1-1-2010

I can't sleep at night with discharging this lady: The personal impact of ending therapy on speech-language pathologists

Deborah Hersh
Edith Cowan University

LEAD ARTICLE

I can't sleep at night with discharging this lady: The personal impact of ending therapy on speech-language pathologists

DEBORAH HERSH

Edith Cowan University, Perth, Australia

Abstract

The ending of therapy is a crucial time for speech-language pathologists and can impact on their sense of achievement and satisfaction. Drawing on literature from psychotherapy, social work and rehabilitation as well as from the area of aphasia therapy, this paper explores how speech-language pathologists juggle the tensions of coping with real versus ideal endings, of managing the building of close therapeutic relationships which then have to be broken, and of balancing a respect for client autonomy while retaining control over caseloads and fair allocation of resources. I suggest that the way in which therapy finishes reflects a merger of how clinicians manage these tensions. Clinicians may benefit from a greater recognition of what they do and feel at discharge, not only to further reflective practice, but also to encourage more sensitive involvement with both clients and students.

Keywords: *Discharge from therapy, aphasia, qualitative research, reflective practice, service delivery, professional issues.*

Introduction

Ideally, speech-language pathology intervention should always end in a cure, an experience of successfully achieving agreed goals, a sense of closure and a job well done. Certainly, this ideal will be achieved in many situations, although perhaps with some groups of clients more than others. However, in reality, there are a range of experiences for speech-language pathologists[1] at the end of therapy, whether ideal or not. Intervention usually has to be brought to a close and the evidence we have, from both within and outside the profession of speech-language pathology, suggests that the discharge process is often a complex negotiation for clinicians which involves a great deal of emotional energy. While speech-language pathologists are obviously concerned with service level issues, discharge criteria, and discharge planning policies, this scientific forum examines the personal impact on them of the discharge process, particularly ending the therapeutic relationship. This subject, while clinically prominent, has been relatively under-explored and infrequently aired in the speech-language pathology literature. This scientific forum will consider questions such as: What do speech-language pathologists do, think and feel at the end of therapy? What challenges does discharge pose for clinicians and why? How does ending therapy impact on therapy itself and how does it colour the nature of the therapeutic relationship? How does the experience of discharging clients vary within the field of speech-language pathology?

Chronic aphasia, the key area explored in this paper, has particular characteristics which render the ideal of a perfect closure unlikely: aphasia is rarely cured, improvement may be slow and prognosis is imprecise. Clinicians know that people with aphasia and their families, faced with the considerable disruption of chronic communication disability, may experience transitions as a time of vulnerability (Hart, 2001), may have unrealized expectations regarding improvement, or may feel a loss of hope or a sense of abandonment (Hersh, 2009a; Parr, Byng, Gilpin, with Ireland, 1997; Sarno, 1993). But, in addition, this is an area of practice where the therapeutic relationship is fundamental. Speech-language pathologists not only invest a great deal of energy and time into organizing ongoing referrals and services but also into ending therapy without upsetting their relationship (Hersh, 2003a).

While some of these characteristics are shared with other aspects of speech-language pathology practice, clinical experiences with, for example, paediatric

clients, adults with acute rather than chronic communication difficulties, and those with terminal illness may yield quite different perspectives. Whatever the client population, this scientific forum emphasizes the importance of the end of our intervention since most of the attention in our literature and in professional preparation courses is on beginnings and middles of therapy. But why focus on how discharge impacts on speech-language pathologists? I argue in this paper that there are three areas of tension for speech-language pathologists which surface particularly at the end of therapy. The first relates to coping with real versus ideal endings, the second to the paradox of building authentic relationships for effective therapy which then have to be broken, and the third to the dilemma of wanting to promote client involvement in decisions while retaining professional control over the discharge process.

This paper begins with a focus on the terminology used to describe treatment endings and then moves to a literature review about the impact of treatment termination on practitioners from the fields of psychotherapy, social work, rehabilitation and then, specifically, aphasia therapy. The three areas of tension mentioned above can be seen to thread through this work and I refer to them again in the next section, a discussion of a qualitative, grounded theory study (Hersh, 2003b) which explored aphasia treatment termination experiences more broadly and which has already been the subject of a number of recent papers (Hersh, 2001; 2003a; 2009a; b).

Reconsideration of terminology

The complex nature of how therapy draws to a close is reflected in the terms we use to describe it such as *discharge, treatment termination, endings in therapy* or *closure*. At first sight, these terms all imply the same thing but a number of authors have pointed out that they are value-laden. For example, Dill (1995), a sociologist, talking about the process of leaving hospital, wrote that the term *discharge* encompasses a sense of explosive release, but one in which the direction may be uncertain, involving a welcome change but also the potential for danger. *Termination* is similarly value-laden, with its associations to *terminal* or the cutting off of life. Furlong (1998, p. 104), a social worker, found that *termination* seemed a "singularly incongruous" term for his final counselling session and he considered the term *celebration* or that used by Relph (1985) of *finishing well*. Williams (1997), discussing how the ending of psychotherapy can cause anxiety for both client and analyst, suggested that the predominance of the word *termination* in psychotherapy is an attempt by psychotherapists to cope with this anxiety. It allows them to sound clinical, in control of the process, and is used as a way to "distance themselves from the vast emotional significance of the event" (p. 346).

