An Alternative View of Termination and Post-termination Follow-up

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Abstract

Traditional psychoanalytic theory presumes post-termination patient-analyst follow-up contact will damage the patient; there is no empirical evidence that this is true. Traditional theory prescribes total patient-analyst separation to support mourning the loss of the analyst, absent evidence for the value of this separation.

Contemporary (especially relational/interpersonal) theory provides an alternative conception of termination and follow-up based on the central role of the real person in a successful analytic treatment involving a mutually-caring patient-analyst relationship.

In this alternative conception, the termination period should include discussion of feelings about post-termination follow-up which provides many advantages for patient and analyst: the patient re-experiences the analyst's caring, has re-invigorated helpful introjections of the analyst, and has additional opportunity to deal with idealization of the analyst. The analyst can learn about the patient's unpredictable, inevitable post-termination changes, positive and negative, and modify his/her understanding of the course and outcome of treatment.

Key words: termination, post-termination follow-up, mutually caring, patient-analyst relationship, real person of the analyst, introjection.

Introduction

However long and arduous an analysis may have been, the terminal phase creates its own problems for both participants. Not infrequently it reveals an incongruence between the patient's and the analyst's conceptions of the goals of the treatment. Whether the analyst is successful in convincing the patient that the analytic work must be limited to goals accessible to treatment and that the terminable analysis be distinguished from the interminable has great practical significance. At the end of a psychoanalytic treatment the patient should have developed some capacity for self-analysis. This means simply that the patient learns and employs the special form of reflection that characterizes the psychoanalytic dialogue. Tied to this ability is the expectation that the capacity for self-analysis will work against the inclination toward regression which may still arise after analysis when new problems are encountered, and that thus the renewed development of symptoms will be hindered. This view is opposed quite often by "the myth of perfectibility," i.e., of the complete analysis, which molds the attitudes of some analysts toward the terminal phase as a result of the pressure exerted by their own exaggerated ideals (see Thomä & Kächele, 1994a). However the growing length of some analytic treatments seems to enlarge the problems connected with separation and –alas – achieving termination. “Good enough ending” (Salberg, 2010) has become an issue.

The lack of consensual agreement about the definitions either of psychoanalysis or of analytic process, make it unlikely that there will be consensual agreement about the concepts either of termination or post-termination follow-up. These conceptions are based upon traditional analytic theory yet have little empirical support. Mendenhall (2009) notes that “Much of the psychoanalytic literature on termination is steeped in ideals of autonomy, independence and permanent cessation of contact” (p. 117). This

paper provides a rationale for an alternative conception of termination and post-termination follow-up to that prescribed by traditional psychoanalytic theory leading perhaps to new goals.

Each analytic dyad is unique, and it seems unlikely that any one theoretical approach would be optimally effective for all dyads (Mendenhall, 2009). The traditional approach may well be most appropriate for some analytic dyads, but not for others, and, therefore, the availability of alternate conceptions of termination and post-termination follow-up might be quite useful and provide a significant enhancement of our armamentarium.
The very term, termination, with its guillotine-like implications, is a dreadful term, but we have been unable to create a useful alternative. Holmes writes, "Ending therapy is a real loss; a significant segment of the client's life is no longer there. … Dependent on mood and perspective, the meaning of an ending can be a death, a bereavement, a completion, a liberation, a funeral … or a joyful moment of maturation and leaving home (2010, p. 67).

Post-Termination Contact with Patients Follow-up

For good reasons medical practitioners traditionally included follow-up observation of their treated patients. Grand Rounds typically is an arena for such discussions. Why did Freud, a physician, and other early medical analysts not regularly utilize follow-up visits? While Freud did report follow-up material whenever it became available (Freud, 1905; Freud, 1909; Freud 1918), he neither proposed nor sought post-analytic contact. Face-to-face follow-up probably would not have been feasible with those of his patients, like Kardiner, who came from other countries. However, more significantly, his priority was on delineating his patients' infantile traumas in order to fashion an encompassing scientific, etiological theory of mental illness rather than seeking corrobation of his theories in learning about his patients' post-treatment lives.

In the following section we want to invite the reader to follow us on a timeline focusing on the reasons why later physician analysts have given for not following-up their treated analytic patients. Rangell (1966) referred to "the post-termination phase of therapy", but if this phase was examined at all, post-termination contact was characterized as deleterious to the former, "terminated" patient. He cautioned "There is sometimes a gratification or stimulation of the patient by a premature and excessive social intimacy which is reacted to as a threatened seduction" (p.162). In a 1969 panel five training analysts "preferred to avoid all contacts with former patients for an indefinite period …[because] it might interfere with post-analytic working through processes" (Panel, 1969, p.235). Likewise Ticho (Panel, 1975) cautioned against the need to 'reassure' patients that the analyst will be available for future consultations, believing that this conveys the analyst's doubts about the patients' ability to continue to grow. In 1982 Calef clearly recognized that "A taboo among analysts seems to exist against possible intrusion and invasion by follow-up studies" (p.94). He understood that analysts believed that post-termination patient-analyst contact for other than treatment would generate increased anxiety and regression in the patient. This theory-based position impaired their freedom to actually experience follow-up contact with treated patients, other than patient-initiated requests for help. Analysts who expressed interest in follow-up contact with a treated patient were criticized for having unresolved counter-transference problems. A further critic, Hartlaub et al. (1986), noted that "we had all shared the unconscious fantasy that after a successful analysis the patient would not need further contact with the analyst, or, conversely, that re-contact somehow cast doubt on the completeness of the analysis" (p.895). Blum (1989), too, asserted that the analyst should not see the patient again, because, hypothetically "the patient's mourning cannot be completed prior

