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Endings
More than saying goodbye

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Professional relationships and therapeutic treatments often, but not always, begin together. Each has its own life cycle, and the conclusion or cessation of treatment does not indicate the conclusion or cessation of the professional relationship. Therapists need to be mindful of the professional, legal, and ethical obligations that survive the delivery of services. Planning for the ending of therapeutic relationships is a fundamental, but often neglected, step in the therapeutic process (Kramer, 1990). Endings can be frightening for the client or the therapist and involve more than saying goodbye.

Ending treatment: treatment starts with the end in mind

Eagerness to develop mastery in a particular domain of functioning motivates clients to pursue therapy. The treatment begins with a presenting goal, which guides the process toward the end of treatment. In broad terms, the process of therapy involves three phases, each with its own structure and function: the intake or introduction phase (understanding the presenting issue and settling on the treatment plan), the middle phase (working through the treatment plan), and the end or termination phase (ensuring that the client is prepared for the conclusion of treatment and return to autonomous functioning). The initial treatment plan sets the stage for the course of therapy including its nature, treatment goals, timeframe, and expected end date. Incorporating end-phase goals into the overall treatment plan from the outset facilitates the ultimate closure of the therapeutic, but not the professional, relationship.

Treatment and termination goals

Treatment goals provide the vectors that guide the course of therapy. To be most effective, it is usually best that they be established early in consultation with the athlete (Bassett & Petrie, 1999). Specific goals give the treatment plan focus and instill a sense of confidence in the client that positive results are achievable. Not establishing specific goals from the beginning is an error that is likely to propagate throughout the course of treatment, resulting
in a disappointing outcome (Kramer, 1990). Like treatment goals, discharge and end-phase goals should be clear, obtainable, and modifiable (see Chapter 51).

Scheduling an end-date helps to identify the conclusion of treatment as a “real” event (Firestein, 2001). It inspires, influences, and pervades the treatment plan. As a real event, the ending of treatment carries the seeds for unintended, though not unforeseeable, consequences. The end of treatment may elicit affective reactions such as grief, sorrow, dependency, and insecurity, carrying the risk of treatment relapse (Firestein). The therapist should be aware of such reactions and address them, well before the last session.

In the case of short-term treatment, a circumscribed number of sessions designated for learning a particular skill or realizing a goal is clearly identified. Time-limited therapy firmly establishes the end at the beginning and side-steps the process of identifying when it would be suitable to end treatment. Even so, the therapist needs to remain sensitive to the emergence of end-of-treatment issues.

For some clients engaged in long-term therapy, setting termination goals may create anticipation for new beginnings or resumed high-level performance. For others, the prospect of ending therapy may evoke myriad negative emotions that trigger feelings of abandonment, sadness, and loss. Such feelings are normal, and avoiding these feelings with long-drawn-out endings may prove problematic and signal termination difficulties for both the client and therapist. When discussing end-phase goals, it is a good idea to observe and record clients’ responses, especially those that indicate potential distress, or are associated with setbacks or transference reactions (See Chapters 1, 6, & 17). A gradual approach to ending is usually preferable in respect of the intimate working alliance and bond created during long-term therapy. Discussing post-termination expectations allows the therapist to assess and prepare for client reactions to the end of therapy. It also allows for adjustments to goals and treatment protocols, acknowledgment of the client’s current state of functioning, and ideally, a comfortable transition to the end of the therapeutic alliance.

Therapist tasks for the end-phase of treatment include confirming the desired outcome (identified or modified from the intake phase), summarizing the progress made, identifying the number of scheduled visits prior to the last treatment session, explaining the nature of follow-up visits (if any), establishing maintenance exercises or routines identifying specific time-targeted goals for ending treatment including the date and nature of the last session, and preparing the client for the end of a professional, yet intimate, relationship. These tasks can be developed over a number of sessions depending on the length of treatment.

Ending a session

Just as the overall process of therapy has a structure, which includes an end-phase, so too does each session. Ending a session can be awkward if it is not given prior thought. Session length is determined and communicated during intake, but the actual work of preparing a client for the end of a session occurs during each and every session.

Telegraphing the ending in advance allows both client and therapist opportunities to acknowledge outstanding issues. Therapist and client preferences will shape the structure of the sessions. Some therapists will anticipate the ending of a flowing format by stating that “time is almost up” and some will structure sessions more rigidly with designated amounts of time for client expression; therapist formulation and communication of plans, concerns, and direction; and finally, session wrap-up statements.