Williams saw a focus on *endings* as central in psychotherapy as much more useful. She pointed out that the word *end*, as well as meaning something that is over, is also something that is striven towards, a purpose or an aim. Similarly, Zinkin (1994), another psychotherapist, stressed the difference between bringing something to an end and simply stopping: "An end always implies a goal or purpose having been achieved . . . but is the end of therapy . . . necessarily expressed at the time the therapy actually stops?" (p. 18).

The shift from a traditional medical model of intervention towards social approaches in aphasia rehabilitation has also stimulated reconsideration of the terms we use. Simmons-Mackie (1998) saw *discharge* as negative and indicative of minimal client input in the process. She preferred *reintegration*: "Rather than shift from treatment to no treatment, the client should experience a gradual transit down a continuum towards assisted community reintegration" (p. 236). Similarly, Pound, Parr, Lindsay and Woolf (2000), reflecting on their work at what is now Connect, the Communication Disability Network, wrote:

> The process of regular goal setting, reviewing change, re-directing therapy and looking to current and future needs is, as with all therapy, geared towards addressing the timing of 'discharge'. We are somewhat uncomfortable with this term, as it suggests medicalisation, doctor/therapist-driven decisions, and lack of agency on the part of the client. If possible, we prefer to refer to what is undoubtedly a complex and protracted process as 'leaving therapy'. (p. 259)

For clinicians working along the continuum of therapy, *discharge* may actually be better conceptualized as *transition* because the emphasis is on a move to another phase of rehabilitation. In some situations, discharge may be understood as a temporary separation where clients are formally discharged to satisfy administrative requirements but are invited back for review. The subtle meanings imbued in these terms are an indication of the importance and complexity of the issues they represent including those of continuity of care, the degree to which discharge is shared or negotiated, and expectations and goals of therapy itself. Attention to terminology is a useful way of raising awareness of the delicate nature of the issue. Within this paper, I have not drawn sharp distinctions between when these terms are used, they overlap to some degree, but I suggest that being sensitive to the metaphorical nature of terminology is valuable.

Literature review

The following review highlights published examples of how therapy endings have impacted on practitioners in the areas of psychotherapy, social work, rehabilitation and then, specifically, aphasia therapy.

Psychotherapy. The psychotherapy literature is rich with references to breaks and endings in therapy. Concepts such as separation anxiety, solitude, attachment and loss, and the therapeutic relationship merge with considerations of termination (Bowlby, 1973; Coltart, 1993; De Simone, 1997; Grinberg, 1980; Quinodoz, 1993). Williams (1997) stressed the centrality of endings in psychotherapy, a force which both ''operates as an influential organizing principle from the start of therapy'' (p. 339) and which can be experienced as a ''rite of passage'', a transition to an unknown future. Quinodoz (1993) wrote that transference and counter-transference are deeply bound up with the approach of the end of the analysis, often affecting both parties in their mourning process. He stressed the need for time in which to mourn, and the need to fix a termination date well in advance. Coltart (1993) viewed the mourning related to the ending of therapy as dramatic:

> When it comes to ending this kind of therapy, there is, however careful the foregoing termination work has been, no substitute for ending. It is precisely the sufferings caused by ending, the pain of bereavement, even symptoms, which most fully test the value of the therapy itself . . . (p. 11)

In view of the importance of termination, psychotherapists have also written candidly about specific aspects of the process. Mathews (1989) commented about the particular concerns facing counsellors in private practice, dependent on their clients for their livelihood, and still having to properly prepare them for termination. She noted that termination was often overlooked in both the literature and professional training of counsellors and that this might mirror ''cultural tendencies to deny and deflect our difficulties with good-byes'' (p. 29). She highlighted the impact of termination on counsellors in a variety of situations: premature endings by clients, clients leaving with bills unpaid, therapist-initiated terminations for clinical or personal reasons.

Talking about forced terminations through a therapist leaving, Siebold (1991) wrote of her personal experiences of dealing with this situation when she changed jobs. She had to break the news to her clients and refer some on to other therapists. She felt sad at not being able to see them through to an agreed conclusion of therapy. In some cases, she had to overcome a reluctance to tell them, and also had to deal with being ''barraged by their feelings'' (Siebold, 1991, p. 195). Siebold noted the importance of sharing information with clients about the process of termination and some recognition that: ''therapists who leave must accept that they are breaking a bond that they encouraged to develop'' (p. 197). She suggested that clients may have anticipatory grief reactions, perhaps only mourning after the loss, but also needing help in the time

leading up to it. Perlstein (1998) wrote frankly about her experiences of difficult terminations in psychotherapy, of impasses and ''premature termination'' where a client pulls out of therapy early. Perlstein saw these as ''slammed doors''. She wrote: ''. . . every interrupted process causes me frustration, reflection, feelings of mini-abandonment and being misunderstood'' (p. 65).

