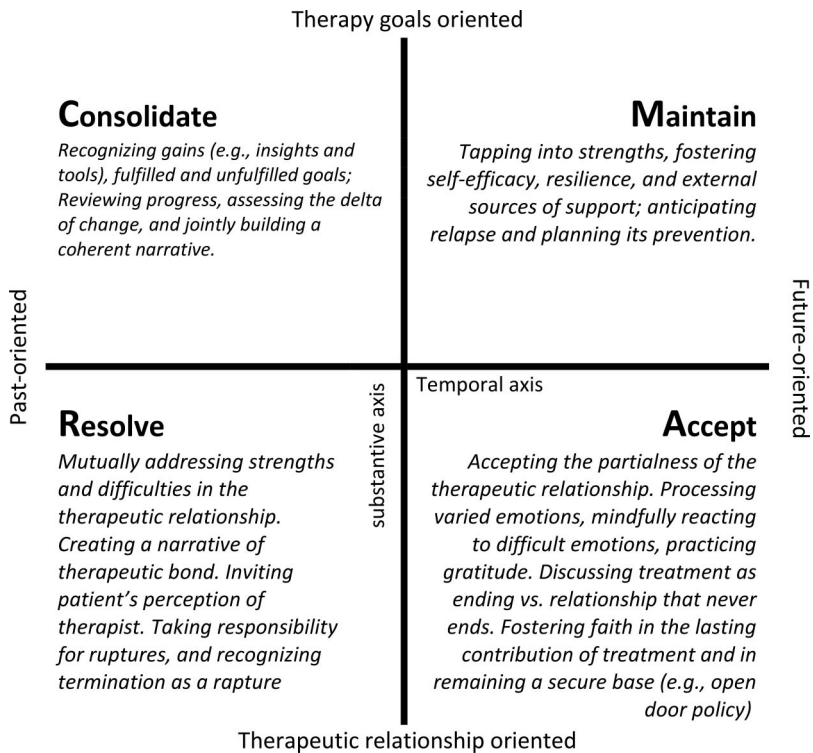
Therapy goals oriented

Consolidate

Recognizing gains (e.g., insights and tools), fulfilled and unfulfilled goals; Reviewing progress, assessing the delta of change, and jointly building a coherent narrative.

Maintain

Tapping into strengths, fostering self-efficacy, resilience, and external sources of support; anticipating relapse and planning its prevention.

Past-oriented

Future-oriented

substantive axis   Temporal axis

Resolve

Mutually addressing strengths and difficulties in the therapeutic relationship. Creating a narrative of therapeutic bond. Inviting patient's perception of therapist. Taking responsibility for ruptures, and recognizing termination as a rapture

Accept

Accepting the partialness of the therapeutic relationship. Processing varied emotions, mindfully reacting to difficult emotions, practicing gratitude. Discussing treatment as ending vs. relationship that never ends. Fostering faith in the lasting contribution of treatment and in remaining a secure base (e.g., open door policy)

Therapeutic relationship oriented

Figure 1. CMRA Model and Keywords of Termination Challenges.

suggests that much of the work conducted in the end phase of such treatments would fall under the rubric of the resolution challenge, which borrows mainly from insight-oriented approaches and often goes unacknowledged by symptom-oriented ones. Finally, the two remaining challenges—consolidation and acceptance do not have the same clear association with one therapy approach or another. Instead, both symptom-oriented and insight-oriented approaches offer wisdom regarding these challenges. Below, we detail each of these challenges.

Consolidation

The first challenge, consolidation of treatment accomplishments, revolves around the therapy goals domain and is focused toward the past. When engaging with this challenge, patients evaluate their treatment gains: what has been learned, what has changed, and what hasn't. In doing so, patients are invited to recall the reasons they turned to therapy and the goals set at the beginning of the journey. These observations, ideally conducted as a dialogue between the patient and the therapist, are aimed toward recognizing gains, nongains (i.e., goals which were not achieved), and possibly even losses. Such recognition requires a mental contrasting between patients' past and present selves. To facilitate this process of packing and storing the therapeutic achievements, these should be labeled and defined, a process which is best repeated multiple times. Successful consolidation is evident when patients feel ownership over the transformation they made, become familiar with their accomplishments, and can describe the process they went through in therapy, deeply and fluently, at least to themselves.

This process—in which the patient's progress in therapy consolidates into a story—is a tool stemming from the narrative approach (White & Epston, 1990). According to this approach, narratives can help give shape to previously amorphic experiences (Morgan, 2000)—as the therapeutic journey might be in many patients'

eyes. Therapists who wish to guide their patients through the process of consolidating treatment accomplishments can help them formulate a coherent narrative of their experience in therapy, one that is centered on their own agency. Beyond making the patients' experience more accessible posttherapy, such narratives have been linked to patients' subjective well-being and ego development (Adler, Skalina, & McAdams, 2008).

