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# Exploring service users' first-hand account experiences of endings from a psychological service or therapy: A systematic review and meta-ethnographic synthesis.

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## Abstract

**Purpose** To review and synthesis the qualitative literature on service users' experiences of endings from a psychological service or therapy.

**Methods** A systematic search of the peer-reviewed literature was conducted. Studies were identified using specific inclusion criteria and included in the synthesis. A modified CASP tool was used to critically appraise the quality of the papers. A meta-ethnographic approach was used to synthesize the findings from the included studies.

**Results** Twelve papers were identified which met the inclusion criteria. The interpretation of findings suggested three key themes: anticipation of ending, service user control and sense of responsibility. Studies were geographically spread and of high quality.

**Conclusions** The review highlights the importance of service users' perspectives in understanding the experiences of endings. The findings complement existing literature and provide new interpretations. Considerations for practice in the UK were limited however the review does provide directions for future research.

**Practitioner Points**

- The nature of the therapeutic relationship and the emotional impact this may have on both service users and staff should be considered when ending therapy.
- Further consideration should be given to how staff manage their own responses towards the ending.
- The time-limited structure of therapy within the NHS may aid the ending process by taking responsibility away from the staff or service user.

By definition, an ‘ending’ in therapy is the process whereby a service user concludes their therapy or treatment. Within the United Kingdom (UK) National Health Service (NHS), the ending point in therapy is influenced by three distinct parties: the service user, the service, and the local commissioners or funders.

Psychological therapy typically consists of four distinct phases; assessment, formulation, intervention, and discharge. The assessment, formulation, and intervention phases are supported in practice by theory, research and specific clinical practice guidelines and protocols (e.g., BPS; 2008, 2011). In addition, they are regularly monitored within service progress reports and evaluations (BPS, 2008). The ending phase, however, is not supported in the same way. Despite being viewed as characteristically different from the rest of therapy (Firestein, 1974), limited attention is given to the ending phase of therapy within clinical practice.

Quite the opposite is true in the clinical literature, where the ending phase of therapy is widely considered to be an important part of the therapeutic process (Baum, 2005; Walsh, 2007). There is a plethora of theoretical literature considering the importance of and manner in which endings are understood and managed. From an early psychoanalytical perspective (Freud, 1937), an analysis should not be considered complete until the individual has processed all psychological conflict and anxieties; thereby coming to a natural end. Considering the time-limited structure of therapy within the NHS, it is clear why the psychoanalytic approach to endings is incompatible with current clinical service delivery.

An alternative model by Quintana (1993) asserts that endings can be experienced as either a time of crisis or an affirming experience of growth. It describes the range of alternative experiences that could be expected during the ending process but offers little explanation of factors influencing them. Experiencing

the ending as a crisis, not only has risk implications but may also render the entire therapy ineffective. As argued by Coltart (1993), negatively experienced endings may compromise the whole therapy and potentially unravel therapeutic gain.

The literature offers a conceptual understanding of endings in therapy. However, it is based on limited evidence, and its descriptive nature limits application to modern day clinical practice. The observed disconnection between the literature on endings and their management in practice may in part be explained by the lack of empirical literature on how the ending is experienced by the participants.

'Experience' in the current context is defined as the personal encounter of the ending process. A true account of the experience would, therefore, be best told by the service users' who lived the experience; this is referred to as the first-hand account experience within this review. Consistent with the 'ask the client' movement (Elliott, 2010), research investigating service users' perspectives is said to be an empowering tool for exploring experiences in psychotherapy (Elliott, 2010). Likewise, Kazdin (1999) outlined the importance of including service users' perspectives when appraising therapy.

Within the empirical literature, there are several limitations which may prevent a clear understanding of how endings in therapy are experienced from the service users' perspectives. Most studies investigating experiences used quantitative survey-based designs to report reasons for and reactions to the ending of therapy (Roe, 2007; Westmacott & Hunsley, 2010). The questionnaire design typically used within such studies limits the exploration and understanding of service users' ending experiences to pre-determined categories set by the authors. Ideally, experiential phenomena, such as endings, would be investigated using qualitative methods, as

this would facilitate depth of understanding and allow service users to voice their own opinions, beliefs, and accounts (Evans, 2002).

Qualitative studies exploring ending experiences have largely investigated health professionals' perspectives of service users' experiences (Fortune et al., 1992; Lanyado, 1999). Although such studies offer valuable insights, they are the therapist's interpretation and not the service user's own account. As demonstrated by Råbu, Binder and Haavind (2013), therapists and service users often have different views of the ending experience. Therefore, the secondary account perspectives offered by therapists may not be an entirely reliable reflection of the ending experience.

In summary, the theoretical literature provides an understanding and outlines the importance of endings in the context of therapy. However, the literature on ending experiences consists primarily of quantitative studies and second account perspectives and therefore lacks the first-hand account as told by service users.

Qualitative studies are useful in understanding service users' experiences of ending, however, each are context dependent and therefore may be limited in informing broader clinical practice (Silverman, 1998). A meta-synthesis would be one method of addressing the issue as it would enable the qualitative literature to be evaluated in a larger interpretive context. Campbell et al. (2003) described how a qualitative synthesis goes beyond the descriptive account often seen in narrative reviews and instead uses interpretations to inform new concepts and theoretical insights.

The most common method of qualitative synthesis is meta-ethnography (Noblit & Hare, 1988). A key component of meta-ethnography involves a process of

translating studies into one another. Noblit and Hare (1988) claim this preserves the distinct characteristics of the individual studies whilst offering an interpretive account.

## Aims

To explore service users' first-hand account experiences of endings from a psychological service or therapy, a systematic review, and meta-ethnographic synthesis were conducted. The review aimed to select and appraise peer-reviewed articles that explored service users' subjective experiences of endings from a psychological service or therapy. Secondly, the review aimed to provide an interpretative synthesis of service users' experiences of endings. Such a synthesis would provide a clearer understanding of service users' experiences of endings, potentially informing clinical practice guidelines and the direction of future research.

