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

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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 & Stepping, 2010; Roe & Leslie, 2010; Roustone & 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...
that it prepares speech-language pathologists for a satisfactory ending difficult (Ahmad, 2010; Kamba- 
follow-up services render their efforts towards a 
are often frustrated when scarce resources and lack of 
contentious’’ (Togher, 2010, p. 320) and clinicians 
next. Nevertheless, when endings are less than 
treatment termination are not always negative. 
the ideal achievement of goals in children with speech sound disorders (E. Baker, 
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 
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; Kamba-
naros, 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 
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. 

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 dis-
cussion’’ 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 exam-
ple 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 
asp ects of negotiating goals within therapy—an 
essential but often time consuming and complex 
process, particularly in the context of communica-
tion disability or cognitive impairment (Kuipers, 
Carlson, Bailey, & Sharma, 2004). In addition, there 
are various reasons why speech-language
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