Social work. Closely related to the psychotherapy literature, in social work there are references to the way in which termination affects practitioners, both positively and negatively (Fortune, 1987; Fortune, Pearlingi, & Rochelle, 1992). Anthony and Pagano (1998) wrote that clinicians typically experience feelings of guilt and have difficulties addressing issues with clients at termination. Baum's (2007) study investigated predictors of emotional responses to treatment termination in a sample of 48 social workers and 92 student social workers in Israel. This involved an empirical examination of the role of process variables (abruptness, control, centrality, choice, desirability) in practitioners' responses to treatment termination. Baum found that both professional and student groups experienced similar emotional responses to termination and that there were no differences between men and women. Client-initiated terminations or poor therapy results generally caused greater negative emotions, more self-doubt and a sense of failure. Where goals were attained in therapy and the outcomes were good, feelings were more positive and were closely tied in with a sense of professional achievement at termination. Where the therapeutic relationship was particularly central and strong, termination caused clinicians to feel a range of strong emotions, a mix of loss and hurt but also positive feelings of achievement for their client. Abrupt terminations were more difficult than gradual ones and therapists were more positive about terminations over which they exerted a greater sense of control. Baum suggested that there should be greater awareness of the normality of emotional responses, ''sadness, loss, fear, anxiety, self-doubt, and so forth that arise with the treatment termination'' (p. 104) and that ending with one person can also be seen as a transition to make room for others or something different. What is of interest from this study is the close relationship between the termination and feelings of the practitioner:

> On the whole, these findings indicate that the way in which the treatment is terminated and its perceived efficacy are closely associated with the therapist's feelings at the end of the treatment. (Baum, 2007, p. 102)

Another paper by Rosenthal Gelman, Fernandez, Hausman, Miller and Weiner (2007) considered how social work students on placement coped with

premature or forced terminations due to the end of their internships rather than the clients' achievement of their treatment goals. They wrote that this aspect of termination had not received sufficient attention:

> . . . because of the inherent challenge to ending well, but also due to insufficient knowledge and skill and lack of preparation for the strong feelings engendered in both worker and client, interns experience these terminations as difficult, and are in need of further guidance. (p. 87)

They found that students commonly experienced a sense of loss, guilt for leaving, anxiety about the client's response and about their own level of skill. Rosenthal Gelman and colleagues suggested that supervisors should be more aware of how termination issues impact on their students, should discuss them and share their experiences early in placements. Their paper is important because it shows that qualified clinicians, who are aware of the impact of treatment termination on themselves, as well as their clients, are in a better position to help their students in the supervisory process, an argument recently made in the area of aphasia therapy (Hersh & Cruice, 2010).

The themes running through the psychotherapy and social work literature have relevance for certain areas of speech-language pathology, including adult aphasia, voice and fluency. As with psychotherapy, although perhaps to a lesser degree, the speech-language pathologist and client may see each other intensively, sometimes weekly or twice weekly over a long period of time. Sessions may regularly last for an hour. The nature of the relationship in therapy with adult clients, as in psychoanalysis, may be one in which personal information, emotions, and feelings are often shared. Certainly, speech-language pathologists working in the area of chronic aphasia may be aiming for change at a most fundamental level, not only in relation to communication itself, but also to adjustment to life with a disability, issues of identity and in the development of coping strategies (Brumfitt, 1993; Pound et al., 2000; Shadden, 2005). As with psychotherapy, the success of the ending of speech-language pathology intervention may be a test of how effective that intervention has been. While this is more blatantly so when treating issues such as separation anxiety, ending therapy is a test of confidence and of readjustment. Coltart (1993, p. 10) pointed out the ''extraordinary paradox'' of having to end a psychotherapeutic relationship which needs to be so authentic and intense in order to achieve its goals, and is yet so artificial. To some degree, the same is so in aphasia therapy, especially for those working within a social approach in which the authenticity of the interaction is so important (Lyon, 2000; Simmons-Mackie, 2000).

Rehabilitation. Papers have been published looking specifically at ethical issues in rehabilitation (Caplan,

1988; Caplan, Callahan, & Haas, 1987; Haas, 1988; Purtillo, 1988; Scofield, 1993) and treatment termination features as an important issue in this context. Caplan and his colleagues (1987) wrote:

> The single most distinctive feature of termination of treatment decisions in rehabilitation medicine is that they are almost always initiated by health care professionals rather than by patients and their families . . . Increasingly, financial constraints . . . are the catalysts that compel a rehabilitation professional to consider ending care for a particular patient. (p. 12)

This quotation highlights two problems, one concerning the degree to which patients and families are involved in decision-making and the other related to resource allocation. The first issue arises as a conflict for practitioners between the two principles of respect for autonomy and beneficence (Beauchamp & Childress, 1994), a difficult issue within discharge planning (Clemens, 1995) and within discharge decision-making in multidisciplinary teams (Opie, 1998). The second is a conflict between respect for autonomy and justice, or one where a judgement needs to be made between respecting the wishes of a client for therapy and fairness in the allocation of resources.

