THE TECHNIQUE OF PSYCHOTHERAPY

GOALS IN TERMINATING TREATMENT

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Table of Contents

Goals in Terminating Treatment

SUCCESS JUDGMENTS

TOWARD A PRACTICAL GOAL IN THERAPY

Goals in Terminating Treatment

Theoretically, psychotherapy is never ending, since emotional growth can go on as long as one lives. Consequently, it is necessary to employ some sort of yardstick in order to determine when to discontinue treatment.

The problem of goals in psychotherapy is one about which there are differences of opinion. On the one hand, there are those who believe that a definition of goals is vital in any psychotherapeutic program. On the other hand, there are many professionals who consider goals to be an extremely arbitrary matter—a manifestation of the authoritarianism of the therapist who seeks to impose on the patient artificial values and standards. "Goallessness" has been mentioned as the procedural stance essential to technical analytic work (Wallerstein, 1965). Nevertheless, therapists of different orientations aim at outcome targets that reflect their special conceptions of dynamics.

Psychological processes may be conceived of in many ways including:

1. As energy exchanges within various divisions of the psychic apparatus (the Freudian hypothesis).

2. As interpersonal events mediated by characterologic distortions (the neo-Freudian hypothesis).

3. As forms of faulty learning and conditioning (the Pavlovian hypothesis).

Goals in psychotherapy are fashioned by theoretical conceptions of personality. Thus, in Freudian theory the goal in therapy is genital maturity in which fixations of libido on pregenital levels that foster regression have been resolved. In neo-Freudian theory the objective is self-actualization that frees the individual in interpersonal relationships, enhances self-image, and expands creativity and productiveness. In conditioning theory it is the extinction of destructive old patterns and the learning-through-reinforcement of new and adaptive ones.

Irrespective of how one feels about the uses made of them, goals are understandably of concern to

the psychotherapist, for success or failure in the treatment effort can be gauged only in the context of set objectives. Before describing goals, however, we must admit that judgments of "success" in psychotherapy are really a matter of definition and may be viewed differently from the standpoints of the patient, society, and the therapist.

SUCCESS JUDGMENTS

From the Standpoint of the Patient

There is a story about a man who confided to a friend that he had just successfully completed an extensive course of psychotherapy. "Why did you need psychotherapy?" asked the friend. "Because," revealed the man, "I thought I was a dog." "Was the treatment successful?" queried the friend. "Decidedly," replied the man, "feel my nose."

Estimates by the patient as to what has been accomplished in therapy are in themselves not a reliable index of therapeutic success. Most patients regard symptomatic relief as the best measurement of positive gain. This index, however, is not a completely valid one in assaying the effectiveness of treatment.

Symptomatic improvement may be achieved in several ways. First, it may be associated with the giving up of vital aspects of personality functioning. For example, where anxiety and guilt are aroused by sexual impulses, the abandonment of all forms of sexual expression may relieve symptoms. Or where close interpersonal relations are conceived of as dangerous, the patient may, in the course of therapy, detach from people, the bargain that the patient makes with anxiety here cannot be regarded as successful therapy, even though suffering is relieved. Second, the patient may, during treatment, propitiate certain neurotic drives, gaining thereby a spurious kind of security. Thus, one may make oneself dependent on the therapist, acquiring a regressive fulfillment of security needs. Symptoms will abate as long as one conceives of the therapist as a bountiful, loving, and protecting parent. This happy situation may, nevertheless, be placed in jeopardy whenever the therapist fails to live up to the patient's expectations. Under these circumstances we cannot consider the surcease of symptoms a sign of cure. Third symptom relief may be produced by the repression of damaging conflicts. Many annoying but

relatively innocuous symptoms may be blotted out of awareness in the course of supportive therapy, only to be replaced by substitutive symptoms of a more serious nature. Thus, the symptom of anxiety may be relieved during therapy by repressive techniques of one sort or another. Anxiety equivalents may, however, appear in the form of psychosomatic complaints. Damage to viscera may later eventuate, of which the patient is not conscious until an irreversible somatic ailment develops, perhaps years after the presumed "success" in therapy had occurred.

