

## Chapter 15

# BEGINNINGS AND ENDINGS, ABSENCE AND ACCESS

You return a phone call from a middle-aged man who is looking to begin therapy. He worries that the company he works for has been struggling and may lay him off. He can't find any other openings in the area and can't stand the thought that he might not be able to support his family. You talk with him for about 10 or 15 minutes getting basic information, including his insurance, and set up an appointment 10 days later, your first opening. Four days later a public defender calls you. The company fired the man, who returned with a gun and shot his supervisor. The public defender is calling you to ask if you would send him your records and talk with her a little about your assessment of the man, who has named you as his therapist. But wait! Did one phone call mean you're the man's therapist? Did your professional responsibilities start when you talked with him, heard why he wanted therapy, asked him for basic information, and decided to schedule a session with him?

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Your client stops connecting for Zoom sessions. You don't know why. She does not return the phone messages or respond to the letter you sent her. Five weeks have passed. Does this meet the clinical, ethical, and legal standards of "termination" in your jurisdiction? What additional steps, if any, would you take?

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A fragile client has been making gradual progress in therapy when his partner dies unexpectedly and he becomes suicidal. The same week his insurance company notifies you that the client has reached the limits of coverage and the company will approve no additional sessions.

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Ethics includes thinking clearly about the boundaries of our work. Where is the boundary marking the start of therapy? What marks the end? Discussing information about the beginning and ending of therapy, as well as about availability of services during therapy, helps our client to provide consent that is truly informed (Chapter 16 provides a more detailed discussion of informed consent).

People who seek our help have a right to know when they become our client as well as when the professional relationship ends. They need to know how available we are, including when and how can they get in touch with us. This chapter discusses some of those issues of beginnings, access, absences, and endings.

## **ACCESSIBILITY FOR PEOPLE WITH DISABILITIES**

Our decisions about how accessible we make our services to people with disabilities reflect our ethical values (Pope, 2005), and they affect many people, both directly and indirectly. About 15% of the world's population—around 1 billion people—experience some form of disability (World Bank, 2020). In the United States, of the 61 million people living with disabilities, 13.7% have serious difficulty with mobility, 10.8% with cognition, 6.8% with independent living, 5.9% with hearing, and 4.6% with vision (Center for Disease Control, 2020). Of the 6.2 million Canadians aged 15 or over who are living with a disability, 37% of the disabilities were mild, 20% moderate, 21% severe, and 22% very severe (Statistics Canada, 2018a). The most common types were related to pain, flexibility, mobility, and mental health. Statistics Canada (2018b), a governmental agency, describes how our understanding of disability has changed:

The concept of disability has evolved over the past three decades, moving from a more medical model to a social one. Initial concepts focused more on physical and sensory impairments as well as the health conditions of an individual. Conversely, the social model of disability has evolved to also include cognitive and mental health-related impairments, in addition to the barriers which may prevent or limit one's full participation in society. It acknowledges that barriers posed by the environment also need to be addressed in order to give everyone an equal chance of participating more fully in society (para. 4).

The following questions are useful in finding out if your practice is accessible to people with disabilities:

- If you have a website, is it accessible to those who have a disability and use assistive technologies such as braille displays, screen readers, screen magnifiers, virtual keyboards, head-pointing-puff-activation, other switch-access systems, etc.? How difficult is it for someone who is blind to navigate your site?
- Would a client who is deaf face needless challenges reaching you?
- What barriers, if any, do people who use wheelchairs, walkers, or other walking aids encounter when they come to the building in which you do therapy and enter your office (Pope & Vasquez, 2005)?
- Would a person who is blind find it easy to navigate your building and find the right room?
- Do you have area rugs, chairs, or furniture that can pose a hazard for people with mobility difficulties?
- Do you have any policies that exclude people with disabilities from receiving services from you (e.g., bringing a service dog)?
- Would a person who uses sign language to communicate be able to receive services from you?

