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After you'd gone: How mental health service users are affected when their consultant leaves

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***Abstract**: Mental health professionals often move across services in the National Health Service (NHS) as a result of organizational change. However, little is known about the impact this has on people who are in receipt of psychiatric services (service users). We conducted an exploratory qualitative study into the experiences of service users under a community mental health team following a service restructure. Nine service users took part in face-to-face interviews, which were subsequently analysed following the principles of Grounded Theory. We found that service users were affected by their consultant leaving in a variety of ways, ranging from grief reactions to improved self-efficacy. We concluded that service users can be significantly affected by their consultant leaving, and this should be taken into account when planning restructures of mental health services.*

***Keywords**: users' experiences; coping and adaptation; grounded theory; health care professionals; mental health and illness*

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Introduction

Health care professionals frequently move across clinical settings for a variety of reasons, including rotation of training placements, personal/financial reasons and service restructures. The impact of clinician mobility on service users has been given some attention within physical health settings (e.g. Misra-Hebert et al, 2004), but there is little corresponding literature within mental health care settings (Fagin, 2007). This is despite the fact that mental health service users might be particularly vulnerable to experiencing detrimental effects from ruptures in the continuity of their care, including drop-out from treatment (Reneses et al, 2009). Community mental health services in the National Health Service (NHS) are largely delivered by Community Mental Health Teams (CMHTs). A CMHT is a multidisciplinary team, including doctors, nurses, occupational therapists, social workers and psychologists, who fulfil both specific and generic roles within the team (see Burns, 2004). CMHTs are frequently restructured in the UK for various policy-based and financial reasons arising from new Department of Health (DoH) initiatives. Service restructures often result in staff mobility, and the subsequent termination of therapeutic relationships between clinicians and service users. Currently, little is known about how this might affect service users, including which factors might predict a more negative or positive outcome for service users, and subsequently how such service changes are best implemented.

The issue of termination of therapeutic relationships is given most prominence within the psychodynamic literature (e.g. Gabbard, 2009). This is perhaps unsurprising given the psychodynamic emphasis on the therapeutic relationship as the primary tool for change. Termination of psychodynamic therapy has been suggested to represent a significant object loss for the client (for review see Quintana, 1993). However, allowing time to prepare the client for the end of therapy, and to work through termination issues in a productive way, is considered an important part of effective and ethical practice in most theoretical orientations (Garcia-Lawson & Lane, 1997; Quintana & Holahan, 1992). This is of course only possible when the termination of therapy is planned in advance. In contrast, when unplanned or 'forced' termination of therapy occurs, as arising from service restructures, there are often reduced opportunities for addressing and resolving termination issues (Vasquez et al, 2008). This is consistent with evidence that clients who experience forced terminations of therapy show a more intense grief reaction compared to clients who experienced a planned termination (e.g. Baum, 2005; Fortune, 1987; Fortune et al, 1992; Garcia-Lawson et al, 2000; Penn, 1990). This also mirrors what has been found from the therapists point of view, in that social worker therapists were found to view the end of therapy more positively the less abrupt the termination, and the more control the therapists had over the termination process (Baum, 2007).

As these studies show, termination of therapy has been mostly studied in the

context of a time-limited course of sessions with a specific professional. However, a consultant psychiatrist or psychologist working within a CMHT fulfils a broader therapeutic role than this, both in terms of managing and co-ordinating different aspects of care and longer-term follow-up and monitoring of service users. We could not find any published studies addressing the termination of this more complex relationship between consultant and service user. An opportunity to study the effects of forced termination of relationships between service users and their consultants in a CMHT setting arose from a service re-organization in adult mental health services in a directorate of a large metropolitan NHS Foundation Trust. Services were reconfigured to align with General Practitioner (GP) practices, leading to a reduction in the number of CMHTs in the area. In one team affected in this way, over 100 patients were discharged or transferred from the care of their regular consultant psychiatrist and/or consultant psychologist, because the consultants were moving teams. The primary objective of the study was to investigate the different ways in which service users were affected by their consultant leaving, and to find out what factors were important in determining these outcomes. We conducted the study with the aim of advancing our knowledge of how best to implement service restructures from a service user perspective, and identifying any possible areas of improvement for future service changes.

