LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY: A STUDY OF THE THERAPIST'S EXPERIENCE

Jean Kotcher

LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY: A STUDY OF THE THERAPIST'S EXPERIENCE

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

By

JEAN KOTCHER

June 23, 2012

CERTIFICATE OF APPROVAL

I certify that I have read LONG-TERM PSYCHOANALYTIC PSYCHOTHERAPY: A STUDY OF THE THERAPIST'S EXPERIENCE, by Jean Kotcher, and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Ph. D. — Chair — 6/8/12 Date

Ph D — Faculty — 6/7/12 Date

Ph. D. — External Committee Member — 04/27/12 Date

Ph D — Academic Dean — 6/7/12 Date

ABSTRACT

LONG-TERM PSYCHOANALYTIC PSYCHOTHERPY: A STUDY OF THE THERAPIST'S EXPERIENCE

JEAN KOTCHER

This qualitative study explores psychoanalytically oriented psychotherapists' experience of work with therapy cases that have lasted 15 years or longer. The data was collected in semi-structured interviews with seven experienced therapists in the San Francisco Bay Area and was analyzed using grounded theory.

Long-term therapy can be transformative for patients. Therapists and patients mutually benefit from the intimacy and experience of being well known by another, through years and milestones of life. Most long-term patients are dealing with painful childhoods with trauma, neglect, and relationship deficits. Some of them need ongoing support, while others have achieved psychological and emotional growth but remain in therapy to enhance maturation in a relationship that is unlike any other in their lives. Long-term therapists are comfortable with dependency and immersion in such therapy relationships. Clinical experience has contributed to their capacity to provide a long-term therapeutic container.

Although the termination literature often disparages long-term therapy, and long-term therapy and termination might be seen as mutually exclusive, the therapists in the study are knowledgeable about termination, and when it enters the long-term therapeutic field, they discuss it with their patients. The seven therapists were guided by different

psychoanalytic theories about whether or not termination is a needed or valuable experience for long-term patients.

Therapists experience uncertainties about their long-term work, derived from both external criticism and internal doubts. An important way to diminish the isolation and self-doubt of working alone with patients over many years is engagement with trusted consultation groups. Participants in the study expressed the wish for open communication in the profession about practicing long-term therapy, communication with curiosity—rather than rigidity and judgment—about how other therapists work.

The findings of this study suggest that therapists who practice long-term therapy experience the process as developmental, implying a lifelong developmental process where patients evolve according to their individual psychic needs and are not expected to terminate *unless* and *until* they are ready. Similar to a young adult leaving and returning home to continue valued relationships, this study found that long-term patients who end therapy often stay in touch or resume therapy again.

DEDICATION

To my husband, Jay.

ACKNOWLEDGMENTS

I want to express heartfelt thanks to Tina Casenza for her friendship, conversation, and support during the years I have been at Sanville, especially for her help in the dissertation process. I thank Angeleen Campra for her kindness, knowledge, and understanding in conveying the complexities of the writing process. I have enjoyed learning from her.

I am extremely grateful to the three members of my dissertation committee. As my committee chair, Sylvia Sussman encouraged, edited and re-edited, provided discussion, insights, organization, and helped me find my way in this research. Whitney van Nouhuys' interest in the clinical aspects of the topic, her team-work with Sylvia, editing skills, and generous support throughout meant a great deal to me. I thank Barbara Blasdel for her excitement and insights about clinical implications as the research progressed. Her confidence in my work and her editing skills were invaluable.

I especially thank my family for their love and support. My husband, Jay, did not falter, even when I did. He listened to my struggles, encouraged me with every step, took care of everyday life and kept me very well fed. My daughters, Sarah and Christine and son-in-law, Bill, bring such joy into my life. They listened to my many updates and provided regular inspiration and needed breaks along the way. A couple of times, Sarah even rolled up her sleeves and helped to edit me out of impossible paragraphs.

I want to thank the seven therapists who participated in the study for speaking so openly with me about their clinical work and their thinking about long-term therapy. Each one enriched the study and I am grateful for their generous involvement.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

This study explores psychoanalytically oriented therapists' subjective experience of working with long-term therapy cases. The focus of the study concerns how therapists think about and work with therapy relationships that do not end within a customary time frame but continue for 15 years or longer. The qualitative approach of grounded theory was used to analyze data collected in semi-structured interviews with psychotherapists who have seen one or more patients for a long time.

The Problem and Background

Therapists who have seen patients in psychoanalytically oriented therapy for 15 years or longer have little in the way of guidelines for their long-term work. Although long-term cases are the exception in any therapy practice, the relatively small number does not diminish the need for knowledge about the phenomenon. Therapists regularly further their clinical and theoretical learning by reading professional literature, attending courses and symposia, and consulting with colleagues. However, psychoanalytic literature has yielded little to enhance knowledge about long-term therapy, and the few references in the literature, most often referring to it as "interminable" analysis, have reflected controversy and, more often than not, arguments against it. Clinical examples of long-term therapy are rarely presented at professional gatherings. These conditions create a dilemma for therapists who, on the one hand, feel that some of their patients benefit from extended therapy and, on the other, have few guidelines for thinking about and managing the complexities of a long-term clinical process.

I became interested in the topic of long-term therapy approximately 10 years ago when some of my patients were continuing in therapy for a long time and did not show

any indications of ending. I discovered that a number of colleagues also had long-term patients and became aware that therapists tend not to talk about these cases. A colleague introduced me to the term "therapeutic lifer" that Robert Wallerstein (1986) used in his longitudinal study of psychoanalysis and psychotherapy. The term refers to patients who remain in therapy indefinitely and, although not explicitly negative in Wallerstein's account, the word "lifer" carries pejorative implications about the phenomenon.

As I began my research, a few of my patients had remained in therapy for close to twenty years. I considered our weekly sessions to be an important resource for them to explore their respective lives in current and past situations, and it did not feel appropriate to direct their therapy toward ending. While therapists experience as many different clinical outcomes as there are individual patients, this study examined two distinct directions that a therapy can take: (a) continuing therapy indefinitely and (b) moving toward termination. Considering these two directions, I wondered how therapists might come to terms with the disparities we find in the clinical and theoretical perspectives on length of treatment and termination.

In preliminary thinking about this study, I spoke with other therapists who had been seeing patients for a long time. Like me, they are deeply invested in the clinical work and often perceive substantial growth and progress. I contacted a colleague who has seen a number of patients for over 20 years and he agreed to discuss the topic in an informal interview. He wanted me to know at the start that he felt comfortable regarding the long-term aspect of his cases, believing that therapy is a developmental and growth process that takes place over time; he did not see it as "cure" or as necessarily reaching a fixed position or termination phase. He referred to these as his "non-suspicious" thoughts.

I asked about his suspicious thoughts and he responded that, although he believes he is on the right track with long-term patients, he does sometimes wonder about traditional views of termination, and they test his confidence. He recalled attending a psychoanalytic lecture where the presenter spoke apologetically about a 14-year case, wanting to explain why the analysis had lasted so long. My colleague realized if he were presenting that paper he might be inclined to say something similar. He added that if he were to read an paper reporting on 25 years of meaningful work with one patient, most likely his first response would be to question the length of time. Susan Mendenhall (2009) gives a clinical illustration in which she and her analysand almost overlooked the possibility of continuing their work together because they were influenced by old models of analysis, which did not include the suggestion of long-term therapy. Inconsistencies between traditional expectations of termination and actual clinical experience can create confusion and lead therapists to question how they think about and conduct their work.