Session endings that are abrupt and not anticipated can leave clients feeling unsettled. Worse, if therapists are not aware of session end times, an end of session emotional event
could leave insufficient time to diffuse or manage the emotional reaction before the client leaves. This problem can be avoided for the most part with the appropriate management of session endings.

**How do you know when the end of treatment is near?**

For explicitly established time-limited performance enhancement training, and short-term solution-oriented therapy, the completion of treatment is clearly indicated by the treatment plan and a specified number of sessions. Time-limited treatment establishes the ending at the beginning and precludes the problem (and possible therapeutic value) of deciding when it would be best to end treatment.

In therapies addressing psychological issues that go beyond enhancing performance, or for extended treatment, there is hardly ever a perfect recipe for ending. Murdin (2000) stated that endings are never complete, or perfect, and suggested that therapists are not always good at recognizing the right time for a client to end therapy.

The therapist's training and experience informs decisions about the overall course and nature of treatment. Psychological training in graduate schools does not always include instruction on ending treatment, and this educational lacuna is especially true for sport and performance psychology. All of us at sometime ask the obvious and important question, how does one know when clients are near the end, or completion, of treatment? The answer is not straightforward; the issues involved may not be obvious, but they are not insignificant.

Therapists usually have their own indicators of readiness to end treatment whether explicit or implicit. Practitioners construct different therapeutic tasks depending on their theoretical models and the interplay between their professional training, their experiences, and client responses to treatment and treatment endings. Often, therapists' objectives for treatment are quite different from their clients' expectations. If clients believe that the therapist's objectives for termination are unreasonable, or not in line with their own, they probably will not agree or comply with the plan. Both the therapist and the client need to work toward mutually agreed upon treatment ending objectives and goals. It is important to understand the client's perspective on treatment and what the end of treatment means so that a manageable schedule for ending therapy favorably is set in motion. Endings in therapy are as different as individual clients and therapists: no two endings are the same.

**Criteria for ending treatment**

The experienced practitioner considers a variety of factors in determining when treatment is complete; they vary with the client, the therapist, and the therapy. For both the therapist and the client to proceed with a clear picture of how the treatment progresses and ends, objective, clear, realistic, and mutually agreed upon criteria for termination should be established at the beginning of treatment (Kramer, 1990). It can be difficult to establish and adhere to strict termination criteria because of the varied issues and uncertainties that constitute the therapeutic process. Even though it seems as though these criteria can be readily established, they may not be identified easily, and the vicissitudes of treatment may prove
set criteria to be more of a hindrance than a help. Nevertheless, there are general guidelines for making decisions about when treatment should end.

During the course of treatment, experienced practitioners gauge readiness to end treatment by reference to one or more of five general criteria: the attainment of treatment goals, symptom resolution, global improvement in functioning (therapists’ judgments that the clients have improved in all or most psychological, physical, social, and behavioral domains), improved intra-psychic functioning (e.g., recognized enhancement in self-esteem, reduced internal conflict), or observable improvements in specific behaviors (e.g., improvement in eating patterns, a reduction in negative self-talk). Objective assessments of improvement in psychological parameters are not always used by practitioners.

Empirically identified client decisions about terminating treatment focus primarily on global improvement (i.e., feeling better) gauged by specific external or internal factors (Kramer, 1990) and a type of cost–benefit analysis whereby the client questions whether the additional gains from continued treatment justify the additional financial and emotional investment. Within the end-phase itself, “the single most important guideline for negotiating a successful termination is to unambiguously acknowledge the reality of the ending” (Teyber, 2000, p. 297).

**Ending the therapeutic relationship**

Given that the therapeutic relationship is established for a limited purpose, it follows that once the purpose is achieved (or abandoned), therapy ought to end. The treatment may end, but what about the relationship?

The professional engagement initiates a process involving two individuals – the therapist and the client. The intended consequence is effecting some change in the client through the instrumentality of the therapeutic process. Not only should the client be ready for personal change, the therapist must be ready to accommodate a change in the quality of the relationship (Murdin, 2000). Practitioners bear the burden of managing therapeutic relationships with a view to achieving good outcomes and salubrious endings. That task is far from easy.

