

1

Termination Strategy: A Pragmatic Approach in Contemporary Practice

Key Questions Addressed in This Chapter

- How does theoretical orientation impact termination philosophy?
- How is termination managed in today's practice environment?
- What makes termination difficult to plan even in brief therapy?
- What circumstances elevate the risks of adverse events at termination?
- What are the main objectives of a pragmatic termination strategy?
- How can we distinguish good termination from bad termination?

THE IMPORTANCE OF TERMINATION

Effectively managed termination is vital to a lasting positive impact, regardless of the type of intervention or when termination occurs. Termination holds the promise of enhancing the benefits and the risk of diminishing these effects of therapy, depending on how well the process is negotiated. In more extreme terms, a good termination can seal the successes of therapy, but a bad termination can sour the best efforts. Even in brief therapy, the process of ending is a crucial part of the experience that helps both client and practitioner to assess their sense of accomplishment and calculate the value of their invested effort. Like any closing effort, termination has special impact on the conclusions, satisfaction, and overall sense of harmony associated with the psychotherapy experience.

Ending therapy is not without challenges. For a mental health professional, termination may be likened to a pilot's task of landing an aircraft. It requires planning, skill, focused attention, nimble responses, vigilance to the risks of adverse conditions or events, and professional composure in action. Just as the pilot needs a flight plan that includes landing parameters,

so the clinician also needs a treatment plan with termination goals. The pilot needs to calculate how much distance can be covered given the fuel capacity, and the clinician needs to determine what can be accomplished with the resources available. When it comes to making the final descent, the pilot may have to accommodate storms, winds, and other inclement conditions in order to land safely. Clinicians ending therapy also may encounter high emotions and non-ambient factors, whether those were predicted at the outset or whether they developed unexpectedly at the end of the journey. Professional composure and effective judgment are crucial to both the pilot and the clinician as each carries their respective task to the best possible conclusion. In the pages ahead, we take an in-depth look at the tools and strategies that clinicians need for this important endeavor.

How Does Theoretical Orientation Impact Termination Philosophy?

In psychotherapy, the best point of completion is not easily defined, nor is there a uniform set of procedures for ending. Even with the many types of therapy available today, the comparative literature on termination is relatively sparse (Barnett, MacGlashan, & Clarke, 2000; Goldfried, 2002; Greenberg, 2002; Joyce, Piper, Ogrodniczuk, & Klein, 2007; Wachtel, 2002; Zinkin, 1994). We might reasonably assume that a provider's perspective on when and how therapy should conclude will follow their philosophy of therapy and its perspective on psychopathology. Two broad perspectives on psychopathology aptly summarized by Weiner (1998) provide a way to compare some essential differences in theoretical approaches to termination. According to Weiner, these are the humanistic, developmental perspective, which tends to be more optimistic about change, and the analytic, dynamic character structure perspective, which tends to be more pessimistic about change.

Providers who approach therapy from a humanistic, developmental perspective believe that people are basically capable and resilient. Minimal intervention is often sufficient to facilitate or redirect their natural growth and development. Providers who approach therapy from a dynamic perspective view conflicts and maladaptation as static aspects of a structured character or personality. Problems stemming from character damage often require rigorous intervention for even minimal change and improved adaptation. Concerning termination, the resilience perspective might argue that treatment can be safely concluded at the earliest signs of symptom improvement. Short segments of therapy are considered adequate for the majority of client needs, as it is assumed that even minor changes precipitate a healthier trajectory of ongoing growth. The unyielding character perspective might argue that symptom-focused treatment is inadequate and even risky. Adequate change is assumed to require intensive effort that is commensurate with the extent of the character damage or conflict.

Both perspectives would likely agree that the optimal point of termination is when the goals of therapy have been met. But therapists of either philosophical persuasion will likely diverge in their opinion of what tasks are needed and how the goals will be measured. From the resilience perspective, there is not a specific state or set of tasks that the client has to complete in order to finish therapy. Growth is a continuous process, so the point of completion can be very flexibly defined. For example, if the client learns to apply anxiety management skills to the task of driving to work on crowded freeways and feels more able to cope, therapy could be considered complete. Or perhaps the client stops struggling with anxiety as an emotional state that might occur on the freeway and is ready to move on with other aspects of living. Further treatment is not necessary unless there are other clinically significant problems or concerns that the client wants to pursue. The termination itself may be a task that is accomplished with relative ease, depending on the client's wishes. From the dynamic perspective, however, the anxious client's ability to drive to work is only initial symptom relief. Therapy would not be complete until the client has taken the time to sufficiently understand the roots and patterns of their self-doubt and inhibited achievement.

To date, there is no definitive resolution that either philosophy should prevail. And in real life, all providers do not cleave into this dichotomous separation of optimistic and pessimistic philosophy. We might simultaneously see the growth potential in our clients and recognize the impact of damaging experience. More central to the issue of termination philosophy, however, is the common denominator of scientific perspective. This perspective is alluded to by Wiener (1998) in his assertion that "psychotherapists are most likely to be helpful when they can provide psychotherapy of whatever length appears clinically indicated and when, if their preferences run strongly to either short-term or long-term values, they can keep humbly in mind that not all the correct answers are theirs" (p. 262). This basic experimental approach was outlined some years ago by Goldfried and Davison (1976) as a fundamental strategy for informing clinical work. Rather than adhering solely to the precepts of a particular school or system of therapy, the scientific provider draws from a spectrum of basic research findings to formulate and test a variety of clinical interventions (Goldfried, 2007).

The scientific perspective is not tied to either a hopeful or a cautious position. It simply focuses on what the client has acquired via scientifically understandable forces. Where maladaptation exists, intervention is geared toward what can be acquired as a means of mediating these problems. There are a number of ways this acquisition can take place, including but not limited to various forms of learning and emotional experience in relationship to the provider. The question of treatment completion then becomes, quite naturally, an empirical one. Data from multiple sources help define treatment completion for any given client. There may be evidence from clinical

trials that provides a general framework for the types of changes needed and the length of time it might take to achieve those changes. This is blended with vital clinical data to arrive at a reasonable assessment of treatment completion for each individual client.