A consideration of long-term therapy raises several important questions about theoretical assumptions. One is about length of treatment: Can we determine how long a therapy should go on? Another is about termination: How important is it that every psychoanalytically oriented therapy includes a termination phase? Another question considers if there are certain patients who benefit most from long-term, open-ended therapy. Although these questions are inter-related in the literature and in clinicians' thinking, it is useful to examine them separately in order to better understand the phenomenon of open-ended, long-term therapy.

Questions about length of treatment have been a concern over the decades of psychoanalytic practice, and there is a range of thinking in the profession about how long

psychotherapy should last. Sandor Ferenczi's (1927) paper "The Problem of the Termination of the Analysis," stated that the more unlimited the time in analysis, the greater are chances of success. Sigmund Freud's (1937) paper, "Analysis Terminable and Interminable," stated that analysis should be as short-term as possible. He found, however, that psychoanalysis could not address the full extent of a person's psychological needs, and patients frequently wanted to continue or return. In Ferenczi's paper, length of analysis is treated as a "problem" and Freud referred to analysis as "terminable" and "interminable." Regarding the translation of Freud's German into the words "terminable" and "interminable," Jonathan Pedder (1988) argues that "finite" and "infinite" or "ending" and "unending" would be closer translations of the German. I submit that the translation of Freud's words into terms that carry a negative connotation inject an inherent negative bias in the subject of treatment length.

Although the majority of patients end analysis or psychotherapy prematurely, an average length of a complete psychoanalytic treatment is often reported as 5 -7 years (Doidge et al., 2002). Edward Glover (1955) wrote that therapists frequently underreport how long treatments actually last, and he attributed this to concerns about accepted professional ideals. Revision of clinical experience is referred to by Donald Spence (1987) as "narrative smoothing," which therapists employ so that they appear to conform to expected standards and do not expose themselves to criticism by the professional community. Therapy that extends far beyond an expected time frame has traditionally provided fuel for controversy and at times provoked passionate responses. It has also contributed to ambiguity regarding the topic of termination.

It is impossible to think about long-term therapy without also thinking about termination. Much of the literature that addresses long-term therapy is contained in discussions about termination. Whether planned or premature, termination is a much more frequent clinical outcome than therapy that lasts 15 years or longer and it is commonly indicated to be the accepted resolution of analysis. Most experienced therapists navigate through many endings of therapy cases, planned or not, and do not begin therapy with the intention or expectation that a patient will want to continue for a long time. Some patients do stay, however, and the focus of this study is on problems that arise for the therapist in a professional culture that has not given adequate attention to phenomena related to open-ended, long-term work.

Regarding patients who might benefit from long-term therapy, it is not uncommon for people who have certain types of characterologic problems and early emotional deficits to remain in treatment for a greater number of years than average. Another group of patients may choose to remain in therapy as long as they want to work on an aspect of their lives, regardless of their psychological make-up. These two kinds of patients represent different clinical circumstances, and both are seen in long-term therapy.

Although the topic of long-term therapy has been neglected, a small number of articles and papers have appeared in the past few decades that discuss therapy as an indefinitely open-ended process that can sustain well being and provide an environment for continued growth (Leigner, 1986; Mendenhall, 2009; Rucker, 1993; E. Shane, 2009; Short, 2009; Tresan, 2007a, 2007b). For some patients, an ongoing analytic relationship can fulfill needed object relations and provide a unique alliance for expression of the self. Naomi Rucker (1993) points out that a patient's or analyst's inclination toward

termination might represent defenses against fears of deeper attachments and mature dependence. Much of the literature that endorses long-term treatment opposes the dictum that termination is essential to analysis.

At the other end of the argument is the tenet originating early in the profession that psychoanalysis is not successful without a formal termination. The early proponents of psychoanalysis assumed this ideal even though the goal was admittedly rarely achieved (Ferenczi, 1927; Freud, 1937). Most of the literature on termination, from the earliest to the most current, reflects the belief that, although the nature of psychoanalysis might be open-ended, it also inherently requires termination. The emphasis here is on goals of independence and autonomy. In contrast, long-term, open-ended therapy is viewed by much of the termination literature as a manifestation of resistance on the part of the patient and inappropriate countertransference on the part of the analyst. Frequent arguments against long-term, open-ended therapy connote gratification of patients' infantile wishes and omnipotent fantasies on the part of the patient and therapist.

Between these positions are perspectives that reflect ambiguities about how long therapy should last and whether termination is essential. Some of the literature asserts that Freud did not adequately address the difficulties of endings, and there has never been a clear plan or paradigm for how therapists should be thinking about and carrying out termination (Bergmann, 1997, 2005; Blum, 1989). There remains a lack of consensus, and the phenomena surrounding endings is often confusing: some patients leave early, some abruptly, and some do not terminate at all. Edgar Levenson (1976) regards termination as a problem of the therapist's aesthetics, which "can be conceived of as having a definite end which should not be overextended; or, as having no end at all. . . .

We must learn to live in uncertainty. Psychoanalysis, like mushrooms flourish best in the dark" (pp. 338, 342). How do therapists think about treatment that remains open-ended when the concept of termination is itself so ambiguous?

Purpose of the Study

The purpose of this study was to discover how therapists who see patients in long-term, open-ended therapy think about the length of these treatments, what relevance they attach to the concept of termination within the treatment process, and what use they make of these ideas in their practice of therapy. Do psychoanalytically oriented therapists consider long-term treatment valid for some patients? How does the concept of termination, which has been addressed much more than long-term treatment in the literature and in commonly held professional knowledge, contribute to their thinking? Do ambiguities in the literature about termination affect conceptualization? Does paucity of information in the field about long-term therapy affect therapists' thinking about their long-term cases? How do therapists bear the lack of information and ambiguities?

By addressing elements in long-term cases that challenge us, we create an environment for increased therapeutic benefits. The more therapists communicate with each other about their thinking regarding long-term therapy, the greater the potential for understanding the complications of the process and for helping our patients. In addition, inquiry into therapists' subjective experience of long-term therapy contributes to the narrative and understanding of an under-studied clinical phenomenon.

Research Questions

The following questions were addressed in my research: How do psychoanalytically oriented psychotherapists conceive of their work with long-term

cases? Do therapists think about long-term cases in relation to the concept of termination, and how do they understand those thoughts? What theoretical concepts guide therapists about the nature of the therapy relationship and the course of treatment as they work with long-term cases?

This qualitative study focused on the subjective experience of the therapist, using a grounded theory approach (Glaser & Strauss 1967). The data consists of in-depth interviews with psychoanalytically oriented therapists with long-term, open-ended therapy cases who were asked to consider their experience, thinking, and work with these cases. The "constant comparative method" of qualitative data analysis as described by Anselm Strauss and Juliet Corbin (1998) was used to analyze data from the study.

Clarification of Terminology

How long the therapy continues in order for the therapist to characterize it as long-term is a subjective determination. I selected 15 years or more to create a standard for consistency in this research. There are schools of therapy that might consider one year to be long-term but some psychoanalytic literature refers to 20 years, or "decades long." Similarly, there is no definitive term that describes the length of treatment represented in this study. For the sake of understanding, I use the expressions that I determine come closest to portraying the length of the time and dispositions in question: "long-term," "open-ended," "extended," and "prolonged" therapy.

I use the terms psychotherapy and psychoanalysis, likewise therapy and analysis, sometimes interchangeably, throughout the study. The data for the study was derived from interviews of psychotherapists whose theoretical orientations are psychoanalytic.

