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Plan-Compatible Termination in Psychotherapy: Perspectives From Control-Mastery Theory

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Termination processes in psychotherapy vary widely across patients, therapists, and therapies. While general guidelines on termination can inform ethical and responsible termination practices, termination decisions and processes are likely optimized using a case-specific approach. Control-mastery theory (CMT) provides a framework for considering the unique ways individual patients work in psychotherapy and can be applied to help therapists understand and facilitate optimal terminations. The present article provides a brief overview of CMT and outlines perspectives regarding the decision-making and discussion of psychotherapy termination, the processing of termination, and the final session of therapy.

Clinical Impact Statement

Question: How can psychotherapy termination be considered and responded to in a case-specific, personalized way? ***Findings:*** Control-mastery theory provides a framework for considering the patient's adaptive goals, pathogenic beliefs, traumas, and tests in determining individualized clinical responses to termination-related issues in psychotherapy. ***Meaning:*** Clinicians can help patients disconfirm pathogenic beliefs—through passing their tests—throughout the termination process, including during the final psychotherapy session. ***Next Steps:*** Further research is needed to understand patients' testing strategies specifically in the context of psychotherapy termination.

Keywords: psychotherapy, termination, personalized, case formulation, pathogenic beliefs

As with many aspects of psychotherapy, termination—the completion or ending of treatment—is highly complex, yet only partially understood. While recommendations to prevent premature termination draw upon research regarding pretherapy preparation, patient preferences, and the alliance (Swift, Greenberg, Whipple, & Kominiak, 2012), limited research is available to inform decisions and processes involved in planning and carrying out effective therapy endings. Rather, clinical wisdom about termination tends to be passed down through training and supervision, often focusing on issues such as reviewing therapeutic gains and preparing for life after treatment. A recent survey of expert psychotherapists revealed remarkable consensus regarding several core termination tasks, including collaboratively determining the pace of termination, review of progress and attribution of gains to the patient's efforts, processing of loss feelings, and support for patients' future functioning and use of coping skills (Norcross, Zimmerman, Greenberg, & Swift, 2017). Such recommendations, combined with ethics-based termination standards (Vasquez, Bingham, & Barnett, 2008), are useful signposts in helping therapists work toward appropriate and satisfactory treatment endings. Yet we still do not know—and indeed lack empirical data for—what constitutes an optimal termination process, a phenomenon that varies widely across patients, therapists, and therapies. Moreover, there may be considerable divergence in patients' preferences for and experiences of termination. One patient may favor leaving treatment shortly following symptom relief to practice new skills independently, while another may prefer to continue the therapeutic relationship throughout a "practicing" phase. One patient may welcome a discussion about loss as treatment ends, while another may experience this as detracting from more salient themes. Thus, termination-related decisions and practices likely require a considerable degree of case specificity and personalization. The present paper discusses termination considerations and processes from an idiographic perspective through the lens of control-mastery theory (CMT).

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A Brief Overview of CMT

CMT (Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986) is an integrative relational cognitive-dynamic theory of mental functioning, psychopathology, and psychotherapy developed and empirically tested by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group (for an overview, see Silberschatz, 2005). Rather than prescribe sets of interventions for therapists to implement, CMT seeks to understand the therapeutic process in terms of the varied means by which patients work in therapy to achieve their goals and remove obstructions to personal growth. One of the basic assumptions of CMT is that individuals are motivated to adapt to their environments, master their problems, and achieve healthy developmental goals (Weiss, 1990). From this perspective, many of the problems that bring people to therapy may be seen as originating in earlier efforts to adapt to adverse experiences and traumas. Perceptions of safety and danger—and the capacity of the human psyche to unconsciously control its processes—shape these adaptations as well as the individual's subsequent use, maintenance, and relinquishment of them over time (Weiss, 2005). According to CMT, beliefs about the self, others, and environments are typically developed out of efforts to understand and adapt to one's circumstances and to avoid future traumas (Weiss, 1990). Under conditions of trauma or unattuned parent–child relations, such beliefs serve the function of helping the child regulate affects; avoid endangering thoughts, emotions, attitudes, and behaviors; and maintain ties with caregivers and family members with whom the child needs to feel close. For example, a child whose attachment-seeking behavior chronically yields angry or rejecting caregiver responses may develop the belief that seeking closeness is dangerous—offensive to the other and potentially damaging to the relationship. Over time, such beliefs can be reinforced through further experience, profoundly influencing the individual's sense of self and of interpersonal relationships: "I am not worthy of another's care and attention, and if I do attempt to be close to someone, I will be rejected." Thus, pathogenic beliefs—often unconscious—are highly constricting, grim, and associated with negative affect. Pathogenic beliefs warn people to avoid pursuing important developmental goals—such as intimacy, autonomy, satisfaction, emotional awareness, and personal achievement—because of their association with danger to oneself or important others (Curtis & Silberschatz, 2005; Weiss, 1993).