to real separation" (p.290). Even Wallerstein – having completed his large scale substantial writeup of the 42 Menninger cases (1986) - cautioned that planning for contact after the end of treatment could impinge on the proper terminal mourning (Wallerstein 1992). And in 1997 Novick described "The fantasy of post-termination contact … is of a transformed relationship in which the doctor and patient will become equals, friends, colleagues, coworkers, or even lovers" (pp. 153, 154). The Swedish analyst Szecsödy (1999) agreed with critics that "Many analysts refrain from offering the analysand the opportunity for contact in the future because they see the self-analytic function of the analysand as the most essential benefit of treatment" (p. 59). Levine and Yanoff (2004) go further and assert that post-termination contact is a dangerous enterprise that may well place the analyst at risk for ethical violations and the patient at risk for explotation. Davies (2005) later presented a more complex view that 'termination' involved multiple goodbyes, and each [goodbye] holds the potential not only for growth, emergence and liberation, but also for grief, despair and narcissistic collapse" (p.783). Elise (2011) concurred that further patient-analyst contact is undesirable since "saying goodbye is an experience that is necessary, valuable and instructive" (p.598). These widespread assertions of the potential destructiveness of post-termination contact are not based on clinical observations; analysts did not attempt post-termination follow-up. They were based, instead, on theoretical assumptions, just as for many years it had been uniformly agreed that homosexuality was intrinsically psychopathological.

Although the accessible literature describes failures of analytic treatment (for a summary see Goldberg, 2012), we could find no paper describing problematic follow-up contact. We agree with the qualification that major unresolved problems in the terminating analytic treatment increase the risk

that such follow-up contact may cause difficulty; then it should be avoided.

Bergmann (1988), is prominent in questioning the dangers of post-termination contact, commenting on the strangeness of analysts' choosing to have no further contact with the patient they have treated, and noted that there is no analogue in human experience for the current conception of termination in which an intense, long-standing relationship is terminated with the prospect of future contact being 'nevermore' – except for death. Limentani (1982) discussed the consequences for the patient of unexpected termination of analysis: "It is the prospect of never seeing the analyst again that is likely to produce prolonged pathological reactions, either through an equation of the idea of separation with that of death … or through the loss of the omnipotent fantasy of fusion with the loved object. This would account for the surprisingly violent responses to the analyst's announcement of an impending move to a different location, or illness" (p.438).

Early Research Follow-up Studies

The founder of Norvegian psychoanalysis, Harald Schjeldrup, unknown to American analysts, conducted what may be the first questionnaire/interview follow-up study (1955) of his own 28 psychoanalytic cases. Nine cases showed a lasting symptomatic cure, 25 cases had improved interpersonal relations, and 22 cases demonstrated enhanced capacity for work and enjoyment of work. No mention was made of deleterious effects on the former patients. Undeterred by assumptions that follow-up contact with the patient may be disturbing to the patient, Pfeffer (1959) courageously evaluated the results of analysis by conducting a series of individual interviews with two patients who had completed successful analyses with other analysts. He recognized that interviews conducted by an analyst other than the treating analyst are advantageous to avoid "A marked

tendency … especially among less experienced analysts, to underestimate [therapeutic] results" (p.440). Pfeffer described the development during follow-up of a vivid transference neurosis in one patient, and noted there was no indication of harmful effects from the interviews. He later (1961) again reported the recurrence of a residue of the patient's analytic transference during his interviews. Pfeffer's last study (1963) was followed 12 years later by follow-up studies conducted by others (Oremland, Blacker and Norman, 1975; Norman et al., 1976; Schlessinger and Robbins, 1983) all of whom reported the persistence of the patient's transference feelings. Patients were quick to identify those responses close to conscious reflection, as did those subjects in Graff & Luborsky's (1977) longitudinal observational study. Kächele et al. (1985) distributed Strupp's follow-up questionnaire to 150 analytic and psychotherapy patients. Factor analysis revealed two dimensions; one was empathy and acceptance and the other was confidence and feeling accepted. These two dimensions were positively reported in 14 of 15 one analyst's analytic patients, though patients of other analysts did not express such positive experiences to this degree. There were no reported ill effects from this follow-up questionnaire study

Traditional Analytic Theory's Conceptions of Termination and Post-termination Contact

Basic traditional theoretical conceptions consist of the following beliefs: 1. Termination requires complete separation of patient and analyst in order to provide the patient with the opportunity fully to resolve the mourning response to the loss of the analyst; this experience is necessary for the full development of the patient's autonomy[1]. 2. Follow-up patient-

[1] While there is no empirical basis for this belief, it may have an historical root when Freud lost his relationship with Jung, he lost his total control of the future of psychoanalysis. This loss of control required that he mourn its loss … but he could not." (Homans, 1999, p. 77).

analyst contacts may involve risks of deleterious effects upon the patient. 3. Follow-up contacts may foster the patient's continued dependency upon the analyst. There are no empirical studies to support any of the three elements of the traditional conceptions of termination and post-termination follow-up listed above.

