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Psychotherapy with the Obsessive Personality

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Psychotherapy with the Obsessive Personality

Psychodynamic Conception of Obsessive Disorders

The therapy of the obsessional states must bear some relationship to the psychodynamic concepts that underlie the etiology of these obsessive disorders. If one views the problem as a process of holding in check sexual or aggressive impulses, we can hypothesize that the patient is overwhelmed by angry, hostile or sexually exploitative feelings that, if unrestrained, would seriously endanger his existence. Our therapy would, therefore, be directed at helping the patient recognize that, in fact, he has such feelings that he is managing to control by displaced obsessional or compulsive symptoms which impair his functioning.

This notion would encourage the therapist to see the patient’s behaviors, overt or subtle, conscious or unconscious, manifest or latent, as distortions, displacements, reaction formations, and the like, of hostile, aggressive or sexual feelings and interpret such feelings in this light. The focus would be on the patient's hostility and even his tender feelings would be viewed as defenses against his hostility. The content of his rituals, doubting, procrastinating, indecisiveness and perfectionistic arises would be visualized by the therapist and translated to the patient as evidence of his hostile designs and intentions towards the significant individuals in his life. The psychotherapeutic process would focus on exposing, interpreting and reviewing these activities to emphasize the hostilities and ultimately relate them to the original libidinal source in the anal psychosexual period of development. The expectation would be that after sufficient exposure of these regressed tendencies through a transference relationship the behavior would be abandoned as unnecessary.

This was the initial conception of these disorders. Freud saw the symptom

as a device for dealing with unacceptable hostile or sexual impulses by using displacement, condensation, and symbolization as defenses against them. The symptom, he thought, was a compromise of “doing” the forbidden wish and at the same time “undoing” it. However, not only sexual or hostile impulses need to be controlled, but also the tender, friendly, or stupid and unworthy thoughts and feelings. In my view, *the obsessive-compulsive dynamism is a device for preventing any feeling or thought that might produce shame, loss of pride or status, or a feeling of weakness or deficiency—whether such feelings are hostile, sexual, or otherwise*. I see the obsessional maneuver as an adaptive technique to protect the person from the exposure of any thought or feeling that will endanger his physical or psychological existence. This extends Freud's views and does not require the postulate of an instinct theory or libido theory.

Psychotherapy

A rational psychotherapy must include an understanding of the pervasive and persistent tendency to resist change in order to preserve the relative stability of the anxiety-reducing defensive structure. It is also necessary to have a knowledge of techniques of therapy which aid the process of illumination, insight and behavior alterations. Awareness of both the neurotic structure and the overpowering need of the obsessive individual to maintain it intact is crucial in the treatment of the obsessional states. Every tactic, gambit, maneuver, interpretation and clinical intervention must take into account the extraordinary capacity of the obsessional to evade, distract, obfuscate and displace in order to avoid confrontation and change. Tactics which reinforce or encourage those defenses must be avoided by the therapist who, more often than not, has many obsessional characteristics himself.

The essence of the obsessional defenses is antithetical and opposed to the essential requirements of the therapeutic process and militates against the exposure and discovery of the patient's deficits and deficiencies. The obsessional often views therapy as a challenge to his omniscience and omnipotence and

steadfastly rejects any new awareness which would require him to admit to himself and others that there are matters about which he is unaware. Since he feels he must know it all, he frequently rejects an observation as invalid—only to present it later as his own discovery. The therapist's early tolerance of this tactic must give way to a later confrontation after a positive relationship has been established. This may be long in developing, since the requirements of trust and commitment needed to bind a therapeutic relationship are precisely what the patient fears and tries to avoid.

