Therapeutic Termination: Translating Clinical Responsibility into Ethically-Informed Practice
Christina M. Schnyders, PhD, LPCC
Malone University
Kristin Bruns, PhD, LPC
Youngstown State University

Author note: Christina M. Schnyders is affiliated with the Malone University and Kristin Bruns with Youngstown State University. Correspondence about this article should be addressed to Christina Schnyders, Department of Counseling and Human Development, Malone University, Canton, OH 44709. Email: cschnyders@malone.edu.

Abstract

Clinical termination is an important aspect of the therapeutic process, yet one that is largely underrepresented in literature across various helping professions. In this article, termination is defined, distinct types of clinical termination are outlined (e.g., clinician-initiated, client-initiated, and forced), and differences in the impact of termination based upon the termination source (unilateral versus mutual agreement) are explored. Further, various reasons for clinical termination are outlined, and the impact of termination on both clients and clinicians are discussed. A case study is presented to illustrate potential ethical considerations associated with the termination process. Finally, clinical responsibility is discussed in order to empower helping professionals to translate ethical guidelines into meaningful and responsible practice.
Therapeutic Termination: Translating Clinical Responsibility into Ethically-Informed Practice

Termination is one of the most important components of the therapeutic process, yet there is limited literature on termination in comparison to other aspects of clinical practice (Jakobsons, Brown, Gordon & Joiner, 2007; Hilsenroth, 2017). According to Vasquez, Bingham and Barnett (2008), termination can include an opportunity for clients and clinicians to review goals, describe important changes that the client has made or incorporated into treatment, and address feelings associated with the termination process. Further, Vasquez et al. (2008) note that, when done well and in an ethical manner, termination is a means of promoting care and can help prevent client harm. By exploring the definitions, types, and reasons for termination, as well as ethical principles and overarching themes drawn from ethical codes regarding termination practices, clinicians can gain knowledge of the ethical and clinical responsibilities that exist to ensure a high level of client care. With this knowledge clinicians can thoughtfully engage in termination practices. Beyond working with clients on the individual level, clinicians can also advocate for clear termination practices to be implemented in a variety of mental health settings.

What is Termination?

Termination can be understood in a variety of ways. First, clinicians can benefit from understanding the definition of the term “termination” and what constitutes termination in the helping professions. Termination can also be understood by type, which highlights where termination is primarily initiated (client, clinician, or as dictated by circumstances). Further, termination can be understood as a process in and through which clinicians have unique ethical responsibilities. By understanding each of these categories, clinicians can better recognize the unique opportunities and responsibilities that exist within clinical termination.

“Termination” Defined

Various definitions of “termination” exist, but the overarching characteristic associated with termination is that it describes the ending of clinical treatment. According to Natwick (2017), “Termination is the term for the process when a client is ending services” with a clinician (p. 18). Gelso and Woodhouse (2002) noted that termination can provide a “…permanent or temporary ending” to a therapeutic relationship (p. 846). Younggren and Gottlieb (2008) asserted that termination is the “…ethically and clinically appropriate process by which a professional relationship is ended” (Younggren & Gottlieb, 2008, p. 500). In each of these definitions, the cessation of a therapeutic relationship is acknowledged, but Younggren and Gottlieb’s (2008) definition uniquely highlights the responsibility for clinicians to engage in termination in ways that are ethically and clinically sound. Although termination is typically associated with the end of treatment, Graybar and Leonard (2008) describe termination as a “…bridge (that) stretches from the initial session and presenting problem, across the evolving therapeutic relationship, through each clinical issue, a final goodbye, and beyond” (p. 56). Because of this, there is a critical need for clinicians to understand the process of termination, its impact, and implications for the therapeutic relationship.