## CLARIFICATION

Therapists must be alert to possible complications and confusions. For example, someone new calls for an appointment. The therapist assumes that the session is an initial evaluation to discuss possible treatment directions (e.g., if therapy makes sense for the individual, or what modality of therapy under what conditions implemented by what clinician seems most promising). The caller, however, assumes that the therapist, by accepting that request for an initial appointment, is now their therapist. Another client, several months into treatment, boils over with rage at the therapist but can't give voice to the anger, bolts from the room halfway through the session, and stays out of touch for the next five weeks, completely unreachable. Is that client still a client, or has termination occurred?

Trying to prevent needless misunderstandings about the beginning and ending of therapy is part of our ethical responsibility. In addition, clarifying availability and access to services are important parts of our ethical duties. Another vital part is to make sure the client understands clearly when and under what circumstances the therapist will be available for video conferencing or in-person sessions, or for telephone or other communication, and what resources will be available for the client when the therapist is not available.

Clarification is important for at least five reasons:

1. It forces the therapist to consider carefully this client's needs for telephone, e-mail, or other access during the course of therapy. For instance, is this an impulsive, depressed client with few friends who might need contact with the therapist or some other form of support in the middle of the night to prevent suicide? Clarification enables the therapist to plan for such contingencies.
2. By leading the therapist to specify backup availability—for example, what clients can do if they are unable to reach the therapist in an emergency—enables the therapist to prepare for therapeutic needs that are difficult or impossible to anticipate. For example, a client with moderate coping resources may attend appointments regularly over the course of a year or two, never contacting the therapist between sessions. However, during a period when the therapist is seriously ill and unavailable, the client may experience multiple losses, such as the loss of a job or the death of a child. The client may become acutely suicidal and need fast access to resources. Careful planning by the therapist allows them to meet the client's needs that may emerge from unforeseen events which are virtually impossible to anticipate.
3. Clarifying access to the client about other therapeutic resources encourages the therapist to think carefully about how times of access and lack of access may affect clients and the course of treatment. For example, some clients are likely to experience overwhelming feelings of sadness, anger, or abandonment when the therapist goes on vacation. Other clients may find the clear boundaries that the therapist has established so uncomfortable and infuriating that they are constantly testing both the therapist and the boundaries. Such clients may frequently show up at the therapist's office at the wrong time for their appointment, may leave urgently cryptic messages ("Am quitting therapy; no hope; life too painful; can't go on") for the therapist without leaving a number where they can be reached, and may persistently try to discover the therapist's home or e-mail address, home or cell phone telephone numbers, ask to become the therapist's "friend" on Facebook and other social media, and scour the web for information about the therapist and the therapist's family.
4. When therapist and client work together to develop a plan for emergencies during which the therapist might not be immediately available, the process can help the patient to assess their dependence and needs for help and to assume—to the extent that they are able—realistic responsibility for self-care during crises. For example, the therapist may ask the client to locate the nearest hospital providing 24-hour services and develop ways of reaching the hospital in an emergency. As the

client assumes responsibility for this phase of crisis planning, they increase their sense of self-efficacy and self-reliance (within a realistic context), become less inclined to view therapy as a passive process (in which the therapist does all the "work"), and may feel less panicky and helpless when facing an impending crisis or the therapist's future absences. In this sense, planning becomes an empowering process for the client.

5. The process of clarification encourages the therapist to consider carefully their own needs for time off, away from the pressing responsibilities of work. Planning helps the therapist avoid burnout. The drawing of boundaries also encourages the therapist to attend explicitly to other sources of meaning, joy, fulfillment, and support so that they do not begin looking to clients to fill personal needs (see Chapter 17). This is a crucial aspect of the therapist's maintaining emotional competence (see Chapter 6).

