12

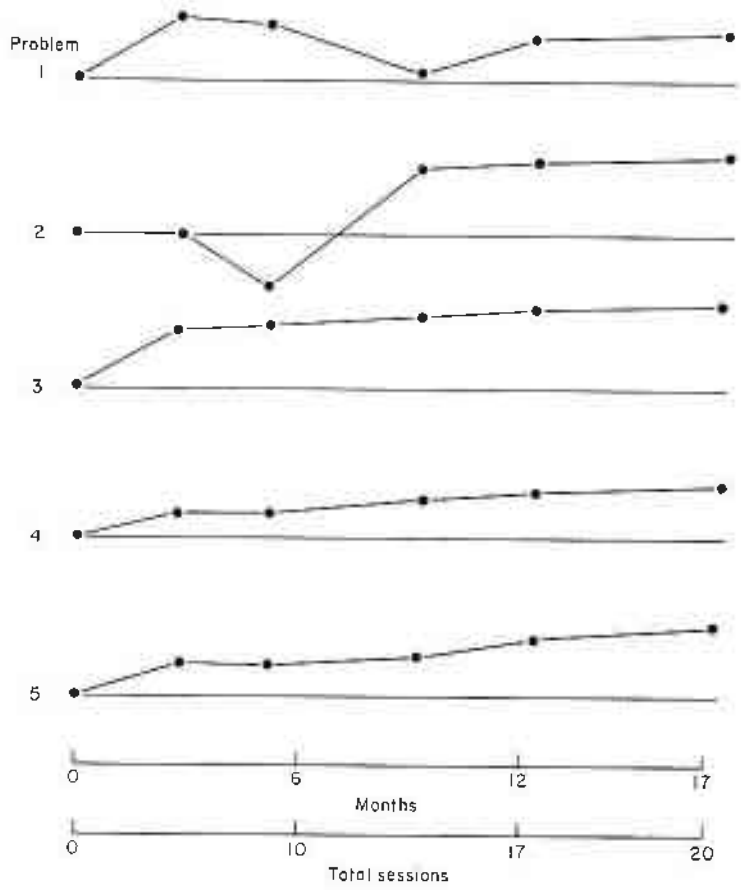
Marking Progress and Ending Treatment

The explicit listing of the focal issues of therapy at the end of the assessment period, in the ways discussed earlier, represents an explanation of the patient's difficulties and an indication of the current obstacles to change. When therapy is set up formally as a structured and time-limited contract, the ending is anticipated from the beginning, and will be referred to as an issue throughout. While this already serves to focus the work, it is also helpful to review how far each issue has been resolved by considering progress at intervals throughout the course of therapy.

MARKING PROGRESS

To rate progress, each target issue is made the basis of a simple rating scale, set out as a vertical line on which the initial state represents the mid-point of the line. The horizontal dimension marks the passage of time. At each review of progress, change is recorded in relation to the vertical scale, marks below the mid-point representing deterioration, marks above, improvement; the top of the scale being labelled with the agreed objective. The patient carries out these ratings every few sessions, taking account of what has happened in his life and in the therapy since the last rating occasion. The therapist can comment and, in particular, needs to look out for signs of inaccurate, compliant rating, or for other transference manifestations, but the patient decides where to put the final mark. These reviews record progress and often enhance the patient's realistic self-monitoring; they also frequently serve to remind him of progress and restore a sense of being in control. The ratings may also identify neglected or unsatisfactorily resolved issues and will lead to examination of the reasons for failure to progress, and may suggest a need for the use of other methods of treatment. The relation of these ratings to the time elapsed and the time remaining in therapy also serves to frame the work and to prevent the kind of comfortable stalemate or infinite postponement which can develop in work done without time limit.

An example of the use of these ratings through the 26-session, 18-month therapy of Rachel (described briefly in Chapter 10) is given in Fig. 12.1.



1. Prone to panic attacks (aim: to be symptom-free).
2. Marked preoccupation with thinness, self-induced vomiting at times (aim: ordinary concern with food and weight).
3. Tendency to be remote from, and in control of, others (aim: to be able to be more exposed and less controlling).
4. Dilemma: if depending and submitting then not cross (aim: to be able to assert and defend own needs).
5. Dilemma: either in control or in chaos (aim: to feel safe in self and able to let go).