Psychoanalytically Oriented Psychotherapy

Differences between psychoanalysis and psychoanalytic psychotherapy have been debated for many decades. James Fosshage (1997) reviewed literature on the topic and submits that there is not a meaningful difference between the two. Extrinsic differences, seen in frequency of sessions and use of the couch, have more to do with meanings for a particular patient and the use the patient is able to make of the work. More sessions per week means more time for the work but patients are unique in how effectively they proceed relative to frequency of sessions; some psychoanalytic patients work optimally four times a week and, for others, an in-depth process with considerable change can occur on a once–a-week basis. Likewise, for some patients, lying on the couch facilitates tuning in to fantasies and affect while, for others, working face to face provides an experience of the therapist that is more useful. Formal psychoanalytic training and certification, another extrinsic difference, is not a meaningful difference for the purpose of this study because many therapists learn and are supervised to practice psychoanalytically. Both kinds of practitioners work, intrinsically, on the patient's transference to the therapist and to his or her whole experiential world "to help the patient to gain freedom from repetitive problematic ways of organizing his or her world and to form new more vitalizing attitudes or organizing patterns" (p. 417).

This study is about therapists' experience of long-term treatment. Although training and theoretical orientations were considered in participants' backgrounds, they are not the focus of the research. Thus Fosshage's (1997) conclusion coincides with the purpose of this study: "theory, research, and practice . . . indicate that the distinction

between psychoanalysis and psychoanalytic psychotherapy cannot be feasibly maintained" (p. 420).

Although conceptual differences between psychotherapists and psychoanalysts can be minimal, I did not interview psychoanalysts because they receive training that is unique to psychoanalytic institutes with an emphasis on increased weekly treatment and the use of the couch. This is a small study with a focus on how the psychoanalytically oriented therapist conceptualizes long-term therapy. How differences in training between psychoanalytically oriented therapists and psychoanalysts might affect conceptualizations of long-term treatment would be an interesting focus for a future study.

Theoretical Considerations

This study questions elements integral to long-term, open-ended therapy in psychoanalytically oriented psychotherapy. Inherent in these questions is the alternative concept of termination. There is a range of theories that represent the practice of psychoanalysis and a particularized view of the need for and function of termination. Freudian analysis and ego psychology represent theories that often determine termination to be the only appropriate resolution in analysis. They were formulated during an era in which the analyst was held as the authority and decision-maker in the therapeutic dyad. The dynamic model was a one-person intrapsychic model. When the patient disagreed with the analyst, it was considered resistance and countertransference was considered an interference to be put aside.

Contemporary theories of analysis tend to be more relational and emphasize the subjective experiences of both patient and analyst; the locus of authority has shifted from a one-person to a two-person model. Relational models are found within the theories of

object relations, self psychology, Jung, interpersonal psychology, attachment, and intersubjectivity; they are also greatly enhanced by the recent research on brain development and the importance of affect regulation in early infancy and ongoing relationships. In these theories, termination continues to be a frequent and sometimes viable outcome of therapy, but there is an added valuation of relational strivings that are privileged.

The purpose of this research is to explore thinking about clinical phenomena rather than to study or build psychoanalytic theory per se. Furthermore, the literature on long-term therapy and termination rarely refers to specific psychoanalytic theories; it does, however, note the shift from one-person to two-person conceptualizing. Therefore, I did not review specific theories in the next chapter but my reviews of the literature do reflect the shift from a one-person to a two-person paradigm in the development of thinking about long-term therapy and termination.

CHAPTER TWO: LITERATURE REVIEW

The focus of this study is how psychoanalytically oriented therapists conceptualize long-term therapy cases. I will begin with a section on length of treatment, followed by a review of the literature that explores long-term therapy. I will then review literature that addresses the concept of termination. In the final section, I will review empirical studies that include the topic of treatment that continues for a long time. My goal is to represent the literature in all these areas that I view to be most important in therapists' thinking about long-term therapy.

The numbers of years needed for treatment and how to think about termination are two topics that have been on the minds of practitioners from the beginning of psychoanalysis, and they are implicit topics in this study. Accounts of one of Freud's analytic cases, known as the Wolf Man because of the patient's early fear of wolves, reflect issues about length of treatment and approaches to termination that go to the heart of the current study. Freud (1937) writes that he attempted to speed up the "case of a young Russian" (p. 217) because certain gains were made but then progress stopped. Freud states that he decided to set a termination date for one year ahead, in order to press the patient toward more changes. This approach seemed to produce success and when the patient terminated in 1914, Freud believed he was permanently cured. Freud writes that he later found he was mistaken about the success of this forced termination. Towards the end of the war (approximately three or four years following termination), Freud states, the patient became destitute, had not resolved transference issues, and suffered attacks of illness that required short courses of treatment for ongoing decades, first with Freud and later with Dr. Ruth Mack Brunswick. The elements of this famous case of Freud's—

concern about length of treatment, consideration about the long-term needs of a particular patient, and issues about how to conceptualize termination—illustrate topics that regularly appear in the literature related to this study and are represented in the following literature review.

Length of Treatment

Duration is an inherent topic in the discussion of long-term treatment, and how it is discussed in the literature is important to therapists' thinking about prolonged therapy. "Implicitly or explicitly, time dominates the psychoanalytic situation" (Hartocollis, 2003, p. 939). The literature reveals that opinions and accounts can vary widely about length of psychoanalytically oriented therapy cases with discrepancies between reported and actual time spent (Glover, 1955), implying therapists' perceptions of vulnerability regarding how many years they see patients. I will review literature that discusses the concept of length of long-term treatment and also the number of years that treatment lasts.

Uncertainties and concerns about length of treatment have been on the minds of practitioners since the beginning of the profession. Ferenczi (1927) asserted that a patient should stay in analysis as long as he wants to and that neither analyst nor patient should unilaterally end treatment but that, ideally, it should "die of exhaustion" (p. 85). Over time, Ferenczi submitted, analysts would know when the process was complete and the patient was ready to end. He allowed that he could not yet point to any analysts who had accomplished this but expressed confidence that, eventually, they would develop these skills.

Freud (1937) began his paper, "Analysis Terminable and Interminable," voicing concern about length of treatment. On the one hand, he suggested analysis should be as

short as possible, for the sake of expedience and because of contempt the medical profession had for invisible injuries. On the other hand, he found in actual practice that the end of psychoanalysis was ambiguous; treatment could not fully address a person's psychological needs; and patients frequently wanted to continue, return after ending analysis, or resume treatment with another analyst, as with the Wolf Man case. These factors confused the issue, making it unclear when treatment should end, other than "when the analyst and the patient cease to meet each other for the analytic session" (p. 219). In reality, psychoanalytic treatments had numerous "interminable" factors that made analysis "a time-consuming business" (p. 216).

Forty years later, Harold Blum (1989) writes that the reported length of analysis has continued to increase over time. Early analyses that were training grounds for followers of Freud lasted six to twelve months with barely enough time for an opening phase but patients frequently returned for additional analysis after termination. Blum writes that over the generations, the desire for deeper and more enduring change emerged. "We have hardly begun to explore the implications of the continued lengthening of analysis" (p. 258).