Termination Defined by Type

Termination can be unilaterally undertaken by the clinician or client, initiated by the clinician or client and then mutually agreed-upon, or dictated by circumstances. Ideally, it is collaborative in nature with the client and the clinician serving as active participants in the process (Gelso & Woodhouse, 2002; Goode, Park, Parkin, Tompkins & Swift, 2017; Graybar & Leonard, 2008). A foundational conceptualization of the types of termination is provided within the context of the counseling profession by Lanning and Carey (1987), who describe three types of termination: client-initiated, counselor-initiated, and mutual agreement. Forced termination is another type of termination that has also been discussed in termination literature (Aafjes-Van Doorn & Woldridge, 2018). Each type of termination has distinct characteristics and an associated impact upon the client and the clinician (Aafjes-Van Doorn & Wooldridge, 2018; Lanning & Carey, 1987; Syracuse University, 2018). While there tend to be commonalities in the process of therapeutic termination, there can also be unique
dynamics and outcomes based on the type of termination (O'Donohue & Cucciare, 2008). Because of this, clinicians hold responsibility to acknowledge both the common and unique dynamics associated with termination type in order to provide optimal care to clients (Graybar & Leonard, 2008).

**Termination initiated by the clinician.**

Clinician-initiated termination can occur through mutual agreement or unilaterally, and can take place for a variety of reasons (Lanning & Carey, 1987). A positive impetus for a mutually agreed-upon termination occurs when the clinician initiates a discussion with the client and together they make the assessment that the client has reached his/her therapeutic goals, as evidenced by such things as a reduction or elimination of symptoms, increased insight, and coping skills to address possible concerns in the future (Lanning & Carey, 1987; Joyce et al., 2007; Syracuse University, 2018). A less positive impetus for a mutually agreed-upon termination would occur when the clinician initiates a conversation with the client about the clinician's judgment that treatment is appearing to be ineffective and that alternative treatment should be considered. In either of these cases, and in indeed in all forms of termination whenever possible, abrupt termination should be avoided and appropriate referrals should be considered and offered to the client.

Unilateral action by the counselor to choose to terminate treatment must be undertaken with great care, given the potential impact on the client, especially traumatized and fragile clients (Aafjes-Van Doorn & Wooldridge, 2018) and the ethical imperative to avoid abandoning clients (American Counseling Association, 2014). We consider circumstances such as clinician terminating due to serious illness or changing practices in the later section on forced termination. Here, we consider the relatively rare circumstances such as a client refusing to pay or co-pay for sessions, a clinician being seriously threatened or endangered by the client or someone associated with the client, or a client who, after lengthy discussions with the clinician over time, refuses to address the clinician's concern that treatment is ineffective, or in extreme cases, potentially harmful, and that a referral or referrals are needed. In these cases, and again in all cases involving termination, best practices dictate that the clinician engage in substantial consultation and/or supervision to ensure that termination is done in the most ethical manner.

**Termination initiated by the client.**

Client-initiated termination occurs when the client is the driving force behind terminating the therapeutic relationship (Lanning & Carey, 1987; Syracuse University, 2018). Similar to clinician-initiated termination, client-initiated termination can occur through mutual agreement with a clinician or unilaterally (Lanning & Carey, 1987). Positively, a client may initiate a discussion about termination when they feel that treatment goals have been met and, through discussion with the clinician, a mutual agreement is reached that future treatment with that clinician is not needed, though there may still be referrals to other services provided by the clinician; negatively, they might initiate a discussion about termination due to their displeasure with its course.

Unilateral client-initiated termination also occurs for a variety of reasons; from the clinician's point of view, what often happens is that the client, without notice, stops coming and does not respond to outreach efforts. Clients may feel that treatment was successful or unsuccessful, or anywhere in between. Clients may feel overwhelmed by treatment and threatened by change, or experience anxiety stemming from the belief that counseling is doing more harm than good, which in turn causes clients to terminate counseling (Lanning & Carey, 1987). One specific form of unilateral termination is premature termination, which occurs when a client discontinues treatment before his or her goals have been met (Swift & Greenberg, 2015). As such, premature termination has been connected to a client's perception of pressure to attend therapy, lower education levels, older age, and increased levels of client distress (Anderson, Tambling, Yorgason & Rackham, 2019; Rubin, Dolve & Zilcha-Mano, 2018). Treatment setting (e.g. college and university counseling centers) and diagnosis (e.g. eating disorders and personality disorders) have also been associated with higher rates of premature termination (Swift & Greenberg, 2012).
Among clinicians, client-initiated termination can prompt a variety of feelings such as insecurity, guilt, or even relief (Syracuse University, 2018). Alternatively, clinicians may feel compelled to blame clients for termination, so supervision and consultation may be warranted to fully explore clinical dynamics associated with the termination (Lanning & Carey, 1987).

