THE TECHNIQUE OF PSYCHOTHERAPY

TECHNICAL PROBLEMS IN TERMINATION

LEWIS R. WOLBERG M.D.

Technical Problems in Termination

Lewis R. Wolberg, M.D.

e-Book 2016 International Psychotherapy Institute

From *The Technique of Psychotherapy* Lewis R. Wolberg

Copyright © 1988 by Lewis R. Wolberg

All Rights Reserved

Created in the United States of America

Table of Contents

Technical Problems in Termination

TERMINATING THERAPY UPON REACHING SET GOALS

TERMINATING ON THE BASIS OF INCOMPLETE GOALS

TERMINATION NOTE

FOLLOW-UP

PATIENTS' REACTIONS TO THE END OF THERAPY

Technical Problems in Termination

The conditions under which termination of therapy is indicated are

1. Achievement by the patient of planned treatment goals.

2. Decision by the patient or therapist to terminate on the basis of incomplete goals.

3. The reaching of an impasse in therapy or the development of stubborn resistances that cannot be resolved.

4. Countertransference that the therapist is unable to control.

5. Occurrence of physical reasons, such as moving of the residence of patient or therapist.

TERMINATING THERAPY UPON REACHING SET GOALS

Therapy may be terminated after the patient has achieved planned goals, such as the disappearance of symptoms, the mediation of environmental stress sources, the acquisition of greater happiness, productivity and self-fulfillment, the resolution of difficulties in interpersonal relationships, or the establishment of creative and productive patterns in living, with the evolution of greater emotional maturity. It is to be hoped that some intrapsychic structural changes will have occurred in which, through a reworking of infantile conflicts, new defenses crystallize and adaptive solutions for old conflicts take place.

With the accomplishment of the purposes of therapy, termination is best effectuated by discussing the possibility of ending treatment with the patient, handling any resistance displayed, warning of the possibility of relapses, and inviting the patient to return after therapy has ended whenever necessary or desired.

Discussing Termination with the Patient

In advance of the termination date it is wise to discuss with the patient the matter of ending

therapy. A tapering-off period may be suggested, and a termination date set, which ideally should be from 6 to 8 weeks. The frequency of sessions may be reduced, and the intervals between visits steadily increased. The following is an excerpt from a session with a patient with a phobic disorder who has achieved adequate improvement in therapy:

Th. It sounds as if you are reaching the end of treatment. How do you feel about stopping?

Pt. Oh, of course I am glad that I am feeling so well, and I am very thankful to you, doctor.

Th. Actually, you did the bulk of the work. Of course, we could go on with treatment indefinitely, reaching more extensive goals in your personality development, but frankly I don't see the need for that, unless you do.

Pt. Well, I suppose I can benefit, but as you say, I am comfortable and happy now with Jim *[the patient's husband]* being so much better now to live with, and all these fears and things are gone now.

Th. If you agree with me that we should begin to terminate, we can cut down our visits to a session every 2 weeks for the time being and then space them at intervals.

Pt. All right, doctor.

During the tapering-off period, any relapses or resistances are handled, sessions being again increased, but only if the patient's condition demands this. In occasional cases it may be decided to terminate therapy abruptly without tapering off, in order to expose the patient to a complete break with the therapist. Forced to function on one's own, the patient may marshal inner strength more rapidly.

Handling Resistances to Termination

If the therapist has conducted the treatment sessions with the full participation of the patient, and if the therapist has avoided playing too directive a role, termination will not pose too great a problem in the average patient. In supportive therapy, however, where the patient has accepted the therapist as a guiding authority with whom he or she has conformed, or in insight therapy where the patient has, on the basis of a residual dependency drive, made the therapist a necessary factor in adjustment, termination may present difficulties.

