A Primer for Psychotherapists

ENDING THE THERAPY

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We must admit that it is exceedingly difficult to set up general criteria which decide when therapy should terminate. Absence of symptoms, freedom from work, social, or sexual inhibitions, and the giving and receiving of love with a loved partner are all theoretical goals whose achievement indicates that therapy can end. Few, if any, patients reach this ideal. In practice, the therapist attempts only to accomplish a limited aim which differs from patient to patient. It may be the relief of a compulsion, or it may be a better marital adjustment with the compulsion remaining. For each individual patient the therapist has a particular goal in mind commensurate with the intensity of the patient's presenting problem and his psychological resources in allying with the therapeutic effort to overcome it.

Sometimes in the middle of therapy the therapist can more precisely assess whether the anticipated goal (known only to him, of course) can be reached. These predictions cannot compare in accuracy with those of an astronomer, but they easily rival most of the weatherman's. Whether the therapeutic goal is reached or not, ending situations can be divided into two groups: (a) those in which the patient himself wishes to stop or must because of external circumstances; and (b) those in which, cured or not, the patient wishes to continue therapy.

At times the patient must conclude therapy because he is moving to another city or his job makes it impossible for him to keep regular appointments. No special maneuvers are necessary in bringing treatment to a close. The last few interviews are handled like those of the middle stages, with the exception that topics requiring extensive interpretations and the working-through of further interviews are not entered into.

Since symptoms or unpleasant life situations brought on by the patient's personality are the propelling fuels of therapy, with their amelioration or removal the patient often expresses a desire to stop coming. This may represent a realistic decision, or it may be the expression of strong resistances against further uncovering. In either case, the pros and cons of the patient's desire are discussed like any other decision. A realistic decision is naturally agreed with. But it is important for the therapist to understand that, even when the patient's motive is a defensive one, if the desire to end survives after discussion, it should not be subjected to an altering interpretive force.

In psychotherapy the therapist should neither induce the patient to undertake treatment nor talk him into continuing it. If the patient is convinced that he wishes to stop, the therapist can only concur and not tamper with the defense. Should the patient have doubts, they can be the subject of further interviews until he decides for himself. The patient made the decision in the following example:

Following the loss of her fiancé in an auto accident two years previous to coming to therapy, a woman became depressed, with the typical symptoms of withdrawal, loss of interest, fatigue, etc. After some twenty hours of psychotherapy she began to improve, going to parties and dances and seeing old boy friends. The lift in her mood, however, was not the result of insight into the mechanisms of her depression. Therapy had been mainly supportive, since it soon became evident that strong defenses were operating against the therapeutic process. The specific elements involved in the transference improvement could not be clearly elucidated.

At the present interview the patient expresses her desire to end therapy.

> **Pt.**: I feel so much better these days I think I'm about over it. I really don't see any reason why I should come back, do you?
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> **Ther.**: No. If you're feeling better and seem to have recovered, there's no need for us to continue. Why don't we meet one more time, and if everything continues well for you then, we can stop.

The therapist does not put pressure on her but agrees with the resistance. Though he may suspect the patient is leaving to avoid approaching her transference feelings, no mention is made of it.

As long as the patient has shown improvement for whatever covering or uncovering reasons, and wishes to stop, ending therapy is in order. It is by no means necessary that the patient or even the therapist have a complete understanding of the dynamics of the neurosis or of the improvement. Such a goal of academic perfection would make psychotherapy interminable.

Ending when the patient, improved or not, wishes to continue is at times more difficult. Certain patients, even when freed of their presenting problem, like to go on in therapy for a variety of reasons: to bask in the noncritical atmosphere of the interview, to have a pleasant conversation with a loved or admired figure, etc. But if the therapist sincerely feels that as much has been therapeutically accomplished as is possible and the patient gives no indication of wishing to stop, then it is up to him to

suggest termination. Such a decision on the part of the therapist must be tempered with the understanding that neurotic processes are not easily or quickly changed. A patient suitable for uncovering therapy should be given a prolonged opportunity, perhaps two or three years, to work toward improvement.

Suggesting an ending when the patient wants to continue requires tact and firm sincerity. Knowing that the patient will, in some part, take the move as a personal rejection, the therapist proceeds slowly and in small stages. With extremely sensitive patients the topic can be introduced weeks or months before the actual ending to allow them to become acclimated to the idea. One method of doing this is shown in the following example:

After eight months of therapy, a housewife has been free of anxiety attacks for almost two months. She shows no interest in discontinuing therapy. The therapist feels that the goal he had in mind at the beginning has been reached and little more can be accomplished. He approaches the subject of terminating.