Fig. 12.1 Example rating scale.

Rachel

Rachel was a young woman of twenty-two, with a past history of anorexia nervosa at the age of fifteen, and of a referral to Child Guidance at the age of nine. She had now consulted on account of panic attacks and a travel phobia. She was still markedly preoccupied with the question of thinness and she often ate compulsively and then made herself sick, by which means she had maintained her weight at the lower end of the normal range. The aims of treatment, formulated on the basis of the assessment sessions, were focused upon the loss of these symptoms and on the revision of the terms of her relationships with others which, in my view, constituted a more fundamental problem.

Looking at the ratings of progress (Fig. 12.1) it is noticeable that her tendency to remain remote from others (3) and the two dilemmas (4 and 5) showed steady improvement throughout the treatment period. The appetite symptoms became worse initially. After 3 or 4 months in therapy Rachel had embarked upon her first happy and sexually fulfilling relationship. Her feelings about the relationships between allowing food and allowing love were summarized in a dream in which there was no food in her kitchen, but a very warm fire burning in her bedroom; she observed that she seemed to be paying for this new relationship with the increased self-induced vomiting (Problem 2) that is recorded on the chart on the second rating occasion. Following the rating session at which the contrasting changes in these problems had been discussed, and the nature of her binging and vomiting again considered, she virtually stopped binging although she suffered a setback with regard to her panic attacks (Problem 1). She remained free of any major food preoccupation when treatment ended a year later and at follow-up, 8 months later. The short-term contrary movements of her ratings could be regarded as an example of "symptom substitution".

ENDING

In most cases of brief therapy, a satisfactory degree of change will have been achieved by the time the termination date is reached. Where therapy has been confined to the more didactic active methods, in which the patient has been taught ways of increasing his capacity to monitor or control his actions, progress will have been clearly marked by an extension of autonomy for the patient, and in such cases the therapist will not have invited a transference relationship. In so far as the transference is manifest, it will usually be in the form of a direct response to the therapists's role as parent or teacher, and will take the form either of compliance or of resistance. Such responses need to be dealt with but if the essential relationship has been a satisfactory teacher–pupil one, then it can usually be relinquished relatively easily. Active methods are therefore particularly suitable for short-term work, or work in contexts where the development and interpretation of transference can conflict with other aspects of the professional role as, for example, in the case of general practitioners or probation officers.

However, active approaches are not adequate in many cases. To the extent that the patient's problems have become defined and dealt with through the metaphoric relationship built up between patient and therapist, the patient's autonomy may well be impaired and will need to be restored before therapy can be considered complete. The issue of termination is, therefore, a central one in such therapies. Only in relinquishing the support of the therapist are the lessons finally learnt, and the personal growth of the patient finally achieved. To the extent that the metaphoric nature of the experience is partly lost sight of by most patients, so that the therapist is seen to provide a replacement of the early significant others, or is seen only as providing a repetition of the frustrations and angers previously experienced, the process of termination will be a painful one, but one which is potentially therapeutic. The therapist must ensure that the disillusion and mixed feelings are both experienced and survived for, if impossible hopes can be given up or if the patient can be freed from his need to continually seek their satisfaction, or from the need to avoid expressing any needs because of their depth and inappropriate nature, then the patient's capacity to pursue attainable and appropriate aims can be enhanced.

In all cases therefore the meaning of the approaching termination must be fully considered by patient and therapist. Some patients will have difficulty in acknowledging its significance and will try to avoid sadness or anger associated with the loss of the therapist. Where an incompletely mourned previous loss has played an important part in the patient's difficulties, living through the end of treatment and fully experiencing what it means is a crucial aspect of the therapy. Even where past losses are not the main issue, most patients will experience some reliving of past disappointments and disillusions, and some facing of the need to give up fantasy and magical expectations. In the course of doing this they will experience, often for the first time, uncomfortable mixed feelings. Such experience is helpful in healing previous splitting mechanisms, whereby others were seen either as idealized or as disappointing and frustrating figures, and leads to a more satisfactory pattern of relationships and of self-care. In patients treated with the therapeutic methods described in this book, the intensity of transference feelings is often eased by the fact that the patient has already acquired many skills and capacities through the use of the explicit framework and active methods. His experience of the therapist and of leaving the therapist will still be an illustration of important themes, but it will be an illustration in the context of a relationship which has included sharing of concepts and understandings, and the dependent transference will not bear the whole weight of the therapy.