Termination of therapy is no problem in most patients who are adequately prepared for it, or who are characterologically not too dependent, or who are seen for only a few sessions and discharged before a strong relationship with the therapist develops, or who are so detached that they ward of a close

therapeutic contact. It may, however, become a difficult problem in other cases. Patients who in early childhood have suffered rejection or abandonment by or loss of a parent, or who have had difficulties in working through the separation individuation dimensions of their development are especially vulnerable and may react with fear, anger, despair, and grief. A return of their original symptoms when the termination date approaches will tend to confound the patient and inspire in the therapist frustration, disappointment, guilt feelings, and anger at the patient for having failed to respond to therapeutic ministrations.

In some patients in whom no manifest dependency operates in the relationship with the therapist, termination may still be troublesome. The patient may be fearful of giving up the protective situation in the therapeutic relationship. Memories of past suffering and anxiety may cause a patient to want to hold on to the security achieved, even at the cost of continuing in therapy indefinitely. M. Hollander (1965) has pointed out "that the role of being a patient in psychotherapy, like being a student in school or a patient on a medical service, may become a way of life instead of a means to an end."

The therapeutic tasks prior to termination with all patients involve analysis of the dependency elements in the relationship, a search for needs in the patient to perpetuate dependency, and a helping of the patient to achieve as much independence and assertiveness as possible. A shift in the character of the relationship may be necessary where the therapist has operated in a directive manner. Here the therapist behaves non-directively with the patient, with the object of helping the patient establish new goals and values.

Resistances in the average dependent patient are multiform. Some patients bluntly refuse to yield dependency, adopting all kinds of dodges, even to relapse in their illness, in order to demonstrate their helplessness. Other patients exhibit a profound fear of assertiveness, perhaps promoted by a neurotic equation of assertiveness with aggression. Resolution of such resistances may consume a great deal of time.

In some patients, and especially in the third phase of treatment (see Chapter 48) it may be necessary to interpret continuously to the patient the reasons for this self-paralysis and to emphasize the need to make one's own choices no matter how revolutionary these may seem. The patient may be told

that if a person has never developed full confidence in oneself as an individual, the right to experience oneself as an independent being may be startling. The insidious operation of this dependency may be illustrated, and the patient may be shown how dependency has crippled efforts toward self-growth. In the relationship with the therapist it is natural for the patient to expect the therapist to give the answers and to make the patient's decisions. Should the therapist do this, however, the patient will never develop inner strength. The therapist may keep emphasizing the patient's need to take complete responsibility for personal decisions. The patient may be apprised of the fact that some of decisions may be wrong; but even though one makes mistakes, the very fact that they are one's own mistakes will teach more than being told what to do at all times. The therapist does not want to withhold support from the patient, but it is necessary to do so now out of consideration for the patient's right to develop.

When the patient accuses the therapist of being cold and distant, the therapist may say:

> The reason I'm not more demonstrative is that if I were to act like the traditional authority, it would eventually infantilize you; you would have to keep me around as a leaning post the rest of your life. You'd have to come to me for every decision with such queries as, "Am I doing something wrong?" or "Am I doing the right thing?" Rather, it's better for you to make mistakes, bad as they may be, and to feel that these are your own decisions than for me to tell you what to do.

A definition of the nondirective nature of therapy is given with the object of supplying the patient with an incentive to take responsibility. This will not serve to liberate the patient completely from dependency demands. Neurotic attitudes and behavior patterns will continue to press for expression. The patient may still exhibit toward the therapist the same insecurity, submissiveness, and aggression that he or she always has manifested toward authority. Habitual ineptitudes in dealing with life and people, destructive acting out and continuing detachment may go on, but with a slight difference: doubts that these aberrations are really necessary.

The following excerpt of a treatment session with a patient resisting termination illustrates some of these points:

> *Th.* You want me to tell you exactly what to do, how to do it, and when. If you really feel that you just don't have strength to do things for yourself, I will do them for you, provided you understand it isn't going to be of help to you if I make your decisions. I'll leave it up to you to decide. If you really feel as bad as you say you do, and you haven't got the confidence to make your own decisions, I'll let you depend upon me, if you *really* want that. *[This statement is offered as a challenge to the patient. There are very few patients that take advantage of it. This patient actually has become quite assertive through therapy but is evincing a regressive dependency reaction*

to prevent termination.]