Consolidation of therapy gains, and specifically, the formation of a coherent narrative about them, is easier when therapeutic goals are explicitly discussed, defined, and agreed-upon in advance. This process—which typically involves identifying specific problem areas and working in a concerted way to reduce the distress associated with these areas—is customary in symptom-focused approaches. Establishing such goals, often measurable ones, makes it easier for both patients and therapists to assess the "delta"—that is, the degree of obtained change that has taken place. It also facilitates the discussion of any gains (or nongains). Indeed, many protocols for short-term symptom-focused work (e.g., CBT for social anxiety disorder; Ledley et al., 2006) culminate in a period dedicated to reviewing and summarizing the treatment process and the progress made within it. This review typically leaves patients with a feeling of accomplishment as well as a sense of efficacy regarding their ability to handle distress.

Patients are likely to "package" past experiences and to "store" knowledge they gain about themselves in some implicit way whether their therapist engages in a consolidation process or not. However, these "spontaneous" narratives would naturally be colored by the patient's characteristic personality. For example, perfectionists may discount any progress that is less than perfect; patients with low self-esteem may dismiss their role in the progress they made during therapy. For this reason, it is important that the consolidation process be conducted jointly. This allows the therapist to steer the narrative to some degree, and also gives the therapist one (possibly final) chance to see the patient's mind in action—and to respond to it in a therapeutic way.

The available evidence regarding active therapist engagement with the consolidation process supports its importance. For example, experienced therapists from diverse orientations consensually identified support for their client's progress in consolidating gains of therapy as a component of successful termination (Norcross et al., 2017). Conversely, a separate sample of therapists reported that the end phase of unsuccessful therapy is often characterized by scant review of the therapeutic process (Quintana & Holahan, 1992).

To summarize, consolidation is a process which is bound to occur as therapy comes to a close, but one which is best conducted as a dialogue between patient and therapist. Therapists who remember that this dialogue can positively affect the patient's perception of the entire treatment (Knox et al., 2011) should consider taking an active part in it. The narratives that result from the consolidation process can contribute significantly to patients' personal development (Lieblich, 2004) and to the preservation of their treatment gains (Adler et al., 2008). As such, the consolidation process sets the stage for engaging in the next challenge: that of maintenance (Spence, 1982).

Clinical Example of Consolidation

Y., a 65-year-old man, survived a treacherous war and suffered posttraumatic symptoms for 40 years without formal recognition by the army. He suffered alone, inflicting misery and anger on his family and friends, who withdrew and moved further away from him. Symptoms intensified after his retirement. His severe deterioration forced him to seek formal recognition for his posttraumatic stress disorder (PTSD) status from the army, and he entered short-term day treatment. When termination approached, he got frustrated and angry: "Why the hell did I come here?" He was confused and couldn't acknowledge any gains. By working on the consolidation tasks, Y's therapist helped him realize how, prior to therapy, he had never stopped to reflect on his trauma. Therapy was thus conceptualized as this rare opportunity to stop and reflect. Subsequently, when Y asked for "help making sense of what we've been doing here," his therapist agreed: "You want the memory of therapy to be different from other chaotic mixtures of memories you have." In the final sessions, Y was able to adopt a new perspective on his progress:

> I look at myself, at how I was—abandoned and lonely, with no routine, apart from my spouse, distant from my children, with no friends. They always said I'm closed-off and violent . . . I never knew why I stopped being the nice young man I used to be. Now I have a name for it: PTSD. For 40 years, I didn't want to look back.

The therapist then pointed out that this act of looking back—so new to the patient—helps create a temporal dimension: "For years, you went AWOL from your current life—in order to survive it." In summarizing the treatment process, Y noted that he felt like he had learned that "talking brings relief," and that he now wanted to talk more "—and not only with you." He reclaimed his responsibility for the relationship with his children and relatives, saying:

> I'm going to remember this one thing you told me—that it's a challenge to talk rather than act, it's a challenge to let people know how I am. Now I feel up to this challenge. I was never a draft dodger, but now I feel like I'm finally recruited for the right mission.

Maintenance

The second challenge, maintenance of treatment accomplishments, also revolves around the therapy goals domain but is focused toward the future rather than the past. This challenge is actually made up of two parts. The first, maintenance, is essentially synonymous with relapse prevention. The second, generalization, involves the effort to foster additional posttherapy growth and expansion of treatment gains. Both maintenance and generalization are aimed at strengthening the patient's sense of hope and self-efficacy. They can be considered a success when patients exit therapy with the necessary tools (and with sufficient readiness to use these tools) to address, on their own, both risks for relapse/recurrence and opportunities for further growth.

Of course, successful maintenance and (to an even greater extent) generalization can be tall orders. As recognized by Freud and many others, even "solved" conflicts may reawaken (Freud, 1937; Kogan, 2007, p. 43). Indeed, the stability of therapeutic achievements is often less than perfect, as reflected in the high frequencies of relapse seen quite frequently in psychotherapy follow-up studies (e.g., Steinert, Hofmann, Kruse, & Leichsenring, 2014). Still, consumers (i.e., our patients) are understandably interested in services that will garner sustainable results. In effect, patients often wonder (and sometimes ask): is there a warranty on my achievements? Will my gains last or dissipate?