CMT suggests that when patients seek psychotherapy, they do so out of a fundamental striving for growth and mastery, in an effort to disprove their pathogenic beliefs and pursue important developmental and personally relevant goals (Weiss, 1998). However, because of their origins in important early bonds with caregivers, becoming aware of—and directly challenging—pathogenic beliefs may be experienced as threatening. Individuals may work unconsciously to become aware of and disprove these beliefs through testing them and developing insights about them (Gazzillo, Genova, et al., 2019; Weiss, 1990). The degree to which the therapist "passes" a patient's tests holds great significance for therapeutic progress. Through testing, a patient may attempt to find out whether it is safe to bring forward forbidden goals and to challenge pathogenic beliefs (Gazzillo, Genova, et al., 2019). The therapist's response signals the degree to which the patient can experience the therapist as supportive of the patient's developmental goals and capable of helping to disconfirm pathogenic beliefs. Subsequent work in therapy may then be done to develop alternative beliefs about self and others, and to pursue personal goals.

It is important to note that CMT regards patients' tests—sometimes manifesting as apparently contradictory behaviors, and evoking strong emotional reactions in therapists—not as by-products of psychopathology, but rather as key aspects of the patient's efforts to feel safe, disprove pathogenic beliefs, and master traumas (Gazzillo, Genova, et al., 2019). This perspective encourages the therapist to consider the ways in which the patient's communications and actions in therapy are reflective of the patient's assumed strivings for mastery and adaptive goal pursuit. The patient may actively address pathogenic beliefs by testing them directly in the therapy relationship, or may simply observe the therapist's attitude to determine whether it is safe to become aware of inhibited goals, remember traumatic experiences, or modify constricting beliefs—depending on whether the therapist is aligned with the patient's objectives. Indeed, CMT suggests that patients may achieve considerable progress in therapy through "treatment by attitudes" (Sampson, 2005; Shilkret, 2006), whereby the therapist's attitudes are keenly discerned as either supportive of or in opposition to the work that the patient is attempting to do. Moreover, in line with the assumption of the patient's active striving to advance therapeutic progress, patients may communicate important information about the kinds of attitudes and responses that will be useful for them (Bugas & Silberschatz, 2000; Sampson, 2005). Referred to as "coaching," such communications may occur either directly or implicitly, to proactively guide the therapist regarding aspects of the patient's goals or preferred ways of working, or to reorient the therapist following a misunderstanding or failed test (Bugas & Silberschatz, 2000).

From the perspective of CMT, a patient's attempt to work in therapy can be conceptualized as following a "plan" (Weiss, 1993) that consists of goals, the pathogenic beliefs that impede the pursuit of them, and the traumas that gave rise to pathogenic beliefs and which the patient needs to master. Therapists' inferences about the patient's plan provide an orientation to therapeutic responsiveness, in terms of the kinds of experiences and insights that would be most helpful to the patient, as well as the ways in which the patient might test in order to feel safe, develop insights, and relinquish pathogenic beliefs. Research has demonstrated that it is possible to reliably formulate a patient's plan (Curtis & Silberschatz, 2007; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986) and that therapist interventions that are compatible with a patient's plan—including successfully passed tests of pathogenic beliefs—are associated with both immediate therapeutic progress (Silberschatz & Curtis, 1993; Weiss et al., 1986) and improved posttreatment outcome (Silberschatz, 2017). Thus, from the perspective of CMT, therapists should help patients carry out their plans—which are inherently idiographic and individualized—more so than adhere to a priori treatment models or manuals (Gazzillo, Dimaggio, & Curtis, 2019). This holds true for decisions and processes surrounding the issue of psychotherapy termination because patients may use termination-related issues to disconfirm pathogenic beliefs, and continue to work on their plans until the very end of the final session (Bush & Gassner, 1986).