These situations of conflicting ethical principles are difficult for rehabilitation clinicians, including speech-language pathologists. Caplan et al. (1987) suggested that one of the reasons for the first problem is the reliance on the notion of the *plateau* or the levelling of improvement towards set goals in treatment. This reliance is certainly a key issue which influences speech-language pathologists' discharge decisions (Hersh, 1998). Clients in rehabilitation settings are under pressure to continue to demonstrate progress, and once this slows, judgements are made by professionals as to whether further treatment is worthwhile (Maclean & Pound, 2000). The way that progress is assessed, and the fact that such assessments tend to be professionally initiated rather than requested by the client, means that moral judgements and values play an important part in the process (see Becker & Kaufman, 1995). Team members may make judgements about people's ability to cope at home, and about how much change is sufficient to justify further treatment. Caplan and colleagues (1987) saw the key ethical flaw in the process as the frequent failure of professionals to inform clients and families clearly about the criteria they use to decide when treatment should stop. Without such sharing of information, client involvement in decisions about their own care becomes difficult.

The reliance on the *plateau* was found in a British study with 16 people following stroke and their physiotherapists (Wiles, Ashburn, Payne, & Murphy, 2004). At discharge, there was often a difference in expectations between clients and clinicians about

how much improvement was possible and, while the term *plateau* was explained to clients, it was softened in a way that made it sound temporary, allowing for review and the hope of further recovery. Essentially, physiotherapists found it difficult to talk about the possibility of bad news. The authors wrote:

> . . . physiotherapists are under considerable pressure to avoid disappointing patients, and are likely to experience discomfort about the difficult emotions to which this may give rise in their patients and, perhaps, their own ability to cope with these. This is not to imply that physiotherapists are bad health professionals but, rather, that they are subject to the same pressures as other people living in a culture in which there is little space for disappointment or failure to achieve a positive outcome. (Wiles et al., 2004, p. 1271)

In another study, involving interviews with ten occupational therapists and direct observation of the interactions of multidisciplinary team members, Atwal and Caldwell (2003) also found that discharge planning was often a difficult juggling act between fitting with the team and adhering to guidelines in the occupational therapy code of ethics. The authors suggested occupational therapists are under pressure to conform to the wishes of the team and should not be seen to be obstructing discharge. Their interviewees expressed "considerable reluctance to voice an opinion for fear of not being listened to" (p. 250), thereby being unable to advocate fully for their clients.

Aphasia therapy. In the area of treatment termination for speech-language pathologists working with people with aphasia, there are a number of sources which identify this aspect of practice as requiring attention or presenting a challenge (Hersh, 1998; Lyon, 1996; Rosenbek, LaPointe, & Wertz, 1989; Sarno, 1993; Warren, 1976). Hallowell and Chapey (2001, p. 181) mentioned it as one of the "agonizing" ethical issues that face clinicians in their delivery of services. Harding and Pound (1999) reported a feeling of "unease" when discharging their client because of their concerns that therapy had not fully prepared him for the realities of life in his previous family and business role. Greener and Grant (1998, p. 163) reported from their survey of speech-language pathologists in Scotland that discharge concerns had an "adverse effect on both morale and the satisfactory running of the service". Smith (1999) wrote about the difficulties that her staff had in prioritizing clients of high and low need when faced with cuts to their budget. Those with chronic aphasia were deemed to be of low priority and were therefore due for discharge. However, Smith reported that, in the end, low priority patients continued to receive therapy. A reason for this was that "therapists with limited clinical experience found it difficult to discharge these patients and hard to cope with carers . . ." (p. 17).

I have explored the impact of treatment termination on clinicians in two previous papers. One involved a case study of a speech-language pathologist, three of her discharged clients with aphasia and a spouse in order to look at the different perspectives of events (Hersh, 2001). A common theme to all three discharges was the speech-language pathologist's difficulty explaining termination and her concern not to cause upset. With two clients, she organized increasingly less frequent reviews over time rather than have to say that she did not feel further therapy was warranted. The other paper (Hersh, 2003a) explored how speech-language pathologists *wean* their clients from aphasia therapy, with weaning strategies defined as actions within the discharge process that move the therapeutic encounter to a close while attempting to preserve a positive therapist-client relationship. It identified and grouped 19 strategies under five categories: wait-and-see; negotiation; preparation; separation; and replacement. Used in combination, these strategies were powerful and allowed speech-language pathologists some control over both the process and the timing of discharge. This finding reflects Baum's (2007) comment that social workers who retained control of the discharge process experienced it as more satisfying. Weaning strategies allowed speech-language pathologists to delay, soften and obfuscate bad news when recovery was limited and allowed caseloads to keep turning over. The strategies appeared to protect clients (although, arguably did not promote their involvement in decision-making) but also protected clinicians from the impact of difficult decisions.

The impact of treatment termination on speech-language pathologists working with people with aphasia

The three tensions mentioned earlier, coping with real versus ideal endings, building authentic relationships which then have to be broken, and balancing a respect for client autonomy while retaining control over caseloads and fair allocation of resources, can be seen through much of the literature review. In this section, I report in more detail on research which also demonstrates how speech-language pathologists experienced these tensions (Hersh, 2003b). This research involved semi-structured in-depth interviews with 30 Australian speech-language pathologists about their work with people with aphasia. The interviews covered therapy approaches and philosophy, views about and experiences of discharging clients, and influences on discharge decision-making. Interviews generally lasted between 1 and 2 hours, and were mainly carried out at interviewees' places of work. All were transcribed verbatim by the author and each interviewee was given a pseudonym. The analysis was guided by grounded theory (Strauss & Corbin, 1998) and involved theoretical sampling

in which data collection and analysis were closely related, making constant comparisons across the data, and making inductions—drawing out concepts from the data—rather than deductions in order to build theory.