Empirical Study of the Post-Termination Mourning Response

Contrary to the concerns about attenuating the patient's mourning, Craige's (2002) empirical study demonstrated that contact with the analyst after the end of treatment did *not* vitiate the response of mourning. Her survey of 121 analytic candidates who had completed their training analysis, reported that 76% of the respondents experienced a mourning process that lasted on the average between six months and one year, even though almost all of them expected to continue to see their training analysts in the course of professional activities. Craige also was surprised to find that neither the [candidate's] *sense of painful loss … nor loss of the unique analytic relationship* …was significantly correlated with *significant emotional loss in childhood* (p. 518). She concluded that "the loss of the actual, present-day relationship with the analyst is, in itself, the loss most keenly and commonly felt after termination" (Craige, 2006, p. 587). This conception is consistent with the relational/interpersonal view of patient-analyst relations described later in this paper. Pedder (1988) contrasted the post-treatment experience of non-analyst patients who have little opportunity for contact with their former analyst, with most analyst/patients who seek out contact with their *own* training analyst. He questioned whether "then are we not asking patients to face something that we analysts may never, or seldom, have to face? (p. 500).

Why did traditional analysts so readily believe that post-termination contact would be deleterious to the patient since most analysts had little experience with post-termination contact other than their own often very different personal experiences with their own analysts? Although opportunities for extra-analytic patient-analyst contact vary widely, we have observed that many analysts appear ill at ease with informal contact outside their office with current or former patients; one possibility is that in casual extra-analytic contact, they may be aware of the loss of the emotional support of their professional persona. The power and prestige of the analyst's role with its accompanying office rituals, may be reassuring to the analyst and none of these protections are available in extra-analytic contacts. Possibly, stated concern that post-termination contact may be deleterious to the patient may serve the analyst´s need to avoid a situation expected to be potentially uncomfortable. Moreover, if the analyst, additionally, has concerns about the degree to which treatment had helped the former patient, he/she may feel uneasy about the revelations in such subsequent contact.

Empirical Studies of Termination and Post-termination Follow-up

A review of empirical studies provides a basis for developing an alternative conception of termination and post-termination follow-up rather than one based upon traditional analytic theory. Hartlaub et al. (1986) mailed a questionnaire to 39 graduate analyst members of the Denver Psychoanalytic Society; 16 responded with data about 71 completed analyses, 85% of which they considered successful. Average time elapsed after termination was 2.6 years. Approximately 50% of these patients had made contact with the analyst by letter, telephone, or other means since termination. Thirty-five percent saw the analyst in person for a brief office

visit, 19% for brief psychotherapy and 2% for reanalysis. Patients contacted their analyst because of: a) reworking termination issues (17); b) due to unresolved issues from the analysis (6); c) life circumstances (8); d) issues previously unrecognized by the analyst (2); e) other (10).

Questionnaire data (Schachter and Brauer, 2001) were obtained in 1994 from 395 APsaA respondents constituting a 54% response rate. We assumed, as most were APsaA members at that time, that many utilized traditional analytic theory. Results indicate, consistent with traditional theory, that respondent analysts did not discuss or propose post-termination follow-up to their patients. Most commonly, 31% of the respondents told the patient that they would be available if the patient needed additional help; the next most common statement (22%) said they would be available to see the patient again. The terminating patients´ view of the analyst´s avoidance of actively suggesting the possibility of post-termination contact has not been explored.

The study also indicated that a much higher percentage of former analytic patients contact their former analyst if that analyst had made some statement about future patient-analyst follow-up contact, in contrast to those analysts who made no statement about the possibility of future patient-analyst follow-up contact. Thus, what the treating analysts says or avoids saying about the possibility of future follow-up contact does influence the likelihood of future follow-up patient-analyst contact. This study also replicated an earlier finding that prior patients were much more likely to contact their former treating analyst if the analyst was a woman rather than a man. Perhaps women analysts value attachment and caring more highly, are less impressed that total separation is necessary to achieve autonomy, or do not value autonomy as a goal as much as male analysts who therefore believe that separation is required for achieving it. (It is noteworthy that

traditional analytic theory is the product primarily of male analysts.) An interesting finding requiring explication is that prior patients were more likely to contact their former analyst if that analyst frequently thought about their *own* analyst – perhaps were more identified with their own analyst - compared to analysts who rarely thought about their own analyst. Overall, we can recognize that the analyst's characteristics and behavior substantially influence the likelihood that the patient will initiate post-termination follow-up contact. However, replication of his findings would be essential.