Regarding actual numbers of years that constitute long-term therapy and analysis, sources depict a range from one year to indefinite. Echoing Freud's concern for expediency and in keeping with the contemporary evidence-based mandate of medical insurers, an internet search provided a definition of long-term psychotherapy that represents the short end of the spectrum. The reference was to an article by Todd Neale (2008), entitled "Long-Term Psychotherapy Outdoes Short-Term for Complex Mental Disorders." In the article, long-term is indicated as at least one year.

The following three authors conducted studies that include treatment length. Glover (1955) found, in his 1938 study of British analysts in which 24 analysts responded to a questionnaire, that analysis lasted, on average, three and one-half years, but chronic cases seen in private practice commonly lasted from seven to over ten years. Wallerstein (1986) reports that at the beginning of his longitudinal study conducted in 1954, he expected some patients to be in treatment "reasonably long-term (from two years to indefinite)" (p. 85). When he began writing his book in 1982, he found that some patients were in psychotherapy for 25 to 30 years. (Glover's and Wallerstein's studies will be examined in more detail in the section on empirical studies in this literature review.) Norman Doidge et al. (2002) conducted a survey of analysts in the U.S., Canada, and Australia; they reported an average of 5.7 years in the U.S., 4.8 years in Canada, and 6.6 years in Australia. The authors state that while analysis is long, "it is not interminable" (p. 609). The primary rationale for studying common length of treatment, according to Doidge et al., is that it is perfectly natural for a patient who is beginning analysis to ask how long it is likely to last. Although duration is complicated by many factors, analysts should be able to respond to this question. Other reasons have to do with financial aspects, both for the patient and for efficacy studies of psychoanalysis.

Warren Poland's (1997) comments on length of treatment address the same ambiguity that Freud expressed in 1937: "How long a journey should take depends on how far the destination lies. And how is one to decide that?" (p. 186). Poland goes on to say that analysis does not come in one size for all but is based on the needs of the individual patient; it is our job to help the patient make the most informed choice but the

choice is ultimately the patient's. In the next section, length of treatment is implicit in considerations and debates that surround long-term therapy.

Long-Term Therapy

Little has been written that specifically addresses the topic of long-term therapy. The literature that does exist favors a patient's choice to remain in therapy and challenges traditional views on termination, which as a rule, are opposed to long-term, open-ended treatment. Throughout the history of psychoanalysis, therapists have had cases lasting 15 years and longer that do not move toward the psychoanalytic ideals of termination: independence and autonomy. "It is clear from the literature that analytic relationships rarely terminate in the manner prescribed in the classical ideal—a complete ending, with the analysand becoming fully autonomous in his functioning" (Mendenhall, 2009, p. 130). Martin Bergmann (2005) acknowledges that people who are very good at their jobs see some patients in therapy for multiple decades. He anticipates the purpose of the current study when he asks how we can bring understanding to this work when there are no good maps for having an extended long-term therapy relationship. Other literature on long-term therapy concurs with a premise of this study that therapists who seek roadmaps for their long-term work find widely varying opinions about the validity of lengthy therapy, including questioning its appropriateness.

In this section I will review literature organized into the following subheadings: kinds of patients who benefit from long-term therapy, therapists who conduct long-term therapy, concepts of long-term therapy, and debates over long-term therapy.

Patients Who Benefit From Long-Term Therapy

Two categories of patients tend to be discussed in the long-term therapy literature as potentially benefiting from open-ended, long-term treatment. First are those with persistent psychological dysfunction. Evelyn Leigner (1986) focuses on patients who struggle with characterologic problems for whom ongoing analytic work can be lifesaving. Rucker (1993) states that it is well known among clinicians that patients with serious psychological problems and limited object relationships can greatly benefit from ongoing therapy. Bergmann (2005) identifies a subgroup of the population that require continued psychological assistance to keep functioning and, he notes, all psychoanalysts see these patients in treatment that are prolonged or "interminable."

The other category of patient remains in ongoing therapy after symptoms have subsided and healthy functioning is achieved. This kind of patient is less recognized in psychoanalytic literature because they do not follow the conventionally sanctioned course of termination when they have resolved the problems that originally brought them into therapy. Rucker (1993) argues that while these cases do not conform to the traditional model of termination that emphasizes separation and independence, they are not guilty of an inability to separate but are guided by the choice not to do so. They continue in therapy in order to continue healthy maturation, cultivate richer relatedness, and evolve in a relationship that cannot be replaced or replicated in any other setting. Leigner (1986) maintains that in some cases, ongoing therapy serves as a kind of mental hygiene, emotional nutrition, intimate attachment and psychological insurance. David Tresan (2007a) observes that there are many analysands for whom extended analysis constitutes

a profound and individualized life education and, at the same time, includes the usual attention to relationships, crises, fears, moods, sadness and loss.

Therapists Who Conduct Long-Term Therapy

Wallerstein (1986) writes that patients who need long-term therapy and therapists who are comfortable working long-term find each other. He describes characteristics of analysts who do long-term therapy, which are echoed in the writings of other analysts. These qualities include patience, the ability to stay involved over a long time without much change occurring and professional self-esteem that does not depend upon producing "more timely" therapeutic results. Bergmann (2005) concurs that this work will not be a good fit if the therapist's superego requires a "cure" within a number of years. Poland (1997) writes that uncertainty about where one is going is accentuated in analyses that last a long time. Referring to what seems to be work with patients who have serious psychological problems, the long-term analyst keeps "faith in the patient's ultimate understandability in the face of frustrating, draining, and corrosive constriction" (p. 192).

Authors who write about working long-term with patients who have mature and healthy functioning emphasize other qualities in the therapist. These include capacities for ongoing healthy and mature interdependence (Leigner, 1986; Rucker, 1993). E. Shane (2009) describes the analyst who can engage in open-ended analysis as comfortable with uncertainty, viewing analysis as a never-completed process, able to commit to another in a mutually caring relationship, and regarding analysis as a unique and idiosyncratic enterprise that is specific to the analytic dyad. Tresan (2007a) holds that the long-term analyst is energized by the ongoing search and experience of the analysand.

Concepts of Long-Term Therapy

For a few decades, several psychoanalytic authors have turned attention to the clinical phenomenon of long-term therapy and provided concepts for a model of therapy that is open-ended and flexible. Their concepts reflect treatment that is empathically attuned to the patient's developmental needs and reflects the unique qualities of the therapeutic dyad (Barish, 1991; Goldberg & Marcus, 1985; Leigner, 1986; Mendenhall, 2009; Poland, 1997; Rucker, 1993; E. Shane, 2009; Short, 2009; Tresan, 2007a, 2007b).

Central to concepts of long-term therapy is an emphasis on the unique wishes and needs of the patient, rather than on pre-formulated, generalized principles of factors dictating termination. Some authors emphatically endorse the sole right of the patient to choose whether to continue or stop treatment. Arnold Goldberg and David Marcus (1985) regard all principles of traditional termination as secondary to the needs of the patient. They favor understanding the patient's process, thus promoting "natural" endings, and oppose "some sort of personal comfort" (p. 64) that analysts might derive from insisting on rules of termination. Leigner (1986) suggests it is ideal for patients and analysts to remain together as long as life and treatment goals are being met and feels that analysts should not impose their own goals upon the patient. Samoan Barish (1991) discusses the narrative unfolding of an analysis that lasted 15 plus years in which patient and analyst shared many important life events. She expresses an opinion pertinent to exploration of long-term therapy as an alternative to termination: "How we use our theories and whether we become their masters or their servants is a matter of ongoing interest to me" (p. 85). Poland (1997) submits that calendar length of treatment is relevant only to the needs of the individuals, that in seeking principles of long analysis we do not find definitive laws

of nature or science but, rather, expanded understandings of unique and particular analytic experiences. He endorses patients making their own choice whether to stop after the pain is lessened or "whether what has already been obtained in the way of insight and mastery leads the patient to want to continue for more" (p. 186).