The patient's estimates of failure in therapy must also not be accepted at their face value, since concepts of failure are based on a false premise. Thus, one may consider treatment unsuccessful where hoped for ideal traits have not been achieved. For example, one patient may have secret notions of being a genius, that are now latent but that will be released through therapy. Another patient may regard therapy as unsuccessful unless one has developed complete equanimity and the ability to remain tranquil, to endure tension, and to vanquish discomfort, even in the face of the most devastating environmental conditions. The failure to develop these and other traits, which are, in the patient's mind, considered indices of health, security, and self-esteem, may cast a shadow on even estimable therapeutic results.

From the Standpoint of Society

Judgments as to success in therapy from the standpoint of social standards must also be held suspect. The patient's family, mate, or friends may have ideas about the kind of individual that they want the patient to become that may not correspond with standards of mental health. For instance, parents may expect and even demand that the therapist mold the patient into a creature who is cooperative and pleasant at all times and who never challenges parental authority. A mate may insist that the patient develop a personality that tolerates his or her own shortcomings and never gives vent to resentment. Friends may have stringent standards of character that might apply to themselves but not necessarily to the patient.

The culture or subculture may also impose arbitrary norms that differ from those of the patient or of the therapist. Political and economic forces in one group may make for a value system that is not accepted by, or acceptable to, another group. Thus, a "normal" individual in a totalitarian framework would be

expected to submit willingly to the yoke of dictatorship and to subordinate personal freedom for the welfare of the state. In another cultural framework the individual's personal rights and the ability to make one's own choices would be paramount; one would not be expected to yield completely to authoritative demands. It is accordingly, important not to regard as goals of normality traits and drives that, though culturally condoned, may prove to be at variance with mental health.

From the Standpoint of the Therapist

The therapist may fashion therapeutic goals around certain set standards and values. These may relate to personal concepts of normality or to a general ideal of mental health.

One may, reflecting cultural concepts, pronounce certain traits as normal believing that the patient must acquire these before being considered emotionally balanced. Another therapist may personally operate under a cherished set of attitudes that constitute for one the highest goal. Thus, if a value is put on ambitiousness, perfectionism, detachment, dependency, narcissism, or power devices, one is apt to consider these real assets toward which one must aim the therapeutic sights. A word of caution must especially be voiced in regard to that group of attitudes collectively embraced under the term of compliance. A reasonable compliance to authority is a necessary thing, but compliance is too often utilized by neurotic persons as a form of security. This is most often the case in those cultures in which the child is considered a relative nonentity who is expected to submit without question and to yield without complaint to the dictates and commands of the stronger, more authoritative individuals with whom the child lives. Where therapists themselves have been reared in an atmosphere that makes compliance tantamount with good breeding, they may expect the patient to adopt a submissive attitude. The patient may sense this trend in the therapist and try hard to please, even at the price of crushing self-strivings and needs for independent thought and action. Therapists may also, because of their own character structure, consider any aggression a sign of recalcitrance and ill will. They must be careful not to try to pattern their patients after their own image, for they, themselves, may be the victims of values that are basically faulty.