Simply put, one size of therapy does not fit all clients, even those with the same diagnosis. Some clients will be ready to terminate therapy once the most intense symptoms have remitted, and others will want to extend the effort to deal with other issues. Some clients will appropriately terminate in fewer than five sessions, and their decision is not necessarily “premature.” Not all clients need intensive treatment, but some will certainly exceed the provider’s predictions for expected length of therapy. Determining an appropriate point of termination is a complex task that involves an integration of clinical, ethical, empirical, and contextual information. Theoretical orientation has a definite impact on the provider’s general perspective. But theoretical orientation is secondary to a more fundamental scientific strategy of using multiple sources of relevant data to arrive at an integrated and individually appropriate termination decision.

How Is Termination Viewed in Today’s Practice Environment?

Today’s standard of care for psychotherapy is based on a health service model. This model includes the following components.

- Documented clinical necessity of services
- Specific goals
- Defined episodes of care
- Evidence-based interventions
- Measurable progress
- Multiple providers
- Focus on consumer satisfaction

These components represent some significant shifts from the standards of care that prevailed even a decade or two in the past. Previous standards of care were based on a system in which providers had more exclusive dominion over clinical decisions. A traditional framework of open-ended therapy with a single provider was most common. Treatment necessity was decided on a subjective basis by the client and the clinician. The goals of therapy were broad and often implicitly held, the timeline indefinite, and the methods were determined by the allegiance of the therapist to a school of therapy.

Changes in systems of service delivery and our clinical and professional standards of care over the past few decades have had a significant impact on therapy termination. These changes have affected how soon, how often,

and why we must address the conclusion of service. With these changes, it has become more and more apparent that our assumptions and practices need to be updated. Here is why. Relative costs and quality of services have become primary issues in the health care system. Valid concerns about cost management have given rise to greater emphasis on oversight and accountability in service delivery. Support for open-ended and extended interventions has significantly diminished in the conservation of resources. Measurable gains are now required to justify the use of resources. As a health-related service, therapy must be clearly linked to signs and symptoms of medical necessity and its purpose must be linked to alleviation of those symptoms. Expectations for observable results within defined periods of time have created certain limits and demands for accountability from both client and provider.

In a managed care environment, psychotherapy providers seldom have the leisure of allowing the client time to discover a readiness for termination before they must raise the issue of ongoing medical necessity for authorizing additional services. There is an obligation to establish a compelling need for therapy or in the absence of such to discontinue services. Providing services that are not expected to be beneficial or are no longer needed is unethical, potentially harmful to the client, and fraudulent use of the system. If a provider knowingly facilitates the fraudulent use of resources, he or she assumes the risk of losing professional integrity and possibly the privilege to practice.

At the same time, providers bear a professional responsibility to protect the best interests of the client and must not abandon clients or fail to maintain a reasonable standard of care. Haste or overzealousness in limiting therapy can be just as hazardous as prolonging treatment. Either can be an error that increases the provider's exposure to administrative, ethical, or legal complications. To complicate matters further, clients with the greatest mental health needs often have the most limited access to services. Reasonable termination of clients with long-term needs is one the provider's biggest quandaries. Even brief therapy relationships can be highly emotionally charged and ending therapy can be difficult, particularly when the reasons for termination are not optimal. Attachment is still relevant to successful intervention, even if it is not considered the focal point of change. With tighter time frames, providers have less opportunity to develop the therapy relationship or to provide support throughout a full cycle of change. This increases the risk that something important may be missed or that the client's overall benefit and satisfaction will be diminished.

Protecting the client's best interests has become an increasingly complex task as both treatment options and limits have multiplied in the health care marketplace. Options can include different types of psychotherapy, medication, case management, self-help and support groups, day treatment, sheltered workshops, online support resources, bibliotherapy, family or couples therapy, skills classes, or other medical or allied health services.

Although the options appear to be abundant, these may not all be easily accessible, clearly indicated, or fully effective for all consumers. However, these options represent a range of alternatives that are potentially useful in the client's overall efforts toward self-regulation.

Specific attention to termination strategies in this new context has not kept pace with these expanding and shifting expectations. It has been commonly assumed that if therapy is more focused or time-limited, it should end easily, without as much need to process the affective, cognitive, interpersonal, and defensive reactions that attend termination in open-ended or dynamic therapy (Barnett et al., 2000; Joyce et al., 2007). Both client and provider may expect that the point of completion will be readily apparent when problems are solved. Termination is recognized as important, but construed as a minor closing step. Although these assumptions may hold true in some instances, problem-focused therapy does not always turn out to be brief or affectively uncomplicated.

When the therapist is under direct supervision in his or her work, as in the case of trainees (practicum students, interns, externs, residents) or those in emerging or limited professional roles (e.g., post-doctoral clinicians or master's level clinicians with a limited scope of practice), another layer is added to the termination considerations. Supervisors play a significant part in determining when and how therapy should end, although their vantage point is that of an inside observer who is legally responsible for what happens. In addition, the supervisory relationship itself includes termination issues that run parallel to many of the concerns that can arise within psychotherapy.

Given the demands of today's practice environment, it is clear that new challenges and expectations have made termination more complex. These changes call for a coherent strategy of managing termination decisions across sequential episodes of care, different modes of intervention, varying clinical needs, and conservatively managed resources.

What Makes Termination Difficult to Plan Even in Brief Therapy?

Brief or problem-focused therapy offers a shift away from global objectives such as self-actualization or insight in favor of more behavioral and symptomatic targets that can be operationally defined and measured. Specific changes are expected within relatively short segments of time through the application of focused techniques. It sounds like a simple process, but may not be so straightforward or predictably attainable in practice.

Therapy intended to be focused and brief does not always turn out to be so precise for a variety of reasons. The degree of optimal structure and pace of change will vary from client to client. Clients may not have the skills or motivation to participate in the most efficient

ways. The client's beliefs and assumptions may function as barriers to improvement, especially when the client remains passive, avoidant, or fearful of self-disclosure. The scope of the client's problems and the degree of desired change might require multiple interventions or an extended course of treatment, as is often the case with recurrent or co-morbid disorders, especially Axis II disorders.

