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When Are Clients Ready to Terminate?

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Termination of psychotherapy has received less attention in the research literature than other aspects of the treatment process. This paper presents a structured framework emphasizing observable markers to indicate when termination with a client is appropriate during cognitive behavioral treatment. The 7 criteria that indicate when a client is ready for termination are: (a) decrease in symptoms as assessed by sound measures; (b) decrease in symptoms that is stable and maintained for 8 weeks; (c) decrease in functional impairment; (d) evidence that the decrease in symptoms is not a spontaneous remission, such as lower symptoms associated with the use of new skills; (e) usage of the new skills, particularly at times or on themes of former vulnerability; (f) sense of pride regarding the new skills, in contrast to initial doubt regarding whether the techniques would work; and (g) carryover of decrease in symptoms to other areas. A case report and discussion regarding the clinical application of the framework is presented.

Establishing termination is one of the more important aspects of treatment, and yet, it is among one of the least well-studied. Moreover, professional ethics emphasizes that therapists are to treat a client's presenting problem(s) until the client no longer needs services (American Psychological Association, 2002). Despite the significance of termination, the topic of how and when to terminate treatment has been largely neglected in the literature. In fact, compared to the termination literature on the whole, relatively little attention has been devoted to the development of specific, discernable criteria for determining when clients are ready for termination during cognitive behavioral treatment (CBT). One major obstacle to research in this area is the lack of a systematic conceptualization for termination. This paper briefly reviews the current termination literature and presents an integrative, structured framework that provides seven observable indicators to help determine when termination of therapy is appropriate.

Brief Review of Termination Literature

Overall, the extant literature regarding termination has primarily focused on predictors of premature termination, therapist versus client reasons for termination, treatment duration, and indicators of termination. More specifically, research has demonstrated that a number of client variables may be related to premature termination. For instance, clients with low income, low education, and minority racial status are more likely to terminate treatment prematurely (Wierzbicki & Pekarik, 1993). Further, Pekarik (1992) established three comprehensive categories of client reasons for premature termination, namely "environmental obstacles," "problem improvement," and "dissatisfaction with treatment," which can also be included as therapist reasons (Todd, Deane, & Bragdon, 2003).

Interestingly, some discordance has been observed empirically between therapist and client reasons for termination. For example, Hunsley, Aubry, Verstervelt, and Vito (1999) found that clients often endorsed dissatisfaction as a significant factor relating to termination, while therapists rarely reported this reason. However, goal accomplishment was cited as one of the strongest explanations for termination in both therapists (39%) and clients (44%). Likewise, in order to reduce premature termination, Hunsley et al. (1999) emphasized the importance of mutually agreed-upon, realistic expectations and goals of treatment between the client and therapist. In a sample found in another study (Todd et al., 2003), 14% of clients rated improvement due to therapy as a reason for termination, compared to 28% for therapists. Clients appeared to cite their own environmental reasons most often for termination, followed by concerns regarding therapist environmental barriers, help-seeking elsewhere, and dissatisfaction. Another study indicated that 63% of clients terminated mutually and 37% terminated unilaterally, out of a sample of clients that completed all measures (Tryon & Kane, 1995). In a sample of 407 clients at a university psychology clinic, therapist documentation indicated that 35.8% of clients stopped attending therapy

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without notice, 23.5% terminated because they were satisfied with the gains made in treatment, 19.9% terminated due to constraints unrelated to therapy, 11.5% sought services elsewhere, 8.5% reported client dissatisfaction with therapy, and .8% of the treatments ended as a result of therapist-initiated termination (Renk & Dinger, 2002). Taken together, a variety of factors appear to be related to termination.

Another area of research discussed in the termination literature is length of treatment. For example, Lowry and Ross (1997) surveyed 1,000 members of the American Psychological Association Division 29 (Psychotherapy) and found that psychologists expected approximately 30 to 40 sessions of treatment were necessary in order to return a client to normal functioning. However, state/federal models of mental health services (cf. Stromberg, Loeb, Thomsen, & Krause, 1996) and managed care organizations (cf. Haas & Cummings, 1991) frequently limit outpatient psychotherapy to between 10 and 20 visits per year. More importantly, research indicates that only limited gains are achieved if termination occurs within the first 2 or 3 sessions (Pekarik, 1986). Some researchers characterize treatment duration by a contracted number of sessions for a particular treatment. For example, Beck, Emery, and Greenberg (1990) stated that the typical course of anxiety treatment generally should consist of 5 to 20 sessions. Notably, research has shown that treatment duration does not appear to distinguish between treatment dropouts and completers (e.g., Pekarik, 1985). In sum, depending on the stakeholder, different perspectives regarding proper treatment duration exist.

Other researchers perceive termination in more broad terms, such as accomplishment of goals. For instance, regarding the treatment of personality disorders, Beck, Freeman, and Davis (2004) proposed that treatment should be terminated when the agreed-upon goals of therapy are met. Specifically, they presented a case example in which preceding termination for treatment of narcissistic personality disorder, the client and therapist devised a list of changes in the presenting problems, such as successful identification and modification of core maladaptive beliefs. Once these changes were made, therapy was terminated. In a similar manner, Leahy and Holland (2000) alluded to achieving the goals of treatment for panic disorder prior to termination, namely, eliminating panic attacks and acquiring coping skills that will decrease the possibility of relapse. Additionally, Pekarik (1986) posited that clients who were no longer in need of services or who terminated by mutual consensus could be regarded as "appropriate terminators." Overall, criteria delineating accomplishment of goals as a marker for termination tend to vary from disorder to disorder and from client to client.

In addition to treatment duration and accomplishment of goals, other researchers deem termination as appropriate when a reduction in symptoms is demonstrated. This decrease in symptoms is frequently measured through assessment instruments. For instance, during the treatment of depression, Leahy and Holland (2000) suggested that scores on self-report scales, such as the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996), can be used as symptom targets or goals when assessing client progress. Similarly, Sanderson and Rego (2002), in a case presentation of a client treated for panic disorder, noted the readministration of intake measures at the 20th session and maintenance of symptom remission for 7 months prior to termination. During the 7 months, monthly sessions occurred. In sum, a strength of using the symptom reduction approach to indicate appropriate termination is that it is easily measurable.