Pt. I do feel just as badly as I told you, but at the same time I can hang on to various little things, one of which is that I long ago accepted the idea that you know what you're doing and I don't want to go against it. [*She seems to doubt the wisdom of her desire to have me function as a parental image.]*

Th. You don't want to go against what I have outlined as the best for you? What do you feel about making your own choices and your own decisions completely, with absolutely no help from me?

Pt. Oh, I think it's great, except that there doesn't seem to be much I can do about it.

Th. Well, what do you think would happen if I told you what to do, if I took you over and acted like a parent?

Pt. I feel two ways about it. I feel, first of all, that it might be an excellent idea because I'm certainly amenable to letting you take me over. But the other way I feel about it is that all this time I've been trying to, more or less, cooperate with you. I trust your judgment and I can see very well that keeping throwing decisions at me is what will in the end make me self-sufficient. Yes, I can see it, but right now I just can't imagine it ever happening or my being able to stand on my own feet. I feel very much as if I have slipped constantly downward during the last few weeks. *[This is since termination was suggested.]* That's all. I mean it's not as if I don't have lucid moments every now and then, but they're very few and far between.

Th. All right, then would you want me to play the role of telling you what to do on the basis that you can't come to decisions for yourself?

Pt. If it was making decisions, I might be able to do it; but I just can't see any decisions to make. There's nothing clear-cut. I don't know where I am at all.

Th. So that you'd like to just let yourself be taken care of by somebody?

Pt. It sounds nice, but I know perfectly well that it wouldn't be so good for me.

Th. You mean my making the decisions for you wouldn't be so good?

Pt. Well, certainly not.

Th. But some people seem to want that.

Pt. Grown people?

Th. Yes, grown people. Their feeling about themselves is so diminutive, their capacity to function so low that they want a parent watching over them all the time. If you'd like to adjust on this level all your life, you'd need to have me around to make your decisions for you indefinitely.

Pt. And then if I wasn't living here, I'd try to find someone else to do it, if I let you go ahead with this plan. *[This is a healthy reluctance to accepting dependency.]*

Th. If you don't develop strengths within yourself so you can figure things out and plan your life and follow it through, right or wrong, then you're going to need somebody around all the time.

Pt. I'd rather not depend on you then.

Because the therapist operates in a more passive role, the patient will be encouraged to act with greater assertiveness, to initiate actions, and to follow them through. There is increasing incentive to take personal responsibility for one's actions, to make plans and express choices. Failure may occur, but there will be successes too. And inner strength will grow on the bedrock of successes. New feelings of integrity and a more complete sense of self will be developed.

Ego growth will thus be catalyzed during the terminal phase, eventuating in the patient's desire to manage one's own life. Such growth is contingent to a large extent on the continued permissiveness of the therapist and the persistent encouragement of the patient's activity and self-expressiveness. The fact that the patient successfully figures things out during the session eventually shows the patient that he or she is not at all at the mercy of forces on the outside. Ultimately the patient comes to the conclusion that one can live one's life, not because one is given permission, but because one has the right to do so. The patient feels equality with the therapist and a growing sense of self-respect. The self-confidence developed in therapy promotes an extension of assertive feeling toward the extratherapeutic environment.

The proper conduct of therapeutic sessions during the terminal phase of therapy requires that the therapist be so constituted that he or she can permit the patient to feel equality and to allow separation from treatment. The personalities of some therapists are essentially so authoritarian that they will not be able to function on equal terms with their patients. Automatically they will set themselves up as leaders, making judgments, giving directives, and setting goals for the patient that they insist must be followed. They may respond with hostility if challenged or abused by the patient. This is least apt to occur where the therapist has had personal psychotherapy and can analyze and control neurotic countertransference before it acts to interfere with the treatment situation.

Even the therapist who has undergone personal therapy may manifest attitudes that support the resistances of the patient to termination. There may be a compulsion to overprotect or domineer the patient and thus an inability to assume a nondirective role. Economics may play a part when new referrals are scarce, and the therapist anticipates hard times ahead. This may lead to interminable therapy, until the patient forcefully asserts himself or herself by the marshalling of aggression, and in

www.freepsychotherapybooks.org

this way violently breaks ties with the therapist.