In a different study, Schachter et al. (1997) studied the impact of analyst-initiated follow-up interviews by three different treating analysts of their own former patients to see if there were deleterious effects. In one case the meetings facilitated the patient's re-entering treatment, leading to significant further growth. In the second and third patients, the meetings re-ignited mourning for the analyst and furthered analytic gains. In this small sample there was no evidence of harm; the contacts were helpful for all three patients, and appeared to provide an opportunity to extend the mutually caring relationship that had developed in treatment. They also indicate that follow-up meetings may result in a patient returning for additional treatment that might not have occurred had the follow-up not taken place.

A Case Report of an Analyst-initiated Post-Termination Follow-up

The description of one post-termination experience in the words of one of the three analysts (not J.S.) is copied from the original published article. We appreciate this analyst's permission to report his work.

Presenting Problems of Patient Named Charlie

Charlie, a 27-year-old single musician, came to me seeking help in 1982 because of 'problems maximizing what I consider to be my potential'. He had many casual friends, but had never dated a woman for more than a

few weeks. ‘People consider me a warm, outgoing clown … I’m a perennial 21-year-old.’ He had embarked on numerous projects, including college, without carrying any through to a successful completion. With considerable guilt and anxiety, he said that he was afraid of his own potential for aggression, especially towards women. Charlie recalled many loud arguments with his mother over his refusal to eat a large variety of foods. He became aware in his teens that she had a drinking problem. He felt responsible for his mother's drinking and her death from cancer when he was 21, his ‘perennial age’. My impression was that conflicts involving aggression had prevented successful mourning for his mother, interfered with male identity formation, and left him with considerable unconscious guilt. The price of appeasing a harsh superego was avoidance of conscious and unconscious aggression in all its forms, including success. Sexual urges were also being ruthlessly opposed. Charlie seemed to experience his life as an unending struggle for self-control against nameless urges.

Summary of the Analysis

Charlie began analysis at a reduced fee with his customary energy and enthusiasm. He developed an initial (defence) transference of making himself a gentle, entertaining submissive clown. I gradually helped him to see how frightened he was of me, and that his fear of me was actually a fear of my discovering his own hostility towards me. As this fear of his own hostility became better understood, the transference deepened through his wish to compete with me, yet he was harshly self-critical for having the wish. Over the next few years clarification of his aggressively charged sexual and competitive wishes and harsh self-punitive reactions to them enabled him to experience more freedom to develop his considerable musical talents. By following his associative pathways from his punitive

expectations of me, we came to consider the possibility that early sexual over-stimulation by his mother had occurred. Early rage reactions and frightening omnipotence were frequently re-lived during these sessions. We understood these to be consequences of his early, over-stimulating relationship with his mother. These and other sources of guilt were worked through with many dramatic and convincing transference enactments. Defensive submission alternated with rage in rapid succession, finally giving way to interpretation. We also made sense of his guilt on the oedipal level, as reflecting a frightening fantasy of competition with father, influenced by an unmodified early sense of omnipotence. By 1987 he had developed confidence in himself at work and with women far beyond anything he had previously known. He felt considerable relief from his burden of guilt. He had completed college, begun a career as a professional musician, and fallen in love with an attractive, capable woman. After several years, they decided to marry.

Termination Phase

When the resulting emotional growth had become evident to him, he brought up the possibility of terminating. I too came to a sense that he was ready to terminate. While I did not suggest that we *would* have contact after termination, I could imagine circumstances in which it might be useful. So I said nothing to rule out the possibility, or to suggest that if we should meet again it would be a sign that analysis had somehow failed.Once we set a date for the last session, many of his prior symptoms surfaced again. I interpreted these as resistance to the feeling of losing me. It was only five weeks before the last session that Charlie realised that he would miss me, through an incident that crystallized his grief. One of his students had finished a series of lessons, but missed the last one. My patient was puzzled and upset about

this. The student had, Charlie told me, been devoted to him and had made enormous progress over years of hard work. Charlie wondered if the student hadn't liked him so much after all. I said: 'You have a blind spot here. You can't see that *your* student was upset about leaving *you* because you're trying *not* to be upset about leaving *me*'. Now he allowed himself to cry during each of the next three sessions, and I too felt tearful. He referred to 'the blind spot' every day for a week. He told me he loved me. Muffled noises on the street outside my office sounded to him like a small child crying. After this poignant episode, we were able to finish on our agreed date without further difficulty.

Post-termination Contact

Five years later, while I was making plans to visit the city in which I had lived during his analysis, I contacted Charlie. I did this only after considerable soul-searching. I was well aware of my wish to see him. I decided that meeting again was unlikely to hurt my patient and would probably help him to re-examine his feelings for me. I felt it was important that I remain in an analytic role; this visit would be a part of the analysis. In thinking this way I was defending myself against the imagined accusation that I was 'acting out' with my former patient.I contacted the original referring psychiatrist to ask him to let Charlie know I would be returning to town for a visit and to enquire whether he would be interested in meeting with me. I wanted to give him the chance to decline without awkwardness. Charlie replied through the psychiatrist that he was delighted to hear from me, and he would be eager to see me again. Since I conceived of this session at the time as an extension of the analysis, despite my having taken the initiative, I charged my previous fee. My views have evolved since then, and today I would not charge for such a meeting. We met in the referring