The provider's skill and deftness in engaging the client is another factor that can alter the course of therapy. Perhaps the provider has limited training in applying specific strategies and lacks confidence in using these methods. Or maybe the provider has a tendency to underestimate the importance of the relationship and other common factors or does not maximize these vital ingredients. In addition, both client and provider may view global objectives as higher order or "real" change and use this as their framework for setting goals. Specific endpoints are then much more difficult to discern as there are no systematic, objective criteria for determining the achievement of global goals (Weiner, 1998).

Even with well-defined goals, behavioral and emotional change does not necessarily occur on a predictable schedule. Empirically grounded interventions are designed for time efficiency, but variability among clients in terms of severity, chronicity, overall needs, beliefs, personal resources and ability to work productively with the therapist all affect the length of intervention for any given client. In addition, the techniques of intervention must be blended into an ongoing interpersonal interaction, another source of variability that is not directly predictable. Other health care services of a technical nature have defined procedures with a clear sequence of action. The provider-client relationship is important but not as highly entwined with the specific service as is the case with psychotherapy. For example, our relationship with our dentist does not affect how our teeth get cleaned and repaired, or how long the procedures take to complete. And few among us would linger just to relax in the dentist's chair once the drilling is done, no matter how much we like the dentist.

In contrast, the process of psychotherapy is less mechanistic and more fundamentally tied to interactive factors. Even with specific, objective goals and tasks, the emotional aspects of the therapeutic bond (Bordin, 1979) act as interpersonal adhesive. When this adhesive is positive, therapy may progress easily, but its conclusion can bring unexpected reluctance and distress. With the relationship as a medium for the service, ending therapy can feel as poignant as saying goodbye to a dear friend or family member. This tension is further complicated by the client's particular style of attachment and by the productivity of the therapy itself, either of which can prolong or shorten the work. Regarding the relationship per se, some clients dread the loss of this emotional connection while others keep a detached stance throughout therapy.

Brief or problem-focused models of therapy typically take a pragmatic approach toward termination. Termination might be considered a developmental turning point or place where a relationship is transformed (Levinson, 1996). In problem-focused therapy, termination is not a final conclusion or loss as much as it is a point of re-evaluation and redirection. From the provider's perspective, the main objective is to create a positive transition that marks the completion of a particular time of collaboration. Future contact is often an option or even part of the plan, as the client can return for "booster" sessions or additional courses of therapy.

To be successful in this endeavor, however, the problem-focused practitioner can not just import the termination strategies of insight-oriented or dynamic therapy. Today's practitioners using cognitive, behavioral, dialectical behavioral, mindfulness-based cognitive, acceptance and commitment, narrative, feminist, solution-focused, prescriptive, integrative, eclectic, or other problem-focused models need a pragmatic approach to termination that is theoretically compatible and consistent with the current clinical, ethical, and practical standards of care. A pragmatic model of termination that addresses these needs is developed throughout this text.

What Circumstances Elevate the Risk of Adverse Events?

Termination may be relatively easy and straightforward when progress is satisfactory and the circumstances of therapy are relatively uncomplicated. The thoughts and feelings of client and practitioner are more or less positive and in harmony. But not all terminations look alike or follow a standard process. Variations, snags, and even stalemates and debacles can result from many different interacting forces, regardless of type of therapy or its intended length. Steady progression toward a natural conclusion may be unlikely or impossible. Such circumstances signal an elevated risk for emotional, practical, ethical, or legal problems, and all providers must be prepared to handle these potential difficulties.

The following is an overview of some of the possible challenges that will be explored throughout this text. These include forced termination, practitioner skill limits, stalled progress, and client resistance to termination.

Forced Terminations Sometimes termination is forced by circumstances that restrict the duration of therapy or compel it to end. Force implies negative pressure and is really a matter of degree, depending on the perspective taken. Alternatively, the term "precipitated" offers a more neutral description of termination that is prompted or hastened by circumstances. A more neutral stance emphasizes the client's autonomy and ability to choose among options, even if those options have realistic limits. There is almost always some degree of choice possible in dealing with the events that are impacting the viability of continuing therapy. One example is a

managed care insurance contract that limits the number of compensated mental health visits during a calendar year. If there are changes in the client's or practitioner's contract with third-party payers, the client may be prompted to choose another provider due to prevailing financial considerations. Describing the termination as "forced" automatically makes it a coercive event, as opposed to describing activating circumstances that include options and alternatives.

Various personal circumstances can precipitate termination, such as when the client or provider moves, changes jobs, completes training, becomes unavailable for health or personal reasons, or a conflict of interest develops. Most therapy that is delivered by trainees ends when the training placement is completed. Sometimes clients abruptly leave therapy or they attempt to prolong therapy when it is no longer feasible to continue. Confusion about how to handle these different circumstances increases the risk of impractical arrangements, boundary violations, emotional distress, and possible unprofessional conduct. Here are three very different examples of precipitated termination and some of the possible pitfalls associated with each.

Case Example: Termination Precipitated by Training Status. Tina was completing a graduate practicum at the university student-counseling center. Although she was excited about moving along in her professional training, she felt sad and vaguely guilty about having to end therapy when her placement was over. Tina had learned that therapy should support the client's growth and self-determination, and that treatment was considered complete *when the client felt ready to end therapy*. Yet her trainee status created a practical time limit on her client relationships. Many of her clients were students and also had practical time limits on their involvement. Therapy had to end or be interrupted at the close of the term, regardless of how ready Tina or her clients felt. Most people accepted this but not without some difficult emotional reactions. Tina and her clients liked one another. They didn't feel ready to let go. This conflict between emotional attachment and practical boundaries confused Tina's clarity of professional action. Tina found herself considering options that could ultimately compromise her professional integrity.

Tina began to ruminate about giving her "favorite" clients her home telephone number and offering to correspond via e-mail or meet for coffee once in a while. That way the therapy relationship could continue. Her anxiety level increased each week as she thought about the approaching end of the term. Several clients finally mentioned their impending departure from campus and need to discontinue therapy sessions. Several others called to cancel, citing a busy examination schedule, or simply failed to show without notice.

Tina ended therapy with all of her clients, but she felt uncomfortable with the forced circumstances. One client asked about the option of

continuing to work with Tina, and she explained the practical boundaries that prevented that option. Tina decided against offering the option of casual contact because this could be construed as unprofessional or improper conduct and might actually confuse rather than help the client. In the case of a trainee such as Tina, offering to continue clinical service outside of a formally supervised setting would constitute unlicensed clinical practice. Tina might discover that she is liable for a reprimand from the licensing board that governs her profession, and she could even encounter difficulty in obtaining her license to practice because of a professional misjudgment such as this.