The overriding need to control one's inner and outer world requires orderly, manageable and guaranteed living. The adaptive devices, such as the ritual, the maintenance of doubts and the unwillingness to commit oneself, along with the attempts of omniscience, omnipotence and striving for perfection and superhuman performance, are all attempts to control one's safety, security and survival. This permits the obsessional to have an illusory feeling of being safe, secure and in control. Being in control means guaranteed certainty and an absolutely secure stance, which interferes with the growth of enough trust for a minimal commitment to therapy. The barrier to trust may never be overcome, regardless of the ostensible cooperative behavior and the willingness to be a patient in an interminable program. No wonder the treatment is long, uncertain and tediously unrewarding for both parties! The obsessional spends many therapy hours in distracting avoidances and contentious disagreements while he is intellectually astute and cognitively capable of clearer analysis. Affectively, however, he is totally unengaged until well into therapy.

To be absolutely safe and certain, it is necessary to know everything in order to predict the future and prepare for every eventuality. The obsessional needs to know everything and emphasizes intellectual attainments above all else. To maintain the fiction of perfection he must never make an error or admit any deficiency. It requires that he never risk, being wrong by taking sides, making definite decisions or committing himself to a point of view or course of action, in case it turns out to be the wrong one. This, in turn, produces the classical

behavior of the indecisive obsessional, who tries to avoid definitive actions of any kind lest he be wrong.

How do we deal with the indecision, and the unwillingness to make a commitment or express a point of view? We must encourage the patient to take the risk of being unsure and even making an error. He must see that this does not imply danger and total rejection. He must try to experience the reality of being human and uncertain. The therapeutic task, therefore, is to encourage action anti decision even when all the facts are unavailable and the issue is in doubt. The therapist must also risk being criticized if the decision he encourages is not the best. This applies to only minor decisions and not to the major ones like marriage, change of job or the like. In cases such as those, the therapist must be very clear and cautious in not providing the patient with the rationalization for his decision and not allowing him to put the responsibility for failure on to the therapist. The patient must be encouraged to take a stand, but the therapist must be the neutral agitator who pushes for a solution without taking sides. In fact, decisions and closures are so difficult for the obsessional that he/she generally makes them by default rather than by committed intention. In any situation the therapist must not take the responsibility for being the decision maker.

The tendency towards procrastination is intimately related to the tendency to doubt as a way of guaranteeing one’s omniscience when life forces a decision or a choice. It is the pervasive doubt that produces some of the most bizarre obsessive symptoms, such as trying a door dozens of times to make certain it is, indeed, locked. No sooner has the action been taken than the individual becomes uncertain that he has carried it out. It is also the doubting that produces the “yes-no” response we call ambivalence. One must entertain both feelings or support both sides of every issue in order to come out correct and in control of the situation. The ambivalent attitude in the obsessional is this aspect of playing both sides and promoting an ambiguity and uncertainty which allow him to maintain doubts and to avoid positive feelings and attitudes.

The rituals, whether they relate to hand-washing, checking the lights or door, keeping books in order, etc., are attempts to achieve certainty and control by magical gestures. At the same time, they shift the focus of the patient's interest onto issues not directly related to the main concern. The ritual activity becomes so pervasive and time-consuming that the original reason for engaging in this activity is forgotten.

Attempting to understand the precise meaning of the ritual may be an interesting intellectual exercise, but in general it will not advance the therapeutic process to any appreciable extent. The same problems which stem from investigating the origin of the doubting also apply in the instance of rituals. Further, while the symbolic meaning of the ritual can often be inferred from the various elements in it, an intellectual elucidation of the symbolic acts seldom, if ever, alters the ritual. The classical hand-washing ritual, for example, can be correctly interpreted as an attempt to guarantee safety and survival by eliminating dangerous germs or sexual contamination or wash away guilt. It could also be a device for keeping the person preoccupied and thereby prevent him from getting on with his living. The particular ritual employed may be entirely accidental or coincidental and may have significance only in terms of the setting in which a severe anxiety attack may have occurred. Since the real roots of the ritual lie in deep-seated feelings of uncertainty about one's safety and security, the proper interpretation of its meaning usually does not influence its continuation. The understanding of the purpose of the ritual may be easily and readily accepted by the patient, while at other times the ritual may be so autistic and complicated that its elucidation is impossible.

