Handbook of Short-term Psychotherapy

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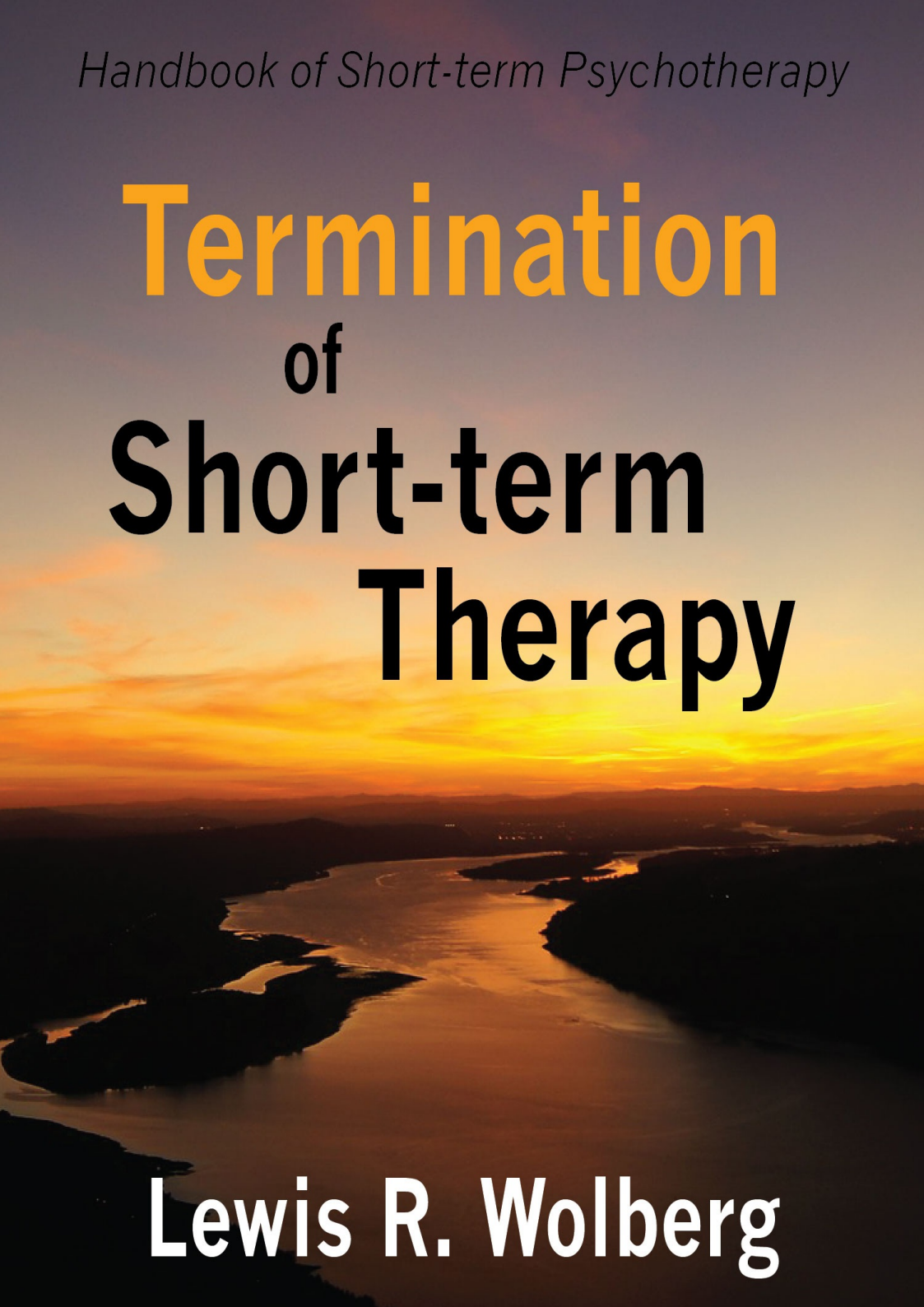

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Termination of Short-term Therapy

Proper termination of treatment is one of the most neglected aspects of the therapeutic process. Ideally, it should start in the initial interview during which the limited time span is emphasized. Even though the patient immediately accepts this provisional arrangement, later, as the therapeutic relationship crystallizes, its ending can pose a threat.

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 off 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-inpiduation dimensions of their development are especially vulnerable and may react with fear, anger, despair, and grief. A return of their original symptoms 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.