Setting appropriate, workable, and therapeutic boundaries around availability involves balancing our own personal needs, theoretical orientation, and style of practice with each client's unique clinical needs. Some therapists maintain flexible boundaries in several areas, including time limits. Others hold to exact time boundaries. With virtually no exceptions, they begin and end the session right on the dot. Even if the client has just experienced a painful breakthrough and is in obvious distress, they do not extend the therapy session. In some situations, ending promptly is a practical necessity: The therapist may have another client scheduled to begin a session immediately. In other situations, observing strict time boundaries is required by the theoretical orientation: Running over the time boundary might be considered by the therapist to constitute a breaking of the frame of therapy or represent the therapist and client colluding in acting out.

When we arrive at an approach to time boundaries that best fits our personal needs, our approach to therapy, and the client's clinical needs, we need to make sure that the client understands our policy. Finally, it is also important for therapists to understand and consider how each person (both therapist and client) conceptualize and use time which is heavily influenced by one's culture. For instance, some clients may respond differently to how sessions are timed, when they begin, how they end. It is important to create space early on in the relationship to discuss and communicate this information.

## **THERAPIST AVAILABILITY BETWEEN SESSIONS**

When and under what conditions do we make ourselves available to clients between sessions? Some therapists receive nonemergency calls from clients whenever they are free during reasonable weekday hours. A very few

therapists take nonemergency calls when they are conducting therapy. We recommend against this practice, which seems disrespectful of the client who is in session and seems to have many potentially harmful effects on the course of therapy for the client whose session is interrupted (or is aware that any session might be interrupted at any time by nonemergency calls to the therapist).

The therapist needs to be clear about the times between sessions when they can be contacted on a nonemergency basis. For example, are weekend calls or calls on holidays such as Labor Day, Memorial Day, or Martin Luther King Jr. Day acceptable?

An extremely important point to clarify is whether the therapist will speak with the client more than briefly by telephone when there is no emergency. Some clients like to use telephone calls or e-mail communication to address unresolved issues from the previous therapy session, share a dream while it is still fresh in their mind, or talk over how to handle a situation at work. Some therapists may see such extra communications as therapeutic for some clients. The telephone sessions may, for example, help particularly fragile and needy clients, who might otherwise require day treatment or periodic hospitalizations, to function under the constraints of once- or twice-weekly outpatient therapy. They may help some clients learn how to use and generalize the adaptive skills they are acquiring in office sessions. The extra communications serve as a bridge between office therapy sessions and independent functioning by the client.

Other therapists may prefer to keep the work strictly within the frame of the therapy session. They believe that phone, e-mail, or text communications between sessions are—except under rare emergency conditions—countertherapeutic. For example, they might view extended telephone contacts between sessions as similar in nature and effect to going beyond the temporal boundary at the end of a session. Other therapists may, as part of their own self-care (see Chapter 17), limit out-of-office contacts to emergencies. Some therapists may suggest that clients journal their thoughts and feelings between sessions and bring those to the next session for possible discussion. Communication of therapeutic content via internet should be considered carefully and used only with adequate safeguards to protect confidentiality.

Again, whether the therapist uses an approach that includes or prohibits discussions with clients between regularly scheduled in-person therapy sessions matters less than that: (a) the therapist thinks through the issues carefully in terms of consistency with their theoretical orientation and personal approach; (b) the therapist considers carefully the clinical implications of the policy for the individual client; and (c) both therapist and client clearly understand the ground rules, including any charges for these “extra” sessions including phone consultations.

Although we have not completed our careful study of every therapist who has ever lived—for which we wildly under-budgeted only six weeks to conduct the interviews—our preliminary results suggest that there has yet to appear a therapist who is immortal and invulnerable. For all of us who are mortal and vulnerable, it is important to prepare for those unexpected times when we are suddenly unavailable to our clients (see Chapter 17).

### STEPS FOR MAKING HELP AVAILABLE IN A CRISIS

Once clients clearly understand how to contact the therapist between regularly scheduled appointments, therapist and clients can discuss how to prepare for times when these plans aren't enough. A client, for example, may experience an unanticipated crisis and be unable to reach the therapist promptly by telephone because the therapist's line is busy for an extended time, the therapist's smart phone mishandles the client's call, the therapist is in session with another client who is in crisis, or any number of other typical or once-in-a-lifetime delays, glitches, or human errors. For the reasons cited earlier, planning for such "unanticipated" breakdowns can enable access to prompt clinical services in time of crisis.