The answer to these questions is, of course, case specific, and requires a discussion of the particular patient's unique vulnerabilities and obstacles. In this way, therapists (who rarely offer explicit warranties) can at least create a framework or a support structure to help patients hold on to (and maybe expand on) their gains.

Both maintenance and generalization are future-oriented challenges. In engaging with these, therapists need to facilitate a process in which patients voice their wishes, dreams, ambitions, and plans—but also acknowledge their worries, concerns, or insecurities, thus anticipating future bumps in the road. The framework for tackling these posttherapy risks and opportunities involves the integrated use of the following therapeutic actions: (a) emphasizing the patient's strengths, (b) turning to realistic aspects of the patient's external world, and (c) preparing for future use of therapeutic tools. We will delineate each of these in the following paragraphs.

Emphasizing the patient's strengths is a therapeutic action that has its roots in ultrabrief therapy. This approach highlights the importance of patients' existing knowledge and motivation to deal with their difficulties (e.g., Bloom, 2001), while connecting them to their naturally existing inner sources of strength (e.g., Cameron, 2007). As such, it is conducted with an explicit awareness of the imminent termination—and with an eye toward the "day after."

An emphasis on strengths also capitalizes on the recency effect (described earlier). Focusing on patients' strengths specifically at the end of therapy helps imprint these strengths in their memory. Patients' deep understanding of their inner resources is reinforced by this imprint, making these resources more accessible for maintaining or generalizing achievements following treatment.

A second therapeutic action involves turning to realistic aspects of the patient's external world. This action has its roots in the systematic approach to psychotherapy. The latter approach posits that the patient's real-life environment merits considerable attention, as it has substantial power to help maintain achievements or conversely, to undermine them. In systemic therapeutic writings about termination (e.g.,

Smith, 2002), therapists who approach termination are encouraged to shift their attention from the patient's inner world, their internal suffering, or the patient-therapist relationship, toward the realistic supports and hindrances that can be anticipated in the patient's external world.

Environmental factors, such as social support, can have fateful consequences—potentially buffering against or pushing toward relapse after treatment (e.g., Norman et al., 2005). In empowering patients to handle their familial and social environments well, therapists and patients may review issues that had already been handled (hopefully, in a fruitful manner) in therapy or outside of it. They may also recognize sources of support and encouragement that exist in the patient's world—ones for which a sense of gratitude and appreciation is called for. But they should also be prepared to discuss issues that have not been handled previously and that may pose future difficulties.

The third therapeutic action involves deliberately preparing for future use of therapeutic tools. This action has its roots in symptom-focused approaches. Indeed, cognitive-behavioral therapists distinctly engage in addressing relapse prevention in the end phase more than therapists from other approaches (Norcross et al., 2017), often to good effect. In CBT, patients and therapists practice various behavioral and cognitive tools throughout treatment, with the intent of helping patients assimilate these so that they can be easily accessed and implemented outside of therapy. However, this action can be taken in any therapeutic approach, as long as therapists can identify "take-home points" that are worth naming, defining, and highlighting.

Indeed, insight-focused psychotherapy approaches often have their own version of this therapeutic action. In particular, they too can be thought of as making use of various tools—such as the exploration and analysis of feeling and thinking patterns, or of acting (out) in therapy or outside of it. As termination approaches, insight-oriented therapists will want to impart these tools—again, identifying those take-home points that merit naming, defining, and highlighting. In earlier, classic traditions of psychoanalysis, such imparting would often occur implicitly as when the therapist's interpretations during the end phase demonstrate to the patient how to deal with painful emotions, by reflecting and understanding oneself (Schafer, 1973). In

contrast, recent psychoanalytic writings suggest more explicit ways in which the therapist can recognize and highlight successful self-analysis by the patient. As some relational psychoanalysts suggest, "It may be helpful for the analyst to remark as termination approaches that this ability is what the patient will use, after termination, to solve problems and to right herself" (Craige, 2009, p. 110).

To summarize: as termination unfolds, therapeutic work has the potential of instilling hope and self-efficacy in patients. In due time, patients' sense of ownership of their new states of mind and of their ability to implement therapeutic tools may contribute to their resilience. Patients who are able to reflect on their gains and who truly take home the intended take-home points become less dependent on the continued guidance and affirmation of their therapists. Such independence can be thought of as an indicator of successful maintenance and generalization, that is, of a well-internalized therapeutic process.