One difficulty inherent in the symptom reduction approach is that there is no clear definition of what constitutes a clinically significant reduction of symptoms as well as improvement in functioning. Considerable change in symptoms and functional impairment, likely falling in the normal range or demonstrating statistically reliable change, represents one view (Jacobson, Roberts, Berns, & McGlinchey, 1999; Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999). However, treatment outcome research for clients with more severe depression indicates that, on average, clients' scores on depression inventories at termination frequently do not fall in normal range (e.g., DeRubeis, Gelfand, Tang, & Simons, 1999). Further, Kazdin (1999) articulated that clinically significant change in therapy may mean a large, medium, or a relatively minor symptom reduction, and often this interpretation depends on the target problem and expectations regarding treatment (cf. Foster & Mash, 1999).

Overall, it appears that research has largely neglected how and when a therapist and client agree to terminate therapy. Although researchers have attempted to define termination by focusing on possible signs of improvement, such as symptom reduction or increased functioning, an integrated framework of observable markers indicative of when a client is ready for termination is notably absent. A barrier to research in this area is that the criteria used to measure therapeutic goals are usually vague and implicit, rather than explicit. Accordingly, the lack of a systematic conceptualization for termination that can be empirically tested has slowed advancement in the termination literature. This paper proposes to build on the current literature by providing a framework of specific, discernable criteria to assist clinicians in determining when a client is ready for termination during CBT.

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A Structured Framework: Seven Criteria for Termination

Hollon and Beck (2004) describe CBT based on the theory that "thinking plays a role in the etiology and maintenance of at least some disorders, [and] these interventions seek to reduce distress and enhance adaptive coping by changing maladaptive beliefs and providing new information-processing skills" (p. 447). Thus, the proposed termination conceptualization offers methods for assessing clients' reduction in distress and coping. Further, we believe that the termination framework is consistent with assessing theoretically meaningful and active components of CBT, such as homework and skills acquisition, and cognitive restructuring (Burns & Spangler, 2000; Feeley, DeRubeis, & Gelfand, 1999; Tang & DeRubeis, 1999). Decrease in symptoms, decrease in functional impairment, usage of new skills, sense of pride regarding new skills, and generalization of symptom decrease to other areas are considered indicators for assessing progress in and the effects of using the components of CBT.

Before discussing the seven criteria to consider for termination, some remarks are in order regarding the generalizability of these criteria across settings, diagnoses, and treatments. We are attempting to propose a general scheme for terminating with almost all clients in most settings. In particular, success in application of the criteria appears most likely for clients diagnosed with anxiety and depressive disorders and treated with CBT in outpatient settings, given better treatment outcome. Even with clients diagnosed with schizophrenia or borderline personality disorder (BPD) (outpatient or inpatient), evidence in the literature suggests that these clients can be treated with CBT and show symptom decrease, improved functioning, and clinically significant change (e.g., Bohus et al., 2004; Cather et al., 2005). However, future empirical testing of this framework is necessary to determine its applicability to various disorders and treatment strategies.

Symptom Decrease

As suggested by most sources, a first and relatively obvious criterion to look for when contemplating termination is symptom decrease. Likewise, termination of therapy should not be considered until the client has demonstrated a marked decrease in symptoms. Ideally, the symptoms should decrease to the point that criteria for the disorder(s) in question are no longer met. Symptom decrease may be tracked over the course of treatment through a variety of means, such as periodically discussing the client's current symptoms during sessions, administering self-report measures such as the BDI or Beck Anxiety Inventory (BAI; Beck & Steer, 1990), or administering modules of a structured diagnostic interview such as the Structured Clinical Interview for the DSM-IV (First, Spitzer, Gibbon, & Williams, 1996) or Mini International Neuropsychiatric Interview (Sheehan et al., 1998). Weekly or by session administration of self-report measures is recommended given that approximately 50% of clients are measurably improved by the eight session (Howard, Kopta, Krause, & Orlinsky, 1986) and many studies utilize weekly or by session administration of measures to track symptom change (e.g., Feeley et al., 1999).[1]

Of course, this criterion raises the question of what constitutes a significant decrease in symptoms. We do not claim to have a precise answer to this question, for this is something that should be addressed on an individual basis for each client. For instance, clients with higher initial depressive severity may obtain higher BDI termination scores than clients with lower initial severity, especially if only 8 sessions are attended compared to 16 sessions (Shapiro et al., 1994). Likewise, clients with lower initial severity may not see a 50% reduction in BDI scores. Given the goals set forth by the client and therapist at the beginning of therapy, the therapist can determine when the client has achieved the desired level of symptom reduction.

When using objective measures like the BDI and BAI, possibilities include a certain percentage reduction of scores (such as a 50% reduction) or a score that falls into the mild or moderate range. Barkham et al. (1996) determined statistically that clinically significant change (cf. Jacobson & Truax, 1991) occurred on the BDI if clients' initial scores were 14 or higher and their scores at termination had been reduced by at least 7 points (reliable change threshold) and had decreased to a score of 13 or below (two standard deviations above the nondistressed BDI mean). Additionally, results from the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP; Ogles, Lambert, & Sawyer, 1995) indicated that 50% of clients treated with CBT achieved clinically significant change, denoted by BDI scores falling within two standard deviations of the general population mean, and 65% of completers scored a 9 or below on the BDI (Elkin et al., 1989), whereby a score of 9 denoted patient recovery. Being aware of typical symptom reduction in treatment outcome studies can help clinicians to decide upon appropriate indices of symptom reduction in their clients.