If the client's need for help is urgent and the therapist can't be reached, is there a colleague who is providing coverage for the therapist? Some settings, such as group practices and community mental health centers, assign clinicians to serve on-call rotations so that someone is always available in a crisis. However, many therapists, particularly those in solo independent practice, may need to create their own plans to provide ensure emergency coverage.

Deciding how to arrange for coverage for a specific client is complex. Perhaps the first question is what sort of information the covering clinician will be provided about the client. Will the covering therapist receive a complete review and periodic update of the client's clinical status, treatment plan, and therapeutic progress? Will the covering therapist have access to the client's chart? Will the covering therapist keep a separate set of notes regarding information supplied by the primary therapist? To what extent will the covering therapist need to secure independent informed consent for treatment by the client? The more foreseeable or the greater the risk is that the client will experience a serious crisis demanding prompt intervention, the more compelling the reason for the primary therapist to brief the covering therapist in a careful, thorough manner.

Once the therapist has determined what degree of coverage fits a specific client, a second question is how to introduce the possibility of, or actually implement, such coverage affecting the client's status or treatment. Some clients might feel greatly reassured to know that the therapist is taking their responsibilities seriously and is carefully thinking through possible, even if

unlikely, treatment needs. Other clients may become alarmed and feel as if the therapist is predicting that a crisis will occur. Still other clients may stall in their progress; the strict privacy and confidentiality of therapy is essential for them, and the knowledge that the therapist will be sharing the contents of sessions with the covering therapist inhibit their ability to explore certain issues or feelings. In many cases, discussion between the therapist and client of the question of whether specific coverage will be provided is useful therapeutically.

If you decide to provide specific coverage, a third question is what best serves the client's right to adequate informed consent for sharing information with the covering therapist and otherwise making arrangements for the coverage.

A fourth question addresses the selection of a clinician to provide the coverage. The primary therapist may incur legal (i.e., malpractice) liability for negligence in selecting the coverage. If, for example, the clinician providing the coverage mishandles a crisis situation or otherwise harms the client through acts or failures to act, the primary therapist may be held accountable for failure to screen and select an appropriate clinician.

However, the ethical and clinical issues are much more subtle than the legal aspects. It is important to select a clinician who is well trained to provide the type of care that the client may need. The primary therapist may be tempted to select a clinician solely on grounds of expedience. The primary therapist may know that the clinician is not a very good one and is perhaps less than scrupulous in professional attitudes and actions. Furthermore, the primary therapist may be aware that the clinician does not tend to work effectively with the general client population that the therapist treats. Nevertheless, the therapist may push such uncomfortable knowledge out of awareness because this particular clinician is handy, and it might take considerable effort to locate an appropriate and trustworthy covering therapist. As in so many other situations discussed in this book, the Golden Rule seems salient: If we were the client, or if it were our parent, spouse, or child who desperately needed help in a crisis when the primary therapist is unavailable, if the careful handling of the crisis were potentially a matter of life and death, what level of care would we believe adequate in selecting a clinician to provide the coverage? If, for example, our parent became suddenly despondent, received a totally inadequate response from the clinician providing the coverage, and committed suicide, would convenience seem sufficient rationale for the primary therapist's selection of that clinician to provide the coverage?