psychiatrist's office for one fifty-minute session. When our eyes first met, he suddenly broke into tears. I felt tearful, too, and excited. Then he quickly suppressed his tears and began by telling me a funny story, the entertaining clown defense. Within moments we fell into the easy, mutual familiarity we had enjoyed before termination. I continued to feel excitement, and I realized how much I had missed him. I asked about his life and, in particular, his current handling of the issues that had been so troublesome before and during the analysis: work, relationships with women, and tolerance of his own aggression. He told me of his considerable professional success, with only a trace of the previous guilt. Sadly, he described his father's recent death and mourning for him.He went on to describe his marital difficulties and the likely failure of his marriage in the near future. I asked him if he wanted me to let him know if I would return again. He said, 'Yes, absolutely'. The mutual pleasure at being together was evident. During this hour he recalled many details of the analysis and referred to them repeatedly. I was astonished at how much the meeting brought back to me also the experience of working with him years ago. The meeting was deeply satisfying, not unlike periodic visits with my own adult children.Two years later, in 1994, I telephoned Charlie to ask permission to publish our experience of the above visit. He was again delighted to hear from me and readily agreed to my request. He told me that he had realized precisely at the time of our meeting that his marriage had failed, and he had since ended it, 'the hardest thing I ever did'. Three months later he met a new woman. They were now living together quite happily and planned to marry. He added, 'This is the first time I have been in a relationship where I felt this kind of commitment, where it really works'. He recalled having dreams of being in my old office both before and after we met two years ago. 'There was a real warmth between us in those dreams. I took them as confirming that I was on

the right track. After meeting with you I realized once again that I can make decisions and live my life as an adult man. It took me a long time to realize [during the analysis] that you didn't have all the answers.' I asked if there had been anything unhelpful about our meeting again. He replied that he didn't think so. 'It would have been artificial if you had come to town and I had *not* seen you. It was a reminder of the genuine search for truth which we had done together.' I also asked if he still thought much about his mother. 'That's the relationship I have the most figured out. If not, I couldn't have married A, and that led to B [with whom he is happy]. I don't think about Mom much any more. That was twenty years ago [that she died]. I'm at peace with her. Now I'm mostly dealing with myself as my father's son. Seeing you again was important to me. It was like seeing my father as a human being.'

Discussion—Charlie

Charlie's initial response to meeting his analyst five years after termination was a tearful re-awakening of mourning for the loss of his analyst, a brief reprise of the week-long crying period during termination. Contact with his analyst also appeared to have re-vitalized the sense of self-worth that he had developed during the analysis. That helped him to accept his realization that his marriage was failing and to move ahead with his life.

A Rationale for an Alternative Conception of Termination and Post-termination Follow-up Contact

We propose that conceptions of termination and post-termination follow-up contact are extensions of fundamental theoretical and technical conceptions of psychoanalytic treatment that are integrated into the psychoanalysis itself. Current analytic theories, particularly relational/interpersonal and its variations, differ significantly from

traditional analytic theory's conceptions of analytic treatment. Traditional theory regards interpretation of unconscious transferences as the fundamental mutative factor. "It is interpretation – leading to insight and awareness – that is viewed as *the* primary carrier of therapeutic action in the classical conception of treatment,' writes Eagle (2011a, p. 90), as a faithful yet critical reporter of that position. He adds, "There also appears to be widespread agreement that it is the interpretation of these new editions of old conflicts, that is, transference interpretations, that are especially conducive to therapeutic change" (2011a, p. 217). Traditional theory recognizes that the real patient-analyst relationship also contributes to therapeutic benefit. Although recognizing that conscious and unconscious identification with the analyst plays a mutative role, this identification is not assumed to be with the person of the analyst, but, rather, with the analyst's *analytic activity* (Olds, 2006; Geller and Freedman, 2011). This formulation is necessary theoretically because, if the patient appeared to identify with the *person* of the analyst, that signified that the analyst had influenced the patient. Such influence might reflect suggestion and hark back to Freud´s fear of therapeutic elements that might undermine the scientific status of psychoanalysis. Alternative theories of analytic treatment, particularly relational/ interpersonal, articulate different conceptions in which aspects of the real patient-analyst relationship are considered to be the fundamental mutative factor. Transference interpretations are regarded as therapeutically useful tools, and identification with the person of the analyst is accepted as playing a positive mutative role.

The Real Relationship in Psychoanalytic Treatment

Anna Freud (1954) had written, "somewhere we should leave room for the realization that patient and analyst are two real people, of equal status, in a real personal relationship to each other" (p. 619). Subsequent

acknowledgment of the significance of the real relationship may be traceable to Gill's recognition and insistence that the patient's transferences are distorted only in part; they also reflect the patient's perceptions of actual, realistic attributes of the analyst. Psychoanalysts should acknowledge and accept the patient's capacity for intuitive, accurate perception of the therapist's character. The patient may also correctly perceive the analyst's genuine concern and caring, thus contributing to the patient's feeling that a good "fit" exists between the patient and the real analyst. Numerous empirical studies have reported a strong association between "fit" and subsequent satisfaction with treatment (see Schachter et al.). Part of the work of analysis involves the patient' s distorted view of the analyst, which Mitchell characterizes as the patient's "pre-designed categories" or templates. The analyst's uncovering and facilitating correction of these distorted views, fosters the development of an appropriate relationship with the real analyst – how the analyst actually is – one of the central tasks of treatment.

