Self -psychology and Termination

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The idea that all psychotherapy eventually ends seems so obvious it could be considered trite. But why is the idea of ending so trite? Why should the processes of psychotherapy end if, say, a person could afford to continue in it, or if it entailed no fees? Taking away the financial considerations enables us to look at the assumptions behind the idea of ending psychotherapy.

The concept of termination in traditional psychoanalysis was influenced by the major goal of psychoanalysis: the individuation of the patient from dependency on parents or their substitutes. During the process of terminating, the reinforcing a patient's individuation was considered to be the most important task. The actual experiences of traditional analysts, however, were that many patients attempted to cling to the analysis long after it had served its goal of analyzing the patient's unconscious. This raises the question of why these patients cling, if successful analysis has developed individuation. Faced with the evidence of failures to achieve individuation, and hence therapeutic failure, Classical analysis adopted the view that clinging behavior was a temporary regression in service of the process of mourning. Such a belief made it difficult for Classical analysts to face the idea that the analysis had failed because of its faulty goal of privileging the patient's individuation.

In classical analysis termination was the last phase in psychotherapy during which a patient went through an anticipatory mourning for the therapeutic relationship, thus reducing the need to cling like one of Bowlby's insecurely, ambivalently attached year old infants. This Classical analytic

view of a need for mourning led to somewhat ritualized procedures for preparing the patient for the reality of life after psychotherapy sessions with the analyst four days a week for about five years. Analysis had the idea that the goal of termination consisted of putting the finishing touches on the therapeutic goal of the patient's autonomy.

In contrast to this Classical view of termination, self-psychology not only avoids emphasizing the importance of this phase, but takes the view that the very concept of the termination goal of individuation may be impossible for psychoanalysis, is at best counter-therapeutic, and at worse, iatrogenic. From a self-psychology point of view, psychoanalytic psychotherapy, if it results in a significant selfobject experience, never ends. The way psychotherapy can be considered a failure from a self psychology point of view is that it ends without achieving adequate internalisation of the process so it can continue without the need for actual sessions. In this paper, we (1) cover in more detail the Classical view by examining Freud's material and the views of Glover, (2) look at Ferenczi's ideas of natural termination, and (3) explore Kohut's concept of termination as internalization.

1. The traditional view

At the beginning of the development of psychoanalysis Freud seems to have paid little attention to the concept of termination. His early cases were mostly short-term, and often came with a preset ending date: the end of a summer vacation when the patient returned to his/her city of residence. After it became evident that these brief periods of psychotherapy did not produce permanent changes in a patient, the cases became longer. But with the lengthening of the duration of psychoanalysis, the question of when to terminate emerged.

The two Freud cases most frequently associated with the issue of termination are Dora and the Wolf Man. Dora (1905b) presented Freud with the problems of "premature" termination after three months of sessions, whereas the Wolf Man (1918) did the opposite, he created an "interminable" relationship which lasted four years (1910-1914), and was finally broken when Freud set a termination date. In both these cases, understandingly Freud the investigator made mistakes, but a reading of these cases (Lee and Martin, 1991, pp. 28-31, pp. 251-256) from a self-psychology point of view points to therapeutic disjunctions as a result of empathic failures that went unrecognized and unrepaired.

Freud saw Dora as a vengeful 18 year old. He (1905b) explains his view of Dora: "Her breaking off so unexpectedly, just when my hopes of a successful termination of treatment were at their highest, and her thus bringing it to nothing--this was an unmistakable act of vengeance on her part" (p.109). Freud believed that Dora had an erotic transference to him as a displacement for the sexual impulses she felt towards her father. Freud thought that Dora projected her sexual impulses on to her father, whom she considered bad because of these impulses, and then expanded her disgusted feelings of him to include all men, who too had these impulses. By leaving treatment, Freud claimed that Dora both avoided facing her sexual desires, and had enacted her contempt of men.

A careful reading of the Dora case, however, suggests a non-sexual explanation for Dora's disgust. A repetitive "red thread" in her case material is a feeling of being betrayed. As a 14 year old, Dora experienced a passionate kiss from Herr K, a friend of the family, and openly accused him of it. When Dora's father believed Herr K's denial of the accusation, Dora felt betrayed, enraged and disgusted. Herr K said that Dora had imagined this event because she had been reading pornography. Herr K’s knowledge of Dora’s pornography reading made her feel betrayed

by Frau K with whom she had shared this secret before Herr K made his advances. A further complication was that Dora's father had been having an "affair" with Frau K for years, which Dora knew about, so she felt that her father had rejected her explanation out of self interest and as a payment to Herr K for tolerating her father's affair with Frau K.