In some instances the therapist may have to be contented with only partial reduction of the patient's dependence. Here the dependency is reduced as to innocuous a level as possible, by encouraging contact with an outside group or, in sick patients who require prolonged treatment, by maintaining a casual therapeutic relationship at extended intervals over an indefinite period.

Warning of the Possibility of Relapses

No matter how thoroughly the patient's neurotic patterns seem to have been eradicated, particularly in reconstructive therapy, shadows of old reactions persist. One may be incapable of eliminating them completely, as one cannot obliterate entirely the recorded tracings in the brain of aspects of the patient's past. Under conditions of great insecurity, when the patient's sense of mastery is threatened, or during periods of disappointment, frustration, and deprivation, old defenses and strivings characteristic of past neurotic modes of adaptation are apt to be awakened.

Symptoms may return insidiously without the patient even being aware of having entered into the old conflictual situations that propagated them. Thus, migrainous attacks may recur in a man who, having learned to channel hostility constructively and to avoid competitive relationships that create damaging resentment, changes his job to one where he is judged solely on the basis of comparison of his productivity to that of other employees. A woman with a propensity for dependent involvements may experience a return of her helplessness and her symptoms when she falls in love with, and acts submissive toward, a power-driven individual who constitutes for her an omnipotent father figure. Unconsciously she has yielded to a childish yearning for complete protection, and she is again paying the price in shattered self-esteem and its attendant symptomatic penalties.

It is essential for the patient to realize that getting well does not guarantee further nonexistence of symptoms. Indeed when confronted with truly crucial decisions some patients respond with a return of complaints. Also when stress becomes too powerful to manage, a temporary relapse is possible. However, if the causes of any relapse are investigated and analyzed, not only will the patient have the best opportunity of subduing suffering, but will also be in a better position to forestall the future return of

www.freepsychotherapybooks.org

symptoms. Some therapists find it profitable to tell patients at termination that they do not consider a person cured until a relapse or two has occurred and been overcome. Such a warning may prevent a patient from classifying therapy as a failure should recrudescence of symptoms ensue. It alerts one to the insidious operation of inner anxieties and promotes continuing self-analysis. The ability to utilize lessons learned in therapy strengthens newly acquired traits and expands personality growth. The therapist may tell the patient:

> You are apt to get a flurry of anxiety and a return of symptoms from time to time. Don't be upset or intimidated by this. The best way to handle yourself is first to realize that your relapse is self-limited. It will eventually come to a halt. Nothing terrible will happen to you. Second, ask yourself what has been going on. Try to figure out what created your upset, what aroused your tension. Relate this to the general patterns that you have been pursuing that we talked about. Old habits hold on, but they will eventually get less and less provoking.

Inviting the Patient to Return for Further Sessions

The therapist may advantageously invite the patient to return for additional interviews in the event of a relapse the patient cannot work out alone. Should the patient take advantage of this invitation, it will be possible for the therapist rapidly to help the patient gain insight into the patterns that have been revived, to connect this understanding with what the patient already has learned in therapy, and to analyze why the patient was unable to deal with the relapse through his or her own efforts. This review will usually occasion much relief in the patient and provide a greater sense of mastery. Relatively few sessions will be required to effectuate this objective.

The patient may also desire to return to therapy in order to achieve more extensive objectives. Growth is a never ending process, and the patient may be so dissatisfied with the present status that a more exhaustive self-inquiry will be insisted on.

For example, a patient in an anxiety state, mobilized by involvement in a love affair that she has been unable to control with her habitual character defense of detachment, may utilize the therapeutic situation to break the relationship with the young man of whom she has become so hopelessly enamored. Restoring her detached defenses and again functioning satisfactorily without anxiety, she may decide that she has accomplished her treatment objective. However, because she has become aware of a conflict that makes close relationships dangerous for her, necessitating withdrawal, she may develop, after she

has stopped treatment, an incentive to return to therapy for more extensive work. She will do this with a new goal in mind; namely to be able to relate closely to a person without needing to invoke her defense of detachment. With this expanded motivation, a reconstructive approach may be possible.