**Forced termination.**

Forced termination can occur under circumstances that were planned or that were unforeseen; it can be undertaken at the supervisory or administrative level, and tends to be felt by the clinician and client as something that has been forced on them (Aafjes-Van Doorn & Wooldridge, 2018; Syracuse University, 2018). Serious treatment or boundary violations can be the impetus for forced termination (Youngren & Gottlieb, 2008) and these and other safety concerns can also be a reason for terminating therapy (American Counseling Association, 2014); in these relatively rare circumstances, a clinician fails to recognize or downplays these concerns and a supervisor/higher-level clinical administrator forces the clinician to accept termination and the need to refer the client to another clinician and/or other services as needed.

More common reasons for forced termination occur when the clinician must terminate with clients because the clinician is moving to a different practice, experiencing a career change, or retiring. Additional reasons include the serious illness or death of the clinician, or when a clinician-in-training completes practicum or internship. For the client, they also include serious illness, death or relocation. The client may change insurance and find that the clinician is out-of-network or may lose insurance entirely and be unable to self-pay. Finally, organizational parameters may limit number of sessions (e.g. a university counseling center’s limit of eight sessions per student), or the client may be a minor and parent or guardian decides to discontinue treatment (except in states that allow minors of a certain age to consent to treatment).

With forced termination, clients may experience a variety of emotions, ranging from mild to intense (Aafjes-Van Doorn & Wooldridge, 2018). For most clients, forced termination is experienced as a greater loss when compared to client-initiated termination (Baum, 2007). Additionally, forced termination can lead clients to experience anger, anxiety, feelings of abandonment, or even indifference (Aafjes-Van Doorn & Wooldridge, 2018; Syracuse University, 2018). Forced termination can also produce emotional responses from clinicians. For example, clinicians-in-training often feel distress, because of the time limits-based ending of the therapeutic relationship and out of concern for clients’ emotional response to termination (Baum, 2008). Furthermore, clinicians who experience forced termination may experience emotions such as guilt, frustration at unfinished business, feelings of loss, sadness, anger, regret, anxiety, or even possibly relief (Baum, 2008; Sherby, 2013; Syracuse University, 2018).

Regardless of the type of termination that occurs, clients and clinicians are each impacted by termination and experience varied emotional responses. Because of this, open communication about the termination process can provide space for clinicians and clients to discuss their emotional responses towards termination (Knox, Adrians, Everson, Hess, Hill & Crook-Lyon, 2011). Clinicians may also seek supervision or consultation to appropriately process their reactions to the termination process. And to reiterate, in all situations where termination occurs, documentation should note the steps taken to ensure that the termination process was ethically sound and that client abandonment and/or neglect did not occur (Natwick, 2017).

**Termination as a Process**

Termination can be understood as a process rather than a one-time event, and within this process, various ethical duties and responsibilities exist. Conceptualizing termination as a “bridge” (Graybar & Leonard, 2008, p. 56) that stretches from the beginning of treatment to the very end helps clinicians to recognize the level of importance that termination holds within the clinician/client
relationship. Acknowledgment and demonstration of healthy termination can empower clinicians to meet the needs of clients and provide opportunity for discussion of relationship endings. Further, clinicians have a unique opportunity and responsibility to model healthy relational closure, which can provide clients with insight, language, and skills for addressing relational closure that they may not have gained elsewhere. In so doing, clinicians can equip clients for future encounters they have with closure well beyond the therapeutic relationship. Throughout the therapeutic process, clinicians are responsible for using ethical principles as an overarching guide to practice, along with ethical codes specific to their profession, in order to guide clinical decisions. In fact, adherence to ethical guidelines has been directly linked to successful termination (Norcross et al., 2017), which further underscores clinicians’ responsibility to translate ethical principles into therapeutically-sound termination approaches. Common terms within ethical principles of clinicians are autonomy, beneficence, non-maleficence, justice, fidelity, and responsibility. Each of these terms will be explored by means of the following vignette to provide a context for which they can be utilized within the termination process.