[1] However, it is worth noting that weekly symptom assessments may be less appropriate for certain symptoms and/or disorders (e.g., suicide attempts in borderline personality disorder). For example, in Bohus et al.'s (2004) clinical trial for Dialectical Behavioral Therapy, symptoms were assessed every four months. Thus, empirical testing would help specify the optimal frequency of symptom assessment for more sporadic symptoms.

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When clients present with multiple disorders, the therapist should use measures to assess symptoms for each disorder. For example, if a client presented with comorbid depression and anxiety, the clinician should regularly assess the depressed and anxious symptoms with both the BDI and the BAI. In cases of comorbidity, the clinician should focus treatment attention toward the area that is most urgent, but still track the symptoms for other disorder(s). That is, the therapist and client should agree on which disorder appears to be the most distressing, impairing, and/or dangerous to the client, and tailor their intervention accordingly-while monitoring symptoms of other disorder(s).

Stable Symptom Decrease for 8 Weeks

We argue that symptom decrease alone is not sufficient to indicate that the client is ready for termination. This symptom decrease should be maintained for at least 8 weeks.[2] This length of time was chosen given that many sources have used 8 weeks to signify remission. For example, the *DSM-IV* has utilized a 2-month period of no significant symptoms indicating the "in full remission" specifier for major depressive episode (American Psychiatric Association [APA], 1994). Additionally, other studies, such as the NIMH TDCRP and Harvard/Brown Anxiety Research Program (Keller et al., 1987; Warshaw, Keller, & Stout, 1994; Yonkers, Warshaw, Massion, & Keller, 1996), have determined whether clients meet criteria for remission by the Longitudinal Interval Follow-up Evaluation (LIFE; Keller et al., 1987; Shapiro & Keller, 1981), which uses an 8-week period. However, empirical testing is necessary to determine whether 8 weeks truly is the optimal amount of time to monitor a client in therapy following the desired decrease in symptoms. Once it has been determined that the client has shown a significant decrease in symptoms, the symptoms should continue to be tracked over the following weeks. Monitoring a client for at least 8 weeks following symptom decrease can serve a number of purposes. First, it provides the client with additional time to consolidate the gains made during therapy while in a less distressed state. At this point, the client will likely have more emotional resources available and will be better able to strengthen the changes made during therapy. Secondly, requiring the symptom decrease to remain stable over 8 weeks lessens the possibility that the client's improvement is simply due to "having a good week or two." The nature of many mental illnesses is that symptoms wax and wane depending on a variety of factors, such as daily stressors and life events. Observing a stable symptom reduction over 8 weeks greatly increases the likelihood that the reduction was due to treatment gains, not just the normal ebb and flow of symptoms. If the client suffers a relapse of symptoms during this time, the criterion is not met and the client is not ready for termination.

Here again, it is important that the clinician tracks symptoms of each of the client's disorders in cases where comorbidity is present. Ideally, as the client has a stable decrease in symptoms over 8 weeks for the disorder that is prioritized, other disorder symptoms will also decrease. We suggest that the client, at minimum, shows 8 weeks of stable decrease in the primary disorder before therapy fully turns to comorbid disorders. As discussed previously, the desired level of symptom reduction should be determined by the therapist and client, taking into account initial severity of symptoms and reflecting either a certain target score (e.g., below 13 on the BDI) or decrease in score (e.g., 7-point decrease on BDI).

Decrease in Functional Impairment

A reduction in functional impairment is just as important as a reduction in symptoms and provides a broader measure of treatment outcome for a variety of disorders (cf. Gladis, Gosch, Dishuk, & Crits-Christoph, 1999). Quite often, it is the functional impairment that drives individuals to pursue therapy rather than the symptoms (Hunt & McKenna, 1993). Moreover, both symptoms and impairment appear to be related and are necessary in order to meet diagnostic criteria (APA, 1994). The importance of this indicator is underscored by the increased emphasis by federal funding agencies, such as the NIMH, on the use of functioning and other quality-of-life indicators as treatment outcomes for investigations (NIMH, 2003).

Research has indicated that symptomatic improvement precedes and often appears necessary for functional improvement to be observed (Howard, Lueger, Maling, & Martinovich, 1993). Thus, it is necessary to assess clients' levels of functional impairment to ensure that their quality of life is improving and that clients are obtaining maximum benefit from therapy. Some clients will experience a significant reduction in symptoms but still exhibit a substantial level of functional impairment. These clients, we argue, are not yet ready for termination. For clients to truly be ready to end therapy, they should not only be experiencing fewer symptoms but also getting along better in their daily lives (e.g., demonstrating functional features of improved quality of life, such as attending work and having interpersonal relationships).

[2] The time span for decrease in symptoms may need to be lengthened if the typical frequency of the symptom is greater than eight weeks (e.g., suicide attempts) in order for the clinician to be confident that the decrease in symptoms is due to the treatment. Length of symptom remission for more infrequent symptoms should be empirically tested.

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The Global Assessment of Functioning (GAF; APA, 1994) scale can be a useful tool for estimating the degree of functional impairment. Unfortunately, as with symptom reduction, there is no clearly specified cutoff that can be used to identify a sufficient reduction in functional impairment. Obviously, a high GAF score, such as one in the 81–90 or 91–100 range, would indicate that a client meets this criterion. However, this decision must also be made on a case-by-case basis, as some clients, particularly those with more severe forms of mental illness, may not reasonably expect to obtain such a high score. Additionally, some clients may present with high functioning, not meeting criteria for a disorder at intake. It is again up to the clinician to determine what an appropriate reduction in functional impairment is for each client.