If no clinician has been identified to provide coverage or if the identified clinician is for some reason unavailable, to whom does the client in crisis turn when the primary therapist is unavailable? It may be useful for the client to locate a psychiatric hospital, a general hospital with psychiatric services, or

other facility providing emergency psychiatric services. There are at least five crucial questions:

1. Is the facility nearby and physically accessible in light of any client disabilities, the need to pass through areas that are dangerous, etc.?
2. Are the services available on a 24-hour basis? If the crisis occurs in the middle of the night, on a weekend, or on a holiday, will the client find help available?
3. Can the client afford to use the facility? Some facilities charge exceptionally high prices and may offer services only to those who can provide proof of ability to pay—for example, an insurance policy currently in effect.
4. Does the client know where the facility is located and its contact information? Especially during a crisis, even basic information (such as the name of a hospital) may be hard to remember. In some instances—for example, both the therapist and client believe that there is a high risk for a crisis—it may be useful for the client to write down the name of the hospital, the address, and the telephone number. Clients can program the name and contact information on their cell phone, carry the information with them, and consider having the information readily available near the telephone at home. Sometimes close friends or family play a vital role in supporting a client in times of crisis. If the circumstances are appropriate, the client may also wish to give this information to a close friend or relative.
5. Do both therapist and client have justifiable confidence that the facility provides adequate care? Substandard care may make a crisis worse. Sometimes no care from certain facilities may be better than an inappropriate response.

If the primary therapist, secondary therapist, and designated facility are all unavailable—for whatever reason—in time of crisis, is there a hotline/helpline or other 24-hour telephone service that can provide at least an immediate first-aid response to the crisis and attempt to help the client locate a currently available source of professional help? Some areas have 24-hour suicide hotlines/helplines. There may be a 24-hour crisis line providing help for individuals with certain kinds of problems. At a minimum, such a telephone service may help a client survive a crisis. For some clients (e.g., those who cannot afford a telephone or access to secure e-mail at their residence), identifying channels of communication that will be accessible in times of crisis will be an important part of the planning.

If all of the resources noted are inaccessible to the client, the client may nevertheless be able to dial 911, the operator, or a similar general call for emergency response. The client may then be guided to sources of help, or, if appropriate, an ambulance or other emergency response may be dispatched.

Whenever a therapist is assessing a client's resources for coping with a crisis that threatens to endanger or overwhelm the client, it is important to assess not only the professional resources but also the client's social resources. Individual friends and family members may play key roles in helping a client to avert or survive a crisis (although a friend or family member can also spark, magnify, complicate, or prolong a crisis). In some instances, nonprofessional groups, such as Alcoholics Anonymous, may provide access to support. The presence of such social supports gains in relative importance when the client's access to professional help is difficult. For example, some clients (especially those who cannot afford a telephone or internet service) cannot find access to a telephone, particularly if they are experiencing a crisis in the middle of the night. Online groups and social supports may be helpful for some. For many clients, the awareness of such social supports helps them to feel less isolated and thus less vulnerable to becoming overwhelmed by a crisis.

Sometimes therapy begins with the client in crisis and that the client's access to a team of clinicians or caregivers may be useful. The *American Psychologist* presented the next case study illustrating a situation in which the immediate creation of a crisis team proved helpful when a person without funds or coverage needed help:

In an instance in which a woman required daily sessions during a critical time in her life, colleagues accepted [the therapist's] request that they serve pro bono as an interdisciplinary team, offering detailed daily consultation to him and providing periodic psychological assessment and clinical interviews for the woman. Her meetings with diverse professionals let her know that many people cared about her. These colleagues mobilized to help a battered woman, a victim of multiple sexual assault, now penniless and homeless, living in her car and hiding from a stalker. She and [the therapist] began meeting daily (later gradually reduced to weekly) for crisis intervention. They agreed that the first priority was her safety. [The therapist] gave her the number of an old college friend in another state. The friend immediately wired her \$500 for food and housing and an airline ticket with an open date for use any time she felt in danger from the stalker. The friend asked her not to repay this loan directly to him but rather to give the money to someone else for whom it would make a difference as it did for her now. Within a year, the woman had taken legal action against the stalker and recovered enough to support herself (Pope, 1995, p. 242).