Resistance to termination affects not only the patient; it is present also in the therapist who for conscious or unconscious reasons may not be willing to let his patient separate. Therapists countertransferentially form attachments to some of their patients, and they may resent sending them away. Sometimes monetary factors influence delays in termination, particularly during periods when new referrals are sparse. Sometimes the projected goals of therapy have been set too high, and both patient and therapist are disappointed with what seem meager results. They will then eagerly cancel the termination contract and hopefully embark on a search for a cure with a fresh series of sessions that will usually eventuate in long-term and in some cases interminable treatment.

The word “cure” is an ambiguous expression when related to emotional problems. Most optimistically it designates an elimination of pathology and the induction of a total and robust state of well-being. To anticipate such a goal in short-term therapy excites unrealistic hope and optimism. Many of the imprints of unfortunate life experience, particularly those compounded in early childhood, are

more or less indelible and cannot be eliminated completely by any method known today. Nor can all characterologic deficits be totally regenerated, residual distortions often obtruding themselves impertinently at unguarded moments even in the most successfully treated inpidual. On the other hand, it is possible to neutralize the effects of inimical past experience, to enhance security, to bolster self-esteem, and to improve adaptation and problem solving through well-conducted short-term psychotherapy. The objectives that we may practically achieve are these:

1. Modification or removal of symptoms and relief of suffering.

2. Revival of that level of functioning that the patient possessed prior to the outbreak of the illness.

3. Promotion of an understanding that there are patterns indulged that sponsor symptoms, sabotage functioning, and interfere with a more complete enjoyment of life.

4. Attainment of some idea of how to recognize the existence of self-defeating patterns and how to measures, explore their consequences.

5. Provision of useful ways of dealing with such patterns and their effects in order to rectify and replace them with more constructive coping measures

Termination Procedures

Following the suggestions detailed in Chapter 4 "A General Outline of Short-term Therapy," the patient is apprised of the limited number of sessions that will constitute treatment, either by designating the exact number in advance and setting a termination date or, after indicating that the number of sessions will be circumscribed, by postponing announcing the ending date until after therapy has started. Once the target date is settled, the patient is periodically reminded of it and responses to this briefing handled (see pp. 45- 46). With rare exceptions therapy should be ended on the agreed-upon date (p. 46). The need to work on oneself is stressed (p. 47), and arrangements for further treatment made if necessary (p. 47).

The question is often asked as to whether symptomatic improvement by itself without some understanding of the underlying sources of the current upset is sufficient justification for the termination of therapy. Ideally the answer would be no. Symptomatic relief may occur as a consequence

of the placebo effect and may expend itself rapidly unless changes are brought about in the environment as well as in the self. Nevertheless, we should not minimize the importance of symptom removal since without it no therapy can justify itself. Relief of symptoms can restore important defenses that are a part of the inpidual's habitual adaptive machinery. In this way we may best achieve the objective of restituting the optimal past adjustment. Most patients are satisfied with this accomplishment, but occasionally some inpiduals expect more extensive results within a few sessions.

It is manifestly impossible to uproot personality difficulties that date back to childhood in a short period, and quite likely even intensive prolonged treatment will fail to budge some patterns. The patient will therefore have to be prepared for termination with the achievement of only less than a complete cure. A patient who came for treatment with a problem of obesity, depression, and strong feelings of inferiority was helped in 10 sessions to correct his food habits and to lose weight. His depression lessened to a great extent, but there was no change in the sleazy image he had of himself. I reminded him that our agreed-upon goal in therapy was to help him develop better food habits and moderate his depression. An excerpt follows:

> Pt. I feel a lot better, the weight and all, but I still feel like I don't amount to much.
>
> Th. We've gone over some of the reasons why you always have felt this way.
>
> Pt. But can't I be cured of this?
>
> Th. Your problem goes so far back that a complete cure would take a long time. Even then a few residues of your childhood may pop up from time to time. This isn't important because you can still keep growing and developing on your own with what you have already learned in therapy. Right now you can overcome your symptoms, like overeating and depression, and function a lot better in spite of how you feel about yourself. The reality is that you are not an inferior person even though you feel you are. Over a long period applying the understanding you now have will wear out this delusion about yourself. But expect no miracles. It will take time. The important thing is to keep working at yourself. Suppose you try things on your own, and in about 3 months we will make another appointment to see how you are doing.
>
> Pt. That's great. Maybe I can work at this by myself, and if I need further help, I'll call you.
>
> Th. Fine. Don't hesitate to call me if any further problems develop.

In avoiding the patient's request for longer-term therapy, we indicate that it is essential for the patient to try to resolve his problems by himself. This is done with no illusion that a cure will come about in any characterologic distortions, but rather to avoid becoming dependent on therapy. Proceeding on

one's own, progress may be made with interim sessions of short-term therapy if necessary. In this case two such brief periods of five and six sessions each were used the first year and three sessions the second year. Single follow-up sessions the third and fifth years revealed extensive and gratifying personality changes.