Generally, the search for the origin of the ritual is not worth the time spent, since one way of evading the therapeutic relationship is for the patient to become preoccupied with descriptions and detailed explanations of the ritual. The presence of many rituals in a patient is some indication of the severity of the obsessional illness and generally implies a poor prognosis, while a paucity of rituals suggests a less severe personality disorder. In either case, the fate of the

ritual is tied to the overall treatment progress, and the patient must be so informed from the beginning.

The ritual will be abandoned when the patient's need for magic and ultimate control of himself and the universe is lessened. If the ritual is particularly incapacitating, the therapist might try to attack it directly and either eliminate it or alter it. In doing this, however, it must be clear that the basis for the development of the ritual has been unchanged even though its presence may have been eliminated.

Communication

The obsessional's need for perfection, which colors his communication, is especially complicated and difficult in a treatment situation, since verbal productions are an integral part of the process. In his effort to be precise and clear, the obsessional introduces more and more qualifications in his presentation to be certain the matter is presented in its fullest and most complete form. This adds confusion to the process and, instead of clarifying, tends only to cloud the issues. While it may appear that the patient is deliberately trying to confine the therapist, the therapist must understand that the patient is trying to be more precise and avoid making errors; he is not trying to sabotage the treatment. The tendency to be distracted and to move off in tangents keeps the patient from getting to the point of his communication and makes exchanges with him seem like a never-ending succession of waves, with each idea setting off a multitude of ripples. Because of the obsessional's tendency to ramble and be distracted, the free association process often serves to defeat its purpose and may involve the therapy in endless trivia and irrelevancies. The therapist must be active and energetic to prevent this development by attempting to interrupt the irrelevancies and focus on the relevant whenever it is apparent to him.

The therapist must always be aware of the limits of his patient's capacities to tolerate certain interpretations or observations; he must stop short lest he

increase the defenses which ordinarily protect the patient against anxiety. Anxiety will limit the patient's capacities to observe and acknowledge the therapist's interpretations. When interpretations are seen as criticisms or as deflating to the patient's esteem, the patient will react with even more elaborate defenses. On the other hand, the therapist's observations must not be too bland or they may be easily overlooked.

Activity

Activity on the part of the therapist is absolutely essential from the beginning of the therapy to the end. Even a meagre understanding of the dynamics of the obsessional state requires that the therapist not permit the techniques which defeat communication to continue for too long a time—although the therapist's activities must never be so intense as to overwhelm the patient or make him feel that the therapy is being dominated by the therapist. Free association, as well as the tendency to endless detail and circumstantiality in the obsessive accounts, must be controlled by the therapist. Therapist passivity can only lead to interminable analyses in an atmosphere that becomes more clouded and confused, which is often the reason for the long, fruitless analyses, which characterized an early stage in the development of the methodology of psychoanalytic treatment of the obsessional.

How do we determine what is relevant and what is irrelevant in the clarification of an obsessional problem? The notion that "everything is relevant'' in a deterministic view of the mind often leads to endless and interminable inquiries which reinforce the obsessional pattern, while discouraging certain communications may imperil the unfolding of significant and illuminating details. Clinical judgment, based on the growing knowledge of the etiology and maintenance of an obsessional neurosis, permits us to make such decisions with reasonable expectation of success.

One must determine, from the abundance of issues presented, those details

and matters which should be dealt with at once and those which can be left for a biter date. What is selected depends on many factors, such as the therapist's theoretical orientation, the nature of the main theme currently being explored, the possibility of a potentially enlightening recollection being introduced, or the contradictions or substantiation of earlier material. Of all the possible determinants I would suggest that the most cogent issue is the therapist's treatment plan and the direction he is currently pursuing. lie should pick the lead that is generally moving towards the goal.

Emotions

Difficulty in controlling one's feelings and emotions, which is onto-genetically more primitive than intellectual capacity, leads to the tendency to avoid, isolate and displace emotional responses. In addition, feelings may involve or commit one to a person or an idea. The need to control emotions prevents a commitment to the process of therapy, to a person, or to the therapist.