Sometimes termination is prompted by actions of the client that preclude any closing discussion. Perhaps the client simply breaks contact and offers no direct explanation. Or in a more complicated situation, the client may make threats or take adverse actions that compromise the therapy relationship beyond repair. In either situation, the client may still have unresolved problems. However, this does not mean that the therapist is obligated to fix those problems. In fact, when adverse actions have taken place, it is very risky to attempt to continue therapy. The termination strategy in either situation does not have to be complicated or drawn out. The ending may be conflicted, but the practitioner can still map out an appropriate professional course of action. To illustrate, here are two case examples of termination by very different client actions, and the challenges faced by the practitioner.

Case Example: Termination Precipitated by Client No-Show. Brian is an enthusiastic and caring practitioner. He sincerely wants to help his clients, and he has very high expectations of his performance as a provider. He always tries to do his best and he is prone to feeling personally responsible for snags in the therapy process. If a client declines treatment or does not follow through, he views it as his personal failure. He tends to think, “If I were a better or more likeable therapist, this client would continue working with me.” Unfortunately, this self-demanding attitude tends to limit his objectivity and create unnecessary emotional distress over routine aspects of his practice. His reactions to his client Cindy provide a good example.

Cindy entered therapy rather reluctantly at the behest of her family. At age 26, she was having problems with a mildly depressed mood and dependence on her family. Cindy was most upset about family pressure on her to get a job and help out around the house. She viewed coming to therapy as a way to get them off her back. She did not see herself as a person in need of “psych treatment.” Her behavior in sessions with Brian was flirtatious and social, and she did not follow through on any homework suggestions, even though he attempted to keep it simple and involve her in the planning. After her third visit, she simply failed to show for her next scheduled appointment.

Brian felt surprised and ashamed that he had been unable to successfully keep Cindy in treatment. He ruminated about what he might have done wrong, and he left several telephone messages with possible appointment times, hoping that Cindy would reschedule. He wondered if he should send her a letter of encouragement. What Brian did not realize was that Cindy was annoyed by his phone messages and deleted them without listening. Her family had eased up on the pressure and she was feeling better, so she had no further interest in therapy. She quite simply was not engaged in a process of self-examination. In addition, she felt physically attracted to Brian, but she had no idea how to discuss or manage those feelings. When he failed to react to her flirtations, she felt rejected and concluded that the whole enterprise was a waste of time.

Understanding the reasons for termination is an important part of adequate closure. When the client ends treatment by failing to return for follow-up, the practitioner may have conflicting emotions and lack clarity about what to do next. Having a plan of action for client communications is only part of the termination strategy. The practitioner also needs a plan for dealing with his or her emotional reactions to termination that is precipitated by the client. Abrupt or unexplained client termination can bring disappointment and trigger painful thoughts about possible professional shortcomings, rejection, or limitations to the process of therapy.

Sometimes termination is necessary because of highly adverse client actions such as demands or threats intended to manipulate or intimidate the provider. Even though these client behaviors may be understandable from a clinical perspective, there is a certain threshold where the adverse actions become pragmatically intolerable. It is especially difficult to reason effectively when one is under attack. Having a clear termination strategy for conditions of duress is absolutely essential.

Case Example: Termination Precipitated by Adverse Client Action. Kate had been working for more than a year with Jennie, an emotionally unstable, depressed young woman with aggressive and self-destructive tendencies when child protective service investigated a complaint of neglect concerning her young son. Kate did not file the complaint, but rather a family member did so because of concern that Jennie was leaving her son in the care of incompetent babysitters. Jennie demanded that Kate provide a letter to the investigators as a testimony to her emotional stability and capacity to effectively care for her son. When Kate declined to write the letter because of her concerns about Jennie's history and current functioning, Jennie threatened to stalk her, "pop" her, and cause her physical harm. Jennie also made reference to enlisting the help of her gang-involved boyfriend to physically force Kate to write the letter. Kate was frightened and wondered whether she should just write a generically supportive letter or continue to refuse and maybe carry a gun for self-defense. Instead, she decided to

schedule more frequent sessions with Jennie to discuss the letter, but also to keep pepper spray and a cell phone nearby at all times.

Kate is unaware that therapist-initiated termination is a viable and correct response when dealing with specific, direct threats to her physical safety. Like many well-meaning providers, Kate is hopeful that increased focus on the triggering issue will be therapeutic for the client. She worries that she could not end treatment at this point because Jennie has so clearly *not* completed treatment in terms of clinical improvements. So her strategy is to intensify clinical contact. However, termination is really the only viable option. Kate is reluctant to pursue this option because she thinks she must not abandon her patient, she does not want to give up trying to help, and she is afraid to confront this threatening patient. She is greatly relieved when Jennie fails to return, but she carries a sense of apprehension about any further contact with her. She worries about possible professional sanctions for abandoning Jennie or that Jennie might actually try to harm her when she least expects it. She is also deeply worried about others who might be harmed by Jennie, and feels disappointed that she did not have a larger impact on this volatile young woman.

This is a confusing situation, as many practitioners believe they must continue to directly manage the interaction and treat the underlying problems or risk charges of client abandonment. They may feel a powerful moral imperative to persist in attempts to contain a client who presents a significant threat to society at large.

From an ethically based risk management standpoint, the therapy relationship is terminated at the point when a threat is made. There is little or nothing to gain by attempting to resolve such a situation through clinical interactions. No further productive therapy is possible because the relationship of trust has been compromised beyond repair. It is not fair to expect the practitioner to continue attempting to manage threats of aggressive action when he or she is an intended target. The actions of the client clearly preclude any further discussion or counseling on the reasons for termination. However, a termination strategy is still needed. Instead of attempting to meet with the client to tie up loose ends, the practitioner needs to establish for the record the fact that termination has occurred and why. If there are other persons in danger, the provider may also need to take steps to warn or take precautions as stipulated by relevant laws and community standards.

