TERMINATION AND CLOSURE

Ethical, clinical, and professional considerations

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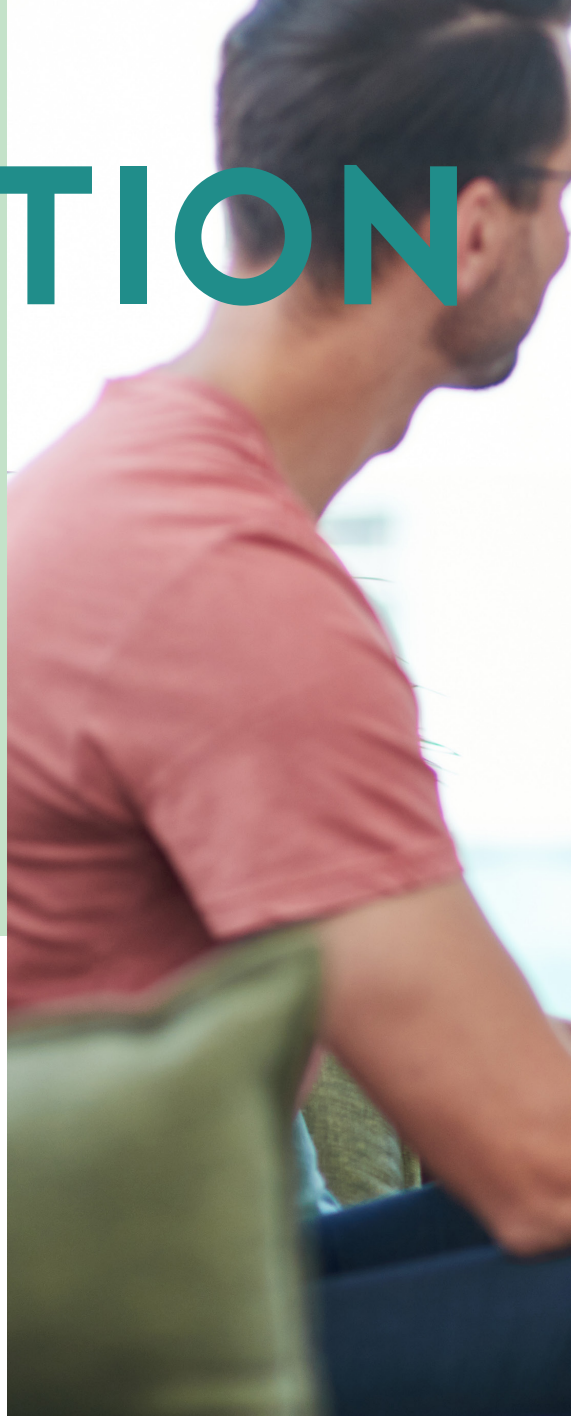

I have supervised many students, interns, clinicians, and supervisors over the years and have developed my own repetitive statement. Sometimes it is so predictable and annoying, my students finish the sentence for me with an eye roll: "I can't tell you what to do, but I can tell you what you must consider."

As irritating as that statement is, because I am not giving an answer, it serves to create disciplined thinking. Disciplined thinking requires that we consider our decisions with consistent methodology and ethos, rather than a momentary judgment or emotional response. And in our profession, disciplined thinking helps us do the right but difficult things.

I use that sentence with all counselling issues when I am teaching and have brought it to bear in my thoughts about client termination.

ETHICS

Big-E Ethics are immutable. They are enshrined in the professional code of conduct we accept and uphold and cannot be changed. We cannot determine to override or underdeliver on elements of the code when we want to use our own dissenting judgment. That is why it is a code. We adhere whether we want to or not.

Small-e ethics are mutable. They are decisions or behaviours we decide we want to adhere to but are not enshrined in the codes and can change if we like. They are also not able to be imposed on other clinicians. Most importantly, they cannot undermine or ignore the Big-E Ethics in any way.

Client termination or closure is a topic that has been embroiled in the E/e ethical discussion a lot recently. I have some theories as to why noted below, but I want to start by stating this fact: there is no Big-E Ethical standard in our code requiring that all clients be terminated at some point. Conversely, there is no Big-E Ethical standard prohibiting therapists from terminating clients. You don't have to bring therapy to closure, and you don't have to not bring therapy to closure.

NO-CLOSURE THERAPY

Therapists range in their small-e ethics on closure. For those of us on the far end of the spectrum where we have a

no-closure ethic (I am one of those), we tend to see the client-therapist relationship as a fundamental treatment in and of itself. We also often have a client base that leads us in that direction.