**Natural and consensual endings**

A consensual ending to treatment emerges when the therapist and client agree that the work is complete. Both the client and therapist feel satisfied about the outcome. In consensual endings, the therapist acknowledges the appropriateness of the ending of therapy, reviews treatment achievements, sets a definite end date, and obtains the client’s consent. To ensure that the consent is informed, the therapist may ask probing questions to assess the client’s understanding about the ending of treatment. Short-term termination phases of about two weeks may be fitting in cases where there is consensus about ending (Teyber, 2000). Even with a consensual ending, the client may experience conflicting emotions in anticipation of ending what may have become an important relationship.

The therapist ought to affirm the client’s mixed feelings, if any, about not just ending therapy, but their relationship as well. The therapist, apart from acknowledging the client’s achievements and readiness for independent and autonomous functioning, should acknowledge the significance of their relationship to the client’s achievement, and the sense of loss that may be experienced with the formal ending of their relationship. This type of ending is the most satisfying one for both client and therapist, and there is usually a sense of accomplishment.
Truncated endings

Client-initiated endings

Unilateral client-initiated endings may not be aligned with the therapeutic targets identified in the treatment plan. The therapeutic work is incomplete, and therefore, the ending is premature. Clients may decide to end therapy for any number of reasons – some well founded and some not. Therapists may find it difficult to navigate issues surrounding client withdrawal. Assuming the client withdrawal comes as a surprise, the therapist needs to evaluate his or her own countertransference reactions to the client’s decision. Outside of extenuating circumstances that rationally explain the client’s decision to withdraw, issues of control often lie at the heart of the matter and formal negotiations of the end of treatment are not made. Suitable referrals can be made if clients announce their withdrawal, but when clients withdraw abruptly, a follow-up phone call or letter offering referral options is warranted.

Therapist-initiated endings

Endings initiated by the therapist may arise in a variety of instances represented in the following four broad categories: (a) the therapist concludes that therapeutic objectives have been reached earlier than expected, (b) the student-therapist has graduated or finished her term, (c) the therapist has become unavailable owing to some change in life circumstances, or (d) a referral to another professional is needed to address certain therapeutic issues beyond the therapist’s competence or tolerance. In all but the first instance, external circumstances lead to the truncated ending. Substantial therapeutic gains may have occurred when the decision to end was made, but the treatment may have begun to only scratch the surface of the presenting problem. Regardless, adequate provision for continuity of care/referral is indicated (see Chapter 22). If not handled sensitively, this truncated ending may adversely influence future relationship endings for the client, induce negative transference reactions, or dissuade the client from trusting a therapist again.

It is crucial that the therapist and client work through the complex issues arising from any externally imposed ending. Clients need time to work through their feelings of anger, frustration, abandonment, disappointment, betrayal, or loss associated with interrupted therapy and relationship endings. Sufficient advance notice of the termination date is necessary so that client concerns, frustrations, defenses, and transference reactions can be addressed adequately. Success in moving through a truncated ending depends on the “therapists’ ability to remain non-defensive and tolerate clients’ protests – rather than feel guilty, become defensive, and make ineffective attempts to talk clients out of their feelings” (Teyber, 2000, p. 300).

It is the therapist’s responsibility to work through the issues with the client. Negative transference or countertransference reactions are more likely to occur in truncated endings, especially when they are therapist-initiated (Kirk-Sanchez & Roach, 2001; Kramer, 1990). The potential differences in opinion between therapist and client about what constitutes readiness to end treatment necessitate an open discussion about expectations and the realities related to continuing or concluding treatment. It may not be easy for therapists to take the time to work through these issues when their own life stressors are overwhelming and, perhaps, the reason for the unilateral termination. In the case of student therapists, the limits on their availability and level of responsibility should be identified for the client at the outset of therapy and emphasized again during end-phase discussions.
Death

Death presents many challenges for the surviving client or therapist. If a client dies unexpectedly, the therapist must work through feelings of grief (e.g., sadness, guilt, anger, despair). At the same time, professional responsibilities associated with the termination of the alliance must be completed. For example, the notification of death needs to be documented in the client’s file, which is then retained for the requisite time specified by the regulatory body. If the therapist dies unexpectedly, ideally the therapist had adequate advanced arrangements in place to cover that eventuality to provide for the management of client referrals and files. If not, those duties will fall to the accreditation boards of the appropriate jurisdictions (e.g., state or national boards). The client is faced with either the transition to another therapist or an abrupt ending to the treatment altogether. The loss of the therapist presents the client with real difficulties such as grief, treatment disruption and interference of progress, possible relapse, and the inconvenience of seeking and acquiring a new therapist.