Wolf (1980b), who views this case from a self psychology perspective, thinks that, from the material just presented, Dora's lack of sexual arousal and her response of disgust to the sexual approaches of Herr K were understandable. Freud, however, was unable to empathize with Dora because, following his theory of sexuality, he thought that Dora was unconsciously sexually stimulated and that her disgust was a defensive reversal. Wolf (1980b) writes:

> It is clear that Freud is not thinking of a young girl, of a person ... in a particular situation, a situation which may be experienced as a frightening attack, humiliating assault, a stimulating intimacy, or perhaps a betrayal of a trust. Freud appears to be thinking only of seeing a nubile sexual apparatus, which in proximity to an arousing sexual stimulus failed to respond with sexual excitement. It is as if the girl were merely an appendage to this sexual apparatus, and, therefore, Freud is bound to diagnose the failure to respond with overt conscious sexual excitement as a kind of pathology, as hysteria. In this rare instance Freud has not been empathic with the girl but has put his theory first, the theory which says that the ubiquitous sexual instincts are at the root of most psychopathology....The disgust experienced by Dora had little to do with whatever sexual arousal

> may or may not have occurred. Her disgust was the appropriate response of an adolescent to the betrayal of trust [p. 42].

Seen from a self-psychology point of view, Dora's reported dream in which she imagines giving fellatio to a man, takes on a new meaning. Instead of linking this event to the symptoms of irritation in her throat and coughing, as Freud did, it is possible to see that Dora was associating to the psychotherapy with Freud. She was expressing in sexual imagery her need to "suck up to Freud" and accommodate his needs when he was supposed to be interested in her point of view and function as her selfobject. Instead, she became a selfobject to Freud and his theory of sexuality (Lee, 1988, 1999). No wonder she left the psychotherapy in disgust! This case, then, is a premature termination because it is an example of gross empathic failure.

The Wolf Man case, which Freud saw as an example of "analysis interminable," led him to set a termination date, and illustrates the problem of an impasse as a result of a negative therapeutic reaction. In an important paper, Brandchaft (1983) reported a review of five of his own cases where major therapeutic impasses occurred and concluded that in each case "the patient had sustained a significant injury to the self immediately prior to the action" (p. 349). This finding of Brandchaft points to empathic failures and subtle therapeutic disjunctions. Not all patients respond to such disjunctions by setting up interminable psychotherapy, but such patients as the Wolf Man do.

The Wolf Man was a wealthy Russian aristocrat who had seen a succession of psychotherapists prior to seeing Freud for four years (1910-1914) and the Freud again for four months in 1919 when he had become a penniless refugee from the Russian revolution. The Wolf Man also saw the psychoanalyst Ruth Brunswick seven years later. Moreover, the Wolf Man had a 30-year

friendship with the psychoanalyst Muriel Gardiner and acquaintanceship with many of the early psychoanalysts. The Wolf Man eventually became so well-known to the analytic community that when he could not pay his wife's hospital bills, Freud took up a collection for him for six years. Clearly, the Wolf Man's special status had turned the analytic community into a group selfobject for him.

The Wolf Man had an animal phobia that was depicted in a dream when he was about four years of age. He says,

> I dreamt that it was night and that I was lying in my bed. (My bed stood with its foot towards the window; in front of the window there was a row of old walnut trees. I know it was winter when I had the dream, and night-time). Suddenly the window opened of its own accord, and I was terrified to see that some white wolves were sitting on the big walnut tree in front of the window. There were six or seven of them. The wolves were quite white, and looked more like foxes or sheep-dogs, for they had big tails like foxes and they had their ears pricked like dogs when they pay attention to something. In great terror, evidently of being eaten up by the wolves, I screamed and woke up [Freud, 1918, p. 29]

Freud, through an elaborate process of associations, linked this dream to the primal scene of parental intercourse and the Wolf Man's fear of castration.