Clinical Example of Maintenance

N., a 33-year-old male accountant sought treatment in a community outpatient clinic because of frequent panic attacks and a marked fear of leaving his house which had begun in the preceding 4 months. N declined medication, and began cognitive-behavioral treatment for panic disorder and agoraphobia. Although psychoeducation and interoceptive exposure were helpful, N became restless, and even angry with his therapist when they began to build a list of activities for in vivo exposures. He was reluctant to practice activities in which he might experience severe anxiety, and after two sessions in which the dyad discussed possible exposure activities, N declared that he does not feel this kind of therapy suits his needs, and announced his intention to leave treatment. A short discussion revealed that his decision was final. The therapist told N that she understands his fear, and respects his decision to terminate. She also argued that even if the treatment as a whole was not a success, a final session devoted to joint reflection on their work could be of value. In this final session, it became clear that N was depressed and hopeless regarding his situation, but insisted that the anxiety that he would undoubtedly have to experience if the

exposure plans were to continue was more than he was willing to endure. A joint review of their work revealed that the interoceptive exposure exercises had helped N distinguish between normal physiological arousal, anxious arousal, and full-blown panic. In light of this realization, N responded positively to the therapist's suggestion that he might be able to return to his daily athletic workout (which he had eschewed since the panic attacks began). He also agreed that it would be worthwhile for him to continue practicing interoceptive exposures at home. The therapist encouraged N to take on these goals, which would help maintain the (partial) gains made in therapy, and might even extend these gains further by reducing panic-related anxiety symptoms, and improving N's mood and functioning. At the end of the termination session, N thanked the therapist, saying, "Even though this type of treatment wasn't for me, I feel a bit more hopeful now. I'll give these things a chance."

Resolution

The third challenge, resolution of issues in the therapeutic relationship, revolves around the therapeutic relationship domain and is focused toward the past (i.e., on the history of the patient-therapist relationship). When engaging with this challenge, patients and therapists embark on a candid discussion of their relationship, in which they review events, moments, and issues that were meaningful to the patient, and allow the celebration of their points of compatibility while acknowledging—and striving to resolve—the road bumps or ruptures. This review contributes significantly to creating a comprehensive therapy narrative (Bauer & McAdams, 2004) and should take place alongside consolidation (i.e., the first challenge described earlier).

It is customary for insight-focused approaches to engage in this process of resolution. In particular, brief relational treatment (Safran, Muran, Samstag, & Stevens, 2001) views ruptures in the therapeutic alliance as any tension or breakdown in the collaborative relationship between patient and therapist (Safran & Muran, 2006). Brief relational therapy, along with its associated alliance-focused training provides therapists with specific interventions to recognize and address such ruptures, and there is

evidence indicating that repairing ruptures in the therapeutic alliance is related to positive outcomes (Safran, Muran, & Eubanks-Carter, 2011). Even in treatment methods that do not focus on alliance ruptures throughout treatment, the approaching termination may provide an opportunity to address events that occurred earlier in therapy, and bring resolution prior to separating.

Most insight-oriented therapies expect both patients' and therapists' interpersonal issues to find their way into the therapeutic relationship, almost inevitably (Davies, 2005; Marx & Gelso, 1987). Reviewing the relationship should give the patient an opportunity to disentangle these issues, as they are reflected in whatever meaningful events linger on in the patient's memory. To do so, both parties should share their experience while actively listening to the other's interpretation of the same events. Often, this will culminate in one or both taking responsibility for their role in the event itself—and for its resolution. Such interactions grant patients a meaningful experience of the "other"—that is, of someone who is a subject taking interest in their experience, while also taking responsibility for their own role.

Although mutual, resolution is not symmetrical. For example, though therapists too may have lingering memories or difficulties from the course of the relationship, they frequently will not have good reason to disclose or discuss these issues, especially ones that have not been an explicit part of therapy up to to this point. Instead, this process focuses on addressing the patient's experience, though this is done in a mutual manner. Specifically, therapists attend to their patients' experience and to the potential disparities between the two parties' experience in the events discussed. For example, a patient's memory of their therapist's attention drifting off in a certain session may be brought up. The therapist should, ideally, take responsibility for his or her role in this faux pas, but also take the opportunity to examine the patient's idiosyncratic reaction (e.g., self-recrimination in some patients ["I must be really boring"], or paranoia in others ["I can't trust anyone"], etc.).

Such memories may come as a surprise in some therapy relationships, or may echo conversations that have already happened previously. Either way, therapists may learn that they behaved hurtfully or that (previously unac-

knowledged) ruptures had occurred in the therapeutic alliance. The end phase of therapy provides one last opportunity for mending these ruptures and providing closure.

Resolution work also provides a chance to see the patient's handling of real-life—and often quite emotional—interpersonal interactions. In certain therapy relationships, and probably more so in symptom-focused approaches, this may be the first time in therapy in which emotional material of this sort is even approached. When successful, this work provides an opportunity for growth. Patients who are able to have a direct and frank conversation about the therapeutic relationship are likely to feel some sense of accomplishment over how both they and their therapists were able to withstand—and possibly even benefit from—the experience of interpersonal tension, staying in the relationship, confronting therapeutic ruptures, sharing responsibility, and creating a shared interpretation. If successful, both parties can feel that they managed the end period—together.