This does not imply that long-term therapy may not be the treatment of choice in some cases. But the selection of patients must be carefully made.

Another common question that confronts the therapist is if at the end of the allotted treatment time a patient feels better but has not reached the goals set by the therapist originally, should termination then be delayed? It is difficult to generalize an answer to this question other than to say that certain patients will benefit from further therapy and others will not. Much as we would like to continue working with a patient, the danger of interminable therapy must be kept in mind. Some patients will not, for sundry reasons, be able to achieve the objectives that the therapist has anticipated or that they themselves covet, no matter how long we keep them in treatment. Indeed, continued therapy may dissipate the gains achieved in the preliminary short-term treatment period, the patient becoming steeped in a negative transference and in crippling dependency from which he cannot liberate himself. The way this problem is best handled is to terminate therapy, enjoining the patient to continue working on his own (with the assigned homework) listening regularly to the cassette tape if one is given him, and reporting back for a session in 2 weeks, then once a month, and after a while once every 3 months. It is not unusual for a patient to have achieved considerable progress by himself after formal therapy has ended once the momentum has been started during the short-term span. Should no progress have occurred several months after termination, and should the patient be dissatisfied with his status, another intensive short-term treatment can be instituted, during which an assay is made of the kind of therapy best to use, the capacity of the patient to change, and realistic goals that may be achieved. Sometimes the second brief treatment trial does the job without further formal therapy being needed. On the other hand, we may not be able to avoid resorting to long-term therapy, and here the kind of therapy and the depth of therapy will suggest itself from the data already obtained.

We must, nevertheless, brace ourself to the possibility of failure no matter what we do. Inevitably there will be persons who do not well with any kind of therapy. Many of these inpiduals go on to

prolonged treatment with the object of achieving reconstructive change through the alchemy of time. The idea that long-term therapy will inevitably succeed where short-term approaches have failed is deceptive. There are some patients who seem doomed to a perpetual immature adjustment, clinging to a parental figure in a dependent way the remainder of their lives. Some theories of why this is so have been presented. One speculation for a certain type of patient is that in treatment the patient is unable "to bring about the internalization of the therapist as an object-anchor around which the patient can organize himself" or to maintain an equilibrium "in the face of the anxiety released by interpretive work" (Appelbaum, 1972). There are other surmises too, but some sicker patients will respond much more to adjunctive environmental manipulation, rehabilitative treatment, social therapy, and pharmacotherapy than to formal psychotherapy, although periodic psychotherapeutic sessions with a skillful and empathic therapist along with adjunctive approaches should produce optimal results.

Most patients, fortunately, may be helped—and significantly helped—by dynamic short-term therapy. Even deep personality difficulties may be influenced. Because entrenched character patterns are dislodged reluctantly, however maladaptive they may be, it is assumed that character alterations while *initiated* during the formal treatment period will need to continue to develop in the post-therapeutic span over an extended interval, even over years, before *permanent* altered imprints are etched into the personality structure.

Managing Untoward Reactions to Termination

In patients who have been in therapy for more than a handful of sessions and who have established a good therapeutic alliance, stormy clouds may gather as the termination date draws near. The fact that the ending of therapy brings out unresolved issues related to the separation-inpiduation theme is not entirely a liability. Indeed, as Rank (1936, 1947) insisted years ago it may become the most important aspect of the helping process by forcing the patient to face paralyzing dependencies and to assume the responsibilities of inpiduation. Many other authorities affirm Rank's belief that the working-through of residues of childish helplessness is essential toward sponsoring greater personality maturation. It is, however, naive to assume that adulthood will break out in a flash solely as a consequence of being evicted from therapy. It will require perhaps years before the fruits of maturity can mellow. The therapist should not deceive himself into believing that inpiduation is easy to achieve and

that with termination the patient, sword in hand, can happily saunter out to conquer the world. Nevertheless, the seeds of self-reliance have a greater chance of germination in the soil provided by the proper management of the terminal phases of the patient-therapist relationship.