From the Standpoint of Mental Health Objectives

"Ideal" objectives of mental health are many. They require that the person be capable of deriving pleasure from creature comforts in life—from food, rest, relaxation, sex, work, and play. The individual is capable of satisfying these impulses in conformity with the mores of the group. Mobilizing whatever intellectual and experiential resources are required, one is able to plan creatively and realistically and to execute one's plans in accordance with existent opportunities. This involves an appraisal of one's aptitudes and limitations, and a scaling down of one's ambitions to the level of one's true potentialities. It includes the laying down of realistic life goals, an acceptance of one's abilities and a tolerance of one's shortcomings. Presupposed is a harmonious balance between personal and group standards, and those cultural and individual ideals that contribute both to the welfare of the self and of the group. The individual must be able to function effectively as part of the group, to give and to receive love, and otherwise to relate oneself congenially to other humans. One must be capable of engaging in human relations without indulging neurotic character strivings of detachment, needs to dominate or to be enslaved, or desires to render oneself invincible or perfect. One must be able to assume a subordinate relationship to authority without succumbing to fear or rage and yet, in certain situations, be capable of assuming leadership without designs of control or power. One must be able to withstand a certain amount of disappointment, deprivation, and frustration without undue tension or anxiety when these are considered to be reasonable, shared, or necessary to the group welfare or when the consequences of impulse indulgence entail more than their worth in compensatory pain. One's capacities for adjustment must be sufficiently plastic to adapt to the exigencies of life without taking refuge in childish forms of defense or in fantasy. To achieve a healthy self-regard an individual must have a good measure of self-respect, the capacity to be comfortable within oneself, a willingness to face the past and to isolate from the present anxieties relating to childhood experiences. The individual must possess self-confidence, assertiveness, a sense of freedom, spontaneity, and self-tolerance.

Unfortunately, limitations are imposed by a variety of factors on the achievement through therapy of such ideal goals. Chief among these are obstacles within the patient, such as lack of incentives for change, diminished ego strength, and practical considerations of insufficient time and money. Additionally, society itself imposes insuperable embargoes on certain aspects of functioning. It supports many neurotic values that necessitate the maintenance of sundry defenses for survival reasons. A

personality structure that is ideally integrated might actually serve as a source of conflict where the individual has to operate in the framework of a severely neurotic culture.

TOWARD A PRACTICAL GOAL IN THERAPY

Modem philosophers contend that achievement of enduring happiness, while worthy of pursuit, is undoubtedly a dream. Total adaptation must be measured against the backdrop of humanity's continuing involvement with violence, exploitation, and devastation of the earth's resources. These and other inescapable calamities are bound to disturb our equilibrium. Achievement of the most ambitious goal in therapy—reconstruction of the personality structure—would theoretically be most helpful in adapting to society's ills while sponsoring constructive efforts to rectify them. However, goals in therapy are more or less patient regulated. No matter how well trained and skilled the therapist may be, nor how extensive the desire to reconstruct the patient's personality, the latter is always in a position to veto the therapist's intentions. The patient is in a position strategically to thwart the ideal goal of personality maturation—the most difficult of all objectives. Irrespective of how thoroughly conversant we, the therapists, may be with the technique of reconstructive psychotherapy, our efforts may prove unsuccessful.

Even where conditions are most favorable, reconstructive efforts may fail. The patient may be able to afford extensive psychotherapy and to make the necessary time arrangements; he or she may desire to achieve deep change, yet may gain little or no benefit from therapy. This fact has confounded many therapists as well as their patients who are wont, as a result, to regard reconstructive psychotherapy as ineffectual.

When we investigate failures in reconstructive therapy in patients who are adequately motivated, we find a number of operative factors. The patient may have sustained such personality damage during the formative years of life that the chances for complete growth are remote. The secondary gain factors may be so powerful as to make health a handicap rather than an asset. Environmental conditions may be irremediably destructive, and the patient may need some neurotic defenses in order to survive them. Disintegrative forces within the personality may be so strong as to threaten to break loose with the employment of uncovering procedures. Finally, neurotic symptoms or character distortions may constitute the only means of adjusting the patient to conflicts, even though one possesses insight into

their nature.

There are some patients who can make an adaptation solely by employing such neurotic facades. While partially debilitating, they help prevent regression and the upsurge of disintegrative tendencies. Thus, a psychosomatic ailment may serve to drain off hostile and masochistic impulses which, deprived of a somatic expression, may shatter the ego and produce a psychosis.