Methods

Ethical Approval

We obtained a favourable ethical opinion for the study from the local NHS Research Ethics Committee.

Qualitative methodology

We selected a Grounded Theory approach for the study as it is a well-established method of generating theory through research data (Glaser & Strauss, 1967). This makes it ideally suited to investigating topics where there is little existing research. Qualitative research methods have been used successfully in previous studies of communication and relationships within CMHTs (Donnison et al, 2009) and other health care teams (Propp et al, 2010).

Participants and sampling methods

The population of interest was defined as all patients who had been on the caseload of their consultant psychiatrist and psychologist for at least one year when the service restructure was implemented (N=104). Permission to contact patients who were still under the care of the CMHT was obtained from their new consultants, in liaison with care co-ordinators where relevant. Patients who had been discharged from services were contacted by letter or by phone with an invitation to participate.

Grounded theory involves a move from selective or purposive sampling to theoretical sampling once theories begin to emerge from the initial data (Strauss & Corbin, 1990). We used purposive sampling to select the first few service users for interview, on the basis of characteristics of interest (e.g. long-term therapeutic relationship with consultant). We then used theoretical sampling to evaluate and refine emerging theories, including the use of constant comparison to look for data both consistent and inconsistent with emerging theories. For example, the first three service users interviewed, all reporting feeling 'devastated' after their consultants left. All of them had a primary diagnosis of depression, which raised the question of whether this was connected in some way to them experiencing their consultants leaving as a loss or bereavement. We tested out this idea by interviewing 2 further service users with a diagnosis of psychosis rather than depression, who provided interesting contrasting cases. The emergent theory that a consultant leaving would only represent a loss experience for service users who had a long-term therapeutic relationship with their consultant, was also tested out by interviewing service users who had only known their consultant for less than 2 years.

In grounded theory research, data collection should continue in theory until theoretical saturation has been achieved. This point can be defined as when no new or relevant information is emerging, and when relationships between ideas and categories of responses are well established (Glaser & Strauss, 1967). Theoretical saturation is rarely achieved in practice, and might not be a realistic goal for smaller scale studies (Pidgeon & Henwood, 1997). However, after the final 9 interviews had been conducted and analysed, we were satisfied that we could develop coherent categories from the existing data and that our initial ideas and theories had been improved and expanded by the processes of theoretical sampling we had employed. The final sample of 9 participants included 5 men and 4 women, with an age range between 30 and 64 years old. Seven participants were White British, 1 was Irish and 1 was Mixed Background. Four participants were married or living with a partner, and 5 were single. None were in paid employment. Participants' diagnoses included depression, bipolar affective disorders, anxiety disorders and psychosis. Participants had been under the care of their consultant psychiatrist or psychologist for between 2 and 9 years, and 4 of them had been subsequently discharged from the CMHT.