Third-party-initiated endings

With third-party payer involvement (e.g., sport governing body, insurer, employer), the potential for interrupted or curtailed service because of funding issues is heightened. National sport organizations, for example, typically have a set fee schedule or limited term for funding treatment. Therapists must be clear about their professional obligations, and ensure that clients understand the nature of such engagements and the limits of confidentiality and the scope and extent of treatment. Should treatment need to be extended beyond the approved number of sessions, and to avoid an interruption of service, the practitioner needs to contact the third party to request continued treatment well before the treatment time has elapsed. In the event of a delay or withdrawal of funding, clients need to be informed, and a course of action determined. Continued or alternative funding may be requested, treatment may be terminated, or it may be continued under different payment options. Keeping the client apprised of these issues and options is important.

Managing sensitive issues and vulnerable clients

Clients who engage in performance enhancement counseling, like all therapy clients, may bring psychological experiences or characteristics to treatment that put them at risk for tumultuous terminations. For athletes with affective (e.g., depression) or adjustment difficulties, eating disorders and associated issues, or for those facing the prospect of career-ending injuries, there may be risks of affective reactions or suicidal ideation associated with termination. Astute practitioners will recognize the importance of addressing these issues by validating client feelings and orchestrating the termination to be as smooth as possible. The gravity and nature of any potential distress requires the practitioner to address it sufficiently to avoid or buffer termination disequilibrium.

Suicidal ideation may emerge during the end-phase of therapy when clients realize that their main support will no longer be available. Individuals who fear abandonment and rejection, or who have attachment difficulties or few social supports, may be particularly vulnerable. Clients with certain personality profiles, or those who have experienced physical or emotional abuse, also may be prone to suicidal ideation. These reactions are expressions of intense helpless feelings (albeit, they may be manipulative behaviors for clients with certain personality disorders), and in the worst scenario they may be signs that
a suicide attempt is imminent (for details about the management of suicidal clients see Kramer, 1978, Chapter 12).

In general, individuals with personality disorders, or those with histories of early, intense, repeated, or prolonged psychic and physical trauma can be challenging to treat. Special attention to ending treatment with such individuals is warranted. When the security of the therapeutic relationship is in question for these clients, transference reactions may arise, such as feelings of abandonment or rejection. The reality of termination may exacerbate symptoms, undo some of the positive changes that have occurred throughout treatment, or create new concerns for the client.

For clients with histories of trauma, the anniversary of the traumatic event (and also the weeks prior to that date) is usually a vulnerable time. Termination dates, if at all possible, should not coincide with that time period. Similarly, the prospect of termination for clients with post-traumatic stress syndrome may trigger a resurgence of stress symptoms such as insomnia, nightmares, cognitive dysfunction, anxiety, or depression. This reactivation of symptoms often occurs if the client anticipates resuming activity related to, or in the vicinity of, the traumatic event.

The seasoned practitioner will recognize the link between the prospect of termination and affective distress, validate the client's feelings, provide support, and may help the client to resolve some of the issues. Overly dependent or superstitious clients may react to the imminent ending of therapy by becoming obviously dependent or attached to the therapist or the ritual of therapy. In such cases, clear end dates and a gradual progression emphasizing successful autonomous functioning are the best path.

**Professional obligations related to ending therapeutic relationships**

*Confidentiality considerations*

There is more to fulfilling the duty to maintain client confidentiality than biting one’s tongue. The practitioner’s duty to maintain client confidentiality is addressed elsewhere (see Chapter 7) and only information pertinent to ending relationships and treatment is outlined here. Apart from purely ethical considerations that are aspirations, there are normative standards imposed by the rules of professional conduct. The failure to adhere to those rules exposes the practitioner to professional discipline that may lead to reprimand or all the way to revocation of license (deregistering, revoking charter). The duty to maintain confidentiality is enduring and survives the end of treatment and even the death of the client.

One major consideration is document and records management (see Chapter 6). Attention to the duty of confidentiality weighs heavily at each step in the document and record life cycle if the inadvertent disclosure of client information is to be avoided. The practitioner may disclose client information with the client’s signed (and informed) consent. Consensual disclosure may be requested long after treatment ends, and the minimum period of document and record retention has expired. The practitioner should keep in mind that even though the rules of professional conduct permit the destruction of client documents and records after a time, the rules are not reason, in and of themselves, for their destruction. The practitioner may well do a disservice to clients by destroying their documents and records at the first opportunity.
Requests for information frequently are made on behalf of clients well beyond the minimum document retention period. A letter request may be made by the client’s lawyer in the context of a personal injury claim where the defendant alleges that the client’s mental distress had its origin in an earlier time and not from the recent road accident. Alternatively, it may be from the authority charged with preparing a presentence report where the client’s mental history has been called into question. Even though treatment has ended, responsibility for the professional relationship endures.