The end phase isn't just an opportunity to discuss past ruptures—it is also, at least in some cases, a breakup or rupture in its own right. For example, termination is often forced on both parties because of outside circumstances, or may result from a patient's one-sided decision to bring the therapy to a close. Even though these terminations pose different sorts of challenges, it is important for therapists to strive and provide a climate of comfort that fosters an open discussion about the termination itself. In such cases, specifically, therapists should actively initiate open, respectful engagement in the resolution process (Craige, 2009; Frank, 2009; Gabbard, 2009), and go beyond the mere discussion of the decision to terminate. Otherwise, therapy is more likely to end abruptly with conflict and disagreement as the lingering feeling (e.g., Olivera, Challú, Gómez Penedo, & Roussos, 2017).

Many treatments do reach their end without sufficient work on therapeutic interpersonal resolution (Fortune, Pearlingi, & Rochelle, 1992; Roe, Dekel, Harel, & Fennig, 2006). This insufficient attention may come about in two different ways. At times, patients (or worse yet, therapists) fail to disclose their intent to terminate until very late in the game, leaving therapy without a chance to adequately address the topic. But even in more adequately planned termi-

nations, or ones in which therapists correctly recognize the signs of their patients' intent, resolution work may fall by the wayside. Therapists may deny warning signs, or have difficulty coming to terms with the imminent separation (Novick, 1997).

In summary, therapeutic work focused on resolution may be elusive and difficult at times, but serves a crucial role in the end phase. When successful, resolution improves patients' ability to reflect on interpersonal issues in a dyadic integrative way. Importantly, it can also restabilize fragile therapeutic alliances or contribute to strengthening already stable ones. Finally, it provides patients with an invaluable model experience of going through a separation in which they are seen and they see the other. They have a chance to process this ending together with "the other" (i.e., their therapist)—an experience unlike that of so many interpersonal endings and ruptures in life.

Clinical Example of Resolution

D., a 26-year-old student was graduating from law school and moving back to her hometown. Due to the move, she was ending therapy after 13 months. She reported considerable improvement in the symptoms for which she had originally sought treatment (mild depression and alcohol abuse). As termination neared, the therapist asked D to reflect on the work she had done on the drinking issue. For the first time, D shared with her therapist that it had been hard for her to admit her drinking problem to the therapist. She felt her therapist withdraw and become disappointed with her about the drinking. The therapist asked D to tell her more about this experience. They tried to identify what parts of the therapist's behaviors gave D this feeling. In reviewing their first conversations about D's alcohol use, the therapist recalled feeling worried and concerned; together, they explored how it was that these feelings came across as disappointment, and realized that D's feeling of being a disappointment to her therapist resembled her ongoing feeling of disappointing her mother. Moreover, they noted how, at times, it is hard for D to distinguish between D's own self-criticism and her feeling that she is disappointing significant people in her life. In reflecting on this resolution process, D noted that her courageous disclosure about her feel-

ings within the relationship ultimately enabled her to feel accepted and helped.

Acceptance of the Separation

The fourth challenge, acceptance of the separation, also revolves around the therapeutic relationship domain, but like the maintenance challenge discussed earlier, is focused toward the future rather than the past. When engaging in acceptance, patients internalize that the therapy relationship is actually ending. This can evoke complex emotions on a spectrum ranging from mourning or catastrophizing to celebrating and welcoming the ending. The end phase calls for making peace with whatever emotions may appear. In it, patients and therapists can move from the resolution process (in which they attend to their actual experience together and to its possible divergence from what had been expected or wished for) to a more present and future-oriented perspective, the acceptance of the separation process itself: that is, to life without the therapy relationship.

When acceptance of the separation succeeds, sorrow, anger, or blame (toward their therapists or themselves) do not take away from the significance of the relationship or undermine the therapy's achievements. When patients fully accept termination, they may feel these feelings—at the same time experiencing gratitude, contentment, and satisfaction. A valuable lesson is that a fully lived, vibrant future is one in which the past "is not actually over" because their internalized interpersonal experience will continue affecting their lives. This perspective may help patients accept and sustain the partialness of the relationship. Accepting the end is, in fact, a healthy reaction to feelings of loss (Kübler-Ross, 2005) or disappointment (Mann, 1973). It should be noted, however, that in some cases, when treatment was successful, termination was mutually decided upon, and the patient has the confidence that he or she will be able to return to therapy if needed, the patient and the therapist may be more engaged in celebrating the excitement of termination, appreciating the patient's resilience, and being pleased with the patient coming to the point of taking a leap or "trying their wings."

Two approaches provide particular inspiration when thinking about the challenge of acceptance of the separation. First, the *existential approach* to therapy has, at its heart, the recognition of endings (including the end of therapy, its partialness, and its limitations). According to this approach, feelings that arise as endings (e.g., a death) near (particularly, existential dread) should not be interpreted away, but rather be permitted to stand on their own, be experienced, and be processed (Yalom, 2008). For example, when a forced ending to therapy leads a patient to engage in denial or bargaining, and to experience anger or depression, the opportunity to express rather than dismiss these will help the patient make peace with the anticipated loss (e.g., Kübler-Ross, 2005).