Coping with real versus ideal endings

Real endings sit within complex and varying social, political, economic and geographic contexts. Speech-language pathologists interviewed in this study (Hersh, 2003b) spoke at length about the complexities of discharge decisions, how closely bound they were to the context of the workplace and the setting more broadly. They talked about how policy changes had made their experience of discharge increasingly difficult: the emphasis on early discharge from hospital to rehabilitation, the limited time within rehabilitation itself, cuts to outpatient services, and their diminishing time for aphasia therapy with the increased demand for dysphagia services. They commonly cited caseload, management and financial pressures as influencing their discharge decisions. Some talked about the inevitability of caseload pressures, seeing them as an unpleasant fact of life: "I think in your heart is always wanting to go on supporting the person . . . but you know, a caseload is a caseload and you can't go on forever" (Rosemary). Decisions were a balancing act: ". . . when you have limits on your caseload, you have to prioritize" (Ros). Clinicians were reluctant to discharge clients with chronic aphasia who had no further services available, or as Alexis put it, to "pull the plug". Jane reported:

> I think it is hardest to discharge someone from your own service when there is nothing else there and you can't replace it with anything else and that is when maybe you keep people on for just that little bit longer . . .

Clinicians went to considerable efforts to seek out other options for clients in the community, for someone "who was willing to take them on" (Murray). Erica described discharge as "much more satisfying" when long-term aphasia groups were available because they alleviated the concern that clients were being discharged without ongoing supports. Jane talked about clients with chronic aphasia in a rural setting, where community supports were unavailable, being "inherited" from therapist to therapist rather than being discharged to no service. For those who did not have the option of re-referral or ongoing supports, discharge was viewed as very difficult. In an extreme case, Roberta told me she had resigned from a job because of her deep concern that she was being pushed by her employer to discharge a client who she felt needed further therapy.

It appears that coping with the realities of less than ideal circumstances for clients at discharge involves actively seeking out creative alternatives, bending rules, and working within limits. We know that such limits impact on speech-language pathologists' levels of stress and work satisfaction, particularly their workload pressures, autonomy in their clinical decisions and whether they feel that their intervention has been effective and made a positive difference (McLaughlin, Lincoln, & Adamson, 2008). Situations where clinicians are under pressure to discharge clients in order to make room for the next person, perhaps before the outcomes are satisfactory, and perhaps in circumstances that they feel they cannot control, are highly unsatisfactory. A study exploring recruitment and retention of speech-language pathologists in Australia and the UK (Whitehouse, Hird, & Cocks, 2007) found that job satisfaction was closely linked to the concept of career motivation, particularly the congruence between one's motivation for entering the profession and the experience once on the job. The most common reason given for wanting to join and remain in the profession was "helping others" or altruism. This finding also relates closely to work by Byng, Cairns and Duchan (2002) who discussed the importance for speech-language pathologists of quality relationships with clients and of having a sense of satisfaction that therapy is resulting in real-life change and improvements. They wrote that lack of job satisfaction has been linked to "a mismatch between personal/professional values and the realities of providing healthcare" (p. 92). I suggest that at the end of treatment, such issues have their greatest impact on clinicians as they assess the outcomes of their efforts, their concerns that they have "helped" their clients, within the constraints of available resources.

Building and breaking relationships

Discharge decisions were closely interwoven with personal values and they carried a significant emotional load. Speech-language pathologists' comments about their personal influence on aphasia therapy and discharge practice indicated that therapist and therapy were inseparable. In other words, therapists were the instruments of therapy, making changes through their interactions with clients:

> You were asking me whether there is efficacy in the therapy, whether our therapy works. And I am saying that I don't think it's the therapy, I think it's the therapist. And how she uses the therapy and how she implements it. (Benita)

The importance of one's personal influence on therapy is well recognized (Holland & Beeson, 1993; Rosenbek, LaPointe, & Wertz, 1989). Hallowell and Chapey (2001, p. 189) wrote that a clinician working with aphasia aspires to be, among other things, "a warm, caring, patient, thoughtful, interesting

person''. Similarly, Mackenzie (1993, p. 586) wrote: "The speech and language therapy profession commends itself to people with an attitude of caring...''. Speech-language pathologists in my study suggested that issues of identity and personal values impacted on their practice, as Rosemary said:

> ...one of our philosophies is to offer support and stimulation and communication opportunities. I mean we are the best ones at it, aren't we?

