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Finishing well: The personal impact of ending therapy on speech-language pathologists

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RESPONSE

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Abstract
This paper is the final response in a scientific forum examining the impact of ending therapy on speech-language pathologists. The lead paper explored 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. The nine respondents in this scientific forum, representing a range of clinical, research, cultural and geographical contexts, have highlighted their concerns, insights and suggestions in relation to discharge practice. In this closing section, I suggest that this scientific forum has the potential to act as a catalyst towards positive change. My reasons for this are threefold, relating to raising awareness, acknowledging the personal impact, and developing or promoting strategies for successful discharge experiences.

Keywords: Ending therapy, discharge practice, speech-language pathology.

Introduction
This scientific forum has examined the impact of ending therapy on speech-language pathologists. In the lead paper (Hersh, 2010), I included a discussion of the terminology used at the end of therapy, a review of related literature and an examination of how speech-language pathologists working in the area of chronic aphasia talked about discharging clients from therapy. Based on this research, I suggested that speech-language pathologists juggle three tensions at discharge: coping with real versus ideal endings, managing the building of close therapeutic relationships which then have to be broken, and balancing a respect for client autonomy while retaining control over caseloads and fair allocation of resources. Nine responses followed this paper, written by speech-language pathology clinicians, researchers and educators from the areas of paediatric speech-language pathology, adult neurology, voice, and palliative care, working in Australia, Malaysia, USA, Greece, Cyprus and the United Kingdom (Ahmad, 2010; E. Baker, 2010; J. Baker, 2010; Body, 2010; Kambanaros, 2010; Quattlebaum & Stepling, 2010; Roe & Leslie, 2010; Roulstone & Enderby, 2010; Togher, 2010). This scientific forum is the first of its kind in focusing on the specific issue of ending therapy across a range of speech-language pathology practice situations. In this final section, “Finishing well” (Relph, 1985), I suggest that it has the potential to act as a catalyst towards positive change. My reasons for this are threefold, relating to raising awareness, acknowledging the personal impact, and developing or promoting strategies for successful discharge experiences.

Raising awareness
First, the nine respondents all agree that the process of ending treatment has not been fully acknowledged or explored in the professional literature. Lack of recognition by researchers of treatment termination as a specific area for study has had implications for professional training and for professional development (Hersh & Cruice, in press). It is hard to give recognition to an issue that is unpublished or unsung. Raising awareness of how intervention ends is of key importance in making change, of getting people to talk and share experiences. In turn, this helps make the implicit explicit, helps speech-language pathologists articulate their reasoning, their concerns and their successes. As Ahmad (2010, p. 317) reported, her interviewees found that “termination of therapy is a difficult process to explain and...
justify” but raising the profile of the issue is a first step in alleviating this difficulty. Even having the space to consider the terminology to describe therapy endings is a move in the right direction, revealing a great deal about the value-laden nature of the words we use. Jan Baker’s (2010) comments about rarely using the term discharge with her voice clients, but saving it for administrative contexts, allows some insight into the nature of her negotiations with voice clients and the primacy of the therapeutic relationship in her clinic. In addition, giving prominence to how therapy ends, as this scientific forum does, may also help researchers secure the funding required for longitudinal studies needed to understand the long-term impact of communication disability and the difficult issue of resolution, raised so clearly by Roulstone and Enderby (2010). As they point out, such research in the area of children’s speech and language impairment has the potential to challenge the very role of the speech-language pathologist: whether to work only on specific speech and language skills or perhaps to have more involvement in associated, longer term competencies. As Elise Baker (2010) also wrote, having good research evidence about optimal treatment intensity and duration is essential to guide clinicians in their discharge decisions.