How intense the reactions to termination become will depend on the patient's residual dependency needs, how thoroughly these needs have been supported during treatment, the way that the patient was prepared for termination, and bringing into the open the patient's feelings about termination. Often these feelings are not explicit, the patient being afraid to express anger or grief openly and the therapist avoiding areas that might be upsetting or embarrassing to him. It is important, consequently, to face the fact that termination can be difficult for the therapist also and because of this may require some soul searching on his part. Will the therapist be relieved in getting rid of a burdensome patient and consequently facilitate the easing of the patient out of his office? Will he feel guilty at discharging a patient who still suffers from residuals of the problem for which help was originally sought? Will he resent the financial loss created by a hole in his caseload? Will he himself suffer separation anxiety caused by his own unresolved separation-inpiduation problems? It will take a good deal of courage to face up to these issues.

Where dreams and exploration of acting-out tendencies are employed, the patient's feelings about termination will be most readily available. A patient was asked at the tenth session how she felt about terminating treatment the following month. She admitted feeling better and said that she was happy that I considered her well enough to be on her own. The next session she admitted feeling a "bit shaky" about handling matters by herself and that this reaction lasted for several hours after she left my office. She denied any feelings of resentment or depression. At the following session she brought in this dream: "I am attending a funeral. A girl with arms cut off in a coffin. She looks like me. I am frightened and run home." For the next few sessions we focused on her feelings of helplessness and fears of what might happen to her after she stopped, as well as her anger at me. Early dependencies fostered by an overprotective mother were explored. No revision of the termination time was made. At the fourteenth session she admitted feeling a great deal better, and she presented this dream: "I am sliding down a chute and falling down, then standing up, then falling down, then standing up, then falling down. Mother and father run up to pick me up. I push them away and I stand alone. I walk unsteadily but under my own power." In her associations she stated that at work she had taken a definite stand. She was proud

of herself because she refused to go to her employer for advice. “I know more about these things than he does.” Termination occurred after the next session. A 2-year follow-up showed continuing and extensive improvement in her adjustment.

The importance of allowing patients to express their feelings of disappointment, anger, and sadness cannot be overemphasized. The therapist will especially be alerted for problems where, as has been mentioned before, the patient as a child experienced a death of or separation from a parent or where in later life a catastrophic reaction followed the loss of or separation from a parent or mate. Patients with a high level of characterologic dependency may regard termination as a personal injury, an unwarranted desertion, or a sign of their lack of importance or self-worth. It is essential not to act defensive or guilty about terminating treatment. Explanations should focus on the need to protect the patient from getting locked into a dependency situation in treatment that will prove crippling and infantalizing. Most patients will handle the termination experience when given a chance to express themselves freely. Occasionally, though, the patient may become so angry or distrustful as to break appointments. If this occurs, the therapist should contact the patient by telephone and discuss what is happening. The fact that sufficient interest exists to induce the telephone call in all probability will motivate the patient to return for the remaining sessions.

I have found that the use of a cassette tape helps the termination process immeasurably. The patient does not experience the shock of being left alone on his own devices. He has a tool that he can utilize by himself to expand the gains that he has derived from treatment. Therapists who imagine that the inpiduation process is expedited by abruptly tossing patients out of treatment after the last session on the theory that the absence of the therapist and the presence of insight are remedial will encounter a rude shock when adequate follow-ups are done. A surprisingly large number of patients, who presumably had achieved maturity at discharge, sooner or later lock themselves into new paralyzing dependencies with some surrogate parental figure or exploit successive offbeat treatment modalities once they reexperience tension or anxiety. The use of the tape makes these feckless resources unnecessary. Speculation that the patient may get dependent on the tape and that this will thwart the inpiduation process is completely groundless. On the contrary, the tape enjoins the patient to continue the working-through process toward greater self-sufficiency.

No short-term treatment program is complete without some provision for this or some other type of self-help as well as maintenance of proper vigilance to prevent slipping back to the previous state. The patient should be enjoined to pursue "homework" assignments given him during the active treatment period (see Chapter 16) and invited to return to see the therapist briefly should serious problems develop in the future that he cannot manage by himself .

An aspect in therapy that is also neglected is providing patients with some means of correcting distorted cognitions. Supplying them with a way of looking at life and at their own experiences, in short with a proper life philosophy, may add to their enhancement of well-being. We might consider this a kind of cognitive therapy. The spontaneous evolution of more wholesome ways of looking at things often occurs subtly as a result of the cogent application of principles that the patient has learned in therapy. Life is approached from an altered perspective. What was at one time frightening or guilt inspiring is no longer disturbing; what brings insecurity and undermines self-esteem ceases to register such effects. This revolution takes time. Value change may not be discernible until years have passed beyond the formal treatment period.

It is often helpful to warn the patient that, while one may feel better, there will be required a consistent application of what has been learned in therapy to insure a more permanent resolution of deeper problems. The need for self-observation and for the active challenging of neurotic patterns is stressed. The patient is also enjoined not to get upset if a setback is experienced.