Contemplating and Discussing Psychotherapy Termination

Patients and therapists can propose termination of therapy for a variety of reasons, including the reduction of problematic symptoms, the achievement of therapeutic goals, financial or scheduling obstacles to continued treatment, or the emergence of difficulties in the therapeutic relationship. In line with general guidelines about optimal termination (e.g., Vasquez et al., 2008), CMT would indicate that the proposal to end therapy should correspond with the patient having made improvement in relevant problems and satisfactorily achieved therapy goals. This involves careful consideration not just of the patient's conscious stated goals, but also of the inferred developmental goals that may be inhibited by pathogenic beliefs. For example, a patient who stated she wanted to reduce troublesome anxiety symptoms may, at a surface level, be seen as ready for termination upon the abatement of panic attacks. Yet the therapist's proposed termination would be premature if an inferred, higher order goal of wanting to be more assertive and ambitious has not been reached. Ideally, an accurate plan formulation would guide the therapist to collaborate with the patient regarding this goal and the pathogenic beliefs against it (e.g., "If I pursue my own ambitions, it will make me seem disloyal to my family") and to support the patient's wish to terminate only when satisfactory progress has been made. In other words, sometimes a patient may propose ending therapy as a test. A patient who is trying to overcome the belief that she is uninteresting and unworthy of care or admiration, for example, may suggest termination to investigate whether the therapist shares this perception of her as deserving to be rejected or whether the therapist's response offers a hope of disconfirming it. This way of testing is known as a transference test: the patient is setting up a trial scenario in which the therapist is placed in the role of an earlier (e.g., parental) figure, in order to rework traumatic interactions and modify the associated pathogenic beliefs (Gazzillo, Genova, et al., 2019; Weiss, 1993). It is important to note that the motive for such testing is typically unconscious. To pass such a test, the therapist would need to avoid taking the request to terminate at face value, and instead provide a response that counters the pathogenic belief and models an alternative to the earlier traumatic interaction[1]:

Patient: *I've been thinking about how much progress I've made in therapy. Maybe it's time for me to stop coming here . . .*

Therapist: *You certainly have made a lot of progress here. Could you tell me more about your thoughts of ending therapy?*

Patient: *I guess now that I'm not so depressed, I don't have anything else to talk about. You could help someone else instead.*

Therapist: *I wonder if we could think about it further. My sense is that there may well be other important issues we could focus on, and I'd be concerned about you ending therapy before having a chance to fully explore these areas.*

Another risk for premature termination can occur when the patient adopts a method of testing that evokes negative feelings in the therapist over a protracted period. In such a circumstance, the therapist may regard the patient as "difficult" or resistant, and may be tempted to introduce the prospect of terminating treatment or referring the patient elsewhere. However, rather than trying to thwart progress, the patient, in fact, may be unconsciously testing pathogenic beliefs arising from earlier traumatic interactions. For instance, a child who is regularly criticized and devalued by a parent may adapt to this abuse by concluding that she is indeed useless and worthy of criticism. In therapy, this individual may test this belief by treating the therapist the way she was treated—for example, by devaluing the therapy and/or the therapist—to determine whether one can experience devaluation without believing it is true and to learn alternative responses to such treatment. This type of test is known as "passive-into-active" (Gazzillo, Genova, et al., 2019; Weiss, 1993) due to the patient actively positioning the therapist in a role similar to one that the patient experienced passively, in order to learn from the therapist's management of the situation. A therapist who—tired of feeling beat up by the patient—accepts the idea that termination is an option because the treatment is "useless" could signal that the criticism cuts too deeply and that the therapist is not strong enough to help the patient fight against the belief that she is worthless. This would constitute a failed test:

Patient: *I've been coming here for months and nothing has changed—what a waste of time! Can't you see how much I'm suffering?*

Therapist: *Maybe it's time you considered seeing someone else. I could give you the names of some colleagues, or you could try group therapy . . .* [failing the test]

Patient: *I knew it, you're just as ineffectual as my previous therapists. Here we go again, another therapy ending with nothing to show for it.*

Therapist: *Hold on, I overreacted and can see that you're not necessarily wanting to stop the work we're doing. I want to hear more about your feelings about the therapy, and how you feel it's not helping you. I also wonder if at some level you're trying to find out whether I'm strong enough to help you with the intense self-criticism that you struggle with?* [passing the test]

Some patients do end therapy prior to the achievement of important goals. This could be adaptive if a patient concludes—perhaps through repeatedly failed tests—that the therapist is not able to help with the patient's goals. Alternatively, conditions in the patient's life may suggest that, despite gains made in therapy, it may not be safe enough to pursue certain goals. A wish to change unsatisfying relationship patterns, for example, may be perceived as too risky and threatening to an existing important relationship, at least at this point in time. Thus, termination may be brought about by the patient's obedience to pathogenic beliefs that warn against pursuing developmental goals. From the perspective of CMT, conversations about the prospect of

[1] Note: all clinical material is disguised and derived from composite cases.

termination always require consideration of the patient's idiographic plan—their unique way of working in therapy—and of the possibility that testing may figure in either the patient's or therapist's inclination to end treatment.