Second, innovative ideas about traversing the challenge of acceptance of the separation also come from acceptance and commitment therapy (ACT), a third-wave approach to CBT. ACT guides patients toward accepting the full array of their emotions and experiences while clarifying and remaining committed to their own important values and goals. For example, when termination nears, an ACT therapist would assist her patient with processing his emotions, accepting them mindfully without being triggered by them into mindless or fused action (e.g., postponing the termination; Hayes, Strosahl, & Wilson, 2012). In doing so, she provides him with an opportunity to act according to his preferred values, rather than react to (and be pushed around by) his internal states, and particularly fear.

Identifying the complex and often contradictory emotions that arise, and connecting them to the separation, strengthens acceptance. For example, disappointment may lead patients to experience pain and anger (either spontaneously or through therapeutic work): "Is this all we could do together?!" or "Can't you stay in touch with me?" At the same time, they may feel satisfaction, wholeness, and gratitude for the relationship they had built and for its contribution to their growth: "look at what we accomplished together!" or "I am ready to move on." Feeling grateful softens the envy, jealousy, and guilt of recognizing loss (Klein, 2013) during (and following) therapy. Gratitude also helps patients embrace vulnerability (Brown, 2012, pp. 117–128) and be open to discussing their feelings of fear and pain regarding ending the relationship. Often, therapist's self-disclosure regarding their own feelings facing termination,

may enable patients to engage in this intimate discussion (Frank, 2009; Shafran et al., 2015).

For acceptance of the separation to go well, two conditions must be met. First, therapists themselves need to believe that the treatment they had offered was valuable, even if it was limited. When therapists believe in the treatment they had offered, they convey an implicit message to their patients that the best had been done. Such reassuring messages help patients adaptively process separation. Of course, therapists often experience disparities between their (initial) hopes for a treatment, and the actual (or perceived) progress made in the treatment. In response, they (like their patients) may feel frustration, disappointment, or anger. It is important to remind therapists that, even as such frustration occurs, it is usually inadvisable to engage in last ditch efforts to "make up" for the disappointing progress. The ending of therapy is not the right time to offer new interpretations, introduce new psychoeducation, or (worse yet) "grade" patients on their progress (e.g., Nof, Leibovich, & Zilcha-Mano, 2017). Even when therapy is perceived as incomplete, therapists should resist the urge to play "catch up" and instead, should engage with their patients in the process of acceptance of the separation. To do so, they will need to first accept the termination internally. In such moments, it may be useful to remember that half of those who turn to therapy can be sufficiently helped in a few sessions, and many others need only 14–20 sessions to experience significant change (Anderson & Lambert, 2001; Wolgast, Lambert, & Puschner, 2004; Wolgast et al., 2005).

A second condition for successful acceptance of the separation is the patient's confidence that their therapist will continue to be their therapist, even when therapy itself is over. This idea—that the work is done, but that it could resume if needed, and that "once a therapist, always a therapist"—is consistent with the attachment theoretical viewpoint. Specifically, a good therapeutic relationship (like a good parental one) embodies the idea of a "secure base" (Farber, Lippert, & Nevas, 1995). Patients can venture out of this base, knowing that when needed, it will be there, awaiting their return.

A common therapeutic practice which helps make this secure base very explicit is therapists' invitation to return to therapy when needed (Marx & Gelso, 1987; Quintana & Holahan, 1992)—that is, therapists' expression of an "open-door" policy. This policy, customary within ultrabrief approaches, is now common among therapists from a variety of treatment orientations (e.g., Norcross et al., 2017), with patients also reporting that they were offered such an option (Olivera et al., 2017).

An open-door policy conveys the therapist's validation for the patient's mature ability to recognize their own needs and difficulties, and to be sovereign about if (and when) to resume therapy. This fosters a sense of independence and security within patients (Cameron, 2007). From a developmental perspective, it grants legitimacy to a process of stepping away and coming closer within the relationship (akin to the rapprochement phase; Mahler, 1966). It may also alleviate some of the patient's mourning regarding termination. Often, mourning stems from the loss of the relationship, rather than the discontinuation of sessions (Quintana, 1993); an open-door policy disentangles the two, and helps clarify that the relationship itself is not entirely over (Craige, 2009; Frank, 2009). This can help patients and therapists focus on what is, in fact, over—namely, this particular chapter in their relationship and in their lives.

To summarize, saying goodbye while engaging in an intimate emotional discussion about separation is both the cause and the result of accepting the end. When therapists come to terms with the limits of therapy and patients come to terms with the limitless therapeutic relationship, they are ready for this challenge. An open, candid successful discussion can also help patients look at other relationships and opportunities in their lives with less idealization and more acceptance. Despite being the last challenge described, acceptance of the separation is the primary challenge. Its success is the key to fully facing the other challenges of consolidation, maintenance, and resolution.