**Vignette: Malik**

Malik is a 22-year-old male living in a large urban community in the United States. The third child of emigrant parents, Malik is a graduate student at a state university where he is studying engineering. Malik has sought services from the campus counseling center, where he has received treatment according to the center’s 8-session maximum per student per year, to address stress and anxiety related to the transition to graduate school. Malik was skeptical of counseling at first, as his father was opposed to the idea, advising that men handle strain on their own. However, he has found himself connected to his counselor, Susan, a licensed professional counselor working in the counseling center.

During his time with Susan, Malik has found himself able to open up about previously difficult struggles with anxiety. Susan and Malik have formed a strong bond with one another, so much so that Malik has trouble thinking about navigating university life without her. That’s why, at a recent session, Malik felt a wave of panic as Susan informs Malik that she has been reviewing his treatment progress and feels he has made sufficient progress to warrant discussion of termination. Susan also reminds Malik that the counseling center typically limits treatment length to 8 sessions and that she has already requested additional sessions from her supervisor, the director of the counseling center. Malik agrees that he feels successful in managing his symptoms, but is loath to terminate the relationship. As Susan continues to discuss termination, Malik announces that he and his new girlfriend are having arguments and he wants to bring her in and begin couples counseling with Susan. While these concerns would be valid topics to address in couples counseling, Susan recognizes that standard clinical practice would dictate that a referral for a different counselor should be given to Malik if he wishes to pursue couples counseling. She senses that his wish to expand the scope of treatment may be an expression of Malik’s reticence about ending the therapeutic relationship.

As Susan reflects on Malik’s ambivalence about termination and seeks consultation, she identifies ways in which she might have more thoroughly and effectively prepared Malik for the inevitable. While her Informed Consent form indicates that counseling is a time-limited process, and that the counseling center limits the number of sessions a student can receive in a year, consultation highlights that it would have been clinically useful to discuss the process of termination regularly over the previous six months. Regardless, she feels an ethical responsibility to bring the therapeutic relationship with Malik to a close, recognizing the her lack of preparation of Malik for this eventuality may complicate termination.

Indeed it did. As Susan presses termination, Malik begins to shut down and emphasizes that he was not ready to be done working with Susan (unilateral termination, as client is not in agreement). Recognizing the situation, Susan works to balance validation of Malik’s frustration with providing information on the natural process of ending counseling. She accepts responsibility for not having
adequately prepared Malik for this over time, she compromises and sets the limit that they will have six
more sessions. While Malik’s emotional well-being is a top concern, Susan knows she needs to
terminate due to treatment outcomes and clinic limits (forced termination). However, she works with
Malik on a plan for their six sessions to better support him throughout the transition. Malik agrees to
the plan, and seems a little relieved to have a set limit and plan. Throughout the next six weeks, Susan
and Malik work with an eye toward next steps. By the end of the sixth week, Malik has begun to
establish his own peer-based support system and expresses readiness to transition (mutual termination).

Ethical Principles for Termination

The following are suggestions for clinicians to consider based on ethical principles of the
counseling profession.

**Autonomy.** Autonomy refers to the recognition that clients have the rights to make decisions
that they believe to be in their best interest. While Susan may have ideas and suggestions about
treatment options, Malik is ultimately responsible for making his decisions about how he uses his
success gained in treatment. In order to help Malik remain autonomous, Susan must provide options for
termination and especially to make time in session to discuss and process termination options with
Malik (American Counseling Association, 2014; American Psychological Association, 2017; National
Association of Social Workers, 2017). While Malik does not want to terminate, Susan is not
compromising autonomy by terminating their relationship as she has provided other, more appropriate
referral options for Malik. While continuing in therapy with Susan is not an option, due in part to
session limits at the counseling center and more importantly due to her need to follow her perspective
on standard clinical practices, Malik is responsible for the future choices he makes in seeking services.

**Non-Maleficence.** Non-maleficence ensures that providers “do no harm” to their clients. At the
most practical level, by practicing ethically, clinicians can prevent harm (Vasquez et al., 2008). By
providing a referral, Susan is avoiding harm by not practicing outside her scope of practice. Further,
Susan can avoid her client experiencing neglect and abandonment by creating time in the therapeutic
process to talk about termination and co-creating a termination plan with the client. Additionally, by
avoiding an abrupt termination, which may cause feelings of abandonment and neglect, Susan works to
do no harm to her client.