Of course, termination can also occur when the patient has arrived at a satisfactory degree of goal achievement and mastery. While establishing this may generally be achieved through a collaborative exploration of the patient's readiness for termination, the therapist's understanding of the patient's plan is again the best guide (Silberschatz, Curtis, & Nathans, 1989). A patient who is overcoming a profound conviction that she is uninteresting and deserving of rejection may—despite significant progress in overcoming this belief—feel threatened by the therapist's suggestion to terminate. This patient may benefit more from being allowed to initiate the conversation about the prospect of ending treatment. In contrast, a patient tackling the belief that people he loves will feel useless if he is independent may benefit if the therapist introduces the topic of termination, thereby conveying that the therapist is not endangered by the patient's independence. A therapist's decision to discuss termination may be influenced by overt signs of progress as well as by indirect clues provided by the patient. In this way, a patient may coach the therapist—often unconsciously or implicitly—to orient the therapist to the kind of responses most likely to be helpful (Bugas & Silberschatz, 2000), including those involving discussion of termination:

Patient: *I was thinking about the lifelong self-doubt that we've been discussing, and where my lack of confidence came from, but also how I'm much less bothered by that now.*

Therapist: *Perhaps we should spend some more time understanding the origins of your self-doubt . . .*

Patient: *Maybe—do you think this dream might help? In the dream I was at a graduation ceremony. I was excited to graduate and leave school, but the dean wouldn't give me my degree, as though he thought I was not ready.*

Therapist: [later in the session] *You've been talking about feeling more confident and making more bold decisions, which were important issues you wanted to address. I agree that you've made significant progress in these areas. I wonder if we should begin talking about the idea of finishing our work together?*

In this example, the patient's coaching—recounting a dream in which the teacher (therapist) does not recognize the student's (patient's) readiness to move on—reoriented the therapist to the patient's need for acknowledgment of therapeutic progress and hinted at the potential appropriateness of discussing termination.

Processing the Termination

When a decision to discontinue treatment has been made, and as the termination date approaches, therapist and patient are faced with the task of preparing for the ending of therapy. Typically, this preparation is portrayed as involving consolidation of the gains made in treatment and facilitation of the continuation of progress beyond the consulting room (Vasquez et al., 2008), and is ideally a collaborative process (Goode, Park, Parkin, Tompkins, & Swift, 2017). The particular aspects of this preparation, and how it is accomplished, vary according to different therapy models. Interpersonal therapists, for example, might focus on grief and loss issues that are evoked as the relationship with the therapist is ending, while cognitive behavioral therapists might focus on reducing the patient's reliance upon the therapist, perhaps through reduced session frequency, and on practicing new behaviors that can guard against future relapse (Joyce, Piper, Ogrodniczuk, & Klien, 2007). From the perspective of CMT, these may well be useful approaches—among many others—but only insofar as they are compatible with the patient's individual plan. That is, the way in which termination is processed should be determined on a case-specific basis according to the patient's goals and pathogenic beliefs. Patients may continue to work on their goals and disconfirm pathogenic beliefs throughout the termination phase, and specific interventions aimed at processing the termination should support such work (for an empirical study supporting this view, see Bush & Gassner, 1986). For instance, if the patient has been working on difficulties with autonomy—involving the belief that to separate from others would cause them pain or hardship—the therapist's emphasis on loss and separation during the termination phase could have the effect of suggesting that the patient's pathogenic belief is correct (i.e., that the therapist might be upset by the patient's wish to finish therapy). Indeed, the patient might even test this belief, with the unconscious intent of strengthening the work she has done on disconfirming it, by inviting the therapist to focus on issues of loss or regret surrounding the termination. The patient, for example, could introduce reluctance and regret while providing other evidence that she is ready to terminate:

Patient: *I've been thinking that maybe I'm not as ready to leave therapy as I thought.*

Therapist: *Can you tell me more about that?*

Patient: *I just have a feeling that it's a bad idea. I know I've made a lot of progress, and I'm doing well, but I worry because therapy—our relationship—has been so important to me. Maybe I'll regret it if I stop coming . . .*