The obsessional exhibits great skill in avoiding any involvement with the therapist, although he may talk extensively about involvement and the problems of transference and countertransference. He will even talk about feelings and emotions. However, it will be a succession of words drawn from an intellectual comprehension of the issues involved, devoid of any real emotional response. It is, therefore, necessary to focus on real feelings and to limit, as much as possible, such intellectual discussions. Obviously, they cannot be avoided entirely, but they can and should be minimized and, whenever possible, the expression of feelings be encouraged with questions such as "How do you feel about that?" or "You must have been annoyed (pleased, etc.)."

Recent Events

Much of the therapeutic process comes from the examination of events that can be explored in the immediacy of the therapeutic hours, especially in the

transference relationship. While this is true in any psychotherapeutic situation, whatever the disorder or personality style, it is crucial in the treatment of the obsessional, whose recollections are pervaded with doubts that limit conviction about the interpretations growing out of earlier reconstructions. The endless bickering, qualifying and uncertainty about past events make it much more convincing when the patient can see his distortions or other defensive activity under circumstances where doubts cannot be introduced or used to defeat insight. The most effective technique is the examination of recent events, here-and-now events, which allow for the least distortions. Even under these circumstances there are many complications. It is difficult to avoid getting involved in a “flypaper relationship” or a tug-of-war with the patient, who reacts to what he experiences as control and attempts to put down the therapist and minimize the value of the exploration.

Our desire to explore the emotions is also aided by the tactic of focusing on recent events. The patient can readily discuss the frustrations, disappointments and despairs of previous years. They are behind him and are open to explanations and justifications of many kinds. Past feelings can be described and experienced calmly, judiciously and intellectually, so that the value of their assessment in the therapeutic process is sharply reduced. However, present hostilities and frustrations, particularly as they involve ongoing relationships, are much more difficult to admit. For the patient they represent failures or deficiencies and expose too much of his feeling.

Sharing his feelings of distrust, dislike or liking for the therapist is very difficult, even though he attends to the formal requirements of the therapeutic contact. Anger is much more easily expressed because it is more actively encouraged and presumed to be therapeutic.

The obsessional is often visualized as having stored up hostilities, and the critical element in the resolution of the disorder is the expression of these aggressive feelings. The overriding tendency towards control blankets both

tender and hostile feelings; consequently, the obsessional appears to be calm and controlled. However, his hostile feelings are more available to him than his tender feelings; they are invariably expressed in subtle, covert, but unmistakable ways in detracting, derogating, sniping, petty oversights and the like. Direct expressions are avoided but the presence of hostility is apparent to the patient and to others. The tender impulses and affectionate reactions, which are viewed as threatening and dangerous, are securely bound down and rarely exposed overtly or covertly, even in the subtleties of his behavior. The obsessional must learn to identify these feelings and be encouraged to express them. I believe the control over these tender and loving feelings constitutes the essence of the obsessional defenses. It is the failure to express these feelings, rather than his hostile behavior, that initiates retaliatory behavior from others, which in turn stirs up the obsessional's wrath and hostile rejoinders.

The emphasis on the "here and now" by many post-Freudian theorists finds its greatest reward in the treatment of obsessional disorders. The more recent conceptions of mental illness do not focus exclusively on the genesis of these disorders as libidinal deformations, nor do they conceive of the beginnings in relation to any specific trauma. The developments are seen as occurring in an atmosphere in which repeated experiences produce effects on the person in obvious or subtle ways. Therefore, discovering the actual origin or beginning of a symptom or personality characteristic seems of less value than a general recognition of the milieu or atmosphere of the household, or the general attitudes of the parents.