## Methods

The systematic review followed the process described by Boland, Cherry, and Dickinson (2014). It consisted of three main phases; a systematic review of the peer-reviewed literature, a quality appraisal of articles that met the inclusion criteria, and a synthesis of findings using a meta-ethnographic approach (Noblit & Hare, 1988).

### Searches

A systematic search was conducted in March 2018 using six electronic databases: PsycINFO (1806-present), PsycARTICLES (1894-present), MEDLINE (1946-present), EMBASE (1980-2016), Web of Science (1900-2016) and Applied Social Science Abstract Index (ASSAI 1987-present). Free text searches of relevant references and Google Scholar were also conducted to ensure all eligible papers had been sourced. Reference lists of identified papers were also checked.

**Search Terms**

An iterative scoping search of target databases was conducted to identify relevant key search terms. Terms were identified using free-text searches and were included if they related to the aims of the review. Alternative database search operators and terms used to catalog similar papers were also included. Relevant key search terms centred around the following four main headings, ‘endings’; ‘therapy’; ‘experiences’ and ‘service users’ as outlined in appendix A.

Different strategies were used to increase the effectiveness of the search (Evans, 2002) and to narrow down the search results. For example, positional operators such as ADJ and Boolean operators such as OR and AND were used to collate similar records or combine key search terms.

The current search strategy did not include a filter for qualitative studies for the following reasons. Firstly, Hughes, Closs and Clarke (2009) reported that electronic databases are insufficient in providing adequate indexing for qualitative research. Secondly, an initial scoping search demonstrated that some qualitative findings were embedded within mixed-methods designs. Therefore, to ensure all qualitative data was included in the search, methodologically related search terms were not included.

**Inclusion Criteria**

To ensure the review was comprehensive but specific to the review aims, articles were included in the synthesis if they met the following criteria:

- Were published in a peer-reviewed journal. This ensured some level of quality control and defined the limits of the review. Policy documents, dissertations and grey literature were excluded on this basis.
- Explored experiences of endings from the service users’ perspective, this criterion was central to the aim of the review.

- Endings were from a mental health service or psychological therapy. Endings from physical health services were beyond the scope and aims of the review.
- Utilized qualitative data collection and analysis. Qualitative data were also extracted from mixed-methods articles. The qualitative criterion was decided because it ensured the data included actual or interpretations of first order constructs. This concerns the meaning of the actual lived experiences of an event and is central to answering the review question.
- Written in English, however, the search was not limited to a specific country. A broader geographic range was deemed to enable a variety of cross-cultural perspectives to be captured within the review.
- Related to adults, aged 18 years or over.

**Selection**

Articles were selected according to the framework set out by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2009). Duplicates were removed before the title, and abstract of relevant papers were assessed against the inclusion criteria by the author.

A total of 2075 articles were produced from the database searches. One additional article was identified through alternate search methods. Once duplicates were removed (N=601), article titles were screened. The majority of articles were excluded at this point (N=1410) as they did not meet one or more of the inclusion criteria. Abstracts of the remaining 65 articles were obtained and reviewed, of which 53 were excluded for reasons listed in figure 1. Twelve full-text articles were reviewed and found to meet the inclusion criteria and therefore eligible for inclusion in the review.

****Insert figure 1 here****

## Quality Appraisal

The quality appraisal of qualitative studies has been much debated, and there is little agreement on whether, and how a paper should be appraised (Atkins et al., 2008). The debate around whether qualitative studies should be appraised is based on a philosophical argument that the evaluation criteria used should be consistent with the approach that underpins the research design (Fossey, Harvey, McDermott & Davidson, 2002). The majority of quality appraisal tools use a checklist style proforma, allowing studies to be evaluated against set criteria.

Previously, the checklist method approach to quality assessment has been criticised for appraising the quality of the written source rather than the procedure (Atkins et al., 2008; Sandelowski & Barroso, 2002). However, the written quality of a paper must meet certain standards in order for it to be replicable, for ethical assurance and to ensure enough information is provided for it to be synthesized within a review. Therefore, despite the discussed limitations, the current review will assess the quality of studies.

The Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2013b) is one of the best documented tools used to rate the quality of qualitative studies. The approach adopts a scoring system similar to its quantitative equivalent (CASP, Public Health Resource Unit, 2013a).

A study by Dixon-Woods et al. (2007) highlighted several limitations of the CASP (2013b), criticised the tool on the basis that it lacked focus on the impact of findings. Given the relevance of endings to clinical practice, it is important that any quality assessment of the literature provides sufficient evidence regarding quality. Therefore in common with previous studies (Campbell et al., 2003, 2011), and

advocated in a review by Spencer, Ritchie, Lewis & Dillon (2003), an adapted version of the CASP (2013b) was used to critically appraise the quality of the twelve included papers. The framework was adapted to include criteria which fit with the purpose of the review. Additional criteria further evaluated the method and analysis and therefore enabled a broader review of the evidence in comparison to the original CASP (2013b). The framework outlines fourteen criteria against which each of the twelve review papers was appraised. A scoring system defined by Bailie and Tickle (2015) was applied as follows: ’2’ if definitely met, ‘1’ if unclear, and ’0’ if not met. Studies were independently ranked by the first and second author, and a mean score was calculated. All twelve papers reviewed obtained a score ranging between 16-27 and therefore met the author’s pre-defined minimum standard for sufficient quality (>14) and were included in the synthesis.

The results from the quality appraisal suggest that the studies represented a wide geographical spread, the overall quality of the studies was high. The twelve papers met 89% of the quality criteria. Four studies were identified from the UK, two of them specific to high secure hospital settings. Given the wide geographical spread of the review studies and the specificity of the included UK studies, contextual factors were considered when discussing the findings of the review.

## Results

The findings from twelve studies were included in the synthesis. The studies included a total of 348 participants ranging from 22 to 70 years of age, from various countries; USA, UK, Israel, Argentina, and Norway. 69% were female and 31% male. Only three studies reported data on ethnicity. Nine studies collected data via semi-structured interviews; two collected written responses via open-ended questions as part of a larger mixed-method design, and one used an online qualitative survey.