Therapist: *I'm wondering about your worry, could it be connected to the guilt that you've historically felt about following your own direction? You've worked hard at overcoming this, but perhaps we should explore it further in the time we have left.*

In this case, the patient's plan called for supporting the patient's work in feeling more autonomous; if the therapist had focused on loss or abandonment, it might have impeded the patient's sense of mastery over separating from others. It is important to note that there could be numerous potential responses that would be compatible with the patient's plan. In this example, the therapist drew the patient's attention to exploratory work they had done, and offered further exploration or interpretive work regarding the patient's interpersonal dynamics. However, an attitude of enthusiasm for the patient's new endeavors might also be effective; many patients may derive greater therapeutic benefit from the therapist's plan-compatible attitudes than from interpretive interventions

(Sampson, 2005; Shilkret, 2006). Collaborating with the patient to decrease the frequency of sessions could also be useful, so the patient could experiment with being less connected while experiencing the therapist's support for her autonomy and independence. For a different patient, however, processing the termination in this manner might be counter to the patient's plan. A patient who was working on feeling more deserving of others' admiration—with a pathogenic belief that others would only be interested and responsive if he was distressed or suffering—might be better served by maintaining the same frequency of contact until the final session. Such a patient might use the termination phase—a period where distress has remitted—to strengthen his work on disconfirming the belief by utilizing the therapist's attention on aspects of the patient's life that have little to do with distress or psychopathology:

Patient: *I feel like there's nothing to talk about now that I'm feeling better and planning to stop seeing you in a few months.* (silence)

Patient: *Really, nothing at all? I had the impression there were a lot of new developments in the work you're doing; you only just hinted at them ever so slightly last week.*

Patient: *Well now that you mention it, I'm pretty excited about this idea that I shared with my team. I think it could really take off, and I was surprised at how well received it was by everyone at work . . .* (continues to elaborate)

Therapist: *This sounds like an important area of development for you, and we could pay more attention to this as we finish our work together. What do you think?*

Patient: *I'd like that very much.*

In this example, the patient sought to consolidate his work on disconfirming a sense of being uninteresting and undeserving of admiration through a transference test. Passing this test was fairly simple: by expressing interest, the therapist helped the patient feel safe enough to experience himself in a new way, compatible with his goal. For this particular patient, the therapist would have failed this test—risking confirmation of the pathogenic belief—by suggesting a reduction of session frequency, or by focusing the remaining sessions on relapse prevention and problem solving for future distress episodes.

Sometimes therapist and patient must process a termination that arises for reasons other than the accomplishment of therapeutic goals. The patient might move away, or a therapist might leave the clinic, or some other external reason may impose an ending—in some instances rather suddenly. Although such occurrences threaten to impede the patient's plan, the therapist's plan formulation may nevertheless help determine the kind of responses needed to support the patient's therapeutic work while processing an imposed termination. Indeed, an unanticipated shortening of the therapy might even increase the frequency or boldness of testing as the patient, consciously or unconsciously, makes the most of the limited time left. Moreover, an imposed termination might feel particularly endangering for some patients, especially if evocative of an earlier, traumatic separation. Thus, the patient may test vigorously to reestablish a sense of safety with the therapist, in order that the therapeutic relationship and work to date may be preserved and utilized by the patient going forward. Of course, processing this kind of termination should include discussion of the goals achieved and of those the patient may wish to continue addressing in a future therapy.

The Final Session

In line with the CMT assumption that people tend to strive toward adaptation, growth, and mastery, it is reasonable to assume that patients may continue to do so right up to and including the final therapy session. Therefore, rather than prescribing a set of procedures for the final session, CMT would encourage the therapist to respond in plan-compatible ways to the idiosyncrasies that occur in final therapy sessions. Final sessions often involve looking back on the work that has been accomplished, with patient and therapist collaborating on saying goodbye in a way that acknowledges each other's contributions (Goode et al., 2017). Indeed, therapist statements that laud the patient's strengths and achievements, or that express the therapist's sense of satisfaction in working with the patient may further consolidate the therapeutic work of a patient who has struggled with a belief that she is incompetent or unlovable. Yet even here the therapist must consider how to respond in an optimal way according to the patient's specific plan. A patient whose traumatic experience included frequent admonishment for expressions of pride might praise the therapist during the final session, inviting the therapist to be proud (and to model healthy and authentic pride) in order to strengthen her efforts to feel comfortable feeling proud of herself:

Patient: *I've been so profoundly helped by this therapy; you should feel very proud of the work you have done.*