While the ideal goal of absolute resolution of blocks in personality maturation, with achievement of complete functioning in all areas of living, is a cherished aim in every patient, in practice very few people if any can reach this objective. Lorand (1946) recognized this when he said that in doing psychoanalysis it is sometimes essential to satisfy oneself with "practical" though superficial results that permit the patient to get along more satisfactorily than before therapy. Many other analysts years ago also recognized the impossibility of achieved ideal goals.

Clara Thompson (1950), in an excellent discussion of what constitutes a "cure" in therapy, describes the need for goal modification. She contends that the patient (1) must be relieved of neurotic suffering, (2) must also be able to relate to others with a minimum of unrealistically perpetuated attitudes that have their origins in early significant relationships, (3) must be capable of achieving as complete a development of personal powers as education and life circumstances will permit. If life situation and the culture in which functions are favorable, he or she will be most capable of relating to the group constructively; if not favorable, he or she may have to learn to endure relative isolation. As long as the person does not deceive oneself through neurotic escape mechanisms, one may remain reasonably healthy even under inimical conditions. However, since we live in a sick society, some neurotic compromises are necessary in order to function. An absolute cure is thus not possible. As long as the person is relieved of anxiety, inferiority feelings, and other destructive elements and is capable of coping effectively with life difficulties as they arise, this may constitute as much as can be done in treatment.

While classical analysts in theory contend that theirs is the only therapy that can regularly and deliberately bring about deep and permanent changes (Strachey, 1937; Menninger, KA, 1958; Wallerstein, 1965), they are not so confident that they can in practice always achieve these all-embracing results. Annie Reich (1950) considers that the bringing about through analysis of an absolute state of

health "would appeal to the narcissistic omnipotence fantasies of the analyst." She adds that an analyst cannot hope to produce perfect human beings, that one should be content if one frees a patient from symptoms, enabling ability to work, to adjust to reality, to engage in "adult object relations," and to accept some limitations. Oberndorf (1942) speaks of a "practical success" of symptomatic relief, and admits that in many psychoanalytic cases "the structure of the disorder with recovery of infantile memories has not been worked out, to say nothing of being worked through." Wallerstein (1965) remarks, "Suffice it to say, that though the most ambitious of therapies in its overall outcome goals, in practice analysis often achieves no more than other less ambitious therapeutic approaches."

These formulations actually repeat what Freud himself conceded were limitations in man's capacities for change. In "Analysis terminable and interminable" (1937) he stated that what analysis accomplishes "for neurotics is only what normal people accomplish for themselves without its help," namely, a "taming" of their instincts to bring them into harmony with the ego. Where the ego for any reason becomes enfeebled, as in illness or exhaustion, the "tamed" instincts "may renew their demands and strive in abnormal ways after substitution satisfaction." Proof of this statement is inherent in what takes place in sleep when in reaction to the lessening of the ego's forces there is an awakening of instinctual demands. In altering the character structure, Freud was pessimistic of the outcome. It was not possible, he said, to predict a natural end to the process. "Our object will be not to rub off all the corners of the human character so as to produce 'normality' according to schedule, nor yet to demand that the person who has been 'thoroughly analyzed' shall never again feel the stirrings of passion in himself or become involved in any internal conflict. The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done, analysis has accomplished its task."

R. P. Knight (1941) has condensed the aims of psychoanalytic therapy as follows:

1. *Symptom disappearance.*

2. *Improvement in mental functioning* with (a) understanding of the childhood sources of conflict, the part played by precipitating reality factors, the modes of defense against anxiety, and the specific character of the morbid process, (b) tolerance of the instinctual drives, (c) realistic self-appraisal with the ability to accept oneself objectively, (d) relative freedom from enervating tensions and crippling inhibitions, (e) liberation of aggressive

energies required for "self-preservation, achievement, competition and protection of one's rights."