Clinical Example of Acceptance of the Separation

J., a 40-year-old woman was in therapy for 18 months, and had progressed significantly. For a couple of weeks, J changed or canceled sessions in the last minute. When her therapist asked her about this sequence of events, she announced, "I achieved my main goal in therapy, so my motivation has decreased." Termination was mutu-

ally decided upon and as the therapist described possible work toward termination, J seemed to have a strong emotional reaction to the idea of accepting the impending separation. She said it is easier to just disappear than to experience the separation fully, or to grapple with the unwanted emotions that this separation brings up. Abruptly ending relationships with significant people was a familiar pattern for J, who used to close herself up emotionally while minimizing the importance of the other (in this case, the therapist) and of the relationship (in this case, the therapeutic relationship), in order to function well. The therapist's encouragement to engage with the acceptance process enabled J to identify and express many novel feelings. Once termination was clearly imminent, J's gratitude became mixed with a sense of guilt and anger toward the therapist. These emotions were familiar to her from other instances of separation and other interpersonal changes, but J felt that for the first time she was able to linger and fully experience them, and to do so together with her therapist rather than alone. As a result, her emotions became clearer, she could somehow name them, and be less threatened by their emergence. In the final session, J shared with her therapist her fear that saying goodbye means she will not be able to come back to therapy if needed. The therapist suggested that her "slamming the door" habit led to experiences that created this fear. He assured her that therapy doors stay open and that she is welcome to return whenever she wishes.

The Therapist's Active Role in the End Phase

The four formidable challenges of the end phase are a compelling reason for both patients and therapists to adopt an active mindset in this phase. However, both parties may experience difficulty with saying goodbye and thus avoid this phase altogether or shorten its duration. This may be why one in five endings are labeled by therapists as premature discontinuation (Swift & Greenberg, 2012)—or in other words, as a missed opportunity for effective termination processes. We argue that, despite potential hardships, it is the therapist's critical responsibility to take an active role in the end phase, to be sensitive to possible issues dealing with termination and to respond appropriately to what

emerges in the therapeutic relationship in regard to that, as soon as termination is on the table.

Therapists who actively engage in the termination work suggested by the CMRA model need to convey the following invitation to their patients:

> Now that we are reaching the end, we have an opportunity to assess and consolidate your gains in therapy, to think about ways to maintain them in the future and apply them to situations we haven't explored until now. This is also an opportunity to think about our relationship, to celebrate things which worked well and resolve things that didn't; and of course to experience and accept the different emotions that arise from saying goodbye.

Certainly, the specific language used to convey this message, as well as the content of the consolidation, maintenance, resolution, and acceptance processes, will depend on the therapist's particular beliefs, and should incorporate only those techniques or interventions (e.g., open questions, interpretations, psychoeducation) which "fit" with the therapy conducted up to that point. With rare exceptions, the end phase would not be the ideal time to introduce entirely new ways of working together.

The focus and pace of termination therapeutic work will often vary depending on patients' personalities and diagnoses, on their previous experiences in therapy (and in other separations/endings), and of course on the strengths and weaknesses of the particular therapy relationship nearing its end. In some cases, patients will spontaneously engage in one or more of the CMRA challenges with their therapists. Therapists should be attentive to such spontaneous opportunities, encourage their patients when this occurs, and help surmount any obstacles which may arise along the way. One way of doing so is to name the (spontaneous) work underway, ensuring that the patient becomes aware of it.

Patients may express their experience of the "here and now" of separation through thoughts, feelings, sensations, and/or actions. The CMRA model helps therapists observe these expressions and see them as windows into the way the patient is handling each of the termination challenges. For example, a patient who brings up memories of a romantic breakup may actually be engaging, indirectly, with any of the four CMRA challenges. In reminiscing about the breakup, she may mention mistakes she would

know how to avoid today, posttherapy; this opens the door to a consolidation discussion. She may express concern about her future dating life; this creates an opportunity to explore maintenance. She may relive relationship ruptures she couldn't discuss then, with her partner; this may lead to resolution work. Finally, she may describe the old hurt evoked by that breakup; this creates a natural segue to acceptance of the separation discussions. Of course, therapists should be attuned to the possible presence of any one of these themes—or to the possibility that more than one is at work.

In certain cases, patients may avoid any termination-related discussion, keeping their thoughts and feelings surrounding termination to themselves. Others may be entirely detached from such thoughts or feelings. In these cases, therapists have a dual responsibility: they need to *react* therapeutically to the avoidance or detachment, but simultaneously *act* to ensure that the challenges of termination are not eschewed. This is particularly important as a corrective emotional experience for those patients who tend to be more avoidant or detached.

In this active role, therapists must remember that therapeutic alliance and collaboration with patients are prerequisites for therapeutic work—even at the end phase of therapy. For example, strong alliance in the end phase of therapy has been found to be associated with better (therapist-rated) outcomes, both for the phase itself and for therapy as a whole (Bhatia & Gelso, 2017). One way for therapists to strengthen the therapeutic alliance is by creating joint goals for this phase with their patients, using the guidelines of the CMRA model.