## ENDINGS

Therapists are ethically required to end the therapeutic relationship under certain conditions. The APA Ethics Code (APA, 2017a) Standard 10.10a clarifies responsibilities to end the therapeutic relationship when appropriate by indicating that "psychologists terminate therapy when it becomes reasonably

clear that the client no longer needs the service, is not likely to benefit, or is being harmed by continued service" (p. 15). The Canadian Psychological Association Code of Ethics (CPA, 2017a) Standard II.37 requires that psychologists "terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed" (p. 23).

In an ideal world, therapists provide continuing service as long as it is needed and beneficial. But few of us have been able to find that particular world, let alone move there. Insurance companies may refuse to approve additional sessions, despite the therapist's professional judgment that terminating services would be harmful—and perhaps fatal—for a client judged to be at risk for suicide. Insurance companies may provide only a limited number of sessions annually for clients without the diagnosis of serious mental illness. Some clients who do not meet the relevant criteria may suffer crises that cannot be safely or effectively addressed in the limited number of sessions. For some such patients, interrupting treatment, even though in accordance with the insurance company's policies and procedures, may constitute abandonment.

How do therapists and clients know when to terminate therapy? One strategy is for the therapist and client to review from time to time the presenting concerns, goals, and progress. This discussion helps clarify how much has been accomplished, as well as what still needs to be addressed, and whether the client and therapist wish to continue. Some clients are able to easily announce that they are ready to stop coming or that their employer has switched insurance and that they would like your help to choose their next therapist from their new therapist list. Others may panic at the idea of stopping without more lead time and preparation.

The issue becomes more complex if the therapist believes therapy is going well, but the client either is either wavering about continuing or wants to stop but finds it hard to say so. Sometimes these clients just stop coming. They say they'll call to schedule the next appointment or else cancel a scheduled appointment, but in either case you don't hear from them again. In addition, many people use therapy in short installments and drop out for a while, later returning to the same clinician or starting with a new therapist. When clients who seemed successfully engaged in therapy stop coming, a note or call to provide them with options can be helpful and provide useful information. Examples of options may include scheduling a review and termination session, or returning to therapy.

When approaching termination, therapists bear an ethical responsibility to address questions that tend to arise around termination. The American Psychological Association's Ethical Principles and Code of Conduct (2017a) Standard 10.10c states the responsibilities of a therapist to engage in a

termination process: "Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pre-termination counseling and suggest alternative service providers as appropriate" (p. 15).

The Ethics Code notes that we have the right to terminate therapy when we are threatened by the client or patient or another person with whom the client or patient has a relationship (Standard 10.10b). This is an attempt to balance the importance of therapist self-care with the responsibilities to the client. It is probably not appropriate to terminate when a client is in crisis.

Vasquez et al. (2008, pp. 661–662) provide 12 recommendations to help make sure that termination goes as well as possible and meets the highest ethical and clinical standards:

1. Provide patients with a complete description of the therapeutic process, including termination; obtain informed consent for this process at the beginning of treatment, and provide reminders throughout treatment.
2. Ensure that the therapist and client collaboratively agree on the goals for therapy and the ending of therapy.
3. Provide periodic progress updates that include discussions of termination and, toward the end of therapy, provide pre-termination counseling.
4. Offer a contract that provides patients with a plan in case the therapist is suddenly unavailable (including death, or financial, employment, or insurance complications).
5. Help clients develop health and referral plans for post-termination life.
6. Make sure you understand termination, abandonment, and their potential effects on patients.
7. Consider developing (and updating) your professional will to proactively address unexpected termination and abandonment, including the name(s) of colleagues who will contact current patients in the case of your sudden disability or death.
8. Contact clients who prematurely terminate via telephone or letters to express your concern and offer to assist them.
9. Use the APA Ethics Code ... your state practice regulations, and consultation with knowledgeable colleagues to help guide your understanding and behavior in regard to therapy termination.
10. Review other ethics codes for discussions of abandonment. The American Counseling Association ... and the American Mental Health Counselors Association ... contain prohibitions against abandonment.
11. Make the topic of termination a part of your regular continuing education or professional development.
12. Be vigilant in monitoring your clinical effectiveness and personal distress. ... Therapists who self-monitor and practice effective self-care are less likely to have inappropriate terminations or clients who feel abandoned.