Data were analysed using a variety of qualitative approaches. Whilst all studies included service users' first-hand account experiences of endings, the research questions, and aims varied. The search strategy did not specify service or therapy characteristics, and therefore the studies included experiences of ending from both individual psychotherapy (N=9) and service transitions (N=3). Available data from studies exploring individual therapy endings indicated that therapy was predominantly delivered by therapists from a psychoanalytical orientation (N=197). Other approaches included integrative (N=30), systemic (N=13), humanistic (N=13), psychodynamic (N=10), cognitive (N=5), interpersonal (N=1), client-centered (N=4) and unspecific (N=15). Two of the studies which looked at transitions were from a UK high secure hospital. Key study characteristics are summarized in table 1.

*** *Insert table 1 here****

**Data Abstraction**

Meta-ethnography is an interpretive approach to qualitative data synthesis which goes beyond the description of the individual studies providing a collective and innovative interpretation of the whole (Campbell et al., 2011). The method includes third level interpretations, which are considered to be more in-depth than numerical or narrative synthesis methods (Campbell et al., 2011). The approach provides a new interpretation which may contribute to theory development, research questions or practice implications within the field (Noblit & Hare, 1988). As discussed, there is little empirical evidence focussing on service users' perspectives, and therefore a meta-ethnographical approach would provide a synthesis of the available evidence.

Campbell et al. (2003) proposed that an example paper identified by experts may be of higher relevance and therefore argue it should be used as starting point for review. No such study was identified in the current topic field, and therefore the

order was defined by the adapted CASP (2013b) quality assessment tool. Each paper was hierarchically ordered, and the highest-ranking study reviewed first. Adaptations to the CASP (2013b) meant the relevance of the studies was factored into the quality appraisal. The authors acknowledge that the order in which studies were reviewed may have influenced their interpretations and the resulting synthesis. The process, however, facilitates replication and allows higher quality papers to be reviewed first.

The seven-phase meta-ethnographic approach defined by Noblit and Hare (1988) informed the synthesis process. Each of the studies was read and re-read until familiarity with the content and detail of the studies was reached. Data was systematically extracted using a bespoke extraction template. The extraction of themes utilized Schutz's (1973) notion of first, second and third order constructs. First order constructs focus solely on service users' perspectives and experiences; second order constructs are the authors' interpretations, and third order constructs are the synthesiser's interpretations.

Noblit and Hare (1988), suggested that a list of themes are used to determine how studies relate; however, they do not stipulate how the process is conducted. The synthesis was therefore guided by methods utilised in previous reviews (Atkins et al., 2008). Themes were extracted, listed and mapped into relevant categories. Comparisons between the themes were used to identify key relationships.
Three forms of meta-ethnographic synthesis, outlined by Noblit and Hare (1988), were used to synthesize the findings of the included studies:

1. Reciprocal translation: similarities across the studies were identified and synthesised into either an existing concept or new metaphor.

2. Refutational synthesis: differences between studies were identified and synthesised into a relevant concept that captured the essence of the conflict.
3. Line of argument synthesis: collates both reciprocal and refutations translations within the review studies into a new interpretive context.

## Interpretation of Findings

The meta-ethnographic process identified key themes, centered around three third order constructs: (1) Anticipation of Ending; (2) Service User Control; and (3) Sense of Responsibility. Within each construct, sub-themes were identified and are demonstrated in a cross-comparison table. (See table 2).

****insert table 2 here****

### The anticipation of ending.

'Anticipation of Ending' was relevant in ten of the studies (1, 2, 3 etc.) and identified in at least one of the three sub-themes: (1) the emotional impact of ending therapy; (2) loss of a meaningful relationship; and (3) service users' perceptions of therapists' anxieties. Each sub-theme indicated that service users' viewed the ending of therapy to be an emotionally evoking experience centering on ending anticipation.

#### *The emotional impact of ending therapy.*

Developed through reciprocal translations the current sub-theme was identified in eight of the studies (1, 2, 3, 4, 6, 8, 9 and 10). The theme collates how the experience of ending evoked powerful emotions such as anxiety, fear, and frustration. Regardless of contextual factors surrounding the experience, it appears that the anticipated loss of therapy was the common antecedent which evoked the emotional reactions discussed in the studies.

Service users who ended therapy typically responded negatively when therapy was either perceived as incomplete or when they were dissatisfied with the process. Study two reported how the challenges of transition from a high secure hospital left service users with “feelings of frustration, dissatisfaction, and anguish”. Service users who reported feeling satisfied with the ending also reported concerns and anxieties about the future and their capability to survive beyond therapy. In summary, the ending of therapy evoked a strong emotional response in service users.

### *Loss of a meaningful relationship.*

Six studies (3, 4, 6, 7, 9 and 10) reflected on the emotional impact of ending a meaningful relationship in therapy. Although the emotional responses to ending the relationship were largely negative, they reflected positive feelings about the therapeutic relationship and therapy. For example, study three reported how service users’ felt, “nervous and grieved the loss of their therapist”.

The therapeutic relationship is like no other in that service users’ may open up more than they have ever done with anyone else in their lives. When a relationship ends, it can bring up emotions of loss, grief, and anxiety; particular in cases where individuals may have early experiences of loss or relationship ruptures. Findings highlighted the importance of the therapeutic relationship in both the ending process and throughout therapy:

> “The relationship that developed with my therapist was the most secure and strong I had in my life, and the thought of termination was difficult.” (Study 9).

### *Perceived therapists' anxieties.*

The final sub-theme interprets therapists' invitations for contact beyond therapy as a mechanism to manage their own anxieties towards the ending. Five studies (3, 4, 5, 8 and 9) found a recurrent theme of staff "leaving the door open" (3, 9) to therapy. Considering the studies individually, therapists' invitation of contact beyond therapy may be a function of offering a sense of security to the service user. However, a broader view of the included studies suggests this may be more a reaction of therapists' anxieties. Firstly, only study 7 reported that service users requested additional contact beyond therapy, suggesting little or no need for therapy extensions, infact the opposite was observed (discussed below). In summary, the anticipation of the ending may evoke anxiety in the therapist, who in response, offers contact beyond therapy.