A suitable way of terminating therapy is to consider the increased spacing of sessions part of the treatment plan. As soon as the therapist decides on treatment termination, the patient is instructed that it is important to extend the intervals between sessions as part of the treatment plan. A 2-week interval is followed by increasing intervals between sessions. When it becomes apparent that the patient is coping well, a yearly session is planned.

Encouraging the Patient to Continue Therapeutic Self-Help

A consistent application of what has been learned in psychotherapy is essential. The patient may be encouraged to engage in self-observation and to challenge neurotic patterns directly should they return, both by trying to understand what brought them back and by actively resisting and reversing them. In some cases the patient may be taught the process of self-relaxation or self-hypnosis to help reduce tension when upset and also to enable the patient, through self-reflection, to arrive at an understanding of elusive precipitating factors that have revived conflicts.

Even where there has been only supportive or a more superficial type of reeducative therapy, the patient may be inspired, as much as possible, (1) to utilize will power for the purpose of facing reality situations, (2) to push one's mind away from ruminative obsessional thinking and preoccupations, (3) to cultivate, if possible, a sense of humor about oneself and situation, (4) to develop the philosophy of living in the present rather than regretting the past and dreading the future, (5) to practice expressing controlled resentment in justifiable situations, and (6) to examine any tensions, anxieties, or irrational impulses in terms of possible meanings, connecting them with what one knows of one's basic neurotic patterns. These precepts and others contained in Chapter 53 on Homework Assignments may be extremely helpful. Self-help relaxation methods, meditation, the playing of an audio tape that the therapist prepares for the patient for purposes of relaxation and ego building, may be prescribed for some patients. See also Chapter 57.

TERMINATING ON THE BASIS OF INCOMPLETE GOALS

Therapy may have to be terminated prior to the achievement of planned goals. There are a number of reasons for this, most important of which is insoluble resistance. Thus, a patient may, with psychotherapy, lose certain symptoms, but other symptoms may cling to one obstinately. One may relinquish many neurotic patterns but continue to exploit a few without which one may feel oneself incapable of functioning. One may develop a number of new potentialities, yet be unable to progress to as complete emotional maturity as either the patient or the therapist may desire. Working on resistance accomplishes little, and the therapist may then deem it advisable to interrupt treatment.

A countertransference obstacle that may require resolution is a too strong ambition in the therapist who expects too much from a patient. Therapeutic objectives may have to be scaled down considerably in certain individuals. Thus, we may be dealing with a sick borderline patient who is on the verge of a schizophrenic break and who is insistent that he be brought in therapy to a point where he can be more normal than normal. This wish, while admirable, is not realistic, for the patient does not possess the fortitude to endure the rigors of a reconstructive approach. Because he does not have sufficient ego strength to work out a better adaptation, one may have to make a compromise with projected goals.

Sometimes therapy is started with a patient whose motivations are unalterably defective. For instance, a woman may have a tremendously arrogant notion of her capacities, and she may seek treatment solely because she has read somewhere that psychotherapy can bring out an individual's buried potentialities. The bloated self-image that the patient supports may be the only way she has of counteracting feelings of inner devastation or of rectifying a contemptuous self-image. Therapy with such a patient may be extremely difficult and may have to be terminated due to impenetrable resistance.

The therapist may be confronted with a patient whose life situation obstructs his or her progress. The environmental difficulty is so irremediable that possibilities of correction are remote, and hence the patient must be helped to live with it or be desensitized to its effect. Or the patient's symptoms may possess so strong a defensive value that their removal will produce a dangerous reaction. Therapy may have to be terminated on the basis of only partial symptomatic relief.

It may be impossible, due to other obstructions, to get some patients to progress beyond a certain

point in therapy. To continue treatment may prove discouraging to the therapist and undermining to the patient. It is better here for the patient to retain some neurotic drives than to be exposed to interminable and frustrating therapy to which, in all probability, the patient will be unable to respond.