Therapist: *I think you have been the one who did most of the work!*

Patient: *So, you agree with my mother. Being proud of oneself is wrong.* (appears disappointed)

In this example, the patient tested by adopting a noncompliant stance toward the pathogenic belief against feeling proud, and sought to enact this with the therapist in the role that the patient had typically been in. This is referred to as a passive-into-active test by noncompliance (Gazzillo, Genova, et al., 2019). The test would have been passed if the therapist in this example had accepted the patient's praise, thereby enhancing the patient's consolidation work in the final session. Fortunately, if the therapist has responded in plan-compatible ways throughout most of the therapy—including the termination phase—missing a test during the final session likely would not have a significantly detrimental effect on the patient's overall progress.

Enactments and Corrective Emotional Experiences in Termination

From the initial consideration of ending treatment through to the final session, patients may utilize aspects of psychotherapy termination to address the pathogenic beliefs that obstruct their adaptive, developmental goals. Whether introducing the prospect of

ending treatment, discussing an impending termination, or saying farewell to the therapist, the patient is likely to be highly attuned to the degree to which the therapist's responses are plan-compatible. Indeed, each of these activities may involve the patient's engagement in testing to disconfirm pathogenic beliefs and consolidate progress toward important goals. Arguably, conceiving of termination as a special phase of therapy could obscure the idiosyncratic ways in which the patient may utilize termination-related phenomena to advance his or her goals. Difficulties surrounding the decision to terminate, or in the processing of termination, may rather be viewed as enactments—unconsciously motivated patient-therapist interactions which, if unresolved, threaten to derail therapeutic work. Enactments have been conceptualized as actions and interactions that represent disavowed experiences—the actualization of transference and countertransference—that shape the therapeutic relationship, typically involving the unconscious contributions of both patient and therapist (see Hirsch, 1998 for a review of enactment theory). Termination in particular offers considerable opportunity for enactments (Gabbard, 2009; Jacobs, 1986; Salberg, 2009), perhaps due to themes such as rejection, dependency, loss, and guilt that may be evoked as two people contemplate and/or proceed to part ways.

While enactments are largely seen as somewhat inevitable, and their resolution as salutary (Hirsch, 1998), CMT extends the concept of enactments by viewing them in the context of the patient's plan. Following the assumption of the patient working to advance his or her goals and to disconfirm pathogenic beliefs, an enactment may emerge out of the patient's testing activity. For example, a patient may repeatedly insist upon ending therapy as a test of whether the therapist will reject her, and whether she is deserving of the therapist's protection (see Weiss, 1993, pp. 46–47 for an example). In this case, the patient invites the therapist to occupy the role of an earlier, rejecting figure. However, an enactment may also arise from the therapist's strong countertransference, such as a feeling of futility—evoked by the patient's apparent resistance—that leads the therapist to seriously consider termination (see Jacobs, 1986, pp. 300–303 for an example). From the perspective of CMT, such countertransference can also be examined in light of the patient's plan as, for example, the therapist's response to passive-into-active testing (i.e., the patient behaving toward the therapist in a manner that evokes affects once felt by the patient under traumatic circumstances). In this way, the co-constructed nature of the enactment may be seen as the patient's effort to master traumas and pathogenic beliefs combined with the therapist's lack of plan compatibility in the face of strong countertransference. Thus, while CMT recognizes enactments at a descriptive level, the appreciation of the patient's strivings toward mastery lends an additional motivational element to their conceptualization. From this perspective, enactments—including those tangled up in termination—may be thought of as the patient's seeking (often unconsciously) of corrective experiences, along with the therapist's responses (either plan-compatible or incompatible) to such efforts.

Just as termination may be fertile ground for enactment, so too may it offer the potential for corrective emotional experiences. Pathogenic beliefs concerning deservingness of attachment, omnipotent responsibility for others, and pride in autonomy and accomplishment may all be worked on through the termination process, to the degree to which the therapist's attitudes and responses serve to correct the particular, plan-specific beliefs and traumas of the patient. The concept of corrective emotional experiences (Alexander & French, 1946), referring to therapist actions that directly counter a patient's relational expectations deriving from earlier, developmental trauma, is embraced by CMT—along with the broader notion of corrective experience, proposed by Goldfried (2019) as a common mechanism in all psychotherapies. Indeed, Weiss (1993) extended the concept of the corrective emotional experience in psychotherapy by arguing that the patient actively—if unconsciously—seeks corrective emotional experiences from the therapist and in the therapeutic relationship that will foster safety, disconfirm pathogenic beliefs, and facilitate mastery of traumas. Thus, the patient keenly observes whether the therapist's attitudes and responses to tests are corrective in terms of his or her own particular plan (Sampson, 2005). One patient, for example, may express hesitation about ending therapy to seek the corrective experience of the therapist's encouragement, to master the trauma of having felt unduly responsible to look after a neglectful parent. Another patient, however, may similarly express hesitation in order to seek the corrective experience of the therapist trying to convince her to stay, to modify a chronic belief that she is unappealing to others. By adhering to an a priori notion of what the termination process should entail, a therapist is at risk of overlooking the particular corrective emotional experiences that the patient may continue to seek, all the way through to the last moments of therapy.