Other authors emphasize the idea that the decision to continue or stop treatment has as much to do with the analytic relationship as with the patient's individual development. Tresan (2007a) addresses analytic relationships that continue over many years. He writes: "I think such work thrives only when both analysand and analyst are equally energized by the search and by each other's experience" (p. 38).

Rucker (1993) describes the patient and analyst having their own particular selfobject components that make every relationship unique. She argues for the plausibility of lifelong analysis in some analytic dyads; she asserts that among many viable orientations of analytic process is one of treatment extending throughout a person's life or the analyst's professional or personal life. She discusses some patients' needs for ongoing empathic attunement and attachment to make significant changes and achieve a mature, mutually dependent relationship with the analyst that enhances capacities for reciprocity, healthy functioning, and intimacy. Rucker promotes a model for ongoing analysis with patients who have resolved the problems that brought them into analysis and whose psychological functioning has reasonably grown. She believes it is not necessary to separate therapeutic and life goals—often called for by more traditional theorists—and argues that analyses are viable that serve both therapeutic and life goals and permit continued psychological integration across changing developmental stages and experiential contexts. Rucker suggests that ongoing analysis might be the only place

that the patient's inner world is understood with such singular continuity and depth and that it can compensate for lack of empathy in other intimate relationships, complement other relationships, and even bridge the gap between analytic and non-analytic relationships.

Mendenhall (2009) refers to the "evolution of a relationship" and a new understanding of ways that patients might use analysis in their life processes: some might stop analysis and seek further treatment later on and some might continue in long-term therapy that is not interrupted. Some patients may wish to maintain continuity and connection with the analyst who knows so much about their lives. Mendenhall joins Rucker (1993) and Estelle Shane (2009) in suggesting that some analysands may develop new configurations of relatedness with their analysts through consultation, collegial relationships, or even friendships.

Barbara Short (2009) calls for opening up ideas about the analytic process and focusing on the patient's developmental process rather that on cure or achieving technical landmarks. She wants to "de-link a termination process from the criterion of success" (p. 7), destigmatizing the long-term therapy endeavor. Short suggests that perhaps patients who remain in a sustained analysis can be seen as making valuable and legitimate use of the work, instead of "shameful analytic secrets about which we neither write not speak, or the dreaded "interminable" analysand whom we talk about with derogation" (p. 21). Short's comments lead me to the next section concerned with debates consisting of arguments for and against long-term therapy.

Debates About Long-Term Therapy

Literature that presents a model of "interminable" analysis almost invariably also contains arguments *against* the traditional role of termination and reveals tensions between the two positions. Poland (1997) asserts that you cannot think about long-term treatment without thinking about termination; "the question of long analyses implies the question of termination" (p. 188), counter to arguments by Short (2009) and others *for* long-term therapy. The extent of the differences that goes to the heart of this study are shown later in this section in my review of articles by Tresan (2007a, 2007b) and Angela Connolly Dragosei's (2007).

In their article, "Natural Termination," Goldberg and Marcus' (1985) intent is to re-examine artificial rules of termination, broaden thinking, and promote natural endings. While not explicitly advocating "interminable" analysis, they assert that timing issues are secondary to the needs of the patient at any cost. They criticize termination literature that promotes prescribed rules and casts long-term patients in the role of hanging on too long, hiding issues, and resisting the relinquishment of infantile regression and the need for gratification from the analyst. The authors refer to Freud's Wolf Man case and his maneuvering the analysis as it threatened to be "interminable"; Freud set a termination date and this clinical tactic ushered in decades of deliberation over how and when to end treatment. Subsequently, termination became an aspect of analysis subject to rule making:

> There has occurred a sort of institutionalization of termination which begins with marking it off as a specific phase of analysis and subsequently characterizing it in terms of the work directed to setting the date for terminating, and thereupon

> working through the analytic material which derives from this act. (Goldberg & Marcus, p. 46)

The authors argue that practices that impose termination and focus on working through material raised by the anticipation of ending place the analyst in an adversarial position in opposition to the unique needs of the patient.

In her article "Analysis Interminable Reconsidered," Rucker (1993) reviews and refutes literature that assumes termination to be the appropriate resolution of all analyses: "with scant exception, the conclusion of an analytic treatment is presumed" (p. 159). In her stated intent to think about how continuous analysis might have "an outcome that can have a richer value and meaning than what has been considered thus far" (p.160), Rucker confronts the long tradition of regarding termination as the ideal.

Mendenhall (2009) presents an extensive review of literature that demonstrates evolving ideas about termination through the history of psychoanalysis. The traditional concept of termination, based on a drive theory model, prescribed the renunciation of infantile strivings and achievement of independence and autonomy; Mendenhall wants to see this replaced with a more flexible model "based on infancy research, neuroscience and clinical experience" (p. 130). Mendenhall supports continuous treatment as a desirable option. She provides a case example in which she almost overlooked the possibility of responding to the patient's needs to continue treatment, reporting a "near miss" in which she initially relied upon her own internal dialogue that reflected old and habitual configurations of termination, rather than attending to the actual dialogue between the patient and herself that called for sustaining the valued ties between them.

E. Shane (2009) argues that the overarching ideal of termination is an increasingly debatable concept, though some contemporary writers still consider it to be essential to analysis. E. Shane identifies tensions between the two positions by elaborating divergences between her previous formulations and her current views. In an earlier co-authored article (M. Shane & Shane, 1984), she argued that termination was essential and critically important to the whole analytic process; without it the work was incomplete. She points out that these views were commonly stressed in the psychoanalytic literature of the 1970s and 1980s. The accepted lore emphasized the patient's relinquishment of infantile strivings, which impeded development, in order for proper endings to be achieved. E. Shane's current position argues that analysis is never complete. It is an important relationship of concern, caring, and a kind of love based on mutual respect with "such deep and enduring meaning, in one sense it cannot, and, in some cases, perhaps, should not, be terminated" (p. 168). A change that Shane identified after she reviewed the literature for her earlier article is the shift from a one-person to a two-person perspective; there are now two affective experiences mutually affecting each other. Another shift in Shane's thinking is that there is no need for universal criteria for termination because each treatment, whether it ends or not, is unique to that therapeutic dyad.

In his article "On Long Analysis," Poland (1997) criticizes analysts who create tensions in the field by challenging the validity of long analysis. He considers long-term work to be appropriate for some analyses and discusses some of his own cases that have been long-term. Poland states that he has been impressed by how intensely some analysts react when told that a treatment by another analyst has lasted 10, 15, or 20 years. He objects to depictions of long-term analyses that imply stalemate or exploitation, "as if the

only real question were whether the practicing analyst were stupid or, instead, a knave" (p. 184). According to Poland, the moral indignation and disdain expressed by some analysts at long treatment betrays motives other than the analytic thoughtfulness and curiosity appropriate to analysis. He argues that it might be more appropriate for them to be suspicious and skeptical about their own defensive moralism.