Based on extensive research of once/weekly psychotherapy, the real relationship is considered to consist of two key elements: a) genuineness and b) realism. Genuineness may necessitate some self-disclosure by the analyst, always constrained by considerations of the impact on the patient. "Strong and effective real relationships require that the patient and therapist have basically positive feelings toward the realistically perceived and experienced other. … These positive feelings may be termed liking, caring … or even a kind of loving" (Gelso, 2011, p. 155). Couch (1999) has reviewed the psychoanalytic picture of the real relationship, and concluded that "The quality of genuineness and naturalness is evident in all of Freud's published cases, as well as in the numerous reports by patients about their analysis with him …" (p. 141*)*. This awareness of the role of Freud's character in

treatment led Nacht (1962) to make the point, similar to the later view of Levenson (2005a, 2005b), that in many fundamental respects, what the analyst *is* has more importance than what the analyst says. Couch added, "many of the analyst's reactions are best seen and conveyed in a clinically appropriate form as genuine reactions to important aspects of the patient's life as a fellow human being" (p. 151). Couch quoted Stone (1961) "Whereas purely technical or intellectual errors can, in most instances, be corrected, a failure in a critical junction to show the reasonable human response which any person inevitably expects from another on whom he depends can invalidate years of patient and largely skillful work" (p. 55). Couch (1999) agrees, "it is quite natural for the analyst to feel some sadness and concern over failures or tragic losses in the patient's life, some anger over the patient's cruelty to others, and some pleasure and satisfaction in the patient's successes and happiness. These are reactions that stem from and reflect the genuine human qualities of the real relationship …"(p. 159). Levenson's focus on the real analyst may be derived from Sullivan's conviction that "You [analyst] had to be a person" (Kerr, 2012). More explicitly, writes Levenson, "The therapist is required to be real, "to have reactions and to be able to use them without shame or guilt" (2005a, p. 201); "The most loving act of the therapist is to be real, to be there and to permit himself the discomfort of engaging the patient's system" (2005a, p. 214). Presumably, this includes the analyst's expressing either angry feelings or affectionate feelings to the patient, as well as acknowledging being scared of the patient, all constrained by consideration of these expressions' impact on the patient. Levenson adds, "The interpersonal therapist must grapple with the *real* matrix of events and personalities in which every therapy is embedded. It is not a question of what the patient has projected "onto" or "into" the therapist, but of really *who* the therapist is and *what* he brings to

the therapy encounter" (2005b, p.21). To explore this, Levenson raises his famous question, "What's going on around here?" which may have been influenced by Sullivan's conception that an interpretation was always a question (Kerr, 2012). Levenson considers the analyst a "real" partner who will grieve if something bad happens to the patient and who will feel sadness at the end of regular sessions together.

Traditional as well as revisionist analysts recognize that in the closing months of a reasonably successful, helpful analytic treatment, the treatment has included the development of an intimate, mutually caring, patient-analyst relationship (Stone, 1961). Breger (2012) observed that it is "impossible to work at a deep emotional level with people over long periods of time without developing real affection for them" (p. 113). In support of this assumption are the numerous reports that analysts themselves react to "termination" with feelings of loss, sadness and mourning, suggesting that they had developed caring feelings toward the patient (for moving reports see Salberg 2010). Granels, writing in the New York Times, noted that physicians have difficulty expressing grief: "Our study indicated that grief in the medical context is considered shameful and unprofessional. Even though participants wrestled with feelings of grief [when patients die], they hid them from others because showing emotion was considered a sign of weakness" (2012, p. 12).

Friedman (2005a), a traditional analyst, refers to "a peculiar intimacy that can be experienced only by someone who [analyst] is in many respects a merely virtual partner" (p.373); Levenson, however, conceives of the analyst as a *real* partner, not a virtual one, and Nussbaum (2005) agrees, challenging Friedman: "Will you grieve if something bad happens to me, or will you just go merrily on your professional way? (p. 380). She comments that Friedman avoids this question …"(p. 380). Friedman (2005b) concludes that the

analyst cannot have "real" loving feelings for the patient; "the classical analyst could never report to work without assuming that his self-reflective distillation of feelings can somehow moderate his response" (p. 387). Eagle (2011b), certainly not a classicist, joins Friedman and says that: "I believe that the claim of loving the patient is a kind of deceit, one that can be quite intimidating to analysts who do not feel they love their patients" (p.1108). For a dyad who had developed an intimate, mutually-caring patient-analyst relationship, to totally end all contact after termination might not feel appropriate. Following Eagle we have elected to substitute "deeply caring" for "loving" in the hope of a less controversial description. Some patients may be so problematic, demanding and exasperating, that "deeply caring" is not easy to maintain, and the analyst is instead faced with regulating his/her hostile feelings to try to avoid a rupture of the relationship and come to a bi-lateral, agreed upon termination.