Spontaneous Remission Ruled Out and Use of New Skills Tied to Lower Symptoms

Spontaneous remission can also be ruled out by the client demonstrating that his or her reduction in symptoms is specifically tied to the use of new skills learned in therapy. Research also indicates that changes in metacognitive or compensatory skills (more skillful use of strategies) taught by cognitive therapists correlate with changes in measures of symptom reduction, such as the BDI (Barber & DeRubeis, 2001). Additionally, one study demonstrated that participation in cognitive therapy groups that included homework assignments predicted more significant improvement in depressive symptoms, and that level of skills acquisition (cognitive restructuring) assessed at posttreatment predicted treatment gain maintenance at 6-month follow-up (Neimeyer & Feixas, 1990). This criterion can be assessed simply by asking the client to discuss situations that have been problematic in the past and how those situations are currently handled. For example, a client diagnosed with generalized anxiety disorder (GAD) might say that when a potential worry arises, she thinks to herself, "I can't do anything about it now" and "Well, the worst possible outcome isn't really that bad." These thoughts then allow her to move on, rather than continue to worry about the situation. In this instance, she is using the skills of cognitive restructuring that she has learned in therapy to eliminate her feelings of anxiety. When clients are able to do this repeatedly, that is, use their new skills to neutralize their symptoms, it provides substantial evidence that the symptom reduction is truly due to the effects of the therapy rather than spontaneous remission.

In the case of comorbid disorders, there is evidence that this termination criterion is met when the client can provide examples skills utilization to cope with problems from each of the disorders. For example, if an individual has an alcohol use disorder and bulimia nervosa, the clinician would look for ways that the client used new coping skills in place of bingeing, purging, and drinking to regulate his or her moods.

Use of New Skills Even at Times or on Themes of Former Vulnerability

Beginning therapy sessions typically consist of the introduction of new skills directed toward treating the client's presenting problem. For example, in CBT, the first few sessions may consist of describing the cognitive-behavioral viewpoint, eliciting cognitions in session, and practicing reframing techniques. The therapist essentially acts as a teacher, guiding clients through exercises that focus on using new ways of thinking and/or behaving in situations relevant to their disorder. Therapists typically use events that occurred during the client's week as highly salient examples of how the client could have behaved or thought differently while utilizing the new skill set. As therapy progresses, an obvious goal should be that the client requires less and less assistance from the therapist during the remediation process.

In order for a client to be deemed ready for termination, the client should demonstrate acquisition of therapeutic skills in situations outside of the therapy sessions and independently of the therapist. Accordingly, the client should also be able to employ skills primarily "in the moment," rather than through retrospective remediation. That is, the client should report daily scenarios where he or she was actually using the skills (e.g., challenging thoughts, behavior change) during the stressful situations. Drawing on newly learned techniques "in the moment" is particularly challenging when an individual is faced with a stressor that has historically been a point of vulnerability. Yet, successfully employing healthy coping strategies at times of vulnerability is essential for maintenance of mental health. If a client can do this, it appears likely that he or she will not only experience a symptom decrease, but, more importantly, sustain the symptom remission after the termination of therapy (e.g., Neimeyer & Feixas, 1990).

When a client reports to the therapist the successful use of new skills during formerly high-risk situations, then the therapist can feel more confident that the client is approaching readiness for termination. Likewise, research indicates that client involvement in treatment, especially through the emergence of a problem-solving attitude, is predictive of treatment outcome (O'Malley, Suh, & Strupp, 1983). Moreover, improvement in symptomatology and severity appears to be related to how strongly the client has been encouraged to practice certain mood-correcting techniques (DeRubeis & Feeley, 1990) and amount of practice of skills (Murphy, Michelson, Marchione, Marchione, & Testa, 1998). For example, a client seen at our clinic was particularly vulnerable to feeling worthless when hearing

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disapproving statements from his family members about his career decisions. After such discussions, he would report experiencing depressed mood for 2 to 3 days. During a session in the latter portion of his treatment, he reported that earlier that week his father was admonishing him for some choices that he had made regarding the direction of his career. While in that conversation, he identified his hurtful thoughts and replaced them with more helpful thoughts, using facts to dispute his feelings of worthlessness. As a result, he was able to skillfully cope with the situation and prevent feelings of worthlessness and lingering sad mood. When clients are able to report utilizing skills, even in times that have traditionally been weak areas, it is an indicator that they are ready for termination. This demonstrates that they have acquired the skills necessary to maintain their mental health on a daily basis without the required assistance of a therapist.

Sense of Pride About New Skills, in Contrast to Initial Doubt Regarding Techniques

Clients' reactions to the introduction of new techniques in therapy tend to vary. One response that is not uncommon is for the client to doubt the efficacy of utilizing techniques introduced by the therapist. For example, a client who had a diagnosis of GAD reported early in therapy that she understood cognitive-behavioral techniques in a logical sense, but that emotionally, she felt that she was lying to herself just to make herself feel better. This client agreed to continue using cognitive-behavioral skills in an attempt to ameliorate her anxiety symptoms for a period of time, even if it felt unnatural for her to approach anxiety in this manner.

Later during the course of therapy, she walked into the session and excitedly told her therapist, "I couldn't wait to tell you—I got a B on a project in one of my classes, and I used the skills we have been working on and stopped myself from going into a fit of worry!" One of the client's former places of vulnerability was earning less than A's on school assignments. Receiving a lower grade often sent her into a whirlwind of catastrophic thoughts about how she was incompetent and destined to fail in school and her career. Despite her initial doubts about the efficacy of cognitive-behavioral techniques, the client began to have a sense of pride regarding her newly acquired skills. When clients begin sessions by excitedly reporting examples of stressful situations in which they relied on newly acquired skills, rather than resorting to their old coping habits, it is one sign that they are ready to terminate. Similarly, research has shown that self-efficacy expectancy (Bandura, 1977) and outcome expectancy (Bolles, 1972) are significant predictors of behavioral intentions and changes in behavior (Maddux, Norton, & Stoltenberg, 1986). Further, research has demonstrated that the more clients expect treatment to be effective, the more likely they will be involved during sessions, which is related to decrease in symptoms (Meyer et al., 2002) and predictive of treatment outcome (cf. Dew & Bickman, 2005), even across different disorders (e.g., Borkovec & Costello, 1993). Therefore, clients' sense of pride in their skills can assure the therapist that clients have fully "bought into" these techniques. When this occurs, clients have integrated the techniques into their repertoire of coping skills, such that they strive to use and even feel proud about their newly learned skills rather than their former coping methods.