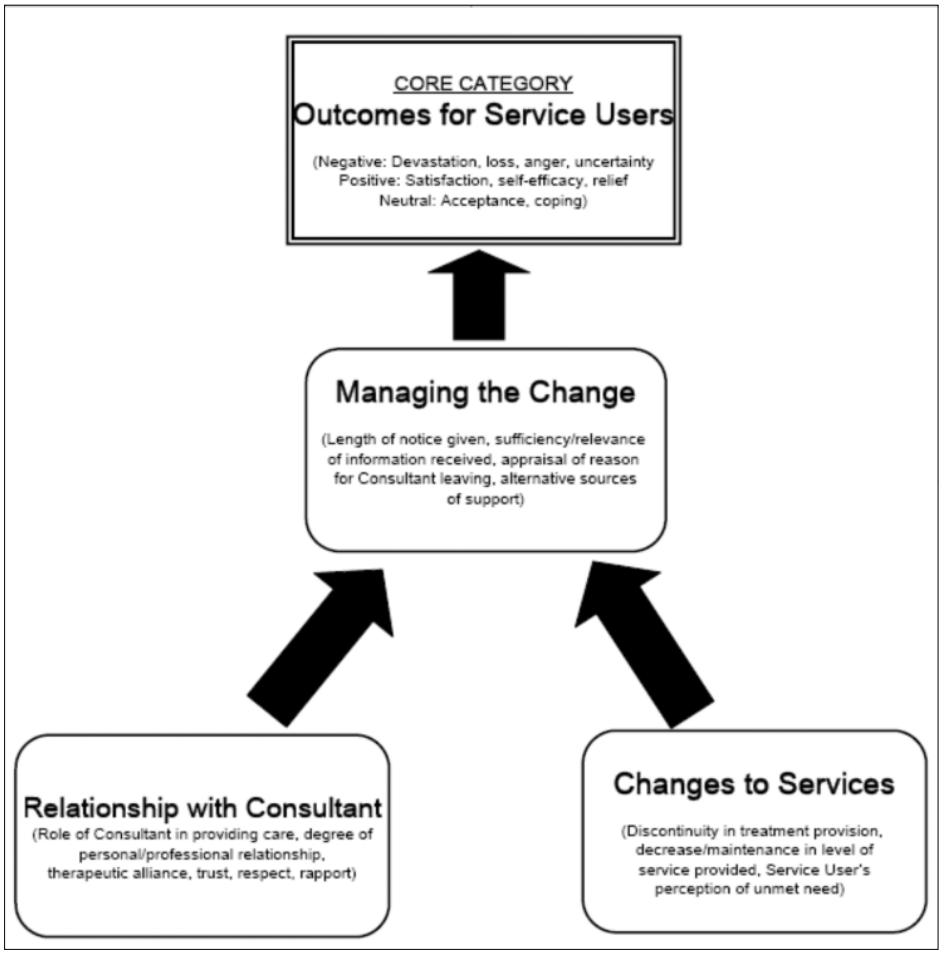
Procedure

All interviews took place in a private room on an individual basis at a location of the participants' choice (CMHT=6; Service user's home=2, University=1), and were audio-taped. We used a semi structured format, exploring key themes including how service users were affected by their consultant leaving, how their consultant prepared them for the changes and how they adjusted to discharge or transfer to a new consultant. As planned, the interview schedule evolved through the course of the research, in order to incorporate emergent themes from each interview. We added two additional themes to the interview schedule at interim stages: 1) comparison to previous experience of changing consultants, and 2) whether it made a difference if the consultant had left of their own accord or not. Interviews lasted from 30-70 minutes. We transcribed interviews verbatim for analysis.

Analysis

The analysis of the transcripts was carried out by primarily by PJ with PH verifying the preliminary findings, in order to check reliability of coding and to provide an alternative view-point on the interpretation of the findings. We coded the data according to the methods described by Strauss and Corbin (1990), including the use of open, axial and selective coding. As with qualitative analysis in general, although each kind of coding operates at an increasing level of abstraction they are not necessarily employed in a strictly linear progression. After several iterative cycles, we grouped emergent themes into broader categories of increasing abstraction, which were then linked together to construct an explanatory model of the main findings, including the identification of a core category, or central theme. Member checking was also used as part of the validation process, by inviting participants to comment on the preliminary results of the study via post or phone. Replies were received from 3 out of 9 participants, who all confirmed they felt their experiences had been well represented.

Figure 1
A model of how Service Users are Affected by Their Consultant Leaving



Results

The model of the main findings of the study is depicted in Figure 1. The properties of the core category and each sub-category are shown in brackets.

Core Category: Outcomes

Service users described a variety of outcomes after their consultant left. Negative outcomes included devastation, loss, anger and uncertainty. One service user compared

the experience as like suffering bereavement, and although she acknowledged no-one had died, there was still a need to grieve as she had suffered such a personal loss. Another service user, who was being treated for depression, identified her consultant leaving as triggering a suicidal crisis.