The Mutative Role of Identification as a Product of the Real Relationship

Identifications begin in infants and children and then progress to emulating the admired and desired attributes of others throughout life. A patient's mature identifications may therefore include attributes of the analyst, often modified for integration with pre-existing templates. Brubach and O'Brien (1999) generalize the outcome of this process: "Each and everyone of us is a walking catalogue of allusions to the movies we've seen, the stories we've taken to heart, the people we've known; we appropriate an actor's gesture, a character's fate, a friend's expression. In the aggregate of these little impersonations and the mutations we bring to them lies our identity" (pp. 161, 162). Our questionnaire study of analyst's attitudes toward training analysis (Schachter et al.) reported that graduate analysts practiced the way his/her own training analyst had practiced with him/her.

Imitating the training analyst's way of practicing is a form of identification with the training analyst, which in these satisfactory training analyses was facilitatory for the analyst-patient's subsequent function as an analyst. There was a significant positive association between the degree to which the graduate analyst emulated his/her own analyst's style of practice and the degree of satisfaction with their training analysis reported by the respondent graduate analyst.

To Terminate or not – Is this a Question?

The medium length, in a large German sample of analytic treatments, is about 600 sessions (approximately four years) , 3-4 times/week (Leuzinger-Bohleber et al., 2003). Dewald (1972) has published a case running for 600 sessions, and Mrs. C., treated by H. Dahl, under the supervision of J. Arlow, went for 1200 session. Glennon (2010) has presented a thoughtful and insightful description of her struggle with a woman patient of 21 years after she proposed her patient should consider ending her analysis. The patient responded, "Why would I even consider that? Why should I *choose* to say goodbye to you? Why would I choose to sever a relationship that is so dear to me, so special, and like none I've ever had before? It feels so unnatural. In life outside this office the only time a relationship like this would end would be due to death" (p. 258).
However, after 21 years of uninterrupted analysis, Glennon also considered what her patient might be missing in terms of the benefits of the mourning process involved in separating from her and her work, as well as from confronting her charcterological limitation that made it impossible for her to separate from her analyst and their joint work. She suggests that it may make it more difficult for the patient to break loose from an analyst, who has allowed herself or himself to be a real person. In this perspective she is in good company with the opinion of some other analysts (who are not

specified in the paper): one could make a strong case for the ameliorative aspects of patients going through a mourning in the presence of the mourned object – the analyst. Glennon concludes, "I still am unclear as to how Julia's analysis will end, if it does, and even how I understand what all the issues have been for her around leaving me." (p. 272). Her patient feels it "to be weird, inhuman, and inauthentic to make a decision to terminate our relationship because *I* think it might produce further psychic gains" (p. 272).

Specific experiences with such therapist-patient dyads shaped our views about termination in long-term analyses. We now assume that there may be certain patients who, like diabetics can never outgrow the need for insulin treatment, can never outgrow the need for continuing contact with an analyst. Anzieu (1987), too, has hypothesized that some patients have a need for a constant auxiliary ego in the analyst. In some way that contact provides an essential, stabilizing element in their lives. However, the question of treatment intensity (sessions/week) remains controversial. Thomä and Kächele (1994b) have described a 20-year-long treatment totaling 600 sessions, six-times/week, followed by 13 years of low frequency, once/week or once/month meetings that consisted of ongoing and fruitful work.
For such long-term therapeutic encounters, we believe that it is quite inappropriate and very counter-therapeutic, for the analyst unilaterally to set termination itself as a goal. Surely, whether termination is an appropriate goal should be determined by shared decision making by the patient and analyst. The presumed loss of benefits from separation from the analyst and the mourning of his/her loss, is based upon psychoanalytic theory for which there is no empirical support.

A Canadian report (Arvanitakis et a. 2000) defines long analyses as those with the same analysts lasting ten years or more at a minimum

frequency of three times per week[2]. This report hypothesized the development of an omnipotent idealization of the analyst in some borderline patients; another common dynamic described occurs in obsessional cases in which the analysand longs for intimacy but does not believe it is available. In borderline case, they write, "the internalization of the analyst as a good, alive, containing object , becomes seriously compromised. The imperative to maintain the analyst as an *external* real object interferes quite seriously with such internalization. … Essentially what we observe is that the analytic process is arrested, and free association as well as true regression cannot take place" (p.32).

These comments are direct representations of traditional psycho-analytic theory, and no illustrative clinical material is provided, let alone any empirical data. Contemporary (especially relational/interpersonal theory) regards the patient viewing the analyst as an "*external* real" person critical to therapeutic work, not a phenomenon that "interferes quite seriously with … internalization". "True regression" is not regarded as desirable. The patient's capacity to see the analyst as a real person clearly results in many therapeutic internalizations of the analyst.

These conflicting conceptions of traditional compared to contemporary (relational/interpersonal) cannot be evaluated in the absence of both clinical and empirical data.