3. *Improved adjustment to reality* with (a) better interpersonal relationships, (b) more productive work capacity, (c) ability to sublimate more freely in recreation and avocations, and full heterosexual functioning.

A realistic approach to all forms of psychotherapy, including psychoanalysis, recognizes principles of goal modification. It acknowledges that we may have to content ourselves with the modest objective of freedom from disturbing symptoms, the capacity to function reasonably well, and to experience a modicum of happiness in living. The patient may continue to be burdened by outbursts of neurosis, which escapes control from time to time. Realistically, some habitual activities will have to be circumscribed, and certain protective devices developed that are a bit restrictive in certain areas. Yet one will be as well adjusted as most persons, which means that average life objectives can be reached while living with some handicaps.

In the process of modifying goals, cognizance is paid to the fact that while each person is capable of change, there are various levels of change—from the altering of relatively superficial attitudes to the modification of the deepest strata of personality. The strength of the ego in itself may bear no relationship to the extensiveness of goals approached during therapy. Thus, in many patients with strong egos, who have successfully dealt with infantile conflicts through repression, compensation, and sublimation and whose present illness consists of a breakdown of these defenses, the goals may advantageously be oriented around mediating the stress situation that has provoked collapse, restoring to the person the habitual defenses.

In patients with a weak ego who have dealt with infantile conflicts unsuccessfully, with a serious thwarting of maturation, one may also have to be content with the goal of restoring repression and of strengthening defenses to bring the person back to customary equilibrium.

There are, in general, three types of patterns that exist in all persons that influence potentialities for personality modification even with depth therapy.

1. *Conditionings acquired during the preverbal period of life that have become so integral a part of the individual that they continued to operate in a reflex way.* Reorganization of these

paradigms may be unsuccessful even after prolonged reconstructive or conditioning therapy, especially where they fulfill important needs, promote gratifications, or serve as defenses. Surviving in almost pristine form, they defy logic and resist corrective influences.

2. *Systems developed in early life that have been symbolized, then repressed and repudiated because they mobilize anxiety or foster such intense guilt that they cannot be acknowledged.* These patterns, often related to sexual, aggressive, and assertive needs, may break through periodically in direct or modified form rationalizations for them being elaborated. Alteration of these configurations may be possible once insight into their nature is gained, their pleasure or adaptive values harnessed, and motivation for their obliteration developed with substitution of more adaptive trends. Where pleasure gains are high and sacrifice of such gains is resented, or where substitution of more mature ways of behaving is resisted, insight will not remove or control their expression. Here selective reinforcements may be partially successful.

3. *Patterns developed in later childhood and in adult life of which the individual is aware.* One may be able to modify or to control these patterns through will power once one understands their nature and consequences. Yet one may also be motivated to retain these destructive modes because of their pleasure and anxiety-reducing values.

Amendment in all of these categories is possible. Some changes come about "spontaneously" in the medium of a rewarding, bountiful environment that does not repeat the frustrating upsetting experiences of the past. They may be the consequence of a constructive human relationship that acts as a corrective experience, rectifying distortions in past relationships. They occur most frequently, however, through a good psychotherapeutic experience with a skilled empathic therapist, the patient gaining some cognitive understanding of one's conflicts, drives, and defenses, and being helped to develop new ways of reacting and relating. In all persons some residues of the disturbed past will remain irrespective of how bountiful one's environment may be, how exhaustively one knows oneself, or how thoroughly one has relearned new patterns.

Were we, in summary, to attempt the definition of a practical goal in therapy, we might say that it is *the achievement by the patient of optimal functioning within the limitations of one's financial circumstances, existing motivations, ego resources, and the reality situation.* Such a goal would put upon the therapist the responsibility of resolving the patient's resistance in working toward the ideal objective of personality reconstruction. It would, however, admit of the expediency of adopting modified goals, such as dealing

with only those aspects of the patient's problem that can be practically handled during the present therapeutic effort.