As soon as the therapist decides that maximum improvement has been obtained or that a stalemate has been reached, the therapy may be brought to a halt by utilizing the techniques described for termination after the achievement of planned goals. The therapist will, however, have to explain the reason for termination in such a way that the patient does not arrive at the conclusion that matters are hopeless and that no further progress is possible. Thus, the patient may be told that therapy has alleviated some symptoms, has brought about an awareness of basic problems, and has pointed the way to a more productive life. Because the patient’s difficulties have existed a long period, resistances may persist for awhile. Putting lessons learned in therapy into practice, however, will provide the best opportunity to achieve a more complete development.

The mere mention of termination, and the discussion of resistances that seem to have blocked progress, may stimulate incentives to break through these hindrances. If a termination date has been set, the patient may work through resistances prior to the expiration date. On the other hand, the termination techniques may not resolve the many impediments to further change. Yet, after the patient has left treatment, spectacular progress may be experienced. The fact that no headway was made while in therapy may have been due to the operation of a subtle transference situation that acted as resistance. For example, hostility toward the therapist may have expressed itself in a refusal to go forward; or dependence on the therapist may have taken the initiative away from the patient. Once the patient is functioning away from therapy under one’s own power, such resistances diminish and a spurt in development is possible.

Planned Interruption of Therapy

Instead of outright termination, a vacation from treatment may be suggested. During this period the learnings from therapy should be put into practice. The interruption can serve as an opportunity to observe the exact manner that one’s personal problems interfere with proper functioning and to analyze what hindrances come up in trying to cope with such problems on one’s own. The proposed interruption

may be presented to the patient as in the following excerpt:

Th. It seems to me that we have reached a plateau in your therapy and that a vacation from treatment may be indicated. How do you feel about that?

Pt. I just can't seem to get any further. I've been thinking of that. How long would you suggest?

Th. Suppose we plan on a month's vacation. After a month call me, and we'll arrange an appointment.

Pt. Do you believe that will be of help?

Th. I do. You might observe yourself during this period and see if you can determine what is happening, what stirs up your symptoms and what alleviates them. We might learn something important, and the interlude may help pull you out of the plateau.

Transferring the Patient

Sending the patient to another therapist may sometimes be preferable to outright termination. Where one seems unable to deal with the patient's resistances, or where one cannot control destructive countertransference, or, for any other reason, feels incapable of helping the patient any more, the decision may then be that the patient will do better with a different therapist. Sometimes a transfer is arranged when it is presumed the patient will benefit by a kind of therapeutic experience other than that provided by the present therapist. For instance, a therapist trained mainly in reconstructive approaches may feel that the patient needs supportive therapy and may consequently want to refer the patient to a professional person who is highly skilled in supportive techniques. Or a change to a therapist of the opposite sex may be considered advisable. Should a transfer be indicated, the therapist may discuss the matter with the patient as illustrated in this fragment of a session:

Th. For some time I have felt that we haven't been making very much progress.

Pt. Yes, I was worried about this. I wondered if you were getting impatient.

Th. Of course not, except that sometimes a snag like this does happen, and a person may be able to work it out better with another therapist.

Pt. You mean you want me to see somebody else?

Th. My desire is for you to get well. What would you feel about seeing someone I would recommend and who I believe can help you? I have a feeling you may do better with another type of technique, and Dr.______ is very excellent at this.

Pt. Well, I don't know.

Th. Why don't you talk to Dr.____ after I determine that he has the time for you? Then, after a couple of sessions you can see how you feel.

Pt. If you think this is best, I'll do it.

Th. I do, and I'll make all the arrangements and call you.

TERMINATION NOTE

At the time of termination a note should be entered in the patient's case record indicating the reasons for termination, the patient's condition of discharge, the areas of improvement, the patient's attitude toward the therapist, the recommendations made to the patient, and the final diagnosis. A form, such as in Appendix H may be found useful.