Karen commented that speech-language pathologists were more "psychologically tuned in than perhaps some others'' and Helena thought them "caring and compassionate''. Interviewees blurred the boundaries between professional and personal, between moral professional practice (Catt, 2000) and being a moral person, or having a virtuous disposition (Pellegrino & Thomasma, 1993). Their sense of compassion made treatment termination challenging because of the risk of abandoning their clients. For example, they sometimes delayed discharge in situations where improvements were not satisfactory, not only because the client was requesting more help, but also because the therapists could not deal with an unhappy cessation of therapy support:

> I like them to be happy that they're going to be finishing therapy. I wouldn't like to say to somebody who is very keen and coming along and likes to be given things to take home and that sort of thing, to say "oh no, look, they're not improving any more''. I think that's about it. I wouldn't be happy. (Felicity)

The speech-language pathologists in this study commonly expressed feelings such as guilt, regret and sadness where they felt they could do no more for a patient who still perceived a need for more help:

> I think if you've been involved with someone for any length of time and you've built up that rapport and bond, and I mean you can just feel their anxiety...you don't just want to go "well, bad luck, your time's up, that's it''...I mean I'd feel really bad if I said to someone "look, I'm sorry, that's enough'' and had them howling in the corridors as you're walking off. (Alexis)

Discharge decisions could affect them deeply, as reported by Angela, talking about her decision to keep treating a young woman post-stroke: "I can't in my own mind, I can't sleep at night with discharging this lady...''. For some clients, therapy was equated with hope of improvement and termination of therapy could be perceived as termination of hope. Celia said "...this is how it's perceived...it's like taking hope away from someone which is, I think, the hardest part of discharge...''.

A number of speech-language pathologists suggested that they had become better equipped over time in handling the separation and concerns of ending therapy. For Benita, this was through a sense of realism and emotional distance. She no longer felt guilty that she could not cure everyone: "I've taught myself over the years that when I say goodbye, I say goodbye and I think I cope with it a lot better than I did before''. Karen said that she had acquired counselling skills over many years and found this useful but that less experienced therapists were likely to find discharge difficult. Most interviewees reported little attention to discharge issues in their training and that they had learnt on the job. Rina, a newly qualified therapist, told me: "I have learned the hard way by getting really upset''.

These comments about compassion and personal values overlapped with another common notion that speech-language pathologists' relationships with clients might be quite different to those of other health professionals. Clinicians, reporting that people with aphasia suffered enormous levels of frustration, thought that they were able to support them and develop a rapport particularly effectively: "I think people with aphasia often don't feel that other disciplines (are) as patient, don't sit and give them the time...'' (Alexis). Ruby suggested that if the speech-language pathologist were the only person who could really communicate with a client, then this meant it would be a "real relationship...more like a friendship...''. This was particularly so for those working in community settings who saw people over long periods. Hazel felt that "the really long-term ones become like friends''. Elizabeth said that when she reviewed somebody with whom she had a close relationship:

> ...you don't sit down and do the WAB (Western Aphasia Battery) on them...it's almost like catching up on old times and meeting an old friend in many respects.

This kind of relationship sometimes made discharge uncomfortable, not just for the client but also for the therapist. Tina found it "really difficult'', particularly when faced with having to break the news to clients that therapy would stop. She said: "I mean you don't ever want to terminate therapy, I mean terminate contact with your grandmother, you know? I mean, does that make sense?''

Despite the possibility of attachment to some clients, speech-language pathologists also recognized the problems of becoming too close. They considered dependent clients and families to be highly problematic, investing all their hope for recovery in their therapist, unable to draw on other resources. Judging over-dependence was a "gut reaction'' but Amanda tried to define it for me: "You know when it happens...you have become bigger than the goals, the therapy, the communication, you as a person...''. Several therapists said that they had a responsibility to avoid this situation: "I think you work as a therapist to keep a barrier up so it's not too dependent...'' (Celia). Pandora viewed dependency as a result of failures in the health care system and

difficulties accessing other services and supports. Conversely, Leanne saw professional distance as built into the health system through promotion of fast turnover and movement between different services, meaning that long-term relationships were less likely. These comments highlight how closely the building and breaking of therapeutic relationships were linked to their context and how these merged as personal, as well as professional, encounters.

Promoting client empowerment versus professional control

Despite a strong belief in client involvement in goal-setting for therapy, speech-language pathologists retained clear control over discharge through effective weaning strategies, and judgements about clients' potential to benefit. Interviewees often referred to the notion of the plateau and looked to ending therapy because they could not justify continuing with someone who was no longer showing signs of improvement: "...I hate overservicing. And I will drop therapy almost when I don't see progress" (Benita). But, at times they expressed a lack of confidence that they had been able to achieve the best result or demonstrate it with the assessments available. The context of aphasia therapy was described as one of diverse approaches, holistic, eclectic, individualized courses of intervention and assessment, and variable levels of confidence in how that therapy was related to improvement for each client. Considering the reliance on the idea of the plateau and the continuing need to demonstrate change in that context, it is not surprising that clinicians faced areas of grey in their discharge decision-making, levels of doubt and unease. Under these circumstances, they were often unable to explain their rationale for discharge clearly to clients or involve them in decisions (Hersh, 2009a, b). However, as Caplan and colleagues (1987) pointed out, clinicians found themselves having to balance client autonomy with allocation of available resources, the need to move people on to make room for new clients.

Conclusion

Throughout this paper, I have explored why the ending of therapy is a crucial time for speech-language pathologists and why it can impact on their sense of achievement and satisfaction. Drawing on literature from a range of professions, and specifically within the area of aphasia therapy, I have shown that therapists juggle the tensions of coping with real versus ideal endings, of balancing their personal and professional selves in the making and breaking of therapeutic relationships, and of respecting client autonomy while retaining control over caseloads and fair allocation of resources. I have suggested that the way in which therapy finishes reflects a merger of how clinicians have managed these tensions and is a

window on the effectiveness of communication and levels of trust and respect between professionals and clients. It can be an indicator of the success of therapy itself.