> *I say it is like a bereavement and I know that this is a sort of process of grieving, I'm not saying that, at least you're still alive so that's one thing to be thankful for, you know its not a death, but it was like yeah having, it was a sort of feeling of bereavement and grieving I guess.*

> *… in January um I was absolutely distraught so took a razor blade to my arms, because I was just so angry and so uptight and I just, I just thought you know 'I can't, just can't stand this'.*

In contrast, other service users reported more positive outcomes including relief and improved self-efficacy. For example, one service user reported feeling relieved after his consultant psychiatrist left because of disagreements in care planning. Being transferred to a new consultant was viewed as a chance to make a fresh start. Another service user echoed this view and said he thought changing doctors was good sometimes as it stopped one doctor getting bored by hearing the same story all the time. Both these service users were being treated for psychosis. Another service user, who had a diagnosis of bipolar affective disorder, described a feeling of greater self-efficacy and confidence in her ability to manage her own mental health needs after she was discharged.

> *You can go 'wow' you know I coped better than I thought I would and the worst didn't happen you know, got a bit down, had a little bit of a relapse but it wasn't that bad and so actually its given a lot more I think genuine confidence about things and real concrete confidence.*

Managing the Change

Key themes in this sub-category included the information service users received about their consultant leaving, the reason they attributed to their consultant leaving, important sources of support and comparisons to previous experiences of service changes.

Service users felt they had been told about their consultant leaving in adequate time, but there was a general consensus of there being no ideal time to tell. The written information provided by local services lacked credibility with some service users, as it did not match with their own perception of what the impact of the changes to the services would be, and did not provide a personalised account of how their care would be affected. For example, a service user who had been treated for anxiety and depression talked about her perceived lack of acknowledgement of the potential impact of her consultant leaving.

There was no apology, no 'I'm really sorry that this may affect your care, um, but it's unavoidable because', but there was no kind of um, well 'I'm sorry we've got to do this but this is why we've got to do it'. It was kind of, 'well this is what we're doing, and of course it won't make any difference to you, you'll still get you know, the same level of care'. Well that just wasn't true.

Service users who were dissatisfied with the outcome of the organizational changes talked about wanting and needing more information from local services. In this way, expressing dissatisfaction about the information received about the service restructure seemed to represent a wider dissatisfaction with the service changes as a whole. In contrast, service users who were more satisfied did not feel more information on the changes would have been relevant or helpful to them. One service user who was satisfied with being discharged after her consultant left, made the following remark after being asked if she would have wanted more information about the service re-organization in general.

I mean if the ethos or you know or the way that people are dealt with, that changes that's different you know if you know just for example, they felt that the service had to be more client-focused and more therapeutic or you know a different kind of service, I'd be really interested in that if they felt they needed to bring new kinds of people in, I'd be interested in that, but anything about re-shuffling no, you know, I'm not really concerned about that no.

Service users also had their own ideas about why their consultant had to leave, regardless of what 'official' story they had been provided with. Service users who reported more positive outcomes after their consultant left made more neutral and accepting appraisals of the reasons for their consultant leaving (e.g. for a 'change in scenery'). In contrast, service users who reported more negative outcomes after their consultant left made more externalising appraisals, such as consultants being forced to move by bad management decisions, as illustrated by the following quote:-

The powers that be, the bureaucracy has, they've decided what was gonna to happen, and that all the doctors were gonna be switched round and the um doctors and psychologists are just kind of caught up in the fall-out.

For service users who had felt adversely affected by their consultant leaving, the main sources of support they identified were family and their GP. Although GPs were valued for providing continuity of care, they were not seen as an adequate replacement for regular consultation with a psychiatrist or psychologist as they lacked the required expertise in mental health, and it was difficult to get an appointment to see them in the event of a mental health crisis. We noticed that even for service users with good family support, they still felt this could not replace the role played by the consultant who had left. This was because family members and friends were seen as having their own problems to deal with, and also as having difficulties in

understanding mental health problems sometimes, as described by one service user being treated for depression.