I practise family therapy and specialize in complex fostering, adoption, and attachment-disrupted scenarios. Most of my clients have children and youth with extensive neurodevelopmental differences, trauma, and abuse histories and complex family scenarios. Most of my clients would be considered acute or high risk, and the adults surrounding them are burnt out, overwhelmed, and terrified. There are no shortages of mental illness and distress, both endogenous and situational. They feel very few people understand their realities (and I agree), and when they find a therapist like me and my few esteemed specialist colleagues, the

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prospect of having to already think about the end of support is intolerable.

I chose to be able to say, "I've got you as long as I do this." But this is my ethic (small e), and I would not apply it if I had a different practice or specialty or planned to retire soon. No-closure therapists have an immense amount of training and experience with long-term developmental trajectories and dynamics; they are not solution-focused — they are process-based and attachment-immersed and often take on very few new clients. They must be prepared to hold space and time.

I feel it important to remind my supervisees that we exist. It benefits them to question where the pressure is coming from in their mind to decide there needs to be an "end" to therapy. In fact, when there is an invisible pressure to find an end, it has the recursive effect of creating a solution-focused bias in the clinician. If there needs to be an end, we must solve a problem, is usually how it goes.

I don't help people change their lives — I help them enrich their experience of their lives. I don't think that has an end.

MY FAVOURITE FLOWCHART

For those of us who are not no-closure therapists, how do we make these decisions? The following list was taped up at our desks where I did my internship many moons ago. A very complicated multi-disciplinary context, it was crucial to get decisions right every time, as it pertained to consent, disclosure, records, health information, legal jurisdiction, and employer liabilities, etc. It should be rote in young clinicians' minds in the first year in my opinion.

When you are wrestling with a decision — and not just whether to terminate — this is a foolproof list to consult:

1. **Your specific professional codes of ethics and standards of practice (in all cases)**
2. **Your local statute and law (in all cases)**
3. **Your binding agreement with any insurers (in all cases)**
4. **A risk analysis supported by a lawyer (when needing assistance with the above three)**
5. **Any further limiting variables, such as employer or contractor agreements (where it applies)**

If you can get through this list without a clear answer, you are then free to develop a small-e ethic.

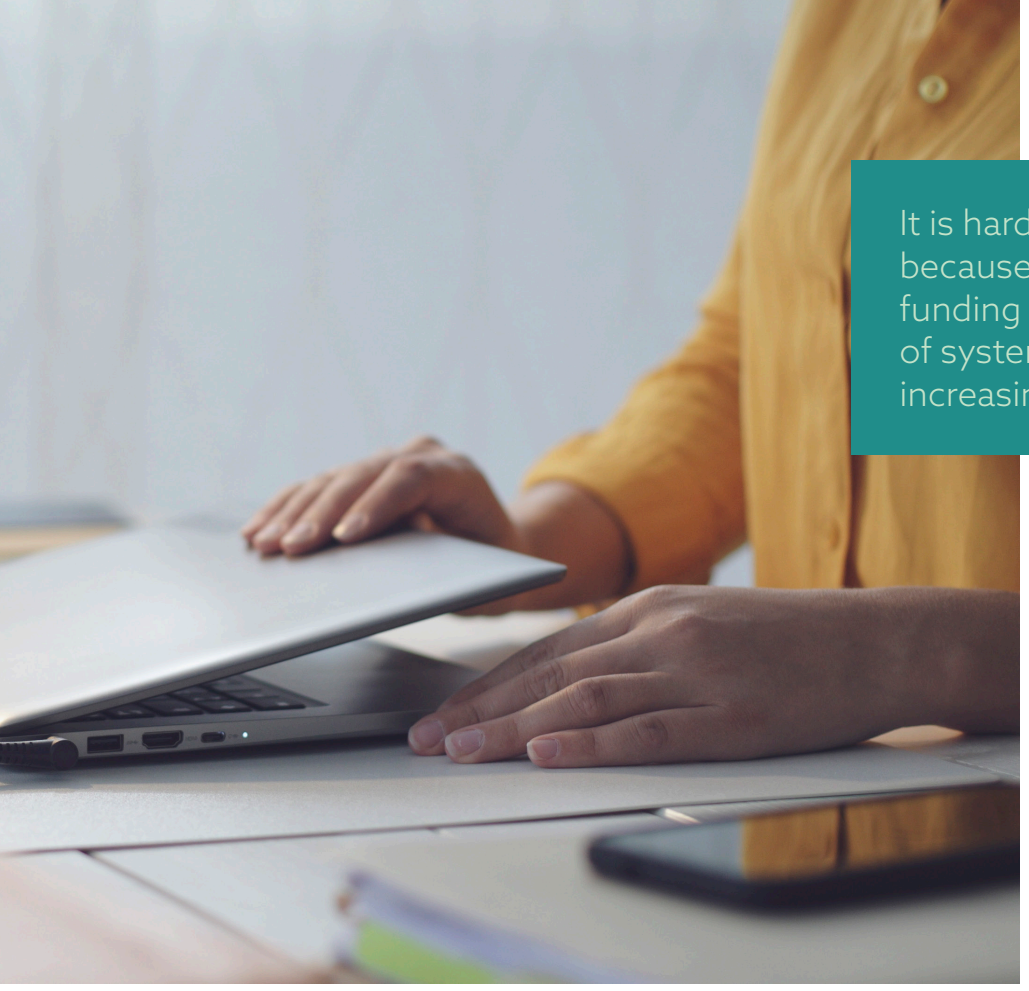
Here are some common scenarios where therapists are required to consider termination or closure and some ethical, clinical, and professional considerations.