## Service user control.

'Service User Control' was relevant as a construct in all studies and identified in at least one of the three sub-themes: (1) Ending experienced as a process of independence and growth; (2) Service user initiated ending, and (3) Preparation empowering the service user. The collective interpretation of the three sub-themes captured the service users' desire to be in and assert control.

### *Ending as a process of independence and growth.*

Nine studies (1, 2, 3, 5, 6, 8, 9, 11 and 12) alluded to service users' experiences of endings as a process of independence and growth. Reciprocal translation led to the following interpretative narrative explanation of what may have brought about this experience of independence and growth. Six studies (2, 3, 5, 9, 11 and 12) reported the predominant reason for ending as the goals of therapy

having been achieved. Goal attainment may have influenced service users to develop a more positive outlook on the future and themselves:

> "I'm a different person to when I first got here." (Study 1).

The newly adopted positive outlook is likely to increase an individual's self-reliance and confidence about the future and, in turn, reduce their dependency on others. Study 3 reported how a former psychotherapy client felt:

> "Good about leaving and ready to handle problems on her own… confident that [she] would be okay."

The synthesis revealed how service users felt a sense of completion and a need for independence from therapy. This may be acted out through their initiation of the ending, as reported in the final, third order construct.

***Service user initiated ending.***

The synthesis poses a question about whether the decision to end is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process. Seven studies (4, 5, 6, 8, 9, 10 and 11) reported that the decision to end therapy was initiated by the service user. For example, study 11 concluded that "service users, not therapists, were the best judges" of when to end therapy and had, therefore, made the decision to end in six out of nine cases. Similarly, study 5 reported how a majority (71%) of service users initiated the ending. In summary, service users appear to have taken the ending decision as a personal responsibility:

> "It was my decision; it was a unilateral decision." (Study 5).

### *Preparation and involvement empowering the service user.*

This sub-theme reflects a consensus amongst five of the studies (1, 2, 3, 7 and 11) that service users felt more in control when prepared for, or involved in, the ending process.

Three studies (1, 3 and 11) reported how being prepared for the ending was helpful for service users managing any anxieties brought up around the ending. In direct contrast, two studies (1 and 2) reported how a lack of preparation and involvement evoked feelings of disempowerment and distress. For example, study 1 described how service users felt “disempowered” because of the lack of involvement they had in the discharge process.

In summary, preparation appears to facilitate the management of anxiety or distress about the ending. Therefore, when anxieties are better managed the individual feels more in control of an uncontrollable phenomenon (in as much as endings in therapy are inevitable). As summarized in study 3, preparation helped service users get the “hang” of ending therapy.

## Sense of responsibility.

A ‘Sense of responsibility’ was implied across seven of the review studies (1, 4, 5, 7, 9, 10 and 11) and identified in at least one of the two sub-themes: (1) Responsibility felt towards the therapist and (2) Ambiguity around the decision to end. The theme captures the underlying sense of responsibility within the dyadic relationship.

### *Responsibility felt towards the therapist.*

Three studies (4, 5 and 12) reported how service users felt anxious about how the therapist would respond to their decision to end therapy. The apprehension and

caution taken in approaching the ending conversation may imply that service users perceived certain vulnerabilities in the therapist and therefore felt responsible for ensuring the therapist was perhaps protected from the consequences of ending.

The findings reported that service users' apprehension was typically influenced by their need to seek out consensus from the therapist around the ending decision:

> "I was alone with the decision [to end therapy] and afraid to share it with the therapist." (Study 5).

When the therapist responded positively, services users reported a sense of relief, however, if the therapist response was negative, this evoked feelings of disappointment and guilt. Findings revealed how the therapist response influenced service users overall ending experience:

> "The therapist's feeling of rejection due to my desire to terminate and my difficulty terminating as a result." (Study 9).

***Ambiguity around the decision to end.***

Developed through refutational translations, this sub-theme was identified in seven of the review studies (1, 4, 5, 7, 9, 10 and 11). It considers the ambiguity around who is responsible for ending therapy.

Earlier translations identified a unilateral service-user led decision to end therapy. However, in contrast, five studies (1, 4, 5, 7 and 10) described the decision to end as a collaborative responsibility, whereby both service user and therapist were involved in the decision and process of ending. For example, study 1 Identifies two themes that alluded to endings as a collaborative responsibility: (1) Trust and Support: "I couldn't have done it on my own"; and (2) Feeling empowered: "We're all very close, you're always in the loop." Likewise, in study 10, one participant reported a collaborative process, "we both decided it wasn't the right time

for me." Such excerpts indicate that the endings were a shared experience in both process and decision making and therefore alluded to the ending being a collaborative responsibility.

**Line of Argument Synthesis**

A line of argument synthesis aims to look beyond the written word to uncover the unsaid meaning of service users' ending experiences. Therefore, the current synthesis also considered the relationship between third order constructs and provides an interpretive narrative of service users' experiences.

The synthesis highlighted how the relationship between the service user and therapist is central to therapy. Therefore, parallel to the ending of therapy, the individual also ends a therapeutic relationship, evoking feelings of loss, grief and anguish. Higher-order interpretations suggest that therapists also anticipate the loss of the relationship, which is acted out by the offering of additional contact beyond therapy- 'leaving the door open'. We may hypothesise that what we witness in the first third-order construct is a display of resistance, from both service users' and therapists against the ending of the relationship and therapy.

The therapeutic relationship is like no other in that there is often a level of exposure, openness, and trust beyond what is experienced in most close romantic relationships (Livesley, 2003). The synthesis implies that, as the ending point approaches, a role-reversal may occur within the therapeutic relationship. As demonstrated in the third-order construct, service users felt a sense of responsibility toward the therapists' ending experience.

Interpretations of therapists' resistance and their negative responses towards the ending indicate that it has an emotional impact on them. Although this review exclusively focused on service users' experiences, they reported how their own

experiences were dependent upon therapists' reactions. This implies that therapists' anxieties were not well-contained. The role-reversal in the dyadic relationship raises a question as to how well therapists contain their responses to endings, as well as a question as to who holds the anxiety around ending.