> *… it's not just a case of talking to anybody, you need to talk to somebody that knows where you're coming from, they say, you know, oh, ring up friends but there's not much use in that, they don't want to know. I mean my sister is very good and will sit and listen but I know she hasn't got a clue what I'm talking about.*

Some service users also drew unfavourable comparisons with previous experiences of changing their consultant or other mental health professional. They felt their previous experiences had been better because they had been given more time to prepare, and been handed straight over to their new consultant, without a break in service provision. In contrast, one service user compared the current hand-over to 'dropping the baton' in a relay race.

Changes to Services

All service users experienced some changes to the services they received after their consultant left. There were varying levels of satisfaction with current care. This seemed to depend on whether people felt their current mental health needs were being met, regardless of whether actual service provision had decreased or increased. Some people had been discharged, or had decreased the frequency of contact with their new consultant, and were satisfied that they were managing their own mental health needs without the need for more intensive input from services. In contrast, some service users who had been discharged or who were receiving less frequent input from their new consultant, identified unmet needs and spoke of feeling rejected by services.

> *I'm seeing some other guy here, Dr. X or something. That's only because my doctor referred me back to here, I wouldn't have seen anybody. God knows what I would have done, I was praying on seeing somebody, I need to see somebody.*

Some service users had been offered other treatment and therapies subsequent to their consultant leaving which they had found helpful, including cognitive behaviour therapy (CBT) and mindfulness based cognitive therapy (MBCT). However, some people were dissatisfied with being offered shorter, fixed-term courses of therapy which they felt were an inadequate substitute for long-term, on-going support from a mental health professional.

> *I think this business about 8 weeks, or 6 weeks, or however long its gonna be, well you can't talk to someone like that in 6 to 8 weeks but that's what the money that the NHS will allow.*

Service users identified several challenges of starting again with a new consultant or other mental health professional. These included needing time to build up trust and respect with someone before being able to disclose personal thoughts and feelings. However, some service users had successfully formed positive working relationships with their new consultants, and acknowledged some advantages in terms of having a 'fresh start'.

Relationship with Consultant

Service users defined a good relationship with their consultant as having trust and respect for each other, which takes time to develop. Emphasis was placed on feeling comfortable enough to be honest and open up during consultations. Although having a good relationship was highly valued, potential drawbacks were identified in terms of becoming too dependent on a particular consultant and leaving yourself in a vulnerable position when they left.

> *I think it was probably a mistake of mine getting close to them, dependent upon them I suppose, maybe I shouldn't have depended on them so much, then it wouldn't have hurt so bad. It was my fault maybe, I just should have treated them like seeing a doctor in an emergency, you know what I mean, hello doctor, it wasn't like that, I got myself close to them, shouldn't have done that, put them on a pedestal maybe, maybe I shouldn't have done that.*

Service users described a variety of relationships with their consultant. There was a distinction between people who described the relationship as purely professional, and those who described the relationship more like a friendship. Professional roles that were mentioned included monitoring of well-being, giving objective advice, help with practical goals such as returning to work and relapse prevention. One service user being treated for depression and chronic fatigue defined a professional relationship in the following way:

> *I fully accept that the professional relationship has to be when you're in the room you joke but once you go out the door that's it. I understand for the patients' sake you have to have no emotional attachment because you don't get the best treatment. So I understand, I totally understand that once you're outside the room, that's it.*

For these service users, because they had been focussed on what was being provided, rather than on who was doing the providing, they were less affected by their consultant leaving in a personal sense. Other professionals or new consultants were seen as being able to take over providing these same aspects of care. In contrast, some service users saw the role of their consultant more in terms of on-going emotional

support, and talked about a special relationship with their consultant that could not be easily replaced or substituted.