Generalization of Skills to Other Areas Besides Target Areas

Another indication that a client is ready to terminate is when both a reduction in symptoms and examples of skill use cited by the client in areas other than what therapy was originally intended to target, are evident. These are signs that the skills learned in therapy have been used enough that they have become a habitual way for the client to cope with different stressors. For example, a client who presented with anger problems was being treated with CBT in our clinic. After his anger outbursts had decreased substantially and he appeared to grasp the tools needed to maintain control over his anger, he disclosed that he had been experiencing PTSD symptoms. When exposure for PTSD began, he started to vocalize cognitions about not being able to handle the distress and then was able to calm himself down by challenging thoughts in the same manner that he had challenged cognitions that led to feelings of intense anger. Evidence of this transfer was further confirmed more objectively by a decrease in BAI and the Posttraumatic Stress Questionnaire (PTSQ; Leahy & Holland, 2000). When a client's first line of defense against distress is skillful use of therapeutic techniques, across varying types of stressful situations, it is a sign that the client is ready to terminate and sustain change without regular help from a therapist. This criterion is particularly applicable to clients presenting with multiple symptoms and disorders. As a result, the therapist may feel more confident about termination when a client transfers and articulates the use of skills to cope with one type of symptoms onto another and observes this generalization on symptom inventories.

Case Presentation of How and When to Use Termination Criteria

In order to demonstrate the application of the termination framework, a case presentation illustrating how and when to use the criteria is provided. Maria is a 53-year-old, divorced Hispanic/Latina female. She did not complete college and was unemployed at the time of referral. Approximately 10 years ago, Maria divorced her

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husband of 20 years because of his frequent infidelity. At intake, Maria complained of chronic feelings of depression, lethargy, difficulties sleeping, appetite fluctuations, excessive guilt, and difficulty making decisions. She endorsed suicidal ideation, plans, and preparation during a conflict with her son 3 weeks prior to the first intake; however, suicidal ideation at intake was denied. Regarding her eating, Maria indicated binge episodes several times per week, which began during the process of her divorce and were followed by weight gain. She viewed binge eating as a "reward" for having dealt with a stressful day. Additionally, she reported several stressors, such as her unstable relationship with her 19-year-old son, Jose, who had a history of substance use and violence. Further, Maria was caring for Jose's 4-year-old daughter, Ana. Ana frequently displayed defiant behavior, which was an additional source of frustration for Maria. Lastly, she felt a great deal of bitterness toward her ex-husband and her interactions with him were usually unfavorable.

At intake, Maria scored in the moderate range on the BDI (22), BAI (12), and Beck Scale for Suicide Ideation (BSS; Beck & Steer, 1993; 9). On the Eating Disorders Inventory (EDI; Garner, Olmstead, & Polivy, 1983), Maria's scores fell in the clinical range on the Body Dissatisfaction (51) and Perfectionism (29) subscales, and in the upper end of the normal range on the Bulimia (20) subscale. At the time of referral, she met *DSM-IV* criteria for major depressive disorder, dysthymic disorder, and eating disorder not otherwise specified. Her overall GAF score was 61, indicative of mild to moderate functioning, including conflicts with her family members, few friends outside of her family, and depressed mood. Given Maria's and the therapist's preference to focus on her chronic depression and family stress, treatment of depression was prioritized utilizing Cognitive Behavioral Analysis System of Psychotherapy (CBASP; McCullough, 2000), an empirically validated treatment for chronic forms of depression. CBASP involves teaching the client to identify thoughts and behaviors that affect interactions with others, and replacing them with alternative thoughts and behaviors that increase achievement of desired goals in specific situations. Due to Maria's reservations about treatment of her binge episodes, it was decided that they would be targeted once her depression was under control, if the binges were still present. Thus, mutually agreed-upon goals and expectations regarding therapy were decided. The therapist also explained the importance of monitoring treatment progress toward their goals, such as through the weekly administration of assessments.

Following the criteria for termination, the therapist first determined the presence of symptom reduction and treatment progress through the weekly administration of the BDI, BAI, BSS, and EDI. During the sixth therapy session, a significant reduction in Maria's symptoms was evident, as her BAI (6), BDI (6), and BSS (0) scores all fell within the mild or normal ranges. In addition, her scores on the subscales of the EDI were decreased, but still fell within the same ranges as at intake. Second, the therapist applied the next criterion, maintenance of a stable reduction in symptoms for 8 weeks. Specifically, Maria's initial reduction in symptoms as measured by the BDI, BAI, and BSS was sustained for 12 weeks from the sixth therapy session. Her scores consistently remained in the normal range during that time period. Additionally, Maria's scores on the EDI subscales fell into the normal range during the ninth session and stayed stable for the remainder of the therapy sessions. In short, the therapist observed a significant and stable reduction in Maria's symptoms for at least 8 weeks.

Following Maria's initial reduction in symptoms, she began showing signs of a decrease in functional impairment, the third criterion. For instance, Maria began attending church weekly and social activities with new friends, and maintaining healthy relationships with her family members. Maria also decided to enter a new occupation, indicating to the therapist that a reduction in her functional impairment had occurred. Given her good functioning and interest in many areas of her life, Maria's GAF was 90 at termination. Both the therapist and Maria felt satisfied with her current level of functioning, which validated that Maria appeared ready for termination.

In order to rule out a spontaneous remission, the therapist looked for evidence of the fourth criterion, namely, usage of the new skills taught in therapy. For example, Maria previously experienced a great deal of conflict with her son and frequently felt unappreciated by him. Beginning with her 11th therapy session, Maria began mentally using the CBASP framework prior to every potential interaction with her son. Furthermore, she approached each situation with the understanding that it was her choice to perform helpful behaviors for her son and she ceased "nagging" him. As a result, achievement of her desired outcomes increased during interactions with her son as Maria realized that she could not control him. Accordingly, her frustration and depression decreased because she was able to control "[her] thoughts which created [her] feelings" during stressful situations. During the latter sessions prior to termination, Maria achieved her desired outcome in every situation with her son, and left each conversation feeling in control of her thoughts and feelings. Thus, evidence was observed by her therapist that her symptom reduction was due to the effects of therapy, not a spontaneous remission.