The anticipated ending point also creates a sense of ambiguity around whose decision it is to end. The synthesis concludes that there is no consensus around who holds responsibility for the ending and therefore poses a question about whether the decision to end is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process. Ambiguity around the ending decision may be influenced by the therapists' resistance to end therapy. However, it may also be a reaction to service users' reach for independence.

Viewing the ending as a collaborative endeavor may be one way to alleviate the distress surrounding the ending process. As demonstrated, service users felt less distressed when the ending was prepared for in collaboration with the therapist (e.g. joint decision-making). Likewise, service users sought out therapists' collaboration around the ending decision, which brought about emotional relief. Collaboration may alleviate distress by creating a sense of control for the service user.

In summary, the construct of 'service user control' may interact with both the 'anticipation of ending and the 'sense of responsibility' felt during the ending process.

## Discussion

The review used a meta-ethnographic approach to appraise and synthesise the existing qualitative research on service users' perspectives of endings from psychological therapy. It provides an interpretive understanding of how endings are experienced by service users under three main constructs: (1) Anticipation of ending;

(2) Service user control; and (3) Sense of responsibility. The synthesis has highlighted key points for discussion that may have implications for the direction of future research and clinical practice.

**Service User Control**

A key finding was service users' desire to be in and assert control over the ending process. Control as a concept underpinned many of the themes discussed within the synthesis. Similar to Quintana's (1993) 'termination as transformation' model, service users described the experience of endings as a process of independence and growth. For some, the ending represents 'moving on' (Walsh, 2007).

The findings outline the importance of ensuring endings are prepared for, discussed and experienced jointly with service users. They also suggest that therapist factors may have influenced service users' sense of control over the ending experience. However, it would be premature to assume therapists' contributions without considering their first-hand account experiences. Therefore, future research should conduct a review and meta-synthesis of therapists' first-hand account experiences of therapy. If considered jointly alongside the current review it may provide a better understanding of the key concepts discussed here.

**Therapists' Anxieties and Attachment Theory**

Interpretations of therapists' resistance and negative responses towards the ending, suggests that therapists hold anxiety around the ending of therapy. We cannot infer any explanatory factors from this review; however, therapist reluctance to end therapy is commonly reported, and typically related to therapist ambivalence (Phillip, 1997).

Attachment theory (Bowlby, 1973) has been used to explain service users' reluctance to end therapy (Holmes, 2010) and the therapeutic relationship (Obegi, 2008). Applying the principles of attachment theory to therapists' anxieties may, therefore, offer one perspective for understanding their experiences when ending therapy. The majority of therapists are considered to have a 'secure' attachment style (Rubino, Barker, Roth & Fearon, 2000). However, this does not fit with their apparent ambivalent response to therapy. Within therapy, the relationships consist of the 'making and breaking of affectional bonds' (Bowlby, 1979) and therefore the therapist regularly builds up and then ends relationships that encompass trust, intimacy, and support (Livesley, 2003). Ending, regardless of the success of therapy, evokes emotions of loss. Therefore, the regularity of making and breaking relationships might create contextual anticipation often seen in individuals considered as having an 'ambivalent' attachment style (Ainsworth, Blehar, Waters & Wall, 1978).

The review has highlighted the dyadic process of ending the therapeutic relationship through interpretations of reported therapist resistance and, the service user' developed a sense of responsibility towards the therapist. Service users assuming responsibility for the therapist's feelings or well-being can be quite risky (Shulman, 1999). We would recommend that further research explores practice support enabling therapists to contain their own feelings about ending therapy.

**Boundaries Imposed by Time-Limited Therapy**

There is no consensus about who holds responsibility for the ending, raising the question whether the decision to end is an individual responsibility and therefore initiated by the service user, or whether it is a collaborative responsibility completed as part of the therapeutic process.

The majority of endings discussed within the review were from private practice psychotherapy clinics from outside of the UK. The number of sessions was not restricted by any government or practice guidelines, and therefore the decision to end was the sole responsibility of the therapeutic dyad.

The current NHS practice within the UK operates time-limited therapy directed by clinical practice guidelines and dictated by local NHS trusts, commissioners or funders. Considering our findings, we propose that time-limited therapy can be beneficial by removing responsibility from both therapists and service users. The UK healthcare system as it is currently may, therefore, be more effective for endings in therapy than endings in private practice.

**Limitations and Conclusion**

As discussed in the introduction, this synthesis is an interpretation of an interpretation and, each layer of interpretation moves further away from the experience-near accounts given by the service users and readers will make their own interpretations of our interpretations.

Given the geographic spread on the included review studies, it may be argued that the current review is limited in its scope for informing and clinical practice within the UK. It does, however, provide key indications for the direction of future research. Additional UK research exploring service users' experiences of endings would provide enough evidence for a UK meta-synthesis and may then be able to make recommendations for clinical practice.

Considering contextual factors, an alternative motive for therapists not initiating endings may be the cost implications of ending therapy with a long-term service user in private practice. Furthermore, the majority of services within the review studies used a psychodynamic or psychoanalytical approach and not limiting the ending or

setting an ending point would be in keeping with Freud's (1937) principles. Future UK research on endings within NHS would allow further explorations of contextual factors.

## References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation.* Hillsdale, NJ: Erlbaum.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lesson learnt. *BMC Medical Research Methodology*, *8*, 21. doi:10.1186/1471-2288-8-21

Bailie, A. H., & Tickle, A. (2015). Effects of employment as a peer support worker on personal recovery: a review of qualitative evidence. *Mental Health Review Journal*, *20*(1), 48-64. doi:10.1108/MHRJ-04-2014-0014

Baum, N. (2005). Correlates of clients' emotional and behavioral responses to treatment termination. *Clinical Social Work Journal*, *33(3)*, 309–326. doi:10.1007/s10615-005-4946-5

Bonsmann, C., & Gubi, P. M. (2017). Exploring clients' experiences of premature termination of counselling and psychotherapy, *The Journal of Critical Psychology, Counselling & Psychotherapy, 17*(3), 149-159. http://hdl.handle.net/10034/620874

British Psychological Society. (2008). *Generic Professional Practice Guidelines.* Leicester: British Psychological Society.