In the adult years, one deals with a problem, the origin of which is only a single element in its continuation; the persistence of the faulty pattern is related to the process of conditioning and habit. Therapy must unravel the detailed and widespread defensive techniques which develop and penetrate into every aspect of the obsessional's life, as well as search for the origins of the symptoms. This requires a knowledge of the patient's present living, in order that the therapist may see the subtleties and intricacies of his defensive processes. This is a most

difficult task and comprises the bulk of the work in the therapeutic process. To achieve this the therapist must be prepared for a long and arduous job of repeating the same observations and interpretations frequently before they are truly recognized by the patient. It requires patience and understanding of the tenacious and persistent nature of the obsessional process.

Grandiosity

To deal with his feelings of powerlessness, and his assumption of omnipotence, the obsessional often develops attitudes which get expressed as belittling and condescending feelings towards others, as well as toward the therapist. The patient remains distant but proper in fulfilling his role. Secretly he feels superior and contemptuous of the therapist and feels he is “on” to all that is happening. He catalogues all the therapist’s deficiencies, storing them up for use at a proper time. In this way he maintains a secret ammunition cache and an advantage over the therapist. The therapist therefore cannot take for granted that the patient, even though he appears to be pursuing the therapeutic process is, in fact, doing so. He may simply be doing the right thing. It is a long time before such patients can experience and express their doubts and concerns about the process. Their omniscient needs do not allow the recognition of deficiencies and, therefore, they resist interpretations which require them to admit they were ignorant about many things, especially interpersonal relationships.

In order for the patient to accept new insights, he must be encouraged to see how it will benefit him instead of visualizing the disasters that will confront him when he feels helpless and is not in total control of everything. This problem becomes acute when the patient is called upon to try out new insights in his living, and his needs for certainty and guarantees deter him from attempting new and untried pathways or solutions. Since the patient will report difficulties and failures in his attempts at change, this tendency must be clarified to avoid becoming entrenched in his neurotic, circumscribed existence which is experienced as safe because it is familiar.

The obsessional’s grandiosity leads him to expect magical leaps and massive advances in therapy. He is impatient with small gains and expects every meaningful interpretation to be followed by great advances or total cure. There is often a profound disappointment when an illuminating exchange is followed by a repetition of the old pattern. When this happens, the patient criticizes the therapist and the psychotherapeutic theory as well as himself because he feels that he has failed to live up to his own grandiose expectations. As he can accept only total and complete restoration of his grandiose self through therapy, he cannot abide the slow, gradual process of learning and changing. This leads him to the frequent charge that the therapy is doing no good—“Nothing has changed; it’s been a waste of time and money.’’

The therapist must avoid trying to justify his work or blaming events on the patient’s lack of cooperation. When progress is slow or absent, the therapist should not put the blame on the patient’s resistance or resort to the concept of the negative therapeutic response. While many factors may be at work in the negative therapeutic reaction, it is clear that many therapeutic impasses or failures are also caused by the therapist’s inadequate handling of the obsessional defense. This the therapist must face and take responsibility for. Therefore, failure cannot be said to be the fault of either the patient or therapist exclusively.

It should be clear that understanding of undue expectation, a need for magical solutions, and feelings of despair and disappointment when immediate success is not forthcoming is of particular significance in the treatment of obsessionals.

Change

The process of therapy involves a tedious examination and exposure of a patient’s patterns of behavior which he compulsively maintains and reluctantly alters. The therapist’s task is to review and strengthen the patient's awareness of these patterns and assist him in overcoming his doubts about the validity of the

view that they play a destructive role in his life. Before any moves can be made to change one's behavior, the individual must have a strong conviction about the need to change and a trust in the understanding derived in collaboration with the therapist. This is especially true with the obsessional who clings rigidly and tenaciously to his behavioral pattern and to his rationalizations and explanations for his behavior. The strength of his defenses demands strict, rigid, compulsive adherence, since the dangers which would unfold if he were to stop defending against anxiety would be severe and dramatic. The obsessional's stickiness, persistent intellectual defiance and resistance to seeing his behavior in alternative ways are intense and stubborn. His views and attitudes are firmly embedded and defended by barricades that must be slowly eroded piece by piece. This requires patience, tolerance and the ability to sustain a continual interest in the face of boring, repetitive behavior which seems to continue in spite of clarification and agreement about its destructive, negative quality. In fact, this is precisely the nature of the compulsive symptom, which is repeated with no alteration and no deviation in spite of the knowledge of its lack of validity.