Modern psychotherapists have revised Freud's assessment of the Wolf Man and diagnose him as either a narcissistic or borderline personality (Blum, 1974; Chessick, 1980a). From this new

diagnosis it is possible to see the Wolf Man's dream as reflecting the cold bleakness of an emotionally deprived and undernourished personality who was in search of selfobjects. The dream reflects, as Brandchaft indicates, his experiences of barely sufficient selfobject functioning to "keep the wolves from the door" - but only just. He lived a precarious life always prone to fragmentation, as reflected in hypochondriacal attacks when he learned that Freud had cancer, depressions, and paranoid states. The Wolf Man continued the treatment with Freud because it enabled him to make considerable improvements and function better, but the treatment was insufficient to take the wolves completely from the door. No wonder he experienced rage, as reported by Ruth Brunswick, after Freud had forced the termination of the analysis.

While working with the Wolf Man Freud was writing his technical papers (1913). In them he proposed thinking about an analysis in three phases: beginning, middle and termination. It was in his discussion of the Wolf Man (1918) that he emphasized the necessity of the analyst terminating cases by fixing a date. After this recommendation, what had been his move to break a therapeutic impasse in one case, unfortunately, became the norm of every analytic case.

The British psychoanalyst Glover (1955) probably presents the most comprehensive coverage of the termination phase from the traditional psychoanalytic position. He argues cogently that, as an analyst's task is to foster a regression neurosis through maintaining strict neutrality, it is necessary to have a termination phase that allows the patient to recover from this regression, in preparation for functioning without the aid of the analysis. The main task of this termination phase in Classical analysis, however, becomes the uncovering of resistances to giving up the analysis. According to Glover, three areas where these resistances occur are: a refusal to give up the regression; an increase in transference feelings; and a return of original symptoms. Glover then addresses the issue of a decision to terminate. He (1955) says,

> in all cases where a typical transference-neurosis develops, a terminal phase is not only an essential part of a successful analysis but that, although the responsibility for giving notice of termination must lie with the analyst, the terminal phase is most of these cases is a spontaneous development [p. 140].

He then he strongly affirms that "unless a terminal phase has been passed through, it is very doubtful whether any case has been psychoanalyzed" (p. 140).

As may be readily understood, self-psychology's well-documented shift from a neutrally conducted treatment to an empathic approach makes Glover's recommendations irrelevant and his arguments untenable. Further, those who practice psychotherapy using the self-psychology model have seen a reduction of so called “typical” behavior associated with the traditional termination phase. If, as Glover argues, the transference neurosis makes a termination phase necessary, the lack of a transference neurosis has led to the disappearance of behavior that could be seen as resistance to the termination phase. This means that an empathically-oriented self-psychological approach to psychotherapy no longer needs the concept of termination as a distinct resistance stage in treatment.

2. Natural termination

If a self psychologically conducted psychotherapy based on empathy has undermined the traditional notion of termination as a phase that needs a focus on fairly predictable resistances, when and how is termination to take place? The answer is to terminate in such a way that the

patient experiences the therapist as being empathic. This idea of an empathically conducted termination has led Goldberg (1985) to Ferenczi's concept of a "natural termination." Ferenczi (1927) states, "my conviction [is] that analysis is not an endless process, but one which can be brought to a natural end with sufficient skill and patience on the analyst's part" (p. 86). In a natural termination, the patient's need for the treatment declines slowly and perhaps "dies of exhaustion" (p. 85). In an open-ended procedure, both therapist and patient eventually realize and acknowledge this de-facto natural termination that has already taken place.

The traditionalists who used Freud's technique with the Wolf Man of setting a termination date, challenged Ferenczi's idea of a natural termination, claiming it was impractical. The traditionalists, for whom Ferenczi was "persona non gratia," argued that there were not the therapeutic resources to justify the luxury of every analysis continuing until a natural termination occurred. When Ferenczi was asked how many of his patients had gone through a completed analysis to a natural termination, he admitted "none." But he went on to say that these would occur when the analysts learned from their [empathic] mistakes, thus showing that he was one of the first to understand that problems of empathic failures and therapeutic disjunctions were behind the therapeutic stalemates that unnecessarily prolonged treatment.

Ferenczi's paper on natural termination was brief and suggestive and needed a follow-up paper to elaborate in more detail his concept of a natural termination. Experiences of self-psychology oriented psychotherapists who practice natural termination suggest that it occurs if therapeutic benchmarks have been given sufficient attention during the psychotherapy. These are usually not just the goals verbalized at the beginning of the treatment, but those benchmarks that have gradually, spontaneously emerged during the beginning and middle phases of treatment. Such benchmarks and the implicit "contracting" that goes with benchmarking are processes that are

continually taking place during psychotherapy. These processes are best learned in a supervisory relationship. The two major components to therapeutic benchmarking are (a) "recognition" of therapeutic goals as they emerge from a patient's material, or (b) calling attention to a patient's "modification" of his/her goals as they emerge during a session.