British Psychological Society. (2011). *Good Practice Guidelines on the Use of Psychological Formulation.* Leicester: British Psychological Society.

Boland, A., Cherry, M. G. & Dickson R. (eds.) (2014) *Doing a systematic review: a student's guide*. SAGE Publication Ltd. London

Bowlby, J. (1973). *Attachment and loss: Vol.2. Separation: Anxiety and anger*. London: Hogarth Press

Bowlby, J. (1979). *The making & breaking of affectional bonds*. London: Tavistock Publications.

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M. & Donovan, J. (2003). "Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care", *Social Science & Medicine*, *56*(4), 671-684. doi:10.1016/S0277-9536(02)00064-3

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R.,… Donavan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, *15*(43). doi:10.3310/hta15430

Coltart, N. (1993). *How to survive as a psychotherapist*. London: Sheldon Press

Cuddeback, G. S., Shattell, M. M., Bartlett, R., Yoselle, J., & Brown, D. (2013). Consumers' perceptions of transitions from assertive outreach community treatment to less intensive services. *Journal of Psychosocial Nursing*, *51*(8), 39-45. doi:10.3928/02793695-20130603-05

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young., B… Jones, D. (2007). Appraising qualitative research for inclusion in systematic reviews: A quantitative and qualitative comparison of three methods. *Health Services Research & Policy*, *12*, 42–47. doi:10.1528/135581907779497486

Elliott, R. (2010). Psychotherapy change process research: realizing the promise. *Psychotherapy Research*, *20*(2), 123-135. doi:10.1080/10503300903470743.

Evans, D. (2002). Database searches for qualitative research. *Journal of the Medical Library Association*, 90, 290-293. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC116400/

Fossey, E., Harvey, C., McDermott, F., Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, *36*,717-732. doi:10.1046/j.1440-1614.2002.01100.x

Freud, S (1937). Analysis terminable and interminable. *International Journal of Psycho-Analysis. 18*, 373-405.

Firestein M. D. (1974). Termination of psychoanalysis of adults*: a review of the literature, Journal of the American Psychoanalytical Association*, *22*(4), 873-894. doi:10.1177/000306517402200410

Fortune, A. E., Pearlingi, B., & Rochelle, C. D. (1992). Reactions to termination of individual treatment. *Social Work*, *37*(2), 171-178. doi:10.1093/sw/37.2.171

Hughes, N., Closs, S., & Clarke, D. (2009). Experiencing cancer in old age: A qualitative systematic review. *Qualitative Health Research*, *19*(8), 1139-1153. doi:10.1177/1049732309341715

Holmes, J. (2010). Termination in psychoanalytic psychotherapy: An attachment perspective. In J. Salberg (Ed.), *Good Enough Endings. Breaks, Interruptions and Terminations from Contemporary Relational Perspectives*. New York: Routledge, pp. 63-82.

Kazdin, A. E. (1999). Overview of research design issues in clinical psychology. In P. C. Kendall, J. N. Butcher, & G. N. Holmbeck (Eds.) *Handbook of Research Methods in Clinical Psychology* (2nd ed., pp. 3-30). New York: John Wiley & Sons.

Knox, S., Adrians, N., Everson, E., Hess, S., Hill, C., & Crook-Lyon, R. (2011). Clients' perspectives on the therapy termination, *Psychotherapy Research*, *21*(2), 154-167. doi:10.1080/10503307.2010.534509

Lanyado, M (1999). Holding and letting go: some thoughts about the process of ending therapy*. Journal of Child Psychotherapy*, *25*(3), 357-378. doi:10.1080/00754719908260301

Livesley, W. J. (2003) *Practical management of Personality Disorder.* New York: Guilford Press.

Madders, S. A. S., & George, C. A. (2014). "I couldn't have done it on my own." Perspectives of patients preparing for discharge for a UK high secure hospital. *Mental Health Review Journal*, *19(1)*, 27-36. doi:10.1108/MHRJ-04-2013-0014

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, *151*(4), 264-269. doi:10.1371/journal.pmed.1000097

Noblit, G. W., & Hare, R. D. (1988). *Meta-ethnography: Synthesizing qualitative studies.* London, UK: Sage.

Obegi, J. H. (2008). The development of the client-therapist bond through the lens of attachment theory. *Psychotherapy Theory, Research, Practice, Training*, *45*(4), 431-446. doi: 10.1037/a0014330

Olivera, J., Braun, M., Penedo, J. M. G., & Roussos, A. (2013). A qualitative investigation of former clients' perception of change, reasons for consultation, therapeutic relationship and termination. *Psychotherapy*, *50*(4), 505-516. doi:10.1037/a0033359

Public Health Resource Unit (2013a). Critical appraisal skills programme (CASP).*Systematic Review Checklist.* Retrieved from http://www.casp-uk.net/#!checklists/cb36

Public Health Resource Unit (2013b). Critical appraisal skills programme (CASP).*Qualitative Research Checklist.* Retrieved from http://www.casp-uk.net/#!checklists/cb36

Quintana, S. M. (1993). Toward an expanded and updated conceptualization of termination: Implications for short-term, individual psychotherapy. *Professional Psychology: Research and Practice, 24*(4), 426-432. doi:10.1037/0735-7028.24.4.426

Råbu, M., Binder, P. E., & Haavind, H. (2013). Negotiating ending: A qualitative study of the process of ending psychotherapy, *European Journal of Psychotherapy and Counselling*, *15*(3), 274-295. doi:10.1080/13642537.2013.810962.