Consequently, a large part of the therapeutic process is concerned with a review and reexamination of issues that are dealt with over and over again. The therapeutic skill lies in the therapist's ability to see the same issues in a new light, adding an additional piece of insight and reviving an additional recollection to strengthen and fortify the patient's conviction about the understanding so that it becomes such an intrinsic part of himself that he finally sees it as if he discovered it all alone. Familiar neurotic tendencies must be explored from the fresh perspective of different events, which include new pieces of data and additional insights. This also relieves the monotonous refrain of the patient, who says, "We went through that already," and the deadly dullness for the therapist, who must become reconciled to the awareness that a single clarification is rarely followed by a change in behavior. Working-through must be seen as a necessary ingredient in the process of change in providing conviction and trust to risk a new and untried approach that previously was considered dangerous by the

patient. This is crucial to the resolution of an obsessional disorder.

Not every obsessional patient presents all of the obsessional characteristics. Some are more prominent than others. Some relate to the need to be in major control by bringing in lists or agendas to the session. Others will have to do with the presence of severe rituals or phobias that occupy the forefront of the communication process. Others are hampered mostly by their grandiosity and contempt for others and still others are overwhelmed by their need for guarantees and certainties that prevent them from taking any risks or accepting any new interpretations.

The particular elements which are most prominent in the patient being treated determine the general principles that need to be applied in each instance. Where intellectual discussions seem to be preeminent, the therapist must permit himself to be somewhat spontaneous in expressing some of his own feelings and perhaps encouraging the expression of feelings from his patient by allowing and fostering the communication of his doubts and certainties. Spontaneous behavior is so difficult for the obsessional that the therapist can encourage this by getting more involved with the patient, taking some risks in exposing some of his own weaknesses so that he can allow the patient to recognize that human fallibility is not a cause for total rejection by others. In this connection it is important for the therapist to be aware of how he is being controlled or manipulated by the obsessional's tactics. The inevitability of being drawn in and being unable to find one’s way after being caught in the sticky mesh of obsessional communication need not be viewed as a failure or a weakness of a therapist’s technical skill. A review of such entrapments by the therapist can be illuminating as an example of the enormous difficulties in seeing one’s way into the process so that one can avoid being caught by the obsessional’s tactics.

Each occasion in the development of the interaction with the therapist needs to be seen in the light of the obsessional mechanisms and the therapist’s tendencies to be fallible. This allows the process of therapy to be one which is not

autocratically determined by the expert and his helpless patient, but rather by two people attempting to explore an issue together in which one has skills the other does not.

Indecision

The indecision of the obsessional is closely related to his morbid doubts. As he requires certainty in every choice he must make and is unwilling to take any risks, it is understandable that he puts off making a decision until he can feel absolutely sure.

It is indecision which keeps the obsessive from coming into therapy early. Once in, however, he may remain endlessly and be unable to leave unless an adequate handling of the therapeutic situation forces a change. He must be very careful, since he presumes that every decision will tie him down permanently, with no way out. This accounts for his tentative acceptance of the exchanges in the therapeutic process; nothing is seen or experienced with any degree of closure, but remains open to alteration or reversal. Therefore, interpretations are rarely accepted with conviction or full agreement, but with a qualifying, uncertain uneasiness. The usual instructions to forego any decision during therapy and to postpone living until more valid decisions can be made play directly into his neurotic pattern. Many obsessionals who should benefit greatly from the psychotherapeutic process find a haven for their neurosis and a reinforcement of their defenses because of inadequate or inept therapeutic handling in this regard. The obsessional prefers to take no action. Thus, psychotherapy, under certain conditions, can become an ideal culture for the enhancement of obsessional doubts and indecisions.