FOLLOW-UP

Prior to discharging the patient, then it is advisable to ask whether he or she would object to receiving an occasional letter from the therapist asking regarding one's progress. Most patients are delighted to cooperate and consider the therapist's gesture a mark of interest in their development. Follow-up letters, briefly inquiring into how things have been progressing, may be sent to the patient yearly, preferably for at least 5 years. This enables the therapist to maintain a good check on what has been happening over a considerable period of time. The patient's replies to the follow-up inquiry may be entered in the case record, and, if necessary, a brief notation may be made of the contents.

Follow-up is an essential practice where one wishes to determine the efficacy of one's clinical activities. It is an important aspect of outcome research. In doing follow-up we must remember that a single contact may not tell us too much. A person does not live in a vacuum after completing psychotherapy, and many intercurrent events can temporarily augment, detract from, or destroy the benefits of treatment. Thus an individual who has achieved a good result and has left therapy in a satisfactorily improved state may be subject to catastrophes that are beyond one's power to avoid or resolve. One may be in a state of depression at the time of follow-up but can later rally and pull oneself out of despair. This may not be evident unless provision is made for further contacts. Personal interviews

are far more useful for follow-up than,, communication by mail, although practical considerations, such as changes in domicile to a remote area, may pose problems. Sometimes follow-ups done over the telephone may be much more satisfactory than by mail. However, patients tend to be more guarded here than in private interviews even where they have had a good relationship with their therapists.

Ideally, appraisals of the patient by other persons with whom the patient is living or working can be helpful, but this may be difficult to arrange. A simple statement of "feeling better" or "worse" means little unless areas of improvement or decline are delineated. Unless the case record has detailed categories of problems and deficits existing at the start of treatment estimates of change may be inaccurate. Researchers who have had no personal contact with a patient are especially handicapped, but even the primary therapist may without recorded backup be prejudiced by optimistic hunches.

PATIENTS' REACTIONS TO THE END OF THERAPY

What follows are some reactions voiced by patients when they finished therapy:

1. All people have problems, and I know now that mine are no worse than anybody else's.

2. I realize I considered my symptoms a sign of weakness. I realize they aren't. I don't pay attention to them and they pass. They aren't such a big deal now.

3. One of the big problems I had was considering myself the center of the universe. It now isn't so important for me to feel so important.

4. When I was so full of guilt, I felt I would burst. When I talked things out, I realized my standards were a lot more strict than those of other people. As a matter of fact, I would purposefully do things to prove I was bad; now I don't have to.

5. The price I would pay for my indulgences was just too high. So I don't burn the world up! So I don't get as much of a bang out of doing ridiculous things! The quietness I feel more than compensates for the high life I was leading.

6. Why knock yourself out climbing on top of the heap? You're nowhere when you get there. You kill yourself trying. I was so ambitious and perfectionistic that I had no time for living. Now I try to find pleasure in little things, and it works.

7. I don't have to blame my parents anymore for my troubles; whatever happened, happened.

Why should I let the past poison my present life? I feel I can live now for what life has to offer me right now.

8. I used to torture myself about the future. Worry about it so much I couldn’t enjoy anything. I knew I was silly, but I couldn’t stop it. Now I just don’t care. I do the best I can now and I know the future will happen as it will happen no matter how much I worry about it. I take things as they come.

These ideas are not capricious whims. They are formulations developed after a working through of important conflicts. They indicate an attempt at solution of basic problems, which permit of a style of living more in keeping with reality.

Interestingly, the essence of such precepts may be found in proposals and rules of living laid down by poets and philosophers from the earliest times that humans recorded their hopes and fears and formulated ways of resolving them. Sometimes individuals arrive at such philosophies spontaneously without therapy, usually during emotional crises that force upon them adaptive ways of thinking and behaving. Sometimes the philosophies are evolved as a result of authoritative pressures or out of respect for leaders whom the individual elevates to a protective or powerful position. A good psychotherapeutic experience, however, will give the individual the best opportunity to remold values and to arrive at a more constructive way of being and living.