Regarding the fifth criterion, Maria demonstrated the usage of new skills even at times or on themes of former vulnerability. For example, one type of previously high-risk situation was interactions with her ex-husband. In

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particular, Maria was easily upset by her ex-husband and they frequently fought. Additionally, Maria often felt bitter and depressed after such interactions. After Christmas dinner, they began fighting regarding who would drive the family to church. Maria applied the CBASP framework "in the moment" to the situation and decided that her ex-husband could drive. She used her newly acquired skills and replaced her hurtful thoughts with helpful thoughts, such as "this isn't worth fighting over." As a result, she did not feel depressed or "out of control" and was able to enjoy Christmas day with her family. When Maria reported to the therapist that she successfully used skills on themes of former vulnerability, the therapist felt more assured that Maria was increasingly becoming ready for termination.

In addition to Maria's consistent use of therapeutic techniques, a sense of pride and increased self-efficacy regarding her new skills was evident, in contrast to her initial doubt about whether the techniques would work. Initially, Maria exhibited difficulty completing the weekly CBASP homework because she was overwhelmed with the stressors in her life and felt that she did not have time to use CBASP during the week. Maria agreed to continue to apply the CBASP framework, even mentally, prior to a potentially stressful situation, despite feeling overwhelmed and doubtful regarding the techniques. By the seventh session, Maria was consistently entering each therapy session with a sense of pride regarding the situations in which she applied CBASP as well as the achievement of her desired outcomes. For example, she had previously felt angry and frustrated regarding her ability to control Ana's behavior problems. However, with repeated use over the course of therapy, CBASP helped her decide on a realistic desired outcome for herself in situations involving Ana. Maria later entered a therapy session and exclaimed to the therapist, "I'm so proud of myself! Ana was having another temper tantrum and I was so angry I wanted to yell at her. Instead, I used CBASP which helped me to use a calm tone of voice and calm myself down. She agreed to go into time-out without a fuss and I felt so much more in control of my emotions!" Rather than resorting to old coping habits, such as yelling, Maria used her newly acquired skills. Consequently, Maria felt more competent and less angry when Ana did exhibit temper tantrums, which also decreased substantially over the course of therapy. The therapist observed many occasions in which Maria entered a therapy session glowing about her ability to control her thoughts and feelings during interactions with Ana. It is evident that Maria's self-efficacy improved with her use of skills and that her outcome expectancy for interactions with her granddaughter became more positive. In fact, at termination, Maria felt so confident in her ability to handle Ana as well as other children that she decided to obtain a child care license to open an in-home daycare center.

The final indication that Maria was ready for termination was evidence of generalization of skills to other areas in addition to her target areas. Specifically, Maria's new skills that she learned from CBASP transferred to her binge eating. In much the same way she approached situations with her son, she challenged negative cognitions and perfectionism regarding her body. For instance, she replaced these cognitive distortions with realistic expectations regarding her body size as a 53-year-old woman. As a result, Maria felt more in control of her emotions and eating. Accordingly, her self-esteem and satisfaction with her body increased. Maria ceased binge eating for the remaining 12 weeks of therapy and lost 13 pounds during this time period. Maria's report of generalization of skills to her binge episodes was also confirmed more objectively by her decreased scores on the EDI subscales. Further, she began eating small meals throughout the day and exercising several times a week. Maria also began wearing makeup and took more of an interest in her appearance. For the first time in many years, she felt "okay" with her body size and reported that she was ready to meet a new partner.

Another area in which Maria showed gains was in her management of Ana's behavior. In particular, her parenting techniques improved, thereby improving Ana's behavior and reducing conflicts in the house. In sum, Maria repeatedly demonstrated the ability to cope in a variety of situations using the CBASP framework. At this time, the therapist asked Maria whether she felt ready and if she desired to terminate from therapy. Maria responded that she had made many gains during the course of treatment and felt confident that she could navigate situations that previously were difficult for her. When Maria met all seven criteria and stated that she was ready to terminate, the therapist was also confident that Maria was appropriate for termination and able to maintain change without her therapist's assistance.

How to Use the Seven Termination Criteria in Clinical Practice

The seven termination criteria are intended to serve as a framework for clinicians to use in the decision process about a client's readiness for termination. Ideally, a client would meet all seven criteria prior to the termination of therapy. In this case, the client's status could be viewed as analogous to a bull's-eye in the game of darts. That is, the goal has been met clearly, fully, and precisely, and the clinician could confidently make the call that the client is ready for termination. However, in cases where there is not a bull's-eye (i.e., the client does not meet all seven criteria, which may be more likely for clients diagnosed with more impairing disorders), the wisdom

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of termination decreases as it is more difficult for the clinician to determine if a client is ready for termination.

In these cases, it may be useful to think of the seven criteria as arranged in a hierarchy where certain criteria are more essential to a client's readiness for termination than others. In this hierarchy, the most important criteria likely are the first four listed: (1) symptom decrease as evidenced by sound measures; (2) the decrease in symptoms is stable for a minimum of 8 weeks; (3) decrease in functional impairment; and (4) spontaneous remission is ruled out, while new skills are tied to lower symptoms. Further, the first three criteria are measurable and provide the clinician with concrete evidence regarding the client's appropriateness for termination, instead of relying solely on the clinician's discretion. Additionally, research suggests that clients who were not depressed at the conclusion of therapy are more likely to remain free of depression at 1 year follow-up than clients who are mildly depressed or diagnosed with depression (Gallagher-Thompson, Hanley-Peterson, & Thompson, 1990). If a clinician cannot truly say that a client had a decrease both in symptoms and functional impairment that was stable over time and due to the therapeutic intervention rather than spontaneous remission, the client is not ready to terminate. The goal of therapy is often to reduce the symptoms that are causing the client impairment and distress; at the very basic level, this goal has not been met unless the first four criteria are satisfied.