We will now consider the use of these ratings and the issues around termination as they presented in the case of David and Anne.

David

In David's case the shortness of the initial therapy was such that only one rating was carried out, at his last (seventh) appearance. The rating scales used allow for a

change of plus or minus 20 mm. David recorded no deterioration on his ratings, and the following improvements: depressed mood – +8; not feeling in control of his life – +7; not able to work – +5; sadness and anger over Patricia – +15; the placation trap — +4; the dilemma, *if* submitting, *then* not cross – +3; on the remaining dilemmas and the snag (see Chapter 7) he rated no change. At the rating session, he reported that his friends had commented on his greater capacity to make claims for himself, and he also described a clear and realistic decision about his future career plans, based upon following a long-standing interest in a field not related to his previous work. Whether David's confusion about the time of his eighth appointment represented a denied aggressive act is uncertain, but the likelihood of there being some disappointment at losing my support, given his previous disappointment in his father and his recent loss of Patricia, seemed high. I suggested this at the sixth session, but he denied strong feelings. Had he come to the eighth session I would certainly have returned to this theme, in case he had failed to acknowledge fully the meaning of the event to him.

David has seen for further individual sessions after a 5-month gap. By that time he was involved in taking his final examinations, which he had prepared for doggedly and methodically. He was seen with long intervals (3–5 weeks) between sessions.

Anne

Anne's initial therapy (22 sessions over 8 months) ended with an agreement to review the situation after 5 months; at that time a further period of treatment was offered. Progress was rated on two occasions during the first phase and once after 8 further sessions. At the time of the first rating occasion, Anne had begun to experience sad and angry feelings about her past life, although she felt these only intermittently. She was anxious about doing the ratings, but in the course of filling them out, came to realize that she had made real progress on many of them. Discussing this perceived improvement with her husband, she was pleased to find that he was in no doubt about it being the case. Her second rating was carried out 6 weeks before the gap in treatment; once more, in doing these ratings, she realized that, regarding the patterns of her relationships with others, she had made further progress. The last sessions of this phase were concerned with her being emotionally present rather than working hard at being a good patient, and with acknowledging her feelings as she became more deeply aware of the meaning of remembered episodes from her past. I did not repeat the ratings at the end of this phase of therapy as I felt this could have been an inappropriately task-oriented approach at that time and as, in any case, it was clear that she had held on to the gains that she had reported at the second rating occasion. During the 5-month gap in therapy, Anne wrote the following letter:

> This is a very difficult letter to write because I had been waiting for a crisis to come to write to you about but, for some reason, it hasn't happened; nor have I actually felt ready to regain contact with you until now. These two things have surprised me, partly because I had fears of not coping while you were away, and also because I had expectations of having to write you frequent letters to calm myself during your absence. Not only that, my destructive impulse has not even sought to disturb this relative mental calm that I have enjoyed over the past 2 or 3 months. Although part of this, I am sure, is symptomatic of my distancing myself out of self-protection, I also feel that the period, as you predicted, has been useful because it has enabled the slow, gradual absorption of everything we talked about. Although I have had periods of tenseness, they have not been characterized by my old friend, the fear of losing control. Generally they have expressed themselves as phases of depressiveness, irritatedness, or complaining; although it is difficult to tell, I think they are sparked off by both/either guilt from not working and/or an abstract need for a session of psychotherapy with you; I say "abstract" because during the whole period of your absence I have felt no need to go and see anybody else because of any problems, yet I have missed talking with you. Although problems like fears of nervous breakdowns are no longer prominent — either resolved (I hope) or put out of mind — my fear of cancer still plagues me occasionally. . . . On the whole my relationship with my husband is much healthier, and I am much more confident about showing my feelings, and that includes anger very occasionally. I have been to my parents' a couple of times and have managed OK. One change was that I felt real depression about my mother's sorry state, after a long talk with her one evening, rather than anxiety or fear. It seems to me to be the more appropriate feeling.