In summary, the expected variation in therapists' methods and patients' reactions to termination, mean that each ending will be unique. To prepare for their active role in this phase, we encourage therapists to internalize the CMRA model. Hence, throughout therapy and when ending comes, they will flexibly and clearly approach termination challenges.

Clinical, Research, and Training Implications of the CMRA Model

We began our work on the CMRA model with the realization that treatment termination has received far too little theoretical or empirical attention. In reviewing the (limited) literature, we were struck by the distinct emphases of different therapeutic orientations (e.g., insight focused vs. symptom focused therapies). We also noted how, despite those theoretical differences, recent research has found that experienced therapists of different theoretical stripes tend to engage in termination behaviors borrowed from differing orientations, and to agree on the utility of most behaviors, across theoretical orientations (Norcross et al., 2017).

How should we understand this gap between theory and practice? We take it to mean that, with experience, therapists learn to approach the end of treatment with an eclectic mindset, borrowing interventions from different orientations according to their patients' needs. This process is somewhat positive, but could be improved by having a formal integrative model of treatment termination, such as the one proposed here. A formal model of this sort can help bring more order even to the work of experienced therapists, which may, otherwise, be a very idiosyncratic "mix-and-match" process. Moreover, it is crucial for the training and supervision of novice therapists, who have not yet gained the necessary clinical wisdom through experience to face one of the most challenging phases of therapy. For both experienced and novice clinicians, the integrative stance of this model can help assess the strengths of their "native" treatment standpoint with regard to the end phase, and then consider what benefits can be gained from adopting other standpoints, presented in this model, into their therapy style (or into work with particular patients).

In developing our model, our intent was to both draw on existing psychotherapy research—and set the stage for greater research attention to the topic of termination processes. Indeed, we believe that the CMRA model lends itself easily to empirical study. As a first step, the feasibility of using the CMRA model as a whole merits examination, as does the exploration of the short- and long-term consequences of this model to therapy training and to treatment outcomes. Over time, we hope that research will proceed toward a more fine-grained test of the contributions of each CMRA aspect in optimizing the end phase in relation to the patient's experience, the therapeutic alliance, and, of course, the treatment outcome.

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Enséñales a decir adiós: El modelo de CMRA para finales de tratamiento

El final del tratamiento trae consigo desafíos únicos. Tradicionalmente, diferentes enfoques terapéuticos han enfatizado distintos aspectos del proceso de terminación. Los enfoques centrados en la perspectiva enfatizaron la relación terapéutica y la retrospección, mientras que los enfoques centrados en los síntomas enfatizaron los objetivos de la terapia y la prospección. En este artículo, presentamos un modelo integrador para terminaciones de tratamiento, que une los énfasis de los diferentes enfoques e identifica cuatro desafíos principales para la fase final. Específicamente, argumentamos que a medida que se acerca la terminación, los terapeutas necesitan evaluar activamente y abordar (1) el progreso y la consolidación de los logros alcanzados en la terapia, (2) el mantenimiento y la generalización de esas ganancias en el futuro; (3) la celebración de la relación significativa junto con la Resolución de las rupturas que pueden haber ocurrido en ella; y 4) la aceptación de la separación inminente entre el terapeuta y el paciente. Argumentamos que estos cuatro desafíos se asignan a dos ejes. Un eje es temporal y ayuda a distinguir las tareas centradas en la revisión o reflexión del pasado de las dedicadas a la planificación y la anticipación del futuro. El otro eje es sustantivo y ayuda a distinguir las tareas centradas en los objetivos de la terapia de aquellos centrados en la relación terapéutica. Concluimos el trabajo con una discusión sobre las implicaciones del modelo para la práctica clínica, la capacitación y la investigación.

terminación de psicoterapia, modelo CMRA, prevención de replanteo, resolución de ruptura, entrenamiento clínico

教导他们如何告别：结束治疗的CMRA模型

治疗的结束带来了独特的挑战。传统上，不同的治疗方法强调了终止过程中的不同方面。以洞察为中心的方法强调治疗关系和回顾，而以症状为中心的方法强调治疗目标和前景。在本文中，我们提出了一个治疗结束的整合模型，它结合了不同方法的重点，并提出了在最终阶段的四个主要挑战。具体而言，我们认为，随着治疗终止的临近，治疗师需要积极评估和解决（1）治疗所取得的进展和对已有收获的巩固，（2）在未来维持和泛化这些成效;（3）庆祝有意义的关系，同时解决其中可能有的关系裂口; 4）接受即将来临的治疗师和个案间的分离。我们认为这四个挑战反映在两个维度上。一个维度是时间性的，有助于区分开重点在对于过去的回顾或反思还是关注在对于未来的规划和预测上。另一个维度是实质性的，有助于将关注治疗目标与以治疗关系为中心区分开来。我们在本文结束时讨论了该模型对临床实践，培训和研究的意义。

心理治疗终止, CMRA模型, 复发预防, 裂口修复, 临床训练