## CONCLUSION

Constant ethical awareness—particularly a careful, imaginative awareness—and a sense of personal responsibility play a fundamental role in making sure that clients have adequate access to the help they need, particularly in times of crisis when the therapist can't be reached. In hospital and similar settings, the *apparent* (though unfortunately not always actual) abundance of staff may lead to a diffusion of responsibility in which no one is available to help a patient in crisis. Levenson and Pope (1981), for example, present a case study in which a psychology intern was assigned responsibility to promptly contact a suicidal individual who had been referred to the outpatient unit by the crisis service and arrange for conducting an intake assessment. The intern, however, was absent from the staff meeting at which the assignment was made. His supervisor, also absent from the meeting, had sent him to attend a two-day training session at another institution. During the next few days, the individual committed suicide.

The hospital's thanatology committee concluded that the crisis service had handled the situation appropriately in referring to the outpatient unit. The outpatient unit itself was not involved in the postmortem investigation because, according to the hospital's procedures, outpatient cases are not opened until the potential patient is contacted by the outpatient unit for an intake screening. The intern himself struggled with his reactions to these events. Among his conclusions was that he had "at some level internalized the organizational view that no one is really responsible" (p. 485).

Imagination is useful in creating an awareness of the types of crises a client might experience and what difficulties they might experience in trying to gain timely access to needed resources. The scenarios for discussion presented at the end of this chapter provide examples.

Thinking things through in advance on a worst-possible-case basis can help the therapist to anticipate the devious ways in which Murphy's law pays surprise visits in our work. If we look back from that imaginative perspective, we can ask ourselves: If any of the worst-possible-case outcomes had happened, what, if anything, do we wish we would have done to prevent them, lessen their impact, or prepare for addressing these events?

No therapist is infallible. The most careful and confident assessment of a client's potential for crisis can go wrong for all sorts of reasons. But we need to take into account our own weaknesses, blind spots, biases, and other fallibilities so that we can plan better for the unexpected, especially the worst-possible-case scenarios.

Similarly, imaginative approaches can create accessibility to needed resources. For example, a therapist was treating an extremely isolated, anxious,

and troubled young woman pro bono because of the client's lack of money. From time to time, the client became overwhelmed by anxiety and was acutely suicidal. However, she had no practical access to hospitalization because of her financial status and the absence in the community of sufficient beds for those who lacked adequate funds or insurance coverage. In similar cases, the therapist had encouraged clients to make arrangements to have a trusted friend come by to stay with them during periods of extreme dysfunction and suicidal risk. However, this client was so socially isolated that she had no friends, and the therapist was unable to locate an individual—from local church and synagogue groups or from hospital volunteer organizations—who could stay with her in times of crisis.

Determined to come up with some arrangement that would help ensure the client's safety and welfare, should she experience a crisis and the therapist be unavailable, the therapist and client finally hit on the possibility of her going to the local hospital's waiting room (the waiting room adjacent to the emergency room was open around the clock). The therapist contacted hospital personnel to make sure that they would not object to the client showing up at odd hours to sit for long periods of time in the waiting room.

The arrangement worked well during the remaining course of therapy. According to the client, simply knowing that there was someplace for her to go helped her to avoid becoming completely overwhelmed by external events or by her own feelings. On those occasions when she did feel that she was in crisis and at risk for taking her own life, she found that going to the hospital waiting room seemed helpful; it made her feel more active and aware that she was doing something for herself. Being out of her small, depressing, and claustrophobic apartment, sitting in a "clean, well-lighted place," and being around other people (who, because they were strangers, would be unlikely to make, in her words, "demands" on her) were all factors that helped her feel better. Knowing that there were health-care professionals nearby (even though she had no contact with them) who could intervene should her impulses to take her own life become too much for her, and aware that she was carrying out a "treatment plan" that she and her therapist had developed together, helped her to feel calmer, less isolated, and comforted in crisis.