There are many different circumstances that can precipitate termination. For any of these, the practitioner needs an appreciation of his or her professional limits and responsibilities, knowledge about possible options for the client, and willingness to bring these issues into the therapy discussion. In instances of a conflict of interest, the practitioner's ability to talk openly about exact reasons for termination may be constrained. However, the discussion can still productively focus on client needs and choices. There may

be strong emotional reactions on both sides, but these feelings should not dictate an unprofessional course of action. The practitioner may experience emotions of frustration, disappointment or anxiety and fear. Ending on a positive note does not necessarily mean that the practitioner and the client both feel happy about the termination, but rather that the process is handled in a systematic and professional manner. Even if the client is unable for whatever reason to participate in effective ways, the provider can maintain this tone with his or her strategic professional stance.

Practitioner Skill Limits Well-intentioned practitioners who do not have the specific skills needed to address the problem at hand may confuse persistence with clinically inappropriate continuation of treatment. Doing so risks loss of professional integrity and potential harm to the client. Community standards of care have established the expectation that mental health practitioners should be familiar enough with basic psychopathology and various treatment options to recognize problems that are beyond their personal scope of practice and to provide appropriate referral.

Case Example: Provider–Client Mismatch. Jeremy was troubled by intrusive thoughts that he feared were blasphemous toward God, so he sought counseling at a faith-based clinic. Jeremy had a history of benign rituals of counting and repeating numbers and phrases in his head. When he was under some particular stress, he tended to check repeatedly, including checking doorknobs, door locks, and written work that might contain a mistake. His friends would sometimes find his requests for reassurance exasperating, but otherwise there were no significant impairments to his overall functioning as the result of his checking. His problems were mild and transient, and he never had a need to seek mental health intervention. That is, until his thoughts became blasphemous.

The practitioner at the clinic explained Jeremy's problem as a spiritual war in his head. He recommended intense prayer sessions and offered to meet with Jeremy twice per week to assist him in finding reassurance through contact with his faith. He instructed Jeremy to be very careful at his workplace, a prison facility, because he might inadvertently pick up more spiritual conflict just by interacting with the inmates. To reduce this risk, he recommended that Jeremy should surround himself with pictures or other icons representing angels to provide reassurance of his contact with good spirits.

Jeremy attempted this plan for two weeks. At the end of the second week, he traveled a short distance to visit his family. During the course of the weekend at home, he was hospitalized for an acute suicidal crisis. He started to have more intrusive thoughts about blaspheming God as well as new fears of harming his sister's children in some way. This led to thinking

that he should kill himself rather than harm a child. When he admitted to his family that he was preoccupied with the idea he should kill himself, his family initiated hospitalization. In the course of his intake, Jeremy learned for the first time that the name for his problem was obsessive compulsive disorder, and that medication and specific psychotherapy could help.

Jeremy did not bear ill feelings toward the practitioner at the faith-based clinic as he had provided the spiritually focused intervention that Jeremy wanted. However, the practitioner lacked the skills to recognize that the problem was obsessive compulsive disorder, something that was not effectively treated by spiritual counseling. This approach actually exacerbated Jeremy's condition, leading to a crisis hospitalization. Fortunately, with the help of this family, Jeremy was redirected toward treatment appropriate for his particular disorder.

Stalled Progress Perhaps the most typical termination dilemma is when there is a good rapport but little evident progress. Will additional therapy produce further benefit? It is not unusual for a client to make some initial progress and then stall at a plateau. Both client and practitioner have an emotional investment in treatment and may be encouraged by some initial gains. The therapy relationship is congenial but moving uncertainly toward an elusive sense of completion, maybe lacking a clear or attainable goal. There is risk in proceeding with such a vague sense of direction because the client is less likely to benefit from unfocused therapy. The contact may fade into unstructured meetings that are more social than therapeutic, raising the risk of an inappropriate dual relationship. Other practical risks include an overwhelming caseload with little turnover and practitioner vulnerability to burnout.

Case Example: Is More Therapy Needed? When it came time to update her will, Melanie wondered, half seriously, if she should make provisions for several long-term clients who seemed destined to continue therapy with her forever. "Maybe," she mused, "they will follow me into the afterlife, showing up for their regular Wednesday appointment in some ethereal office like nothing has happened." These clients were all adamant about the need to continue therapy. Although there were notable differences in educational and economic backgrounds of these clients, each had a marginally stable but fragile existence. Their therapy sessions often had a social tone, but there was no gross distortion of professional or personal boundaries. In their own personal way, each relied on regular contact with "Dr. Melanie" to help regulate chronic emotional problems and manage stress, particularly the stress of social isolation.

Melanie is dealing with patient dependency and unclear treatment goals. She does need a plan for her personal will to stipulate someone who

can provide confidential, professional management of client files and assist with referrals in the event of her unexpected death or unavailability. This is responsible and ethical practice management. The treatment relationships are very good, but the “automatic pilot” nature of the therapy indicates a lack of focus that could potentially be redirected in more productive ways. Periodic review and re-evaluation is critical but often overlooked in extended treatment relationships.

Eliciting the client’s and the practitioner’s thoughts about termination can yield important information about barriers to further progress. Pinpointing specific beliefs or skill issues can provide direction and new energy to the therapy work. For example, the client may be thinking, “I’ll never be able to give up therapy. I would be too lonely.” Or, “It’s too risky to end therapy. I might have a relapse.” The practitioner may think, as Melanie did, “If I bring up termination too soon, it might harm this client.” Or, “If I bring up the subject of termination, the client will feel rejected.” These ideas can be addressed within therapy, as part of an active process of working toward a positive termination, rather than just hanging on to therapy until it feels right to let go.

Melanie and her long-term clients might decide to continue treatment if there is identifiable benefit and relevant criteria for medical necessity are met. Some clients need continuous care, even if their progress is slow or minimal. By talking about the idea of termination, they are in a much better position to strike a negotiated agreement on the proximity or distance of closure and actively work toward this goal. Having a termination strategy for longer-term clients will help focus therapy and mediate any drift toward unproductive or inappropriate interactions.