Future Directions

Despite rigorous research supporting plan compatibility as an individualized responsiveness to patients' goals (Silberschatz & Curtis, 1993; Silberschatz, 2017), further research is needed to support CMT principles in the area of psychotherapy termination (Bush & Gassner, 1986). Future studies could examine the ways in which patients test pathogenic beliefs through the contemplation of ending treatment and through the processing of termination. A particular challenge would be to examine changes in the patient's goals across therapy, including through the termination phase. Research supporting CMT has relied upon plan formulations developed early in treatment, yet patients may become aware of or develop new goals, or may prioritize different pathogenic beliefs and testing strategies as treatment unfolds over time. Thus, there is much to learn about the evolution of patients' plans throughout therapy, and the plan compatibility of therapists' responses during termination. Another important area of discovery pertains to the maintenance and extension of therapeutic progress following completion of treatment. For example, to what degree does managing termination in plan-compatible ways contribute to posttherapy gains? While CMT suggests that patients continue to draw from their therapy experiences after treatment has ended, research is needed to examine how this is done and to what effect.

Conclusion

CMT provides a powerful framework for understanding how patients and therapists work together in psychotherapy—including the termination process—to effect change. CMT suggests that patients strive to achieve their goals and overcome their obstacles, often in highly unique ways that involve using their therapist's

attitudes and responses to test their pathogenic beliefs. As with all aspects of therapy, termination-related phenomena (e.g., the contemplation of therapy ending) may become entwined in the patient's testing activity. Moreover, testing may continue throughout the termination process and final session. Indeed, other psychodynamic authors have noted the potential for enactments—unconsciously determined patient-therapist interactions—to influence termination decisions and processes (Gabbard, 2009; Salberg, 2009). According to CMT, such enactments may be understood by the therapist as tests, or aspects of the patient's seeking of corrective emotional experiences (Alexander & French, 1946; Weiss, 1993) to overcome obstacles and achieve goals. Thus, the patient continues to work throughout termination, discerning the therapist's plan-compatible responsiveness until the very end of treatment. Given research demonstrating patient progress in response to the therapist's plan compatibility (Silberschatz, 2017), a CMT perspective suggests that handling termination in ways that align with the patient's plan will most likely ensure a positive termination experience.

References

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy*. New York, NY: Ronald Press.

Bugas, J., & Silberschatz, G. (2000). How patients coach their therapists in psychotherapy. *Psychotherapy, 37,* 64–70. http://dx.doi.org/10.1037/h0087676

Bush, M., & Gassner, S. (1986). The immediate effect of the analyst's termination interventions on the patient's resistance to termination. In J. Weiss & H. Sampson, & the Mount Zion Psychotherapy Research Group. (Eds.), *The psychoanalytic process: Theory, clinical observation & empirical research* (pp. 299–320). New York, NY: Guilford Press.

Curtis, J. T., & Silberschatz, G. (2005). The assessment of pathogenic beliefs. In G. Silberschatz (Ed.), *Transformative relationships: The control mastery theory of psychotherapy* (pp. 69–91). New York, NY: Routledge Press.

Curtis, J. T., & Silberschatz, G. (2007). Plan formulation method. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (2nd ed., pp. 198–220). New York, NY: Guilford Press.

Gabbard, G. O. (2009). What is a "good enough" termination? *Journal of the American Psychoanalytic Association, 57,* 575–594. http://dx.doi.org/10.1177/0003065109340678

Gazzillo, F. (2016). *Fidarsi dei pazienti. Introduzione alla control-mastery theory/trusting patients* [Introduction to control-mastery theory]. Milan, Italy: Raffaello Cortina.