Roe, D. (2007). The timing of psychodynamically oriented psychotherapy termination and its relation to reasons for termination, feelings about termination, and satisfaction with therapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, *35*(3), 443-453. doi:10.1521/jap.2007.35.3.443

Roe, D., Dekel, R., Harel, G., Fennig, S., & Fennig, S. (2006a). Clients' feelings during termination of psychodynamically oriented psychotherapy. *Bulletin of the Menninger Clinic*, *70*(1), 68-81. doi: 10.1521/bumc.2006.70.1.68

Roe, D., Deke, R., Harel, G., & Fennig, S. (2006b). Clients' reasons for terminating psychotherapy: A quantitative and qualitative inquiry. *Psychology and Psychotherapy: Theory, Research and Practice, 79*(4), 529-538. doi:10.1348/147608305X90412

Rubino, G., Barker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. *Psychotherapy Research*, *10*(4), 408-420. doi:10.1093/ptr/10.4.408

Sandelowski, M., & Barroso, J. (2002). Reading qualitative studies. *International Journal of Qualitative Methods, 1(1),* 74-108.doi:10.1177/160940690200100107

Scamardo, M., Bobele, M., & Biever, J. L. (2004). A new perspective on client dropout. *Journal of Systemic Therapies*, *23*(2), 27-38. doi:10.1521/jsyt.23.2.27.36639

Shulman, L. (1999). *The skills of helping individuals, families, groups and communities* (4th ed). Itasca, IL: F. E. Peacock. Retrieved from https://trove.nla.gov.au/work/20047697

Schutz, A. (1973). In M. Natanson (Ed.), *Collected Papers, vol. 1: The Problem of Social Reality.* The Hague: Martinus Nijhoff.

Silverman, D. (1998) Towards an aesthetics of research. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice.* (pp. 239–253). London, UK: Sage.

Spencer, L., Ritchie, J., Lewis, J., & Dillon. (2003). *Quality in qualitative evaluation: a framework for assessing research evidence.* Government Chief Social Researcher's Office, Occasional Papers Series 2. Retrieved from https://www.heacademy.ac.uk/system/files/166_policy_hub_a_quality_framework.pdf

Tetley, A. C., Evershed, S., & Krishnan, G. (2011). The transition from high secure, to medium secure, services for people with personality disorder: patients and

clinicians experiences. *The Journal of Forensic Psychiatry and Psychology*, *22*(3), 321-339. doi:10.1080/14789949.2010.528011

Walsh, J. (2007). *Endings in clinical practice: Effective closure in diverse settings*. Lyceum Books.

Westmacott, R., & Hunsley, J. (2010). Reasons for terminating psychotherapy: A general population study. *Journal of Clinical Psychology*, *66*(9), 965-977. doi:10.1002/jclp.20702

## Figures and Tables

Figure 1.

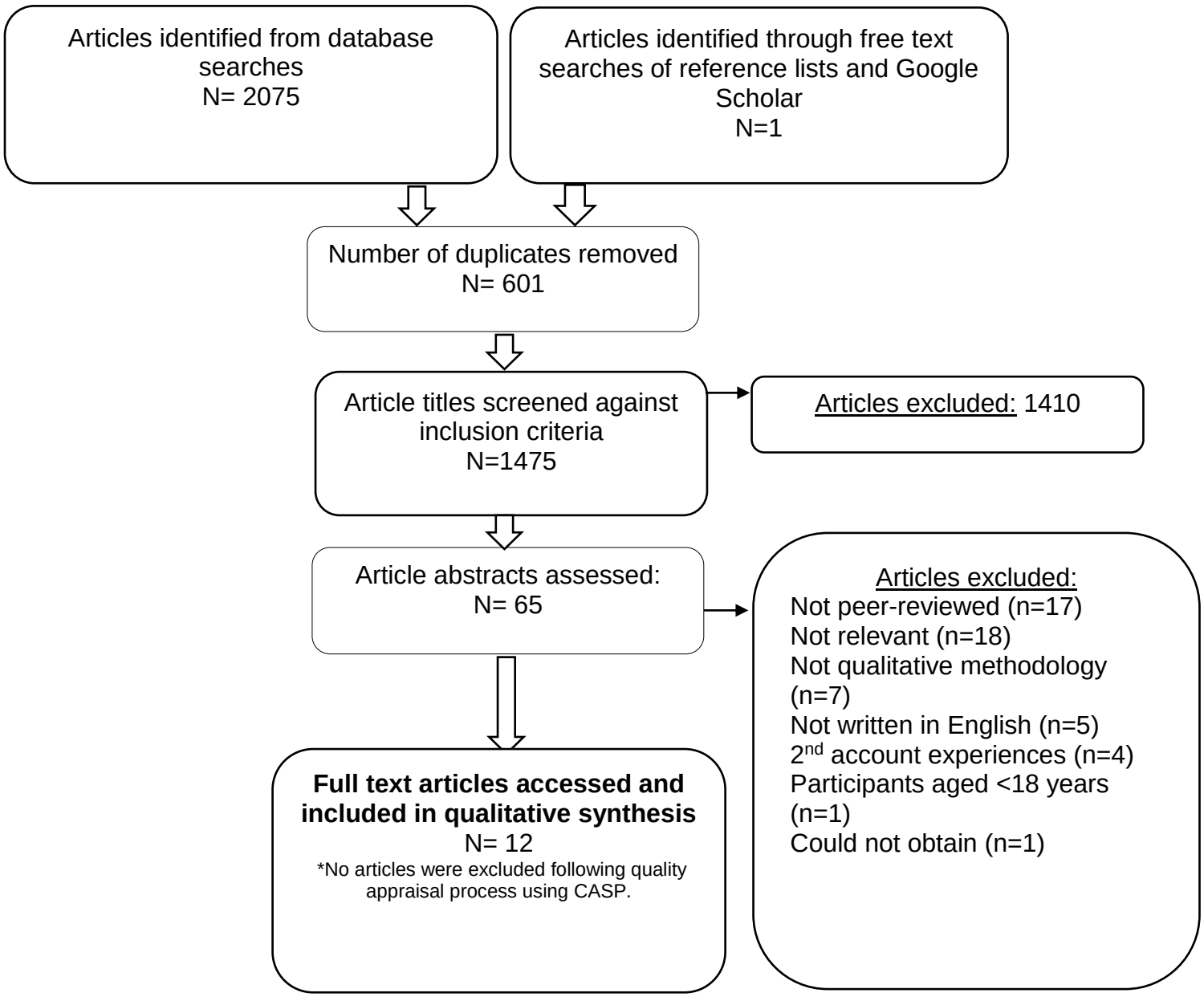


*Figure 1*. The process of data selection and exclusion (Moher et al., 2009)