Providers must make an active decision whether or not to include longer-term treatment within their range of services. If longer-term treatment is offered, treatment objectives that are consistent with a collaborative model can be formulated (e.g., Beck, Freeman, Davis, & Associates, 2004). If extended treatment is not an option, it is even more important to create a positive transition that marks the completion of a particular segment of collaboration. This encourages the client to feel good about the time invested, to be agreeable to returning for further therapy in the future, or to be open to seeking out alternative services or other providers.

Termination Resistance Some clients are persistently unready and even resistant to termination. When the practitioner attempts to discuss progress, the client has strong emotional reactions and may avoid or subvert the discussion. There are a host of possible reasons for this behavior, the most likely being the presence of Axis II psychopathology (Beck et al., 2004). Some clients react to the mere subject of progress evaluation in an automatically defensive way. Secondary gain may also foster the client’s

reluctance to let go. Or the client may perceive the therapy relationship in emotionally distorted ways, a situation that some practitioners may not expect or be fully prepared to manage. Perhaps the client construes the end of therapy as an absolute separation, one that threatens their future existence. Being in therapy is “safe,” but ending therapy is “dangerous.” Some clients attempt to exercise an inordinate degree of power or entitlement in therapy, acting as if the practitioner “belongs” to them and is obligated to meet their demands, reasonable or not. Various idiosyncratic reactions may reflect the client’s effort to escape perceived rejection, compensate for a sense of helplessness, or maintain proximity to a source of nurturance and support. Sometimes clients will go to extreme lengths to maintain control and access to the therapy relationship.

Trying to conclude therapy with a termination-resistant client can be likened to our initial aircraft pilot metaphor. Termination without an individualized strategy is like flying on autopilot and then trying to land blindfolded while heading into a storm. The safety and quality of the therapy interaction may diminish rapidly and could become dangerous to one or both parties. The provider can eventually land, but needs help to prevent untoward events. Staying in a holding pattern might buy some time, but it might also complicate the situation as the client’s most maladaptive behaviors have prevailed and now control the interaction. Consider the following example of an actual case where control struggles resulted in a nightmarish legal and personal situation for the provider.

Case Example: Harassment as Refusal. In the case of *Ensworth v. Mullvain*, the client’s resistance to termination eventually forced the provider to obtain not one but two restraining orders from the court. At first, the practitioner was persuaded by the client to resume therapy to address the termination issues. When this proved fruitless, a second termination was forced by the client’s actions. As a cumulative result of this termination struggle, which took place over the course of several years, the psychologist suffered significant emotional and professional distress.

According to case documentation (Ensworth v. Mullvain, 1990), Ensworth was a psychologist practicing in Pasadena, CA. She worked with Ms. Mullvain for nearly two years and then terminated the treatment. Mullvain resisted the termination, so Ensworth resumed sessions to help her resolve the termination issues and disengage from the provider. Unfortunately, a series of harassing incidents forced the second termination with Mullvain. Ensworth then obtained a restraining order against her former client, which diminished the number of harassing incidents for a period of approximately 15 months, but nevertheless incidents continued to occur. The former client followed Ensworth in her car, tried to stop her car in the middle of the street, circled the psychologist’s office building, drove repeatedly around her house, made numerous phone calls to the psychologist, sent threatening letters,

and made phone calls to other professionals in the community in an effort to harm Ensworth's reputation.

Shortly after the first restraining order expired, Mullvain sent a letter to Ensworth stating that she would repeatedly violate any restraining order, that she was willing to go to jail, and she was willing to do whatever was necessary to continue contact and ensure that Ensworth did not forget her. She alluded in her letter to committing suicide in Ensworth's presence. Ensworth filed for a second order of protection, which Mullvain appealed in court. Mullvain attempted to argue that she had legitimate business near Ensworth's home. She stated that she had lost money and business as the result of the restraining order as it prevented her from pursuing her work, which included three different door-to-door sales jobs and "all the realms of photographic art and advertising." Her counsel argued against the restraining order, stating that Ensworth had failed to establish emotional damage as the result of Mullvain's actions and therefore the injunction was not supported by sufficient evidence. Further, the injunction would infringe on Mullvain's fundamental right to pursue a lawful calling, business, or profession.

The judgment of the court in issuing the second restraining order was affirmed in the appeal process. In essence, the judicial review found no merit in the client's claim that this injunction would impair her fundamental right to pursue her occupation because she did not demonstrate an *inability* to do her work in places other than near the psychologist's home. The court found that the client knowingly and willingly engaged in a course of conduct that seriously alarmed, annoyed, or harassed the psychologist. The psychologist actually suffered substantial emotional distress by being followed, spied upon, repeatedly contacted by phone and letter, and threatened with being a forced witness to the client's suicide.

The court verified the unacceptable nature of conduct by the former client and provided a means for pursuing further criminal charges if the actions persisted. However, this legal recourse was tantamount to the helping hand pulling the struggling practitioner out of the quicksand just before she sank completely into the pit. She had already endured more than two years of harassment and the effort needed to seek protection via the courts. There are no easy solutions for ending such a power struggle once such intensity has developed. It is yet another reminder of the potentially urgent need to give early and serious consideration to termination strategy.

As these case examples illustrate, progress toward an end of therapy is not necessarily tidy or direct. Many times therapy *does* end because the expectations for a positive accomplishment have been met. However, there may also be disagreement or uncertainty as to when therapy should end, strong emotions or attachments that make the ending difficult and even alarming in some cases, or circumstances that force termination before the client or provider are ready. Failure to directly address termination can leave

the provider and client struggling with confusing feelings and uncertain actions. Failure to terminate therapy when it is appropriate to do so can have unproductive or even harmful results. Effective strategy is needed to create the best possible closure, maximize the usefulness of therapy overall, and minimizing any possible stress or harm.

PRAGMATIC STRATEGY FOR TERMINATION

Paradoxical as it may seem, effective termination begins in the first few meetings. This is when the initial direction of treatment is planned, the informed consent to service is obtained, and the client is oriented to therapy participation (Barnett, 1998; Beck, 1995; Bernstein & Hartsell, 2000; Kramer, 1986). If there are any known circumstances that could affect the course of therapy, perhaps a predictable change in provider availability or insurance coverage limits, it is best to discuss these considerations at the outset. The client's expectations are assessed at this point, including expectations for how quickly change should occur and how long therapy should last. The first few sessions are also a time of socializing the client to the model of therapy and the tasks associated with it.