JURISDICTION

Closure sometimes must occur when the client moves; this may be for a few reasons. Whenever a client moves within Canada and they would like to continue service, it is crucial to call your insurer. Being armed with information as to whether the other Canadian jurisdiction has a college of counsellors or therapists is helpful as it can be determinative. However, don't assume it is always a "no" because there is a college in another jurisdiction. People move for many reasons and for many lengths of time. And clinicians are insured differently depending on education, provider, and context. Treat these scenarios like fingerprints — each is unique and requires investigation. Insurers are your key source of information for keeping a client in another jurisdiction.

So, let's say you are comfortable and able to continue providing services. Clinical implications are not to be underestimated either. If we filter our considerations through the lens of adaptive vs. maladaptive, my biggest question for clients who move is, "We need to decide if keeping me helps your move or hinders it." If we determine that it may hinder their progress, I terminate the client and refer them in their new jurisdiction.

Moving is not to be underestimated. Ranging from a reinvention to an escape to the upending of a person's life, these are immensely sensitive moments for people. The literature is clear in regard to our emotional ecosystem — we are vulnerable entities. I have learned to treat moves with delicacy. When I must close for a professional reason like lack of insurability, we prepare together, and I help them search for a therapist. In



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ideal circumstances, I reach out to the new therapist with or for the client.

DUAL RELATIONSHIP AND ITS POTENTIAL

Dual relationships are a common reason to terminate or close. However, it is important we refer to the code. I coach my supervisees to read this portion thoroughly as it does not state what most people think it does:

> *16) Avoid dual relationships or the perception of a dual relationship in circumstances where the existence of a dual relationship may adversely affect the professional relationship.*
>
> *17) Where a dual relationship exists or is perceived to exist, take immediate and reasonable steps to address any resulting harm or the potential for such harm.*

I want to note here that it is the harm to be avoided. Number 16 notes adverse effects to the client-therapist relationship, and 17 notes addressing harm to the client. This is not a blanket prohibition of dual relationship, and this is because it is often impossible to avoid.

In remote communities, the vast majority of B.C., it would be impossible to access services if dual relationships were prohibited. "The Counsellor" (which they are often called in smaller towns) needs to get coffee in the morning, and it is likely the barista could use therapy at some point.

Community is also not just locale. I think of the professional community I move through. So many parents of my client kiddos have become professionals in our world. I manage many dual relationships. Being able to prevent dual relationship or predict it would be fantastic and would make life easy, but when it is unavoidable, it is the harmful impact that should be managed. You can prevent harm without eliminating the dual relationships. But not always.

And sometimes this means closure. I ask my students to play "imagination game" with worst case-scenarios. "Pretend your new client ended up being your child's swimming instructor. Create the worst-case scenario of dual relationship and then tell me if you would terminate them or not."

FURTHER LIMITING VARIABLES

Our ethics and standards can be further limited and constrained. In fact, they often are. The most common arena of further limitation is within a contracting or employer agreement. It is true that your job or contract can limit your professional and ethical latitude, and it is so crucial clinicians understand this. A simple example is contracting with a health authority or ICBC. Within the contract you sign, you agree to submitting reports pertaining to the client's information and situation not typically shared in another scenario. This is a further limitation.

This significantly affects the issue of file closures because, when working for an employer, it is almost always the case that termination or file closure is required. And even though our standards seek to ensure we always position the client's health first, it can be the case that we are required to close a file when we feel it is not clinically appropriate to do so. This is

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hard and can lead to burnout. It is hard to end client relationships because of service duration or funding cessation, but the world of systemized mental health is an increasing portion of our sector, and therapists have had to embrace its structures. These types of closures are often handled by discussing them on the first day and "beginning with the end in mind."