Table 1

Characteristics of Studies

| No | First Author, country, year | CASP score | Age(yrs), Gender(F/M), Ethnicity | Sample and Context | Method of data collection and analysis | Research Aims |
|---|---|---|---|---|---|---|
| 1 | Madders, UK, 2014 | 27 | 1F/8M | 9 patients transitioning from high secure hospital | Semi-structured interviews, thematic analysis | To explore factors influencing discharge preparation from the perspectives of patients. |
| 2 | Tetley, UK, 2011 | 26 | 16M | 16 patients transitioning from a high secure hospital | Semi-structured interviews, thematic analysis. | To explore the experiences of personality-disordered patients during the transition process. |
| 3 | Knox, USA, 2011 | 25 | 23-60yrs, 11F/1M, White/American European | 12 clients terminated from individual outpatient psychotherapy | Semi-structured interviews, Consensual Qualitative Research(CQR) analysis | How do clients experience therapy termination? How does termination unfold? How does termination affect clients and the therapy process? |
| 4 | Råbu, Norway, 2013 | 23 | 25-52 yrs,10F/2M | 12 former psychotherapy clients | Sessions recordings and interviews, thematic & narrative analysis | How is a decision to end treatment negotiated? How do the two parties experience the process of ending? |
| 5 | Olivera, Argentina, 2013 | 23 | 22-54 yrs, 11F/6M | 17 former psychotherapy clients | Semi-structured interviews, Consensual Qualitative Research (CQR) analysis | Investigate former clients' perception of change, reasons for consultation, therapeutic relationship and termination. |
| 6 | Råbu, Norway, 2013 | 23 | 25-62yrs, 24F/13M | 37 former psychotherapy clients | Interviews, thematic analysis | How do clients consider their own and therapists contributions in the last phase of therapy? |
| 7 | Cuddeback, USA, 2013 | 22 | 44 yrs(Mean), 5F/6M, 6 Caucasian, 5 African America. | 11 clients transitioned from assertive community team (ACT) to case management | Semi-structured interview, content analysis | To examine the experiences of consumers who were transitioned from ACT to less intensive services. |
| 8 | Etherington, UK, 2011 | 22 | 3F, 31- 45 yrs | 3 ex-counselling clients | Interviews, narrative case study approach | To show clients lived experiences of reviews and endings. |
| 9 | Roe, Israel, 2006a | 16 | 20-30 yrs(36%), 30-40 yrs (54%),+40 yrs (10%) 66F/18M | 84 former psychodynamic psychotherapy clients | Open-ended questions, inductive coding analysis | To explore clients' feelings during termination of psychotherapy. |
| 10 | Bonsmann, UK, 2017 | 20 | 18-30yrs(7%),31-50yrs (73%)51-70yrs (20%), 35F/15M | 50 former clients from varying therapeutic models | Qualitative online survey, thematic analysis | To understand clients experiences' of premature termination to provide insights for practitioners and services to reduce its occurance. |
| 11 | Scamardo, USA, 2004 | 19 | 23-45 yrs, 7F/2M, 3 African American,3 Hispanic and White, 3 Non-Hispanic | 9 former individual therapy clients | Semi-structured telephone interviews, inductive coding | How clients determine the length of therapy, decide when to discontinue therapy and change expectations of therapy. |
| 12 | Roe, Israel, 2006b | 16 | 20-30 yrs (36%), 30-40 yrs (54%),+40 yrs (10%),66F/22M | 88 former psychodynamic psychotherapy clients | Open-ended questions, inductive coding analysis | Investigate clients' perception of the reasons for psychotherapy termination and how these related to demographics, treatment variables and satisfaction with therapy. |



Table 1

**Table 2.**

Themes and sub-themes developed from a meta-ethnographic synthesis

| Theme or sub-theme | Madders 2014 | Tetley 2011 | Knox 2011 | Råbu 2013 | Olivera 2013 | Råbu 2017 | Cuddeback 2013 | Etherington 2011 | Roe 2006a | Bonsmann 2017 | Scamardo 2004 | Roe 2006b |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Anticipation of Ending | | | | | | | | | | | | |
| Emotional impact to ending | * | * | * | * | | * | | * | * | * | | |
| Loss of relationship | | | * | * | | * | * | | * | * | | |
| Perceived therapists' anxieties | | | * | * | * | | | * | * | | | |
| Service User Control | | | | | | | | | | | | |
| Ending as independence and growth | * | * | * | | | * | | * | * | | | * |
| Service User initiated ending | | | | * | * | * | | * | * | * | * | |
| Preparation empowering the service user | * | * | * | | | | * | * | | | * | |
| Sense of Responsibility | | | | | | | | | | | | |
| Responsibility felt towards therapist response | | | | * | * | | | | * | | | |
| Ambiguity around the decision to end | * | | | * | * | | * | | * | * | * | |

Note. * indicates the presence of a sub-theme within the reviewed studies that contributed towards the development of the third order construct

**Appendix A- Search Terms**

Key Terms and alterative terms used in the search strategy

| | |
|---|---|
| Endings | ending* OR ended* OR termination* OR discharg* OR discontin* OR dropout* OR drop-out* OR dropping out OR complet* OR incomplet* OR non-complet* OR attrit* OR compliance* OR non-compliance OR transition* OR treatment termination |
| Therapy | therap* OR treatment* OR psychotherap* OR psychoanaly* OR psychoeducation OR psychological techniques OR group therap* OR individual therap* or mental health service* |
| Experiences | perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR evalu* OR idea* OR feel* OR opinion OR idea* OR thought* OR value* OR emot* OR expect* |
| Service users | client* OR patient* OR participant* OR serviceuser* OR service-user* OR consumer* |