What happens after this initial orientation varies according to the provider's basic theoretical orientation or philosophy of termination. In the psychodynamic model, termination is conceptualized as an ending phase of psychological and emotional change. This phase of completion happens after certain structural alterations have been established and stabilized in the working phase of therapy (Weiner, 1998). In contrast, the viewpoint proposed here is a pragmatic one where termination is conceptualized as a task of the therapeutic alliance. This perspective allows issues of termination to be dealt with throughout the duration of any episode of care. Termination as a task can easily be incorporated into the initial socialization process, as the client is oriented toward the ways to effectively participate in and conclude therapy. Termination does not necessarily hinge on completion of large-scale changes but rather is a point of re-evaluation and redirection. The client is specifically prepared for participation in determining an appropriate point of termination and primed to expect that this concern will be periodically assessed.

Although there may be common ground between this pragmatic model of termination and a psychodynamic model, especially the common scientific denominator, this model is intended for learning-based approaches. No assumptions are made concerning its usefulness or compatibility with dynamic therapy. Details of a psychodynamic model of termination can be located in other resources (e.g., Barnett, 1998; Barnett et al., 2000; Curtis, 2002; Joyce et al., 2007; Kramer, 1986; Novick & Novick, 2006; Weiner, 1998).

What Are the Main Objectives of a Pragmatic Termination Strategy?

As therapy begins, one primary aim is to ensure its satisfactory conclusion. A pragmatic termination strategy is organized around two main objectives: developing the collaboration and forming a reasoned course of action that will lead to the most satisfactory conclusion that is possible under the given circumstances.

To engage the client's collaboration, the provider presents termination as a component of the entire process of planning and evaluating treatment. Thus, various considerations of ending therapy are an acceptable and expected part of their regular discussions. Some of the commonly encountered reasons for termination may be outlined in the informed consent and discussed early on, such as the achievement of goals or limited time frames. It may be useful to touch upon less common reasons for termination as well, particularly reasons of possible adverse reactions or noncompliance. The amount of attention given to the discussion of termination will likely vary across the course of therapy, but it is clear that this is a shared process of decision-making.

The second objective of a pragmatic termination strategy is to formulate a reasoned course of action for continuing versus ending therapy. As therapy proceeds, it is important that a plan for termination is under consideration. The ending of therapy is not something that just happens, but is incorporated into the overall treatment plan. This plan is determined by a mutually negotiated agreement between client and therapist. Either client or therapist can initiate a decision to terminate treatment, and this can occur for various reasons. If the provider is to effectively initiate termination, he or she must have a clear understanding of the relevant parameters that guide this decision.

Providers typically develop and refine their plan for termination as therapy unfolds over time. Given a vast number of intervening variables that are not fully apparent at the beginning, the terms of the treatment plan usually need to be somewhat flexible. Providers can be alert to potential triggers for termination, and take into account relevant clinical, empirical, ethical, emotional, and practical information as it becomes available. This allows various contingencies to be addressed as "if-then" formulations about ongoing work. If the client participates in treatment and responds well, then therapy will end when the goals are achieved. If the client becomes worse, then discontinuation and referral options should be considered. If the client must work within certain financial constraints, then the goals must be limited to what is feasible in 15 sessions. Routine procedures can be developed for frequently encountered situations, tailored to the practitioner and setting. For example, the routine procedure may be that if a

client fails a scheduled visit, then he or she will be encouraged to reschedule. But if a client fails three scheduled visits, then treatment may be terminated without further contact. Templates based on typical situations and policies can then be modified as indicated by special circumstances or clinical judgment.

Thus, a pragmatic termination strategy is distinguished by two key elements: active collaboration on the task of termination and the use of a reasoned course of action to achieve the best possible conclusion.

How Can We Distinguish Good Termination from Bad Termination?

There is no specific definition of a good or bad termination that consistently holds across different theoretical orientations. However, there are some commonly accepted ideas about termination that shape a basic distinction between desirable and undesirable conditions. One commonly accepted idea is that good termination occurs either when therapy has achieved its goals, reached its maximum potential, or is no longer needed. Bad termination occurs when there is harm to the client, the provider, or both. Termination that occurs too early or too soon might fall within the scope of undesirable termination. This is often referred to as “premature” termination, when therapy ends before the client can benefit from the service.

Premature termination has many negative connotations and difficulties as a concept. It is viewed as a problematic waste of resources, a source of discouragement and evidence of ineffectiveness of services (Reis & Brown, 2006). Yet our understanding of premature termination has been hampered by the lack of a uniformly reliable description of the phenomena. For research purposes, termination that occurs after one to four sessions (Garfield, 1994) or before completion of a predetermined number of sessions (Pekarik, 1992) has defined “premature” termination. A more qualitative approach describes premature termination as therapy that ends without the sense of psychological closure associated with having resolved problems or at least understanding the reasons for ending therapy (Kleinke, 1994).

Although the term “premature” may be useful to describe some instances of termination, it implies a number of things that are not necessarily accurate for all of the instances to which it is applied. The word “premature” refers to something that takes place before a proper (Merriam-Webster, 1984), customary, correct, or assigned time (American Heritage, 2001). Clients who stop therapy after a few sessions or before they achieve the changes sought by the provider represent a heterogeneous group. The judgment of a termination as “premature” may be due to a mismatch of the expectations of provider and client, where the provider is biased toward longer-term treatment and skeptical of quick fixes, but the client expects and prefers brief intervention (Reis & Brown, 2006). The negative implications for the client are

largely inferred by the provider's assumptions, whereas the negative effects on the provider are aggravated by perceptions of ineffectiveness or uselessness of their efforts.

If we conceptualize change as a cyclical rather than a linear process (Prochaska & DiClemente, 1992; Prochaska, DiClemente & Norcross, 1992; Prochaska & Norcross, 2003), we can better understand the progression of client change across time and through interaction with multiple influences, one of which may be formal psychotherapy. Even a single session of therapy can activate skills and motivation that continue to foster change without further contact with a therapist. Termination of therapy before the complete resolution of a problem may be reasonable and appropriate, and indeed is typically the case (Prochaska & Norcross, 2003). Termination after a limited period of time, after circumscribed tasks are accomplished or in response to compelling circumstances, is not necessarily improper, uncustomary, or incorrect.