> *The trouble was he used to come round to the house, or I'd visit him here, like an old friend coming for a cup of tea, you know what I mean, when he went I was devastated, I still feel as if I need them, I know I've got a doctor here but its not going to be the same, its not going to be the same.*

Discussion

This was an exploratory qualitative study on how community mental health service users were affected by their consultant psychiatrist or psychologist leaving the team because of service re-organization. There were both positive and negative outcomes for service users after their consultant left the team, and some service users were affected more significantly than others. The two most important factors in determining individual outcomes were the relationship the service user had with their consultant and the wider changes occurring in service provision. These connected to a third variable of how well the service user felt changes to the team were managed.

The service users who were most significantly affected were those who described a close and personal relationship with their consultant. This resulted in feelings of loss and grief when their consultant left, and the belief that their consultant could not be easily replaced. Other service users described a more neutral, professional working relationship with their consultants. For these service users, an alternative route to negative outcomes arose from feeling set-back in their treatment progress by experiencing a break in service provision before being handed-over to a new consultant. Negative outcomes also arose from dissatisfaction with current care, and the identification of unmet mental health needs which included the need for frequent consultation with a mental health expert, rather than just their GP. Positive outcomes arose from a satisfaction with current care, in terms of meeting the service user's own perception of need. For some service users, this involved a continuation of the care that had been provided by their old consultant, whereas for others this involved less frequent consultation or discharge from the team altogether.

The ending of a therapeutic relationship has been widely characterised as a loss experience in the psychodynamic literature, particularly when it is brought about prematurely. Contrary to the assertions of the psychodynamic approach, not all service users experienced their consultant leaving as a loss experience. However, the service users in this study who did describe strong grief reactions to their consultant leaving were all being treated for depression. This is interesting as themes of loss are often salient in the thoughts and schemas of people with depression, and they might be particularly vulnerable to feelings of rejection. The cognitive model of depression

proposes that it is the appraisal of an event that is crucial in determining its impact, rather than the event itself (Beck, 1967). Therefore the ending of a therapeutic relationship with a consultant seemed to take on a variety of meanings for different service users, depending on how they appraised the event. For example, a reduction in the frequency of consultations or discharge from services altogether was viewed as a positive thing for some service users who had greater confidence in their own capabilities and resources for coping. This is consistent with the findings of Baum (2007), who concluded that 'treatment termination is better viewed as a transition than a loss', and follows the conceptualisation by Quintana (1993) of 'termination-as-transformation'.

As well as relating to one-to-one therapeutic relationships, service user's experiences should also be placed within the wider context of organizational change in the NHS. For example, the recent Improving Access to Psychological Therapies programme in the UK (IAPT; DoH, 2008) aims to increase availability of evidence-based, time-limited treatments for anxiety and depression in the NHS. There is also evidence that brief, time-limited therapy within a CMHT setting is effective in reducing psychological distress (Carter, 2005). However, we found that some service users viewed time-limited therapies as inadequate in meeting their needs and identified an on-going need to be seen in specialist mental health services.

Service users made several suggestions for how the changes to services could have been improved. These included the provision of individual letters for each service user giving personalised information on the changes, a dedicated helpline at the teambase offering information and support to affected service users, and a smooth hand-over to new consultants or therapists with no break in service provision. Following the suggestions of Vasquez et al (2008), all mental health professionals should take proactive steps to address termination issues, and should be alert to factors which are likely to make successful completion of therapy or treatment more challenging, such as a premature or unplanned termination. The results of this study also suggest several categories of reflective questions that professionals could explore when thinking about how best to support service users around termination issues. For example, it might be important to consider the general quality of the therapeutic relationship, what information about the changes the service user considers relevant and useful, and any perceived disparity between the level of care a service user requires, and the level of care they are actually receiving.

This was a small-scale study and therefore its generalisability to other situations might be limited. We also acknowledge the existence of other 'disconfirming' cases not included in the current sample. However, the aim of qualitative research is to understand the perspectives and experiences of a small group of people in detail and as such this study met that aim. The majority of the service users who took part in the current study defined their ethnicity as White British, meaning that service users from black and minority ethnic (BME) communities were under-represented in the sample compared to the service user population of the CMHT as a whole. More

feedback from BME service users who declined to participate in the study would have been helpful in identifying any particular barriers to participation.