Acknowledging the personal impact

Secondly, there has been overall acknowledgement that treatment termination may carry an emotional load for speech-language pathologists. The three dilemmas of coping with real versus ideal endings, of having to build and then break relationships and of encouraging client involvement in decisions while maintaining professional control appeared to resonate across different areas of clinical practice although with varying emphases. These three conflicts are challenging but emotions associated with treatment termination are not always negative. Reading about the ideal achievement of goals in children with speech sound disorders (E. Baker, 2010) reminded me of happy endings when I worked with such children. I remember, for example, feeling somewhat smug when, following a short burst of therapy, one particular 4-year-old, Christopher, no longer called himself “Pistopher”, a change certainly appreciated by his mother. At the opposite pole and even when facing individual tragedy, Roe and Leslie (2010, p. 306) demonstrate that there is the potential for great satisfaction helping someone “die a good death”. Nevertheless, when endings are less than ideal, treatment termination can be “fraught and contentious” (Togher, 2010, p. 320) and clinicians are often frustrated when scarce resources and lack of follow-up services render their efforts towards a satisfactory ending difficult (Ahmad, 2010; Kambanaros, 2010).

The value in acknowledging the emotional load is that it prepares speech-language pathologists for a range of feelings and allows them the space to reflect and accept these as part of the job. This is not to say that acceptance entails complacency or lack of action to pursue improved services or conditions for clients. But it does provide insight into an aspect of our work which needs to be handled sensitively. Jan Baker (2010) notes that there are no published studies on the personal impact on voice therapists of dealing with difficult therapeutic endings, even for those working with people long-term. Learning from the psychiatric and psychoanalytic fields, she stresses the need for therapists to “begin to acknowledge that they too experience rewards and losses in the therapeutic relationship” as part of the process of dealing with difficult endings more effectively (J. Baker, 2010, p. 312).

Towards successful discharge experiences

Thirdly, this forum provides a wealth of suggestions about how speech-language pathologists might tackle the dilemmas discussed in the lead paper. For example, Quattlebaum and Steppling (2010) focus on the importance of including “dismissal” in training programs and using the four key areas of: caseload management, service delivery models, funding and counselling as “springboards for discussions” on the topic (Quattlebaum & Steppling, 2010, p. 313). They, like all the other contributors, stress the need to start the process of discharge early in intervention. Body (2010, p. 303) captures the key points: “realistic, collaborative goal-setting at the outset of therapy; transparency of assessment and discussion of progress; a planned, controlled move towards the end of therapy”. Similarly, Togher (2010, p. 323) writes: “A positive discharge process is one that requires planning, forethought and clear communication between the clinician and the client from the outset”. These comments place the discharge process rightly as an integral part of therapy, rather than an afterthought at the end. Indeed, as Togher notes, building social integration into therapy can lessen over-reliance on the clinician when therapy ends (if indeed, it should—and for further discussion of this point, see Elman, 1998). Roulstone and Enderby (2010, p. 294) suggest that the structure provided by episodic intervention helps “to establish defined and agreed end points and a mechanism for monitoring change”, another example how the therapy structure and approach impacts on how it ends.

Such suggestions are fundamental components of good discharge practice. Of course, the process of negotiating the duration of therapy shares many aspects of negotiating goals within therapy—an essential but often time consuming and complex process, particularly in the context of communication disability or cognitive impairment (Kuipers, Carlson, Bailey, & Sharma, 2004). In addition, there are various reasons why speech-language
The end of therapy is deeply dependent on what happens at the beginning of therapy, and the quality of the relationships developed at the start. Discharge from intervention is a process. It is not simply closure of therapy that is organised at the end. Discharge dilemmas occur, although in varying guises, across the areas of speech-language pathology intervention. Therapy discharge can be described in various ways and the differences in terminology capture divergent perceptions of the process. It is important to raise awareness of the impact of treatment endings on both clients and speech-language pathologists for teaching, practice and research contexts. Treatment termination should be addressed during professional training, particularly within discussions of caseload management, service delivery models, funding, counselling and also clinical ethics. Addressing this issue is helped by reference to real cases and to sharing previous clinical experiences in professional development situations or with colleagues, supervisors or other members of multidisciplinary teams. Dealing with ideal and not-so-ideal endings involves making implicit processes and emotions more explicit, as well as acknowledging feelings, rewards and losses. Good discharge negotiations require clear communication, realistic, collaborative goal setting, transparent assessment and discussion of progress. Therapy needs to promote client responsibility, shared decisions, ongoing social opportunity and improved self-management. Therapy needs a good evidence base with information about the long term consequences of communication disability, the potential for change (including neuroplasticity) and effective intervention strategies. Service delivery models need to be sufficiently flexible to respond to those groups of clients for whom formal discharge is inappropriate.