Although discharge from therapy may be primarily significant for clients and their families, I have argued that this aspect of intervention is also extremely important for clinicians. Just as successful discharges result in feelings of achievement, other endings may result in feelings of guilt, concern or sadness. Clinicians may feel a sense of loss. Not only should these feelings be acknowledged and seen as normal, they should also be recognized as reflecting the kinds of therapeutic relationships built up during the course of effective intervention. This forum is an opportunity to raise awareness of these experiences, see how they reflect the values within and outside the profession, and how speech-language pathologists cope with treatment termination in variable work contexts across the spectrum of intervention. Speech-language pathologists may benefit from a greater recognition of what they do and feel at discharge, not only to further reflective practice, but also to encourage sensitive practice for clients and sensitive supervision for students and novice clinicians.

Note

1 In this article, the term "speech-language pathologist" is used synonymously with "clinician" and "therapist". The term "client" is generally used in favour of "patient".

References

Anthony, S., & Pagano, G. (1998). The therapeutic potential for growth during the termination process. *Clinical Social Work Journal*, 26, 281–295.

Atwal, A., & Caldwell, K. (2003). Ethics, occupational therapy and discharge planning: Four broken principles. *Australian Occupational Therapy Journal*, 50, 244–251.

Baum, N. (2007). Therapists' responses to treatment termination: An inquiry into the variables that contribute to therapists' experiences. *Clinical Social Work Journal*, 35, 97–106.

Becker, G., & Kaufman, S. (1995). Managing an uncertain illness trajectory in old age: Patients' and physicians' views of stroke. *Medical Anthropology Quarterly*, 9, 165–187.

Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics (4th ed.)*. Oxford: Oxford University Press.

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

Brumfitt, S. (1993). Losing your sense of self: What aphasia can do. *Aphasiology*, 7, 569–591.

Byng, S., Cairns, D., & Duchan, J. (2002). Values in practice and practising values. *Journal of Communication Disorders*, 35, 89–106.

Caplan, A. (1988). Informed consent and provider-patient relationships in rehabilitation medicine. *Archives of Physical Medicine and Rehabilitation*, 69, 312–317.

Caplan, A., Callahan, D., & Haas, J. (1987). Ethical and policy issues in rehabilitation medicine. *Hastings Center Report*, 17, 1–20.

Catt, J. H. (2000). The language of ethics in clinical practice. *Journal of Medical Speech-Language Pathology*, 8, 137–153.

Clemens, E. L. (1995). Multiple perceptions of discharge planning in one urban hospital. *Health and Social Work*, *20*, 254–261.

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

De Simone, G. (1997). *Ending analysis: Theory and technique*. London: Karnac Books.

Dill, A. E. P. (1995). The ethics of discharge planning for older adults: an ethnographic analysis. *Social Science and Medicine*, *41*, 1289–1299.

Fortune, A. (1987). Grief only? Client and social worker reactions to termination. *Clinical Social Work Journal*, *15*, 159–171.

Fortune, A., Pearlingi, B., & Rochelle, C. (1992). Reaction to termination of individual treatment. *Social Work*, *37*, 171–178.

Furlong, M. (1998). Finishing well. *Journal of Family Studies*, *4*, 103–105.

Greener, J., & Grant, A. (1998). Beliefs about effectiveness of treatment for aphasia after stroke. *International Journal of Language and Communication Disorders*, *33*(supplement), 162–163.

Grinberg, L. (1980). The closing phase of the analytic treatment of adults and the goals of psychoanalysis. *International Journal of Psychoanalysis*, *61*, 25–37.

Haas, J. F. (1988). Admission to rehabilitation centers: Selection of patients. *Archives of Physical Medicine and Rehabilitation*, *69*, 329–332.

Hallowell, B. & Chapey, R. (2001). Delivering language intervention services to adults with neurogenic communication disorders. In R. Chapey. (Ed.), *Language intervention strategies in aphasia and related neurogenic communication disorders* (4th ed.) (pp. 173–193). Baltimore, MD: Lippincott, Williams and Wilkins.

Harding, D., & Pound, C. (1999). Needs, function and measurement: Juggling with multiple language impairment. In S. Byng, K. Swinburn, & C. Pound (Eds.) *The aphasia therapy file* (pp. 13–39). Hove: Psychology Press.

Hart, E. (2001). System induced setbacks in stroke recovery. *Sociology of Health and Illness*, *23*, 101–123.

Hersh, D. (1998). Beyond the 'plateau': Discharge dilemmas in chronic aphasia. *Aphasiology*, *12*, 207–218.

Hersh, D. (2001). Experiences of ending aphasia therapy. *International Journal of Language and Communication Disorders*, *36*, 80–85.

Hersh, D. (2003a). ''Weaning'' clients from aphasia therapy: Speech-language pathologists' strategies for discharge. *Aphasiology*, *17*, 1007–1029.

Hersh, D. (2003b). *Experiences of treatment termination in chronic aphasia*. Unpublished PhD thesis, Flinders University, South Australia.

Hersh, D. (2009a). How do people with aphasia view their discharge from therapy? *Aphasiology*, *23*, 331–350.