Explicit differences and strongly felt tensions over long-term analysis are expressed in the following arguments between two Jungian analysts: Dragosei's (2007) critique of Tresan's (2007a) article in support of long analysis. In her critique, she states that when treatment continues open-endedly, important aspects of time are being denied and the analytic pair is frozen in futile and indefinite waiting. Also, there is an avoidance of separation, an unwillingness to leave or be left, and an inability to accept the partial nature of the analytic process. According to Dragosei, the process has failed, and the failure is masked by idealization of analysis and an inflated valuation of possibilities. Tresan (2007b) responds that he was at first chilled by Dragosei's critique, but then found himself to be heated. He acknowledges that long-term analysis challenges a shibboleth of all analytic schools but insists his intent is to explore phenomena that have been in existence and ignored for a long time. He counters Dragosei's criticisms by describing analysis as an elastic institution that can lend itself to all problems of the psyche and soul, including an attuned, constant relationship that consolidates and expands identity and pursues truth and reality. Tresan notes that Dragosei's article reveals her concern with enduring pathology in long-term work and he encourages her to explore this topic in its own right instead of assuming that all long-term analysis is pathological. Regarding his

long-term experiences, Tresan argues, "Far from being frozen, these patients are the most supple I know" (p. 49).

Termination

In the literature, the topic of termination is addressed in a body of work that stands in contrast to the dearth of literature on long-term therapy. In this section I undertake an extensive review of the literature that addresses essential concepts of termination. This is relevant to the current study in that what has been written about termination represents much of the academic knowledge base available to psychoanalytically oriented therapists as they think about their work with long-term patients. The literature on termination is rich and complex and reflects how ideas about this often-perplexing concept have evolved over time.

Early in the profession, problems with ending analysis arose and were unresolved, and this legacy has lasted for decades. Otto Rank (1924/1957) attempted to free analysis from extensive investigation by defining the parameters of psychoanalysis through a focus on the primary trauma of the birth process, "to repeat and to understand the birth trauma and its solution during the analysis in the transference" (p. 213). He conceptualized termination as a symbolic equivalent of birth itself. Ferenczi and Rank (1925/1969) noted that, in the final part of treatment, the infantile libido fixes on the analysis and the patient has difficulty accepting withdrawal of the libido from the analytic work. Freud (1937) found that some people have an "adhesiveness of the libido" (p. 241), and the process is very slow because they cannot easily shift cathexes from one object to another; that is, leave the analyst to find a new love object outside of analysis. Following many years of relatively little attention to termination, recent decades have seen an

abundance of termination literature. Relevant to the current study, Bergmann (2005) asserts that one reason for the recent increase in attention to termination reflects a sense of urgency in the profession over the many numbers of patients who remain in ongoing treatment.

I will begin the review of termination literature focusing on traditional conceptualizations. I will then examine the conceptual evolution of three traditional tasks of termination—a resolution of the transference, mourning analysis, and internalization of the analytic relationship.

Traditional Views on Termination

Jack and Kelly Novick's (2006) work on termination reflects traditional concepts within more contemporary configurations. In *Good Goodbyes: Knowing How to End in Psychotherapy and Psychoanalysis*, the authors present a road map for termination. Long-term therapy gets little mention other than the recognition that some treatments are long because of complex problems and intense difficulties in patients' lives. They theorize that "interminable" treatments occur when the patient refuses to progress and resists a pretermination phase. "Refusal" is seen to be based on fears of "open-system," competent, loving, and creative functioning. The Novicks' long-term patient is enmeshed in "closed-system," static and sadomasochistic relationships. According to the authors, the therapist of "interminable" treatment has been "pulled into a relationship of enthrallment with the patient, a joint search for impossible perfection" (p. 11).

J. Novick and K. Novick (2006) maintain the position that, although it is complicated for the patient and the analyst to end a valued therapy relationship, formal termination is essential, even crucial, in the psychoanalytic process. "There is mounting

evidence that a mishandled termination can destroy an otherwise successful treatment and may, in some cases, result in permanent psychic crippling, physical catastrophe, and even death" (J. Novick, 1997, p. 159). The Novicks (2006) encourage patients and therapists coming to a mutual decision to move toward ending treatment. Their idea, however, that the therapist should keep an open-system goal in mind toward a good ending from the beginning of every therapy relationship implies that the therapist is in the driver's seat and their thoughts about termination comprise much of the road map.

J. Novick and K. Novick's (2006) ideal therapist holds the criteria for ending in mind and these reflect three important commonly held goals of traditional treatment: resolution of the analytic relationship, mourning the loss of the analyst and analysis, and development of the self-analytic function. They state the criteria this way:

> What are the tasks for the patient during the termination phase?
>
> 1. To consolidate competent, open-system functioning so that there is a genuine, evenly balanced conflict between old omnipotent solutions and newly acquired or reactivated open-system functioning.
> 2. To work through revived conflicts in the context of saying goodbye.
> 3. To set aside infantile closed-system beliefs, especially in omnipotent power to control others.
> 4. To mourn the loss of the unique relationship, setting, and ways of working established in the treatment.
> 5. To internalize the loving, supportive, and ego-enhancing aspects of the therapeutic relationship. (pp. 104-105)

The therapist's tasks are to allow for the patient's "realistic sadness, grief, and mourning" (p. 104), to deal with their own sense of loss of an important relationship and the opportunity to use their skills. The authors also caution therapists not to alter the style of work or nature of the therapy relationship as it comes to an end.

I will now review other literature that addresses the three often stated goals of traditional treatment, reflected in J. Novick and K. Novick's (2006) tasks: resolution of the analytic relationship, mourning the loss of analysis, and internalization of the analysis that leads to self-analytic functioning.

Resolution of the Transference And Transference Neurosis

Literature in support of resolution.

The psychoanalytic literature reveals a great deal of attention to the nature of the relationship between the patient and therapist in the form of the transference. Conceptualizations of the transference, the transference neurosis, and their resolution, leading to termination, have been central to psychoanalytic treatment over the century. Building on Freud's ideas, Blum (1971) differentiates between transference and transference neurosis. Transference is ubiquitous, automatic and not limited to therapy relationships; it is " a displacement of aspects of an unconscious mental representation of an infantile object onto a mental representation of a current external object" (p. 42). The transference neurosis is more intense, rooted in neurosis, and is specific to the analytic relationship: "the analyst is perceived and reacted to in terms of the crucial infantile object representations, allowing a living redramatization of the distorting influence of the past" (p. 43). A predominant goal of psychoanalytic treatment in the traditional literature calls for resolution of both the transference neurosis and the transference. By resolving

the transference neurosis in analysis, the patient recovers from his neurosis; by resolving the transference, the patient relinquishes the relationship with the analyst.

Freud (1905) wrote about transference phenomena in an early paper about his analysis of his patient, Dora: "Fragment of an Analysis of a Case of Hysteria." He observed in the clinical work that the patient experienced present situations as though they are a revival of early life conflicts. He described transference as an intense attachment to the analyst, but an illusory one because it is rooted in the patient's early relationships. Analytic work became focused on understanding the patient's transference and resolving it so the patient can end analysis and live free of internal conflicts. Freud said about transference:

> All the patient's tendencies, including hostile ones, are aroused; they are then turned to account for the purposes of the analysis by being made conscious, and in this way the transference is constantly being destroyed. Transference, which seems ordained to be the greatest obstacle to psycho-analysis, becomes its most powerful ally, if its presence can be detected each time and explained to the patient. (p. 117)

In a subsequent entry, Freud (1914) distinguishes the transference neurosis and places it at the center of the work toward resolution and cure:

> We regularly succeed in giving all the symptoms of the illness a new transference meaning and in replacing his ordinary neurosis by a "transference-neurosis" of which he can be cured by the therapeutic work. The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made. (p. 154)

However, at the end of his career, Freud (1937) submitted in "Analysis Terminable and Interminable," that for some patients, analysis did not create immunity from experiencing new disturbances or a recurrence of old conflicts. He revised his treatment focus from a cure of the transference neurosis to a more attainable goal: "to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task" (p. 250).