**Legal considerations**

The failure of the professional to exercise the requisite degree of skill, care, judgment, and diligence measured by professional standards, which results in compensable harm to the client, exposes the professional to civil liability for malpractice. The abrupt or inept termination of professional services may amount to malpractice if it results in significant mental distress for the client.

**Fiduciary obligations**

The practitioner–client relationship is recognized as imposing fiduciary obligations on the practitioner. Expressed simply, the fiduciary bears a duty of loyalty to the client that requires it to act in the best interests of the client. The fiduciary either significantly influences the client’s decision through the advice given to the client, or exercises the power of decision for the client. Because the client is reliant on the fiduciary, the law imposes on the fiduciary the duty to act in the client’s best interests. So, for example, the practitioner may be obliged, in the best interests of the client, to make a referral to another professional, even if that is to the practitioner’s financial disadvantage. To do otherwise is to put the interests of the practitioner ahead of those of the client.

Because the practitioner, in a fiduciary capacity, represents an influential force, professional boundaries must be recognized and maintained. As long as the therapist, or former therapist, is in a position to exercise an improper influence over the client, the client remains at risk of exploitation. Client vulnerability does not stop with the end of treatment.

**When a friend is not a friend: maintaining professional boundaries post-termination**

Following termination, therapists need to maintain their ethical standards especially as they relate to avoiding dual or multiple relationships with clients. Kagel and Giebelhausen (1994) suggested that a dual relationship is one where a boundary violation has, or may occur. When a therapist, or former therapist, engages the client in a different type of relationship, or assumes an additional role, so that the two are now business associates, friends, or romantic partners, professional boundaries have been crossed.

Travel, competition, social events, and the nature of team interaction may make it difficult to draw strict professional boundaries for sport psychology practitioners. The nature of some performance enhancement therapies does not usually involve intense emotional issues and attachments arising from in-depth therapeutic processing. That scenario, in itself, could lure the client (and sometimes the therapist) into thinking that after performance-enhancement treatment has terminated, they are not only practitioner and client, but friends, too.
In a different context, Rangell (1980) identified two possible errors that psychoanalysts can make when happening upon clients post-termination: (a) they may maintain an analytic attitude at unsuitable times and places, or (b) they may conduct themselves with premature and excessive displays of intimacy. Both may precipitate anxiety or difficulty for the client. In a sporting context, athletes may not want to acknowledge publicly that they have seen a therapist, so it is a good idea to be cautious with post-termination contacts and let the client take the first steps in the initial greeting.

Ethical codes vary with respect to the length of time that is required to elapse between the termination of a therapeutic relationship and the beginning of an intimate relationship between therapist/former therapist and client. Many major professional associations stipulate that sexual contact more than two years after termination of a therapeutic relationship is per se ethical. Others maintain that a sexual relationship before or after termination is never ethical. Much more remains to be said on the need to maintain professional boundaries following the termination of the therapeutic relationship, but that topic goes well beyond the scope of this chapter.

**Conclusions**

In this chapter issues related to ending treatment and therapeutic relationships have been outlined. Endings involve processes that can be complex, complete or incomplete, cause for celebration, or cause for concern. Successful endings to treatment can be rewarding for both the client and the therapist. Mismanaged endings can be disastrous.

Even though treatment and the therapeutic relationship end, the professional relationship never ends. By addressing the practical, ethical, and legal implications accompanying the conclusion of the therapeutic alliance, the therapist advances the interests of the client and attends to professional responsibilities. In doing so, case closure may not always lead to a happy ending, but the ending will be a well-managed one. See Box 8.1 for take-home messages from this chapter.

**Box 8.1**

*Take-home messages about client–practitioner relationship endings*

- Ending treatment is not the same as ending the therapeutic relationship.
- The professional relationship extends beyond the end of treatment.
- Client confidentiality does not end with treatment.
- Start the ending of treatment from the intake.
- During treatment, identify potential difficulties with ending the relationship.
- Endings evoke feelings and transference reactions for clients and therapists.
- Prepare guidelines and goals for end-phases of treatment.
- Clearly set an end-date.
- Maintain professional boundaries post-termination.
- Ending professional relationships is not always simple or easy.
- Endings entail much more than saying goodbye.
**References**