In terms of future research, it would be interesting to explore the impact of service restructures and staff mobility in other contexts such as in-patient or residential services, and to extend the research to mental health professionals other than psychiatrists and psychologists. A better understanding of the processes involved could be used to develop ways of improving outcomes for service users affected by their consultant or therapist leaving in this way.

References

Baum, N. (2005). Correlates of clients' emotional and behavioural responses to treatment termination. *Clinical Social Work Journal, 33,* 309-326.

Baum, N. (2007). Therapists' responses to treatment termination: An inquiry into the variables that contribute to therapists' experiences. *Clinical Social Work Journal, 35*, 97-106.

Beck, A. T. (1967). *Depression: Clinical, Experimental and Theoretical Aspects*. New York: Harper and Row.

Burns, T. (2004). *Community Mental Health Teams: A Guide to Current Practices*. Oxford: Oxford University Press.

Carter, M. F. (2005). Time-limited therapy in a community mental health team setting. *Counselling & Psychotherapy Research, 5,* 43-47.

Department of Health (2008). *Improving Access to Psychological Therapies. Implementation Plan: National guidelines for regional delivery.* London: Department of Health.

Donnison, J., Thompson, A. R., & Turpin, G. (2009). A qualitative exploration of communication within the community mental health team. *International Journal of Mental Health Nursing, 18*, 310-317.

Fagin, L. (2007). On leaving. *Psychiatric Bulletin, 31,* 350-353.

Fortune, A. E. (1987). Grief only? Client and social worker reactions to termination. *Clinical Social Work Journal, 15,* 159-171.

Fortune, A. E., Pearlingi, B., & Rochelle, C. D. (1992). Reactions to termination of individual treatment. *Social Work, 37,* 171-178.

Gabbard, G. O. (2009). What is a 'good enough' termination? *Journal of the American Psychoanalytic Association, 57*, 575-594.

Garcia-Lawson, K. A. & Lane, R. C. (1997). Thoughts on termination: Practical considerations. *Psychoanalytic Psychology, 14,* 239-257.

Garcia-Lawson, K. A., Lane, R. C., & Koetting, M. G. (2000). Sudden death of the therapist: The effects on the patient. *Journal of Contemporary Psychotherapy, 30,* 85-103.

Glaser, B. & Strauss, A. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.

Misra-Hebert, A. D., Kay, R., & Stoller, J. K. (2004). A review of physician turnover: Rates,

causes, and consequences. *American Journal of Medical Quality, 19,* 56-66.

Penn, L. S. (1990). When the therapist must leave: Forced termination of psychodynamic therapy. *Professional Psychology: Research and Practice, 21,* 379-384.

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in psychological research. In N.Hayes (Ed.), *Doing Qualitative Analysis in Psychology* (pp. 245-273). Hove: Psychology Press.

Propp, K. M., Apker, J., Ford, W. S. Z., Wallace, N., Serbenski, M., & Hofmeister, N. (2010). Meeting the complex needs of the health care team: Identification of nurse-team communication practices perceived to enhance patient outcomes. *Qualitative Health Research, 20,* 15-28.

Quintana, S. M. (1993). Toward an expanded and updated conceptualization of termination - Implications for short-term individual psychotherapy. *Professional Psychology-Research and Practice, 24,* 426-432.

Quintana, S. M. & Holahan, W. (1992). Termination in short-term counseling: Comparison of successful and unsuccessful cases. *Journal of Counseling Psychology, 39*, 299-305.

Reneses, B., Munoz, E., & Lopez-Ibor, J. J. (2009). Factors predicting drop-out in community mental health centres. *World Psychiatry, 8,* 173-177.

Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. London: Sage.

Vasquez, M. J. T., Bingham, R. P., & Barnett, J. E. (2008). Psychotherapy termination: Clinical and ethical responsibilities. *Journal of Clinical Psychology, 64*, 653-665.