The waiting room strategy enabled this client, who was highly suicidal, to be treated safely, although hospitalization was not feasible, during the initial period of therapy when outpatient treatment alone seemed, in the judgment of both the therapist and an independent consultant, inadequate and when the client could not afford additional resources. It made imaginative use of resources that were readily available in the community and were accessible to the client.

Understanding the degree to which individual clinicians and mental health organizations will be accessible and will make help available is a crucial aspect of the client's informed consent, the focus of the next chapter.

## SCENARIOS FOR DISCUSSION

Chapters 15 through 27 in this book end with scenarios, each accompanied with a set of questions for discussion. This approach had been used in *Sexual Feelings in Therapy: Explorations for Therapists and Therapists-in-Training* (Pope et al., 1993). Although we have created original vignettes for the other chapters in this book, the following scenarios and questions are adapted from *Sexual Feelings in Therapy and What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients* (Pope et al., 2006).

You notice that it is exactly 2:00 P.M., the time you are scheduled to meet a new client, and your waiting room is still empty. The telephone rings. It is your new client. She asks if you would mind coming out to the front steps. You're puzzled but say "I'll be right there." When you go to the front steps, you see your new client in her wheelchair at the bottom of the steps.

- How do you feel?
- What thoughts go through your mind?
- What do you think is the first thing you would say?
- What would you like to do?
- What do you think you would do?

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You are late getting to the airport, in danger of missing your plane (during a holiday season, so it would be very hard to get booked on a later flight), when you receive an emergency call from a local hospital. One of your therapy patients has tried to commit suicide and has been hospitalized. The client is desperate to talk with you in person—refusing to talk over the telephone—immediately about having just discovered a horrifying secret. You have no idea what the "secret" is.

- How do you feel?
- Are there any feelings about the patient, the emergency room staff person who called you, or the situation that are particularly difficult to acknowledge?
- What are your immediate options?
- What do you think you would do?
- To what extent, if at all, do any concerns about a malpractice suit influence your judgment?

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A new client begins the first session by saying "I need therapy because I lost my job, and my partner, whom I lived with for three years, left me for someone else. I don't know whether to kill myself, kill my boss, kill everyone else, or just try to hang on since now I'm all my little baby has left."

- How do you feel?
- Assuming that you cannot rule out that the person's threats are serious, what steps do you take in clarifying access to you and others before the client leaves this first appointment?
- What concerns, if any, do you have about this person's adequate access to prompt and adequate help?
- Is there anything you wish you would have told the person about your availability or anything else before the person made these statements?

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You work for a large Employee Assistance Program providing individual and family therapy full time. You meet with your manager late Friday afternoon and are told that the company has been taken over by a new owner, who is merging several companies. There are now too many therapists, and it is with the greatest regret that your manager tells you that reorganization has led to your no longer being retained by the company. This is your last day. Your clients are being reassigned. You will be allowed to return to your office only with a security guard, you will be able to stay only 30 minutes to clean out your desk, and you will not be allowed to copy any telephone numbers or other information or to take any charts with you.

- How do you feel?
- What are your options?
- What steps do you think you would take?
- Would you make any effort to contact the clients you had been seeing? If so, how and what would you tell them?

■ ■ ■

A former client, whom you had seen in therapy for three years, called in crisis. She said that she had started therapy with someone else, given a change of jobs and a new insurance plan. You were not listed on the new insurance provider list. However, she cannot reach that new therapist during her crisis. Besides, she feels more comfortable with you.

*(continued)*

*(continued)*

- What do you feel?
- Do you have any legal or ethical obligations to this former client, and, if so, what are they?
- If you agree to talk with this client on the telephone for a while or meet with her for one or more crisis sessions, what legal, ethical, or clinical responsibilities, if any, do you have in regard to coordinating your work with her current managed care therapist?
- Do you chart this telephone call?
- Do you have a clear policy regarding contacts with former clients? If so, are clients made aware of this policy prior to termination?