Although Freud had lost his optimism about permanently curing the patient through resolution of the transference neurosis, the concept of a complete cure has remained a pillar of traditional psychoanalytic theory that has informed therapists' thinking about treatment and termination.

James Strachey (1934) states that with the discovery of the transference, Freud identified the most important tool of analysis. He describes the process with neurotic patients: intense feelings of inner conflict are shifted from experiences in early life and artificially attached to the analyst in the form of "transference neurosis." The transference consists of loving and hostile feelings. The loving transference feelings provide the atmosphere for the patient to work with the analyst directly on conflicts of the past. The process allows for the patient to create new solutions instead of old ones and replace behavior that is more based in reality. According to Strachey, when the work is finished, the patient detaches from the analyst and never falls back into his previous neurosis. Two decades later, Ralph Greenson (1958) continues exploration in the same spirit: "Psychoanalysis is that method of treatment of emotional disorders in which the relationship between the patient and the therapist is so structured that it facilitates the maximal development of a transference neurosis" (p. 200). The patient recapitulates the infantile

neurosis to resolve his neurotic conflicts and, as with Strachey, Greenson's changes are considered permanent.

According to Glover (1955), the termination phase is concerned with reversing the patient's regressions and dissolving the transference, after which treatment should be terminated as soon as possible. He argues that treatment that goes beyond this stage represents a stalemate. The termination phase as a theoretical construct is generally credited to Glover and he contends that, unless there is a termination phase, it is doubtful that a case has been properly psychoanalyzed. His points of view reflect early and traditional conceptualizations of termination that have appeared in the psychoanalytic literature for many decades.

Hans Loewald (1962) and Ernest Ticho (1972), both prominent authors on the topic of termination, reassert traditional thinking about the nature of the transference relationship. Loewald states that, with the transference neurosis, the analyst becomes the substitute for lost love objects; the goal of analysis is "to resolve the transference neurosis, a revival of the infantile neurosis" (p. 488). E. Ticho (1972) writes in his article, "Termination of Psychoanalysis: Treatment Goals, Life Goals," that an indication to begin the termination phase is a substantial reduction of the transference neurosis and the realization that analytic work has reached a state of diminishing returns. His treatment goals concern removal of obstacles to the patient's potentials, and life goals are what the patient seeks to attain by putting potentials to use. Ticho conceives of analysis that goes on for "too long" as reflecting the analyst's inability to keep treatment goals and life goals separate. With substantial reduction of transference neurosis the mood in the analytic work has relaxed, the patient seems less dependent and the analyst has become

more human to the patient. Ticho points to a danger at this stage that the analyst will lose control of the countertransference and go from "depriving the patient (which is a necessary part of the growing process) to gratifying him" (p. 324). In a similar vein some analysts may reassure their patients by telling them they can return if they need further help but, Ticho cautions, at the end of a completed psychoanalysis this gives the message that "I don't believe you will ever be able to stand on your own feet" (p. 331).

Brian Bird (1972) captures ambiguities inherent in work with the transference. He writes that transference goes on all the time in an analysis but that it has never been satisfactorily explained and means different things to different people; "nothing about analysis is less well known than how individual analysts actually use transference in their day-to-day work with patients" (p. 271). Bird distinguishes between three transference configurations. One kind is based on ordinary feelings that are repetitions of the past, and patient and analyst remain separate identities; transference occurs in all situations, not only analysis, and is never "resolved." A second kind of transference in analysis is based on the real situation. The third is the transference neurosis in which the patient includes the analyst in aspects of his neurosis and their separate identities are lost: the analyst comes to represent the patient in certain expressions of the patient's neurosis. He notes that by 1952 many analysts were giving up on the concept of the transference neurosis because it was the hardest part of the work. He cautions the analyst against giving up on the transference neurosis and dwelling only in the realm of the transference; if the analyst does not become involved in the patient's neurosis, the analytic work remains "safe" and does not go far enough. A problem in analysis, according to Bird, occurs when the analyst gives substantial help to the patient—the analyst might be the most stable, open,

and honest relationship the patient has ever had, and the real value of dealing with immediate problems can be immense. The trouble is that when the real relationship is too good, the patient might never go deeply enough to resolve crippling internal problems. Bird depicts termination as the prime time for issues of the transference neurosis and original neurosis to come to the foreground. On the one hand, he declares the best way to work on them is not to change analytic technique or taper off. On the other hand, he acknowledges:

> There can surely be no more likely time for an analyst to surrender his analytic position and, responding to his own transference, become personally involved with his patient than during the process of separating from a long and self-restrained relationship. . . . Because of this a great many patients may lose the potentially great benefit of a thorough resolution and are forever after left suspended in the net of unresolved transference" (p. 287).

In the end, Bird asserts, "it may be better to slur over the ending lightly than to mishandle it in an attempt to be rigorous" (p. 287).

Bird (1972) conveys the message that, although analysts are drawn to the unresolvable and more personal transference relationship, they need to manage the personal aspects well enough so that they can redirect their attention to resolving the difficult and conflictual transference neurosis. Ambiguities raised by Bird about the difficulties inherent in work with the transference expand the conceptualization of transference from the traditional model to include interpersonal aspects of the analytic relationship.

Literature that questions the possibility of resolution.

Bergmann (1988) traces psychoanalytic literature that focuses on the fate of the transference and the difficulties ending the psychoanalytic relationship. Although a traditional task of termination was to analyze and resolve the neurotic transference, Bergmann asserts, it is a "troubling problem that termination does not always lead to resolution of the transference neurosis" (p. 137). He observes that Annie Reich (1958) might have been the first to write about this problem. In 1950 Reich writes that it is hard for the patient to give the analyst up because the transference involves infantile gratification; this gratification "is the basis of our method" (p. 181) and should not be denied the patient. Reich argues in her paper, however, that the need the patient feels for the analyst has to be relinquished—no matter how long analysis takes. In 1958, she asserts the value of the relationship further: "the analyst may become the first really reliable object relationship in the patient's life, a contingency which of course entails the danger that it may seriously interfere with the possibility of the transference ever being analyzed" (p. 230). Bergmann describes transference neurosis and resolution of the transference having a complementary relationship; psychoanalysts "may well be in the position of the sorcerer's apprentice who can begin a process that he cannot bring to conclusion" (1988, p. 146).

In a study that demonstrates evolving changes in understanding the nature of the patient-analyst relationship, Arnold Pfeffer addresses the post-analytic fate of the transference neurosis, and he discusses his findings in a series of articles (1959, 1961, 1963). The procedure of his study consisted of interviews with nine patients who had terminated analysis approximately four years earlier. The interviews were conducted by

analysts who were not the original treating analysts. They occurred once a week, were open-ended, analytic in style, and ranged from two to seven in number, as determined by the participants. Prior to the interviews, the interviewing analysts were given pertinent information from the treating analysts and, after the study, the two analysts conferred. The findings of the study were that the transference neuroses returned during interviews with the interviewing analysts, and they subsided during the course of the interviews. Pfeffer (1963) notes: "Conflicts underlying symptoms are not actually shattered or obliterated by analysis but rather are only better mastered with new and more adequate solutions" (p. 234). Similar studies by Nathan Schlessinger and Fred Robbins (1975) and Haskell Norman, K. H. Blacker, Jerome Oremland, and William Barrett (1976) confirmed Pfeffer's findings that psychoanalytically conducted interviews with patients who have had satisfactory analyses, produce intense recapitulations of the patient's analyses as well as the resolutions the patients had achieved in analysis. What was significant about these studies was that the original Freudian concept of the total resolution of the transference neurosis in the original analysis had not occurred.