Table I. Key points for increased understanding and effective discharge experiences.

- The end of therapy is deeply dependent on what happens at the beginning of therapy, and the quality of the relationships developed at the start.
- Discharge from intervention is a process. It is not simply closure of therapy that is organised at the end.
- Discharge dilemmas occur, although in varying guises, across the areas of speech-language pathology intervention.
- Therapy discharge can be described in various ways and the differences in terminology capture divergent perceptions of the process.
- It is important to raise awareness of the impact of treatment endings on both clients and speech-language pathologists for teaching, practice and research contexts.
- Treatment termination should be addressed during professional training, particularly within discussions of caseload management, service delivery models, funding, counselling and also clinical ethics.
- Addressing this issue is helped by reference to real cases and to sharing previous clinical experiences in professional development situations or with colleagues, supervisors or other members of multidisciplinary teams.
- Dealing with ideal and not-so-ideal endings involves making implicit processes and emotions more explicit, as well as acknowledging feelings, rewards and losses.
- Good discharge negotiations require clear communication, realistic, collaborative goal setting, transparent assessment and discussion of progress.
- Therapy needs to promote client responsibility, shared decisions, ongoing social opportunity and improved self-management.
- Therapy needs a good evidence base with information about the long term consequences of communication disability, the potential for change (including neuroplasticity) and effective intervention strategies.
- Service delivery models need to be sufficiently flexible to respond to those groups of clients for whom formal discharge is inappropriate.

pathologists find discharge discussions difficult (Hersh, 2009a) including feeling uncomfortable with discussing withdrawal of a service with people eager to benefit from it. I suggest that our focus should go beyond stating the need to embed discharge negotiations early by also considering how this can best be done. For example, establishing a good rapport and relationship lays the groundwork for more open and meaningful discussions of both therapy goals and discharge plans. Raising closure even before therapy is well underway requires sensitivity and avoiding the mistake of making options too rigid or perceived as inevitable: “I can see you for X number of sessions and then we’ll review...”. Too structured an approach gives clients little leeway for anything other than agreement. They are often acutely aware of scarce resources and feel obliged accept a professionally led suggestion in order to make room for the next person on the waiting list even if they would have liked continued therapy (Hersh, 2009b). Giving information about potential treatment directions may not be enough for the transparent negotiations recommended above. Information exchange should be two-way and clients also need to know that they have real choices for true shared decisions (Charles, Gafni, & Whelan, 1997). What makes the discharge negotiation hard is that there may actually be few choices, for either speech-language pathologists or clients, especially when resources are slim (e.g., Ahmad, 2010). Finally, the expectations regarding client involvement in negotiations, for either therapy or discharge goals may vary. As Ahmad (2010) has pointed out, for some therapists, there is a professional expectation that they must control discharge decisions.

Table I provides a summary of the key points for improved understanding of treatment endings and good discharge experiences suggested by the respondents in this scientific forum.

In conclusion, by raising awareness of issues at the end of therapy, acknowledging the personal impact on speech-language pathologists and sharing expertise on good discharge practice, this scientific forum paves the way for positive change for both clinicians and clients. The process of ending therapy will continue to evolve just as therapies themselves evolve. But it is essential that speech-language pathologists continue to share ideas and research, and to debate all the many facets of drawing therapy to a close just as they do about therapy itself. Being aware of the issues also serves as a good base for negotiating discharge decisions more clearly with clients. On that basis, finishing well is bound to be more likely and more satisfying.

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References