What we lack is a descriptive perspective on termination that will allow more relative judgments about various conditions of termination. Such a perspective would illustrate reasonable termination actions in operational and qualitative terms, and avoid *a priori* assumptions about correct or customary length of time and extent of change needed to complete treatment.

The beginnings of a descriptive perspective can be found in the definition of termination offered by Younggren and Gottlieb (in press). They define termination as "an ethically and clinically appropriate process by which a professional relationship is ended." If we direct our attention to the collaboration between provider and client as the medium of this ethically and clinically appropriate process, we can develop a dimensional perspective on the range of possible conditions.

The following five types of termination collaboration are proposed here to describe the process of communication between client and provider. The five types of termination collaboration are:

- Prospective termination
- Flexible termination
- Complex termination
- Oblique termination
- Unprofessional termination

Prospective termination is planned in advance and agreed to by both parties. It occurs most often when the client has reached the planned goals and has no further need for service. Prospective termination might also occur in well-defined situations where there is a known endpoint determined by circumstances. An example of this is the clinician in training who must terminate services at the end of their assignment. Another example is the managed care situation where the number of sessions is significantly limited and there are few if any degrees of freedom for negotiating different financial

arrangements with the client. As noted by Younggren and Gottlieb (in press), there is usually little conflict associated with this type of termination and it presents little risk to the clinician or the client.

Flexible termination describes those situations where there is relatively little advance planning, but the decision to conclude is mutually agreeable and generally without conflict. The provider and client communicate about the issues of continuing or ending and decide that a proximal conclusion is appropriate. This may be negotiated with the intent to pick up again at a later point, but without an explicit commitment to do so. Flexible terminations may be implemented in response to unanticipated circumstances, and are often accompanied by recognizable improvements in the client's presenting problem. Flexible terminations intentionally maximize the client's autonomy in determining the duration, intensity, and focus of therapy.

Complex termination refers to sensitive, protracted, or volatile communications about progress and the conclusion of therapy. This type refers to the difficult termination where there is likely to be some conflict or intense client emotional reactions that have a negative or complicating impact on the termination process. Client issues are the main precipitants of complex termination, but there are other factors, including the therapist's reactions and the situation, that interact with the client's difficulties. Complex terminations are very important and will receive closer consideration in chapters two and six.

Oblique termination, on the other hand, is cloudy, evasive, and unilaterally enacted by the client. There is little or no discussion or response to the provider's attempts to address the client's absence. The client exercises autonomy, but does so without involving the provider or gaining closure within the collaboration. Providers might attempt to follow up or gain closure, but they can not force the client's cooperation. Complex terminations may be difficult or frustrating, while oblique terminations can be haunting and worrisome if one lacks a reasonable degree of discernment about respective responsibilities of the client and provider.

There is only one type of termination that is categorically "bad" and that is an unprofessional one. Unprofessional terminations are not purely a matter of insufficient termination skills. It is incredibly rare to have a bad termination of good therapy. "Bad" terminations tend to flow directly from a provider's failure to manage the course of therapy and maintain appropriate professional standards of conduct and practice (Hjelt, 2007). Unprofessional terminations do not happen because of small misjudgments or differences in clinical opinion that arise at the end. Bad terminations are more typically situations where the provider veered significantly off-track earlier in therapy, even from the beginning. Unprofessional actions or complaints of such concerning termination are in effect a marker for a trail of errors. Perhaps the overall treatment plan was inadequate or an unstable

client was allowed an inappropriate degree of control over the relationship and the provider failed to take corrective action. As an example of grossly unprofessional termination, consider the provider who fails to show up for sessions and does not respond to any of the client's attempts to communicate about the disposition. The therapist is simply gone, checked out mid-therapy without a word of good-bye or explanation. Such cases of true abandonment are rare, however. Situations where steps were taken to terminate properly but conflict or complexity was mismanaged are more common. Other potential errors include inadequate notice, improper self-disclosure, failure to refer, or failure to consult. Attempting to provide service beyond the scope of the provider's competence is frequently a core mistake that produces a pattern of therapy mismanagement (Hjelt, 2007). Burn-out, impairment, poor coping and stress management, inadequate skills or professional socialization and therapist character problems, such as narcissism, are all possible antecedents to provider misjudgments and professional error (Freeman, Felgoise & Davis, 2008).

Because of potential confusion with various connotations, the label "premature" is not used in this descriptive spectrum. Premature termination may be a relevant clinical phenomenon, but it is highly intertwined with potential biases toward long-term interventions, and it does not describe the processes of provider-client collaboration.

SUMMARY POINTS FOR APPLIED PRACTICE

1. Effective, positive termination is not a matter to leave to chance. It takes planning and discussion, beginning with the informed consent process and continuing throughout therapy until its conclusion.
2. As in most relationships, either party has the right to bring the interaction to an end. The client has the right to terminate therapy at any time, without cause. The provider is professionally responsible for advancing the best possible termination, given the particular circumstances.
3. Views on the optimal length and aims of therapy can vary a great deal among providers of different philosophical perspectives and between providers and clients.
4. The limits and parameters of today's health care environment require careful attention to the necessity and effectiveness of therapy, thus raising the bar on termination responsibilities.
5. Completion of treatment is not a clear-cut matter, but rather a contextual decision that is negotiated between provider and client.
6. Emotional attachments, practical concerns, treatment goals, clinical progress, and ethical limits are all part of the context that affects termination decisions.
7. Both haste and procrastination can increase the risks of error in termination.
8. Some terminations hold a greater risk for adverse events. These include terminations stemming from precipitating circumstances, stalled progress, limited provider skills, or clinical complexity.

9. Pragmatic termination strategy is a proactive tool for orienting both client and provider to the task and process of ending the professional contract in problem-focused models of therapy. Two main objectives of the pragmatic termination strategy are to foster the client-therapist collaboration and to use that collaboration to form a reasoned course of action for concluding their work.

10. Good termination is negotiated by the provider and client. Truly bad termination occurs when the provider's actions fall below acceptable professional standards. Bad termination is usually not just something that accidentally happens at the end of good therapy. Most often it has antecedents in other errors, such as failure to properly manage the course of therapy.