It is only in recent years that psychoanalysts have begun to recognize that the routine therapeutic techniques are not suitable for all types of character structures and sometimes need to be adjusted to the particular characteristics of the personality involved. The obsessional should be encouraged to arrive at

conclusions and to make decisions which are the product of a reasonable and adequate exploration of the relevant; factors. The technique for dealing with the patient's indecisiveness involves the need to clarify his quest for absolutes and certainties.

Use of Dreams

The analysis of dreams in the therapy of the obsessional must take into account the tendencies to evade and obfuscate the therapeutic process, since such patients tend to either comply or resist suggestions. If the therapist puts undue emphasis on dreams or displays any special interest in them, he may be flooded with dream material, or else get no dreams at all.

There are no particular characteristics of the obsessional's dreams. They reflect the life problems and the emotional relationships of the patient with the therapist, friends, etc., as all dreams do. The patient also utilizes the particular techniques of defense in the dreams which are characteristic of his patient's waking life. As so much of the obsessional's life is preoccupied with problems of control, it is not surprising to find that much of the dream material concerns itself with control.

The dream content should be examined in terms of the "here and now," as it sheds light on the current living of the patient, and can be very illuminating with regard to sources and unacknowledged feelings and attitudes. The tendency to get deeply involved in understanding all the associations and every bit of detail can become a trap for the therapist. It can turn into an obsessional investigation in which the ultimate effect is to become distracted from the main pursuit. The dreams must be treated as simple data and dealt with in the same way as other productions of the patient.

Termination

When the patient comes to therapy, his goal is to achieve a state of anxiety-

free living while retaining the same collection of personality traits that he had originally. During the course of therapy the patient must recognize the extreme nature of his demands and accept some limitations of his expectations. It is hoped that he will be able to achieve some balance and compromise; instead of having to be a superhuman, he will be able to function as a fallible human being. This simplified picture of the therapeutic goal of treatment of the obsessional provides some clues as to guidelines in determining a termination date.

What are the criteria for assessing termination? First, there must be a recognition that termination must be done gradually and experimentally, and rarely in an absolute way. To begin with, the number of interview hours can be cut down, or the frequency reduced over a reasonable period of time. Experimental reductions in therapy hours can begin when the patient becomes comfortable enough to accept some reverses in his living which heretofore stimulated panic or severe anxiety. There should also be a reduction of tension in many areas of his living, coupled with a greater emotional involvement in all his relationships. Another criterion is evidence of reduction in ritualistic behavior; also, many of the obsessions which plagued the patient when he came to treatment should have become less tenacious or no longer occur. There should be an increased capacity to enjoy life without having to fulfill certain demands all the time. But even these criteria should be flexible. The therapist must not get trapped into postponing or abandoning his plans to terminate because the patient gets a renewed anxiety attack when termination is under consideration. It must be clearly understood by both patient and therapist that anxiety attacks will occur throughout the life of the patient and that therapy is not a permanent guarantee against disturbed living.

The therapy of the obsessional involves illuminating and exposing the patient's extreme feelings of insecurity and uncertainty—which he tries to handle through the complicated patterns of defense already described in detail. As he comes to understand his neurotic structure as a defense against recognizing these weaknesses, he can then begin to build a new security system.

At therapy’s inception, the obsessional defense cannot be abandoned because the individual is afraid of the consequences. As his esteem grows and the awareness of his strength increases, he can slowly risk abandoning such patterns and be freed to function on a more productive level. The goal is to move from superhuman expectations to human productiveness—which can reach whatever limits the individual is capable of. 'When he recovers, his ambitions will no longer be sparked by his neurosis; rather, his achievements will be limited only by his capacities. The impossible goals which left him disappointed will be abandoned. An awareness of his valid capacities to produce may actually stimulate greater activity. In essence, the obsessional must learn that in abandoning rigid, inflexible patterns of behavior designed to control and protect himself, he can actually feel more secure and more capable—and be more productive as well.