Next in the hierarchy is the fifth criterion: use of new skills even in times of former vulnerability. If clients are not able to use their new skills during high-risk situations, they are likely at higher risk for relapse. Therefore, if clients have not met this criterion, the clinician should be cautious about deeming them ready for termination. On the other hand, if clients have demonstrated that they can skillfully deal with situations that previously posed as sources of vulnerability, the clinician may feel more confident that relapse may not occur. Some evidence supports this assertion as one study found that depressed clients who had responded to cognitive therapy demonstrated fewer dysfunctional attitudes after a sad mood was induced, and that the degree of dysfunctional attitudes predicted depressive relapse at 30-month follow-up (Segal, Gemar, & Williams, 1999). For example, imagine that a client has been in remission from depression, and this client was especially likely to hold negative self-views during final exam week. If the client can use newly learned skills to disprove those dysfunctional attitudes during finals week (a particularly vulnerable time for the client) throughout the course of therapy, he or she may be at lower risk for relapse after termination from therapy.

It is defensible that a client may be ready for termination without necessarily meeting the sixth and seventh criteria: (6) sense of pride about new skills, in contrast to initial doubt regarding techniques, and (7) generalization of skills to other areas besides target areas. However, without meeting these criteria, it is not as clear that clients have integrated the newly learned skills into their repertoire of coping skills. If they do not have a sense of pride in their skills or utilize them in nontarget areas, they may be more likely to experience symptoms after termination. For instance, one study found that client expectancy of improvement was significantly related to reduced severity and decreased symptoms at 6-month follow-up (Borkovec & Costello, 1993). Furthermore, if clients do not meet the sixth (sense of pride about new skills) and seventh (generalization of skills to other areas) criteria, they may have not fully incorporated their new skills into coping with daily stressors in multiple areas. Individuals who do not meet the seventh criterion (generalization of skills to other areas) may also be more vulnerable to the development of symptoms outside of the target area than individuals who have successfully generalized their skills. For example, if Maria did not meet the seventh criterion at the time of termination, she may have recovered from her depression symptoms, but her binge eating symptoms may have persisted or recurred.

However, we acknowledge that more difficulties may arise when applying these criteria to certain cases, such as clients diagnosed with schizophrenia, a personality disorder, or comorbid disorders, as well as clients receiving treatment in an inpatient setting. More specifically, research indicates that clients diagnosed with BPD respond to treatment at a slower rate than clients diagnosed with anxiety or depression (Howard et al., 1986). Another study (Pilkonis & Frank, 1988) demonstrated that clients diagnosed with comorbid depression and personality disorder responded more slowly to treatment than clients diagnosed with only one of the disorders. Consequently, we believe that the progression through the termination criteria and rate of improvement may be slower in these clients compared to those diagnosed with one disorder, such as depression or anxiety. Regarding clients diagnosed with comorbid disorders, we recommend that a client ideally meet the seven termination criteria for each disorder prior to termination. This may not be possible for certain clients (e.g., with high initial severity) and realistic goals for each criterion may need to be set on an individual basis between the client and therapist. Relatedly, research also indicates that clients presenting with more severe symptomatology often have less positive or benefit less from outcome expectancies (Asay & Lambert, 1999; Barker, Funk, & Houston, 1988), which are related to treatment outcome. As a result, clients presenting with more severe symptomatology may frequently not meet this criterion.

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Overall, at the beginning of treatment, the therapist and client should agree on which symptoms, areas, and situations are most problematic and relevant to diagnosis, and monitor the client's experience and responses (some of which will differ necessarily from disorder to disorder). For example, some evidence of meeting termination criteria for BPD may appear similar to other disorders, such as demonstrations of decrease in self-report symptom measures (e.g., decrease in BSS score) and improvement in functioning (e.g., less time away from work and increased social adjustment). A therapist may also look for a decrease in number of anger episodes and in impulsive behavior to determine if a client meets criteria for the symptom decrease criterion. However, as noted previously, length of symptom remission for more infrequent symptoms (e.g., suicide attempts) may need to be modified.

In summary, it is proposed that the status of a client who meets all seven of the criteria can be viewed as a "bull's-eye" by the therapist in terms of readiness for termination. However, as one progresses out from the bull's-eye and certain clients may be ready for termination without having met all seven criteria, it is less clear as the decision-making process will involve more clinician judgment. It is proposed that a client should meet at least the first five criteria before therapy is terminated, and more importantly, the first four criteria, which are viewed as essential for the conclusion of therapy. Alternatively, as discussed previously, depending on a client's presenting severity of disorder(s), a smaller decrease in symptoms and functional impairment at termination may be appropriate and clinically meaningful for certain clients.

Client Considerations When Enacting Termination

Given that a relationship between therapeutic alliance and treatment outcome has been demonstrated in the literature (cf. Horvath & Symonds, 1991), it is important that the clients' experiences and "attachment" to the therapist are considered in the context of termination. In light of evidence suggesting that discordant client-therapist treatment goals may be related to premature termination (e.g., Hunsley et al., 1999), collaboration on goals and expectations of treatment between the client and therapist should be emphasized throughout treatment to help maintain working alliance (Horvath & Greenberg, 1989). The importance of addressing clients' therapeutic experiences is further exemplified by meta-analytic research indicating that mean dropout rates are 47% (Wierzbicki & Pekarik, 1993).

Moreover, the therapist can obtain information regarding the client's experience throughout the assessment of the termination criteria. For instance, criterion one, "symptom decrease," and criterion two, "stable symptom decrease for 8 weeks," rely on client input through the use of objective self-report measures regarding their perceptions of current symptomatology. Additionally, the therapist determines whether the client meets the criteria "use of new skills tied to lower symptoms," "use of new skills at times of former vulnerability," and "sense of pride about new skills" through client feedback regarding success in navigating formerly high-risk situations. The therapist can obtain input regarding clients' therapeutic experience by simply maintaining open communication with the clients and asking them about their progress. In particular, one study found that clients prefer to discuss their feelings, especially during termination (Marx & Gelso, 1987).