**Beneficence.** Beneficence refers to clinicians making decisions with the intention to do what is
most beneficial for clients. Susan can ensure beneficence by providing an individualized termination plan
for Malik (e.g., providing referral options). Further, by terminating the therapeutic relationship with
Malik under the rationale of scope of practice issues and knowing that there are other clinicians in the
area who therapeutically specialize in Malik’s area of need, Susan is attempting to make sure services are
as beneficial as possible for Malik instead of continuing unnecessary treatment or treatment that is
outside of her scope of practice (Natwick, 2017).

**Justice.** Justice includes treating clients equitably and fostering fairness and equality (American
Counseling Association, 2014). When engaging in all aspects pertaining to therapy with Malik,
including the termination, Susan needs to not only provide adequate services, but also create and give
access to a termination plan (including referrals). The principle of justice would suggest that clinicians
should create an individualized termination plan for each client. Further, as each client’s concerns and
treatment goals will vary, referral and resources should match client needs.

**Fidelity.** Fidelity identifies the need for clinicians to honor their commitments to clients
(American Counseling Association, 2014). Susan would make sure she is following through with
anything discussed in the treatment process with Malik. Specifically, Susan would need to make sure
she is following the protocol she created with Malik for his termination plan (e.g. provide time in
session to discuss termination process, provide appropriate referrals, complete appropriate documentation for transfer/referral).

**Responsibility.** Clinicians are expected to fulfill their responsibilities to their profession, (American Counseling Association, 2014), which at minimum is guided by their respective codes of ethics and codified state laws. Susan is able to demonstrate responsibility by following her specific code of ethics, as well as aligning her decisions with all of the aforementioned ethical principles. These guiding principles set forth the ground work for the following section, which will discuss five themes found throughout a multitude of health professions’ codes of ethics specific to termination. A full comparison of ethical codes on termination is found in Table 1, which highlights the key concepts and identified codes within each of the themes discussed in the following section.

**Discussion and Recommendations**

Based upon consensus from various helping professions, it seems apparent that clinicians maintain responsibility to engage in ethically-sound termination with clients. Because of this, it is important to acknowledge the impact of termination and to recognize the ways that termination can and should be integrated throughout the entire treatment process. It is also helpful for clinicians to recognize termination as a means of advocating for clients.

Termination can have a positive or negative impact on clients, depending on the dynamics that occur during the termination process. In one study, positive termination experiences were linked to a positive clinician-client relationship, clear and thoughtful planning, discussion of termination, and discussion of clients’ self-care strategies (Knox et al., 2011). Further, positive termination experiences are associated with mutual engagement in activities that pertain to the termination process (Norcross et al., 2017; Shafran et al., 2019). Additional components of successful termination practices include identifying the client’s growth areas, discussing what went well in the therapeutic process, empowering the client to own gains and areas of growth, planning for future growth, and adherence to ethical guidelines (Norcross et al., 2017).

In contrast to this, Knox et al., (2011) noted that problematic termination experiences were associated with those whose presenting concerns were often related to issues of grief/loss, which may have led to more fragility on the part of clients. Further, clients seem to feel dissatisfied with termination when they are not active participants in the activities and processes associated with termination (Shafran et al., 2019). Other aspects of problematic termination include therapy not meeting the expectations of clients, an unresolved rupture in the counselor-client relationship, or lack of planning or discussion about termination within the therapeutic process (Knox et al., 2011). When therapy ends prematurely or without adequate termination, it can lead to feelings of abandonment on the part of the client (Vasquez et al., 2008). Interestingly, findings from Anderson et al. (2019) suggest that client distress, which is often associated with premature client termination, is mediated by the therapeutic alliance, which underscores the value of the client-clinician relationship. When termination does occur, clinicians should address the impact termination may have on both themselves and on clients, as both clients and clinicians can experience emotional reactions to termination (Baum, 2008; Syracuse University, 2018). Further, addressing the emotional impact of termination on both the client and the clinician has been linked with successful termination (Norcross et al., 2017). Because of this, it is imperative that clinicians recognize the divergent responses clients may have towards the termination process and take responsibility to ensure that termination is conducted in an intentional and thoughtful manner.