As an example of benchmarking in psychotherapy, Freud promised that the Wolf Man, through analysis, would overcome the constipation that had necessitated his man servant to administer an enema every day to evacuate his bowels (Gedo and Goldberg, 1973, p. 115). "Thereupon," as Gedo and Goldberg indicate, "the bowel became the barometer of the Wolf Man's confidence in Freud and in a short time recovered its normal functions" (p. 115). Benchmarking becomes a concrete way for both the patient and the therapist to recognize therapeutic progress. Generally the patient needs such a tangible barometer. These are often symptoms, but there can also be personality traits. It fosters good therapeutic results and a natural termination for therapists to understand and then openly acknowledge ways that a patient, often unconsciously, is measuring therapeutic progress.

Another therapeutic process may involve the modification of already presented patient's treatment benchmarks. For example, in one case a patient sought treatment for a severe depression and stated so in the first session. The therapist and patient initially agreed to work at eradicating this depression as a treatment benchmark. An idealizing transference soon developed that led to a rapid diminishing of the depression, except for periods of empathic lapses by the therapist that then led to exploration and repair of the relationship. After several years of treatment the patient was able recognize that she was gaining confidence managing her depression. She still became depressed at times, but the episodes were not as severe, did not last as long as before, and were followed by longer periods of depression-free living. She had commenced the treatment so fed up

with her depression that her benchmark for the treatment was to have the depression completely eradicated. She eventually realized that this eradication would take years and that she would be content with achieving an ability to manage her depressive episodes so they were no longer the annihilating dread of her life. Her benchmark had changed. This change in therapeutic goals during psychotherapy is an example of the transformation of archaic narcissism (Kohut, 1966).

A patient's modification of the goal of absolutely eradicating some symptom or behavior, and the acceptance of a less totalistic one, is a significant sign of therapeutic change. Patients who are narcissistically wounded, often set as a compensatory benchmark, the eradication of future wounding or shaming, which is a constrictive (defensive), narcissistic solution. After such patients have experienced the therapist as a selfobject for a period, the narcissistic need for perfection may be abandoned for more attainable benchmarks. Benchmark modification from archaic goals to more attainable ones moves more easily into a natural termination.

3. Kohut and internalization.

In Kohut we find a shift from the traditional idea of termination, with its goal of individuation, to that of internalization.

Kohut ideas on termination place a heavy emphasize on transmuting microinternalizations. Kohut makes it clear that these microinternalizations involve gradual, minute changes that lead to accumulating change. Sudden transformations, in comparison, do not reflect stable internalized structures because they utilize gross identifications that are more subject to sudden fluctuations.

Self-Psychology after the death of Kohut, although it never accepted internalizations, even microinternalizations, as the only means of self-structuralization, never rejected Kohut's idea that internalization leads to structuralization. Structuralization means patterns that last or are, at least, slow to change. It is also clear that Kohut rejected ego psychology's concept of individuation as a goal of psychotherapy, and this rejection freed self psychology to explore others ways to terminate than the traditional idea of making a clean cut, permanent break with the therapist which enacts a death-like experience. What happens in psychotherapy is not the resolving of the need for selfobjects, a position of the ego psychologists --- selfobjects are needed throughout the whole of life --- but enable a person's selfobject needs to be less intensely from a rich variety of sources.

Kohut's ideas on termination are best grasped through the Psychology of the Self Casebook (Goldberg, 1978). What Kohut concentrates on is the way in which narcissistic patients terminate. The first case, Mr. I, is called "The resolution of a mirror transference: clinical emphasis on the termination phase." The whole case can be read with benefit, but special attention needs to be paid to pp. 79-114. The cases of Mrs Apple and Mrs R also have sections on the issue of termination.

As one reads these cases it is clear that self-psychologists no longer follow the Freudian practice of a therapist announcing a termination date. Termination decisions are mutually determined once the material of the sessions suggests that the goals have been achieved and the case is winding down towards a natural break. When the therapy is winding down, the patient reflects behavior that indicate transformations of a grandiose self and a reduced need for idealized, mirror or twinship selfobject experiences. These transformations are reflected in the patient's increased development of the qualities of creativity, empathy, wisdom, humor and a sense of finiteness (p. 10).