Although one study found that most clients (63%) terminate mutually, a smaller percentage (37%) terminate unilaterally (Tryon & Kane, 1995). As a result, it appears that some clients and therapists disagree regarding termination. Thus, in addition to asking clients about their progress and confidence in using newly learned skills, the therapist should ask the client whether he or she feels ready and desires to terminate from therapy. It is important to obtain the client's input regarding termination and whether the client feels that treatment goals have been met for it is consistent with self-determination theory (SDT; Ryan & Deci, 2000). SDT states that the well-being and motivation of clients may be increased if the therapist attends to the clients' human needs of autonomy, connectedness/relatedness, and competence, which is particularly applicable to the termination process, as well as the entire course of therapy. If the client and therapist disagree that treatment goals and expectations have not been met, or that the client is not ready for termination, the therapist should not enact termination. Instead, a discussion guided by SDT principles (Sheldon, Williams, & Joiner, 2003), such as empathy, choice provision, and rationale provision, should result until both the therapist and client agree on the termination process.

Regarding attachment to therapist, clients typically report positive feelings about the end of treatment and being satisfied with how treatment ended (Marx & Gelso, 1987). Further, a potential framework for termination procedures has garnered some empirical support in Marx and Gelso's study. Findings suggest that typical procedures for termination should consist of exchanging client and therapist feelings regarding termination, reviewing treatment goal attainment, and discussing an ending date and future plans, which can be considered in the context of clients' "attachment" to the therapist. Moreover, this termination procedure is consistent with SDT, which will likely enhance client motivation and well-being. Again, if disagreement occurs during the treatment process, the use of empathy, choice provision, and rational provision is recommended, which will enhance

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the experiences of clients during this time, until agreement is reached (Sheldon et al., 2003).

Directions for Future Research

Clearly, further research is necessary to provide support for and clarify the model presented herein. An obvious place for such research to begin would be studies comparing termination following the seven proposed criteria to termination as usual. We expect that clients who terminate therapy after meeting the proposed criteria would fare better than clients who did not, particularly on such measures as relapse or symptom count 1 to 2 years posttermination. Additionally, clients who terminate therapy after meeting these criteria should be less likely to seek out mental health resources in the future. Studies that collect repeated follow-up data on these clients will help illuminate the potential benefits of adhering to these termination criteria.

Following such research establishing the utility of the termination criteria presented here, additional avenues of research investigating different combinations of the seven criteria may serve useful. As we have speculated, clients who meet some, but not all, of the proposed criteria may still experience improved long-term outcome as compared to individuals who do not meet any of these criteria or clients who meet only one or two criteria. Studies comparing clients who meet four or five of these criteria to those who meet all seven and those who meet two or less will help to clarify which of these criteria may be most important in predicting long-term outcomes.

In particular, it may be most useful to compare clients who terminate therapy after meeting only the first five criteria with clients who meet all seven criteria at termination of therapy. Contrasting long-term outcomes of these two groups will help to resolve whether all seven criteria are necessary for optimal outcome or if the first five criteria are sufficient. Other factors may also influence long-term outcome, such as comorbidity. For clients who present with comorbid disorders, it may be especially important that they meet the sixth criterion: generalization of skills to other areas besides target areas. However, clients who present with a single disorder may not need to show this generalization of skills as there may be no other significant problem areas.

Future studies are also needed to determine the applicability of each termination criterion to clients diagnosed with schizophrenia and personality disorders, as well as clients treated at inpatient settings. More specifically, it should be tested whether modifications are needed in the use of the criteria to different types of disorders and different settings. In particular, studies examining which specific symptoms and skills for clients diagnosed with schizophrenia and personality disorders are most useful to assess for the symptom decrease and usage of new skills criteria are needed. Further, the frequency of assessment for the symptom decrease criterion and the time span for which it is required to be clinically significant may differ for various disorders, settings, and types of cognitive behavioral treatments (e.g., dialectical behavior therapy; Linehan, 1993a,b). Additionally, studies determining the typical amount of decrease in symptoms and decrease in functional impairment for personality disorders, schizophrenia, and inpatient settings would be beneficial. Thus, studies should empirically investigate the utility of each termination criterion in these different conditions (e.g., disorders, settings, and treatments) so that realistic expectations and long-term utility can be established.

Other areas that deserve further examination are methods to help make the therapist's decision-making process less subjective regarding whether certain termination criteria are met (e.g., usage of new skills, sense of pride regarding new skills, and generalization of skills to other areas). Therapist opinion of patient report of new skill usage and sense of pride regarding the new skills appears to be the best method available to assess these criteria at the current time. Future research should focus on developing and assessing the utility of more objective therapist and client measures of these criteria.

We believe that this framework for determining when a client is ready to terminate therapy will be a valuable guideline for therapists. If, as expected, future research bears out this model and supports these criteria as predicting better long-term outcomes than termination as usual, we hope that this framework will become common practice for clinicians. At the very least, this model serves to help inform clinicians regarding issues that should be considered when contemplating the termination of therapy and provides direction for research investigating markers of appropriateness for therapy termination.

Conclusion

Overall, termination is one of the most important aspects of treatment, as it dictates when a client no longer needs services. The framework described in this paper builds upon current perspectives with regard to termination. More specifically, this conceptualization provides a coherent, structured approach, utilizing specific indicators of when clients are ready for termination during CBT. A case example and discussion regarding the use of the criteria demonstrate the clinical application of the seven termination criteria proposed herein. Moreover, success in the use of the criteria seems most probable for clients diagnosed with depressive and anxiety disorders in outpatient settings, given improved treatment outcome. In conclusion, the termination framework proposed in this paper shows initial promise and awaits future

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empirical testing of its applicability to different disorders and types of treatment.

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