Clinicians are responsible for addressing clients’ needs regarding termination, whether common or distinct to an individual client (O’Donohue & Cucciare, 2008). Because of the impact that termination can have on the therapeutic relationship, effective termination should not be addressed solely at the point of termination, but rather it should be integrated as part of therapeutic dialogue throughout the t
process (Goode et al., 2017; Graybar & Leonard, 2008). Therefore, conversation about termination should be incorporated at the beginning of the therapeutic relationship through informed consent, throughout treatment, at the end of treatment, and when following up with clients who have unilaterally terminated treatment. Although clinicians hold clear responsibility when it comes to client termination, embracing this responsibility helps to ensure that clients receive an ethically-sound, meaningful approach to termination.

Clinicians hold responsibility to ensure that client termination occurs in a responsible and ethical manner. Clinicians should, at minimum, follow their respective code of ethics when making decisions about termination. The codes of ethics associated with various health professions outline a baseline of expectations for termination of a therapeutic relationship (American Counseling Association, 2014; Association of American Marriage and Family Therapists, 2015; American Psychological Association, 2017; Australian Psychological Society, 2007; International Association for Marriage and Family Therapists, 2017; National Association of Social Work, 2017). These codes, summarized in Table 1, are there to assist clinicians in constructing a course of action that best serves the clients who are engaged in and utilizing therapeutic services (American Counseling Association, 2014).

There are many additional practices that can be used to encourage ethically-minded and thoughtful engagement in the termination process. First, discussions about termination should occur throughout the therapeutic process. By talking openly about termination, clients and clinicians will feel empowered to discuss the termination logistics as well as their own emotional responses to termination (Knox et al., 2011). Clinicians should explore how clients are experiencing the therapeutic process throughout therapy and also discuss clients’ self-care strategies, which will ensure that struggles and problems as well as coping skills are being adequately addressed prior to initiating termination (Knox et al., 2011). Next, strategies can be used to ensure that documentation and communication promote client wellbeing beyond what occurs within counseling sessions. When engaging in the termination process, clinicians are responsible for ensuring that documentation outlines reasons for termination and adequately describes the termination process (Younggren & Gottlieb, 2008). Additionally, clinicians should attempt to contact clients who miss appointments without notice, by phone or in writing, in an effort to provide an opportunity for collaborative engagement in the termination process (Vasquez et al., 2008). These measures allow clinicians to demonstrate responsibility as they ensure that clients are well cared for throughout the therapeutic relationship and at the culmination of the therapeutic process.

In addition to bearing responsibility towards clients when it comes to termination approaches and practices, clinicians should be mindful of their role as advocates for responsible and ethical termination through their ability to advocate for practices that impact society at large. For many clinicians, this responsibility translates into advocacy efforts on behalf of clients in managed care settings and in interactions with third-party payers. Outside pressures for termination exist, including financial pressure to terminate based upon an allotted number of sessions being paid for by third-party payers and/or managed care organizations, which could potentially lead to premature termination (O’Donohue & Cucchiare, 2008; Reynolds, Welzel & Danzinger, 2008). In light of this, outside pressures for termination should not be the motivation for termination, and clinicians should advocate for changes within managed care systems to better support clients and their mental health needs (Reynolds et al., 2008). By doing so, clinicians can keep client needs at the forefront of the termination process while also advocating for clients on a societal level.

Conclusion

Termination, regardless of type, occurs with every therapeutic relationship. While there are multiple types of and causes for termination, all clinicians have an ethical obligation to make sure client care is at the forefront throughout the process of termination. Ethical principles and codes of ethics provide guidance for termination practices. Additionally, clinicians can, and potentially should, use consultation and supervision to address the nuances of client-clinician relationships and client needs, specifically in times of clinician impairment. As clinicians learn to own and practice the highest level of
responsibility regarding termination processes and practices, true benefit can be gained by all parties involved in the termination process.
References


PsycHtherapy Resarch, 28(5), 672-684.