In the case of Mr. I, the termination issue was forced into the foreground by the knowledge that his work may require him to leave the Chicago area (Goldberg, 1978, p. 52). Such a threat "of separation from the selfobject indeed entailed the question of whether his own independent psychic structure would be strong and stable enough" (p.87) to cope with life without fragmenting. Dreams reflect Mr I's experience of the threat of termination. In one Mr. I is naked, lying on a frame. In response to the dream the analyst remarked that the patient needed the frame to accomplish his task, that the frame was the analyst, and now represented Mr. I's own internal structure. Mr. I was able to add that in the dream he was dismantling the couch, piece by piece. This piece by piece dismantling was seen as depicting the process of microinternalization.

The evidence for internalization from the dream material of dismantling the couch during the termination phase is supported by another dream in which "this guy swallowed the clarinet, and he managed to breathe so that it played, with his mouth open. The clarinet sounds were coming out....He realized he was swallowing it whole, taking it with him and making it a part of himself" (p. 99). Mr. I understood this dream as depicting his feeling that he was retaining the analyst within him. He also thought that analysts retain their patients by writing about them, and he envisaged his analyst incorporating him into a new idea.

So self psychology's basic theme on termination is not about getting rid of a therapist but how to retain him, capture him for ever, that is, internalize him. Think about this with patients who enter psychotherapy fearing dependency. In fear they may be trapped into an interminable relationship, they resist greatly, especially resisting the therapy proceeding in such a way that little if any internalization takes place. As Kohut has brilliantly understood, the way towards liberation from perpetual dependency is not to resist it but to allow the dependency to be resolved through internalization.

In any internalization, it needs to be clear that it is not the therapist as a total person who is internalized. Rather, what becomes internalized and, hence, permanently structured are the selfobject functions that the patient finds so essential for maintaining a cohesive self.

In a personal example, towards the end of my eight year training therapy I experienced some anxiety about the possibility of hearing my training therapist lecture after I had ended the psychotherapy, and was especially concerned about his expressing views with which I firmly disagreed, whether this would destroy my ability to use my therapeutic experience as a source of nourishment. Then one day it came to me that my co-created relationship with him, like every co-created relationship, was unique. No-one could destroy it, not even my training therapist himself, once it had been internalized. Envisaging the worst possibility, I thought of him going stark raving mad. How would I respond? Suddenly I felt free. I realized that if this happened he would not then be the training therapist I knew. The experiences of him had been so internalized that only my own death would destroy the memory of that co-created experience with him.

Ever since then, where possible, I seek to keep people in psychotherapy "for ever." By this I don't mean formal sessions, but psychotherapy as an internalized process. Once this internalization of the psychotherapeutic interactions has taken place the need for further scheduled therapeutic sessions dies.

On the evening of November 4, 1984, I anxiously lay in a bed at Evanston hospital awaiting surgery for an Aortic valve replacement the next morning. It was now after 10.00 p.m., the night shift had taken control, I had gone through the enema routine, and a nurse had checked to see if I needed a sleeping tablet. I said "no," and became aware that the dastardly intrusive noises of a

busy modern hospital had been stilled. For the next half hour I focused on an imaginary psychotherapy session, even though the formal sessions had ended years before. I shared my concerns and anxieties to my imaginary training therapist and imagined hearing many of his familiar responses. Soothed and calmed, I fell to sleep and only awakened when the cart came to take me to the operating theatre the next morning. The next thing I knew was a voice of the nurse in the recovery room telling me that the operation had been a success. I then realized that my labored breathing had disappeared and rejoiced in my new valve's "kuthunkety thunk, kuthunkety thunk."

I have never terminated from psychotherapy with my training therapist, and never will. What a silly idea it is, that in the name of individuation we are to throw away a relationship that is so valuable and gained at such great cost. Patients in traditional psychoanalytic psychotherapy who resisted termination can now be seen as healthy because they resisted termination. Since my training therapy, this internalization of an intimate, empathic relationship has been a valuable, hidden resource for which I shall always be grateful. Internalization, as Kohut indicates, is the goal of psychotherapy, not termination. After sufficient internalization takes place the importance of formal sessions gradually declines and ending them feels like a healthy, natural, and appropriate process.

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