Gazzillo, F., Dimaggio, G., & Curtis, J. T. (2019). Case formulation and treatment planning: How to take care of relationship and symptoms together. *Journal of Psychotherapy Integration*. Advance online publication. http://dx.doi.org/10.1037/int0000185

Gazzillo, F., Genova, F., Fedeli, F., Curtis, J. T., Silberschatz, G., Bush, M., & Dazzi, N. (2019). Patients' unconscious testing activity in psychotherapy: A theoretical and empirical overview. *Psychoanalytic Psychology, 36,* 173–183. http://dx.doi.org/10.1037/pap0000227

Goldfried, M. R. (2019). Obtaining consensus in psychotherapy: What holds us back? *American Psychologist, 74,* 484–496. http://dx.doi.org/10.1037/amp0000365

Goode, J., Park, J., Parkin, S., Tompkins, K. A., & Swift, J. K. (2017). A collaborative approach to psychotherapy termination. *Psychotherapy, 54,* 10–14. http://dx.doi.org/10.1037/pst0000085

Hirsch, I. (1998). The concept of enactment and theoretical convergence. *The Psychoanalytic Quarterly, 67,* 78–101. http://dx.doi.org/10.1080/00332828.1998.12006032

Jacobs, T. J. (1986). On countertransference enactments. *Journal of the American Psychoanalytic Association, 34,* 289–307. http://dx.doi.org/10.1177/000306518603400203

Joyce, A. S., Piper, W. E., Ogrodniczuk, J. S., & Klien, R. H. (2007). *Termination in psychotherapy: A psychodynamic model of processes and outcomes*. Washington, DC: American Psychological Association. http://dx.doi.org/10.1037/11545-000

Norcross, J. C., Zimmerman, B. E., Greenberg, R. P., & Swift, J. K. (2017). Do all therapists do that when saying goodbye? A study of commonalities in termination behaviors. *Psychotherapy, 54,* 66–75. http://dx.doi.org/10.1037/pst0000097

Rosenberg, S. E., Silberschatz, G., Curtis, J. T., Sampson, H., & Weiss, J. (1986). A method for establishing reliability of statements from psychodynamic case formulations. *The American Journal of Psychiatry, 143,* 1454–1456. http://dx.doi.org/10.1176/ajp.143.11.1454

Salberg, J. (2009). Leaning into termination. *Psychoanalytic Dialogues, 19,* 704–722. http://dx.doi.org/10.1080/10481880903379255

Sampson, H. (2005). Treatment by attitudes. In G. Silberschatz (Ed.), *Transformative relationships: The control mastery theory of psychotherapy* (pp. 111–119). New York, NY: Routledge Press.

Shilkret, C. J. (2006). Endangered by interpretations: Treatment by attitude of the narcissistically vulnerable patient. *Psychoanalytic Psychology, 23,* 30–42. http://dx.doi.org/10.1037/0736-9735.23.1.30

Silberschatz, G. (2005). *Transformative relationships: The control mastery theory of psychotherapy*. New York, NY: Routledge Press.

Silberschatz, G. (2017). Improving the yield of psychotherapy research. *Psychotherapy Research, 27,* 1–13. http://dx.doi.org/10.1080/10503307.2015.1076202

Silberschatz, G., & Curtis, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology, 61,* 403–411. http://dx.doi.org/10.1037/0022-006X.61.3.403

Silberschatz, G., Curtis, J. T., & Nathans, S. (1989). Using the patient's plan to assess progress in psychotherapy. *Psychotherapy, 26,* 40–46. http://dx.doi.org/10.1037/h0085403

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43,* 379–387. http://dx.doi.org/10.1037/a0028291

Vasquez, M. J., Bingham, R. P., & Barnett, J. E. (2008). Psychotherapy termination: Clinical and ethical responsibilities. *Journal of Clinical Psychology, 64,* 653–665. http://dx.doi.org/10.1002/jclp.20478

Weiss, J. (1990). The centrality of adaptation. *Contemporary Psychoanalysis, 26,* 660–676. http://dx.doi.org/10.1080/00107530.1990.10746684

Weiss, J. (1993). *How psychotherapy works*. New York, NY: Guilford Press.

Weiss, J. (1998). Patients' unconscious plans for solving their problems. *Psychoanalytic Dialogues, 8,* 411–428. http://dx.doi.org/10.1080/10481889809539259

Weiss, J. (2005). Safety. In G. Silberschatz (Ed.), *Transformative relationships: The control mastery theory of psychotherapy* (pp. 31–42). New York, NY: Routledge Press.

Weiss, J., Sampson, H., & the Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observation and empirical research*. New York, NY: Guilford Press.

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