> Th. Setbacks are normal in the course of development. After all, some of these patterns are as old as you are. They will try to repeat themselves even when you have an understanding of their nature. But what will happen is that the setbacks will get shorter and shorter as you apply your understanding to what produced the setback. Gradually you will restructure yourself. In a way it is good if a setback occurs, for then you will have an opportunity to come to grips again with your basic problems to see how they work. This can build up your stamina. It is like taking a vaccine. Repeated doses produce a temporary physical upset, but complete immunization eventually results. In other words, if your symptoms come back, don't panic. It doesn't mean anything more than that something has stirred up powerful tensions. Ask yourself what has created your tensions. Is there anything in your immediate situation that triggered things? Relate this to what you know about yourself, about your personality in general. Eventually, you will be able to stop your reaction. But be patient and keep working at it.

Another neglected aspect of therapy are follow-up sessions. Prior to his discharge the patient may be told that it is customary to have a follow-up session I year after treatment, then yearly thereafter for a few years. Most patients do not object to this; indeed, they are flattered by the therapist's interest. An

appointment for a session is best made by a personal telephone call. Where the patient, for any reason, finds it impossible to keep the appointment, a friendly letter may be sent asking him to write the therapist detailing his feelings and progress if any.

Conclusion

The termination phases of short-term treatment are often minimized, many therapists imagining that the end of therapy will come about automatically. Left to their own resources, a considerable number of patients, if they can afford it, or if treatment is paid for by a third party, will want to continue in treatment indefinitely. The goals of short-term therapy are often set too high by both patients and therapists. Realistically, it is a forlorn hope that patients can undo in a few sessions a lifetime bundle of personality immaturities they could not eliminate with long-term treatment over an indefinite period. It will be essential, therefore, for the therapist to accept modest attainable goals within the brief span of treatment, while alerting the patient to problems to be worked on by oneself after therapy has ended. Therapy with a few exceptions should be terminated at the designated set time limit.

Termination, however, can be a problem for both patient and therapist. As the termination date approaches, the patient may experience a regression with symptom revival. The therapist will then be tempted to proceed beyond the termination date hoping that a few more sessions will save the day. Instead of yielding to this temptation, the therapist more propitiously should examine what termination means to the patient and to himself. Usually it will have stirred up the old dependency- autonomy conflict in the patient. And the fact that the patient has not achieved the entire hoped-for cure may, in turn, open old unhealed wounds in the therapist, including grandiosity and narcissistic need to prove invincibility as a therapist. It may also kindle the separation anxiety sparked by the patient's threatened departure. Both transference and countertransference will require exploration at this point to help the separation process toward allowing patients to stand on their own feet, putting into practice the lessons learned in therapy. The therapist must accept the fact that no patient can be completely cured at the termination of short-term therapy. The most that can be hoped for is that enough has been gained in treatment to have achieved symptom relief, abandonment of an old destructive pattern or two or at least some understanding of these patterns, and ideas of how one can keep working on oneself to assure continuing improvement.

Therapeutic change does not cease at the termination of therapy. It may continue long after treatment has ended, perhaps the remainder of the inpidual's life. Indeed, follow- up studies of patients who stopped therapy in a stalemate or because of no apparent improvement have revealed gratifying alterations that seem to have required the ripening effects of time.

Too frequently therapy is presumed to terminate with the last interview. The fact that over 60 percent of patients who have completed short-term therapy seek out further treatments (Patterson et al, 1977) indicates that an ongoing therapeutic experience of some kind, formal or informal, is deemed necessary by the great majority. If the therapist does not provide a direction, the patient will search for one personally, perhaps blundering into adventures that are unrewarding to say the least.

One way to foster continued improvement is to prepare the patient to work toward altering a destructive environment so that it ceases to impose strains on adjustment. The lines along which such modulations may be made will be determined during the active treatment phase. "Homework" should be encouraged. These may embody (1) tension reduction and ego- building through self-relaxation exercises or listening to a cassette tape, (2) inculcation of a proper philosophical outlook by imparting new meanings to one's existence, (3) observation of one's behavior to detect patterns that provoke problems, and (4) the studied practice of more constructive modes of coping with essential responsibilities.

Lest we chide ourselves at not having achieved with dynamic short-term therapy a completely "analyzed" patient on termination, we may heed the wise words of Freud who wrote: "Our aim will not be to rub off every peculiarity of human character for the sake of a schematic normality, nor yet to demand that the person who has been thoroughly analyzed shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task." We are, of course, hopeful that with continued work on themselves our patients will proceed beyond this objective.