PROMOTION OF PATHOLOGY AND CLIENT RISK

It can be hard to consider this one, but not all clients benefit from therapy. I have worked with several people for whom therapy, and not just me specifically, was worsening their condition. In the mental health world, where we deal with treatments of many organic and complex conditions, it is crucial for us to look out for the promotion or exacerbation of pathology.

People with varying forms of psychosis, for example, must have breaks from introspective therapies. That is not to say they wouldn't be seen by a medical professional, but depending on their treatment cycle and stage, rest from introspection is crucial. Without this rest, some conditions can be worsened by therapy. This can be a very important time to terminate a client and ensure they are prepped to check in with medical supports.

Sexually intrusive or predatory clients can require termination. The increased focus and introspection on the topics can have a reverse effect on their symptoms and require therapists to close. Addictions therapists often decide to close. Again, the theme is that ongoing focus on the issue can sometimes "keep it at home," as my supervisor used to say.

So, client closure relating to client health is a crucial consideration. More is not always better, and forever is not always better. This kind of closure is considered clinically indicated and should be guided by a skilled supervisor, but the consideration is that therapy can need to have an end, when the end serves to promote the client's health.

CLINICIAN RISK

Safety first. I have worked in places where therapist safety has been questioned or compromised by a client who is dangerous or threatening. This is another area that should be guided by a skilled supervisor, because terminating

a client you feel at risk from is a risk in itself and not to be taken lightly. That said, risk is sometimes universal and sometimes unique. There are clients who are a risk to everyone and clients who are only a risk to particular people. Those of us who have worked in correctional situations or with high-risk offenders know the unique world that it is. A skilled supervisor and colleague can help determine the client's risk profile and your level of risk tolerance.

For those of us not interested in working with populations that import this kind of risk, terminating clients who feel a risk to you should always happen sooner than later. If risk is not part of the population you assume responsibility for, and you are not in a supported context, the risk will not lessen over time.

REFER OUT

Most of our code of conduct focuses on a way of being with a client. Passages contain language to help us consider how we treat our client and how we should see the relationship. Envisaging the relationship in a particular way assists us in determining what to do. But there is one element of our code I find to be overlooked, and I ensure clinicians remember it and embed it in their workflow.

We should always refer out when closing. Referring out, as noted in the code:

> *13) If it becomes necessary to limit, suspend or terminate treatment, assist the client to obtain the services of another qualified professional.*

This is something we must do. This is an immutable ethic that applies whether we have an opinion against it or not. The duty of care transcends other details of the situation, and in all cases we must refer. If the client relationship has soured in some way, or they have become difficult to contact, I send a final voicemail or message listing two professionals in their area, so I know the last thing they have from me is a commitment to their well-being.

HOW TO CLOSE

Therapy is relational. The impacts of our communication, behaviour, affect, and approach are significant to our clients. Ending a relationship or closing a process means something. Our brains will insist we make meaning of it.

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I am diligent when supervising therapists on the meaning-making they create when ending with a client. It is crucial therapists create a therapeutic and client-centred meaning out of closure. It is not treatment if we lead a client to believe, even by omission or silence, that they are somehow at fault or failure when closing. As treatment professionals, we must ensure endings are also treatment. Defining closure as beneficial for the client in some way is crucial so they are not hamstrung by our decision to close. When we fail to do this, we cease to be in our treatment role, and the client can sometimes be sent off in a worsened state. When we hold true to treatment ideals and focus on their adaptive functioning right until the end, we enhance their experience of therapy. We set them up for further growth with someone else.

I encourage clinicians to:

1. **Always close in the methodology consistent with the course of therapy. If you were in face-to-face sessions, do not terminate over text or email. However, if you were doing narrative letter work, also do not make the first phone call a termination. Respect the structure of the interactions and give them a final interaction that isn't avoidant or aggressive or out of the norm.**
2. **Always treat closure clinically where possible. Integrate it into treatment and frame it as part of their work. Make it meaningful if you can.**
3. **Always approach it as a care professional and ensure they have information about other professionals or services. It reminds them that the profession is more than just you.**

Closures occur in many scenarios, some forced and some sudden. They can feel wrong at times and poorly timed. We can want to hold on if it feels premature, and we can want to speed it up if we feel the process was difficult. If we are adhering to our code, we create client-centred closures that are clinically relevant and productive and, above all, communicate our duty of care. ■

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