Hersh, D. (2009b). Breaking the connection: Why is it so difficult to talk about discharge with our clients with aphasia? *International Journal of Speech-Language Pathology*, *11*, 147–154.

Hersh, D., & Cruice, M. (2010). Beginning to teach the end: The importance of including discharge from aphasia therapy in the curriculum. *International Journal of Language and Communication Disorders*, *45*, 263–274.

Holland, A. & Beeson, P. (1993). Finding a new sense of self: What the clinician can do to help. *Aphasiology*, *7*, 581–584.

Lyon, J. G. (1996). Optimising communication and participation in life for aphasic adults and their prime caregivers in natural settings: A use model for treatment. In G. L. Wallace (Ed.), *Adult aphasia rehabilitation* (pp. 137–160). Boston, MA: Butterworth-Heinemann.

Lyon, J. (2000) Finding, defining and refining functionality in real life for people confronting aphasia. In L. E. Worrall, & C.M. Frattali (Eds.), *Neurogenic communication disorders: A functional approach*. New York: Thieme.

Mackenzie, C. (1993). Concern for the aphasic person's sense of self: Why, who and how? *Aphasiology*, *7*, 584–589.

Maclean, N., & Pound, P. (2000). A critical review of the concept of patient motivation in the literature on physical rehabilitation. *Social Science and Medicine*, *50,* 495–506.

Mathews, B. (1989). Terminating therapy: Implications for the private practitioner. *Psychotherapy in Private Practice*, *7*, 29–39.

McLaughlin, E., Lincoln, M., & Adamson, B. (2008). Speech-language pathologists' views on attrition from the profession. *International Journal of Speech-Language Pathology*, *10*, 156–168.

Opie, A. (1998). ''Nobody's asked me for my view'': Users' empowerment by multidisciplinary health teams. *Qualitative Health Research*, *8*, 188–206.

Parr, S., Byng, S., Gilpin, S. with Ireland, C. (1997). *Talking about aphasia*. Buckingham: Open University Press.

Pellegrino, E. D., & Thomasma, D. C. (1993). *The virtues in medical practice*. New York: Oxford University Press.

Perlstein, M. (1998). Where, oh where has the therapeutic alliance gone? Disquieting log-jams in the therapeutic relationship. *Women and Therapy*, *21*, 63–68.

Pound, C., Parr, S., Lindsay, J., & Woolf, C. (2000). *Beyond aphasia: Therapies for living with communication disability*. Oxford: Winslow Press.

Purtillo, R. B. (1988). Ethical issues in teamwork: the context of rehabilitation. *Archives of Physical Medicine and Rehabilitation*, *69*, 318–322.

Quinodoz, J. M. (1993). *The taming of solitude: Separation anxiety in psychoanalysis*. London: Routledge.

Relph, A. (1985). The last time: A metaphor for leaving. *Australian and New Zealand Journal of Family Therapy*, *6*, 123–127.

Rosenbek, J. C., LaPointe, L., & Wertz, R. T. (1989). *Aphasia: A clinical approach*. Austin, TX: Pro-ed.

Rosenthal Gelman, C., Fernandez, P., Hausman, N., Miller, S., & Weiner, M. (2007). Challenging endings: First year MSW interns' experiences with forced termination and discussion points for supervisory guidance. *Clinical Social Work Journal*, *35*(2), 79–90.

Sarno, M. T. (1993). Aphasia rehabilitation: Psychosocial and ethical considerations. *Aphasiology*, *7*, 321–334.

Scofield, G.R. (1993). Ethical considerations in rehabilitation medicine. *Archives of Physical Medicine and Rehabilitation*, *74*, 341–346.

Shadden, B. (2005). Aphasia as identity theft: Theory and practice. *Aphasiology*, *19*, 211–223.

Siebold, C. (1991). Termination: When the therapist leaves. *Clinical Social Work Journal*, *19*, 191–204.

Simmons-Mackie, N. (1998). A solution to the discharge dilemma in aphasia: Social approaches to aphasia management. *Aphasiology*, *12*, 231–239.

Simmons-Mackie, N. (2000). Social approaches to the management of aphasia. In L. E. Worrall, & C. M. Frattali (Eds.), *Neurogenic communication disorders: A functional approach* (pp. 162–187). New York: Thieme.

Smith, M. (1999). Learning to love service cuts. *Royal College of Speech and Language Therapists Bulletin*, *562*, 16–17.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Warren, L. (1976). Termination and follow up. In R. Brookshire (Ed.), *Clinical aphasiology conference proceedings*, 6 (pp. 358–361). Minneapolis, MN: BRK.

Whitehouse, A. J. O., Hird, K., & Cocks, N. (2007). The recruitment and retention of speech and language therapists: What do university students find important? *Journal of Allied Health*, *36*, 131–136.

Wiles, R., Ashburn, A., Payne, S., & Murphy, C. (2004). Discharge from physiotherapy following stroke: the management of disappointment. *Social Science and Medicine*, *59*, 1263–1273.

Williams, S. (1997). Psychotherapeutic ends and endings. *British Journal of Psychotherapy*, *13*, 337–350.

Zinkin, L. (1994). All's well that ends well. Or is it? *Group Analysis*, *27*, 15–24.