Ther.: Now, I think we should give some thought to the idea of ending treatment. You seem to be getting along well these days.

Pt.: But do you think I'll continue that way if I stop now?

Ther.: I see no reason why not.

Pt.: Well, I'm not sure I'd like to stop right now.

Ther.: We don't have to stop immediately. Let's just keep it in mind. Another thing we might consider is that you come once a week for a while and see how it goes.

Pt. : That would be all right with me.

The therapist indicates his feeling that therapy should end but allows the patient to break off gradually by diminishing the frequency of the continued interviews.

The patient may have some anxiety or dissatisfaction from losing a supporting relationship on which he has become dependent. These advents are discussed, interpreted, and worked through like any other material in therapy.

When the patient is only slightly improved or is unimproved after prolonged therapy but wishes to continue, again the therapist has the frequently awkward task of bringing about an ending. When the therapist recognizes that little more can be done, he can begin to help the patient accept the situation without imparting the feeling that all is hopeless. For example:

1. After almost two years of twice-a-week psychotherapy which at first seemed to offer a good prognosis for the patient, a woman with a hysterical character, the therapist realizes that her personality structure is irreversible. Supportive and uncovering efforts to modify her infantile impulsiveness and crisis-producing theatrical behavior have failed. In spite of this the patient wants to go on. The therapist honestly states his views.

> **Ther.**: I really feel that we have done about as much as we can. Some of these things are just too deep-seated and complex to work out.
>
> **Pt.** (*distressed*): But what am I going to do about them if this treatment doesn't work?
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> **Ther.**: It isn't as bad as all that. I think you can work on some of the things you've learned about yourself here. If you put some of it to use, I'm sure it will help you.
>
> **Pt.**: Is this our last interview?
>
> **Ther.**: Oh, no. Let's talk a few more times and tentatively plan to end at the end of this month. Maybe we can work a little more on your relationship to Sam.

2. In the first interviews and beginning stages of therapy, a middle-aged man only moderately troubled by a compulsive neurosis made good progress. However, as time went by the therapist began to feel that beneath the neurotic defenses lay a schizophrenia. The patient, for no clearly explicable reasons, became more and more upset by the interviews despite a reduction in their frequency and a change in the therapeutic technique, (cf. Chapter 9.) Hence the therapist decides that even though the patient is interested in continuing, therapy is too disruptive and should be concluded, to allow previous natural compensatory mechanisms to reinstitute an equilibrium as they had spontaneously done in the past.

> **Ther.**: If it's all right with you, I think we should interrupt our work for the time being. These spells of hysteria and crying after the interviews indicate that this treatment is too upsetting for you. At this time it's doing you more harm than good.
>
> **Pt.**: You feel I'm not responding the way I should?

The patient takes the suggestion as an implied accusation that he is not cooperating.

> **Ther.**: Not at all. Don't feel that I'm dissatisfied with our results so far. I think we've made some progress. Perhaps we have been going too fast and you haven't had a chance to assimilate some of the things you've learned. At any rate I suggest we discontinue for a few months. Let me see you off and on during that time and maybe later we can consider regular interviews again.

The patient will be followed, of course, but plans for future therapy will be influenced by the principle that often it is best to leave well enough alone.

Many patients expect that something different or special will take place in the last few interviews. Some expect a summary of their problems and therapy, others anticipate that finally, as they have hoped all along, a wise authority will advise them what to do. If these expectations are evident, the therapist may interpret them, using the methods of the middle stages. Usually in the final interview the therapist makes some kind of statement that his door is open, that he will be glad to help in the future if he can.

Psychotherapists who rotate through a clinic have the problem of ending treatment when the time comes for them to leave the service. It need not be as much of a problem as it sometimes is if the patient is informed of this eventuality in the very beginning of therapy. Beginning therapists, because of their own anxieties about the patient's reactions, are often loath to do this and then find themselves and their patients in a mess when the news is suddenly broken a week or two before ending. If it is felt that the patient can profit from further work and he wishes to go on, then another therapist should take over. Neither the patient nor the therapist should believe that there is only one person in the world fit to do the job.

There are no rules about how long psychotherapy should last. Each case is unique. Cures or improvements may require a few months to several years. Patients with schizophrenias may be in treatment for many years to a lifetime. Finding briefer methods of doing the work is a problem for organized research. The beginning clinician must content himself with managing as correctly as possible the techniques thus far known to be effective.