Anne's last phase of treatment was concerned with experiencing more deeply what she had learned earlier, and with preparing for termination. Her ratings on the third occasion, after a total of 34 sessions over 15 months, were as follows: preoccupied with the fear of a nervous breakdown – +17; inability to trust others – +12; compulsive care-taking – +18; depressive thinking – +18; social isolation trap – +17; guilt relief by self-deprivation – +19; *if* hopeful or effective, *then* imagining death of parent – +13; *either* helpful and controlling *or* dependent and potentially crazy – +17; *if* loved, *then* feeling trapped – +19; *if* striving for perfection, *then* stressed; *if* not striving, *then* guilty – +12; snag-avoiding fully achieving, enjoying, claiming or having a life, *as if* own life is at the cost of mother's – +15.

To conclude this chapter, I would like to consider further the way in which termination is defined and carried out. For most patients it is quite simple: the job is done and one says "goodbye" forever. For others, the work has indicated that some further therapy of a different kind may be indicated; for example group, family, or marital therapy. In other cases, it may be appropriate to offer follow-up appointments, and in some cases these may continue for a long time. Such follow-up appointments do not mean that the patient is denied the experience of termination; it is rather that they represent a sign that the work is expected to continue, and that there will be a witness for it. The therapist is often the only other person who can really understand the way in which the issues discussed in therapy are still of active concern. This process of continuing work can be difficult, and it cannot easily be shared with others, for friends, especially those who are emotionally close, often find the importance attached to therapy and the therapist incomprehensible or absurd.

Ultimately, the revision of strategies and assumptions, and the more integrated and effective sense of self which successful therapy achieves will be sustained by the patient, and the necessary separating and mourning process will be completed. The therapist, who was a new "other" to the patient's self has offered forms of understanding and of relationship which have allowed a modification of the terms on which the patient's life is lived; and, as these terms are claimed by the patient as his own, the living therapist can be forgotten. In terms of the PSM, the sense of competence has been enhanced, the identity of the self is more fully known and integrated, self-knowledge and self-monitoring are more accurate, and the criteria of self-judgment are less critical and are based on a clearer understanding of the limits of responsiblity.

The resolution of splitting and projective identification, whereby the perception of others is distorted and the division of the self is perpetuated, will be achieved most securely by the experience of relating to the therapist, who elicits and accepts aspects of the patient on both sides of the split. The therapist, in ending therapy and in all the other ways in which he fails to meet the patient's more regressive and often unconscious wishes, will evoke disappointment, sadness, or anger. If he allows and acknowledges this as well as being, and being seen as, a good and caring figure, then the patient's tendency to see others as polarized between idealization and denigration, and himself as either perfectly cared for or utterly rejected, will be mitigated. Many relationship dilemmas, as described in terms of the PSM, are maintained by such polarized role perception, as was discussed in Chapter 5. However, the interpretation of the projective elements in the transference may not be the only way to resolve these problems. The revision of the terms of current significant relationships, on the basis of understandings achieved and the encouragement given in brief therapy based on sharing understandings, in the terms described in previous chapters, may be achieved without depending exclusively on the transference.

DISCUSSION

The detailed specification of goals of treatment, and the recording of progress towards these goals, often by way of successive sub-goals, was evolved largely by behaviourists. Where it has been adopted by therapists of other persuasions, the purpose has been to assess change rather than to organize the course of treatment (e.g. Battle *et al.*, 1966). The approach proposed here, and first described in Ryle (1979), aims to extend this behavioural approach, which is restricted to the modification of observable behaviours and symptoms, by specifying in addition the conceptual and procedural problems that require revision. The rating of progress on target problems, traps, dilemmas, and snags serves, as in behavioural treatment, both to focus the work of therapy and to provide a basis for the assessment of progress at different stages. Improvements recorded by a series of fifteen patients on rating scales of this type were accompanied by appropriate changes in repertory grid

measures relating to dilemmas, indicating cognitive revision, and on scores on a symptom inventory (Ryle 1980).

As regards the issue of termination, only psychoanalysts have considered in depth the meaning of the therapeutic relationship and of its ending, and the importance of dealing with these meanings explicitly in brief interpretive psychotherapy has been stressed by many authors, notably by Malan (1976a) and Mann (1973). "Transference cures" achieved by the patient's need to please the therapist, or by their "internalizing" the therapist as a "good object" may be satisfactory for some problems, especially where positive transference has been utilized to guide the patient towards more effective forms of self-control and self-care; but in some cases changes achieved in this way will be unstable or insufficient.