Limitations of the Therapeutic Efficacy of Psychoanalytic Treatment

There may be a general assumption that psychoanalytic treatment can be significantly helpful to virtually all persons who are troubled or

[2] The issue of allocation of public resources in cases of very long term treatment must be raised in terms of the ethical principle of fairness. Psychoanalysts due to their high qualification are public goods, even when patients privately pay (Beauchamp et al. 1994)

emotionally disturbed. We question this assumption, and believe we should try to develop specific indications for psychoanalytic treatment. The effectiveness of psychoanalytic treatment in the treatment of addictive disorders has been questioned, and the psychoanalytic treatment of schizophrenic disorders remains controversial. Psychoanalytic treatment of personality disorders is probably considered the most effective, but here, too, there are limitations. If such a patient lacks the capacity for empathy, e.g., successful psychoanalytic treatment is unlikely to provide that patient with a reasonably satisfactory capacity for empathy. We need large scale outcome studies to assess specific efficacy of psychoanalytic treatment.

Conclusion

Contemporary clinical psychoanalytic theories indicate how unlikely it would be for all analytic dyads to be best served by the single conception of termination and post-termination contact prescribed by traditional analytic theory. Mendenhall (2009) agrees and concludes, that "a new understanding emerges that moves beyond the concept of termination to the idea that analytic relationships may evolve over time in many ways that are determined uniquely in each dyad" (p. 130). The widespread theoretically-based conviction that post-termination follow-up may constitute serious risks for the patient is not substantiated by a single empirical study and may well prove incorrect. Alternative conceptions of termination and post-termination contact have been developed by relational/interpersonal and other analytic theories and may be most appropriate for some analytic dyads. The patient's development does not end with termination but continues, willy nilly, with or without the analyst's participation in the post-analytic phase of development. Following a successful analysis Freud (1937) wrote, "the processes of ego transformation will go on of their own accord and that [the former patient] will bring new insight to bear upon all

subsequent experience" (p. 402). During this period, the patient may lose some of the therapeutic benefits gained during treatment, or, conversely, may resolve some problems treatment had been unable to help. At least a dozen analysts have documented cases in which substantial and even dramatic changes occurred after "termination" (Milner, 1950; Nunberg, 1954; Saul, 1958; Eissler, 1963; Holtzman, 1964; Hoffs, 1972; Firestein, 1978). Both Macalpine (1950) and Ackerman (Panel, 1955) reported that marked improvement may occur following termination. However, Kantrowitz et al. (1990), in her follow-up research of 17 patients concluded; "Neither analysts' assessments at the time of termination nor patients' assessments of themselves or assessments based on psychological tests one year after 'termination' predicted which patients would improve or retain psychological change" (p. 471). Follow-up, by providing the analyst with information about post-termination changes, both positive and negative, in the former patient's life may give the analyst the opportunity to reassess his/her assumptions and understanding of the patient's course and outcome at termination.

If the analyst is considering that post-termination follow-up may be mutually beneficial, and if the patient has not raised this possibility, the analyst has the option of introducing the issue by noting that both analyst and patient are likely to have feelings about the upcoming ending of regular sessions, and that they should consider and discuss how they feel about the possibility of post-termination follow-up. Possible fears, risks and advantages may then be considered. Such meetings should be considered thoughtfully in order to avoid any harmful enactment of wishes by the patient or the analyst. Holmes observes that "The attachment implication [of termination] is that one can only leave home if there is a secure base to return to … including, if need be, a continuing relationship with a therapist"

(p. 80). He adds that "the meaning of such arrangements must always be thought about and discussed in therapy – in other words, mentalized" (p.69).

Post-termination follow-up may demonstrate the analyst's continued deep caring about the former patient's welfare. Follow-up may also provide the former patient with reinvigoration of positive, internal representations of the analyst that facilitate the patient's continued development and emotional adaptation. Based on interviews with former analysands a group of patients have been identified who continue to rely on analyst introjective fantasies for the purposes of self-soothing (Dorpat, 1974; Giovacchini, 1975; Kantrowitz et al., 1990; Pfeffer, 1993; Schlesinger and Robbins, 1974; Falkenström et al. 2007). In addition, follow-up contact may provide the patient an improved opportunity to modify persistent idealization of the analyst (Buxbaum, 1950; Reich, 1950). It is possible that some of the patient's unresolved issues become stirred up during the follow-up, and may become disturbing to the patient. The patient may or may not elect to return for additional treatment to try to deal with this discomfort. One patient at the end of a second interview in a follow-up study (Leuzinger-Bohleber et al., 2003) told the interviewer, "I was very glad of the opportunity to talk to you. I have just realized that something in me now has come to an end – I think these interviews have helped me to finally complete my analysis. I no longer have the feeling of having left my analysis too early. Talking to you I realized that I am in good contact with my unconscious and can continue the dialogue with the hidden parts of my soul without my analyst now …" (p. 278). The authors of the study reported that "Many of our colleagues have told us how valuable it has been for them to listen to former patients and what they have to tell us, consciously and unconsciously, about their positive and negative experiences with their psychoanalytical treatments." (p.

285). Decisions about post-termination follow-up should preferentially weight the patient's feelings and should be mutually-agreed by patient and analyst. Since follow-up meetings are not continuations of analytic treatment, and may benefit both patient and analyst, we suggest leaving to the discretion of the analyst whether to propose a fee for such contacts.

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