Bergmann (1988) notes that by 1971, the mainstream of psychoanalysis was transforming the concept of the transference neurosis. He points to Loewald's (1971) shift in formulations: in 1962 Loewald is concerned about resolving the transference neurosis and in 1971, insistence on resolution no longer appears; instead, Loewald emphasizes the interactional possibilities between patient and analyst.

Judy Kantrowitz, Ann Katz, and Frank Paolitto (1990a, 1990b, 1990c) describe their study of patients' experience following the termination of analysis. In 1972, twenty-two patients agreed to participate in a longitudinal study before entering supervised

analysis at the Boston Psychoanalytic Institute. The following data comprised the research: interviews of patients and analysts one year after termination, psychological testing of patients before and after analysis, and patient interviews five to ten years after termination. On the fate of the transference, the authors found that there are unexamined issues in every analysis and, even in analyses where the transference is largely resolved, "there remain aspects of the transference which have not been fully understood or worked through" (1990c, p. 676). They also discovered a phenomenon regarding the nature of the analytic relationship that seems to reflect a paradigm shift in the decades since the inception of the study to the follow-up articles:

> Given that analysts strive to maintain a certain anonymity with their patients and that patients' perceptions of their analysts are greatly shaped by the complexity and depth of transference reactions, it is especially striking that patients' perceptions of their analysts as real people often have considerable reliability when compared with more "objective" evaluations (1990c, p. 674).

Lora Tessman's (2003) interviews of analysts about their experiences of their own analyses also reflects the decades that saw the dismantling of the resolution of the transference. In her book, *The Analyst's Analyst Within*, Tessman reports on her qualitative study in which she talked with 34 analysts about how their own analysts remained memorable after termination; the participants' analyses ranged from satisfying, limited, unsatisfying, and damaging. The taped interviews lasted between two and eight hours in "spontaneous narrative and responses to 13 lines of open-ended questions" (p. 5). Tessman was to discover that most of the participants had either two analyses or another extended therapy with an analyst. Relevant to the current study, she writes: "I

have come to regard second analyses as denoting an affinity for analytic process and its yield, rather than dissatisfaction with a first experience" (p. 5). Her participants were analysts who had experienced their training analyses during a time of changing paradigms in theory and practice. Tessman writes that for many decades the resolution of the transference was deemed to be criteria for determining readiness for termination, but she asserts this has not proven to be the case: transference can be transformed but not resolved. In conclusion of her sensitive and insightful study, Tessman discusses her own view of the nature of the analytic relationship, which reflects a considerable evolution from Freud's description of transference as an intense but illusory attachment to the analyst that is rooted in the patient's early relationships. When loving a person, Tessman suggests, "one may be gratified that the loved person behaves differently from the way one could have imagined, that in fact his own and different reality has swept away and altered the love yearnings from the past" (p. 317). This enables the person to be freed from attachments from the past and more open to present attachments. "Pleasure is focused on the actuality of the other, outside one's projections. Then the analyst within, not born of illusion, can partake in generative collusion" (p. 317).

A relational perspective on the resolution of the transference.

The idealization of complete cure with the resolution of the transferences was dismantled in the relational shift from a one-person to a two-person conceptualization of the analytic relationship. Lewis Aron (1990) writes that the original and fundamental theories about psychoanalysis reflected a one-person model; that is, the transference existed in the mind of the patient and was not an interpersonal dynamic. Aron states that relational, or two-person, models developed in reaction to the traditional model; it was

apparent that who the analyst is and how the analyst works has a real affect on the patient, and transference became seen as an interactional, joint creation of the patient and analyst. Stephen Mitchell (1988, 1993) also focused on the shift from an intrapersonal drive model to the interpersonal relational model in psychoanalysis. While Mitchell, as a prominent spokesperson for relational thinking, emphasized a reconceptualization of the nature of the analytic relationship, he also maintained a more traditional view of ending: termination is necessary "if the analytic work is not to become a static alternative to a fully lived life" (1993, p. 229).

Relational perspectives struggle with, but defend termination as an essential process in psychoanalysis, as stated by Mitchell (1993) and reaffirmed in Jill Salberg's (2009) statement: "there is some necessary integrative work that may [be] possible only when ending treatment" (p. 704). Termination remains a cornerstone of analysis in the relational approach to theory and practice but perspectives on the end of the analytic relationship have undergone changes. In traditional termination, gratification from the analyst is a transference illusion that is resolved and renounced; with the relational turn, the emphasis on an illusory, past relationship has shifted to the experience of the actual relationship in the here and now. Relational connections between patient and analyst are based on real configurations. "The analyst, as new object, is allowed to survive" (Skolnick, 2010, p. 230). Jody Messler Davies (2009) writes that traditional termination, with its goal of resolving distortions of the transference neurosis, eluded psychoanalysts from the beginning: we now believe that the analytic relationship is bi-directional, in the moment and real. In a relational approach to termination, the patient and analyst give up a relationship that continues to be valuable.

In a recent compilation of papers on termination, *Good Enough Endings: Breaks, Interruptions, and Terminations from Contemporary Relational Perspectives*, Jill Salberg (2010a) and other relational analysts discuss the complexities of ending analyses. A common theme many of these authors address throughout their individual bodies of work is that of multiple self-states that the patient and therapist bring to the work. With termination, these self-states are involved in multiple endings and good-byes in a mutual process of letting-go; this can be a long process. Salberg (2009, 2010c) considers termination an enactment: "The mutual processes of attaching and detaching, of growing close and then saying good bye, elicit powerful feelings and equally powerful dissociative processes" (2010c, p. 116). Sue Grand (2010) calls for a change to the traditional ideals of termination: "The termination literature is implicitly tilted towards making us better citizens, who adhere to the law" (p. 137). She argues that termination is a gendered issue, with resistance to termination having been "feminized" and willingness to go through termination "masculinized." Anthony Bass (2010) is concerned that we can never be sure if ending will foreclose new growth, and he prefers to "hold the notion of termination lightly" (p. 302) because how long is necessary is totally subjective between patient and analyst. He does, however, argue that when the patient reaches the point of living a life that is unhampered by major problems of fulfillment, there is little reason to continue meeting. Davies (2010) discusses analysis as a deeply felt, loving, and sometimes hating, experience over a long expanse of time in which multiple self states are given the time they need to experience and re-experience old and new ways of engaging and, ultimately, of saying goodbye. Davies (2009) submits that it makes sense for the analyst to err on the side of giving too much, including indulging the desire for

timelessness in analytic work, so at the end the patient is able to mourn something he has actually had. She writes that patients' and analysts' desires and limits collide and they need to survive this so that the "illusion of a limitless, boundless, and never-ending idealized love will dissipate gently and be transformed into a post-analytic love that will endure" (p. 743). Lynn Layton (2010), similar to Grand's gendered termination, identifies a cultural dynamic that she calls "maternal resistance," in that dependence and attachment to caretaking others is seen as weak and causes patients and analysts to avoid dependence. Layton does not argue for termination or continuing analytic work but, rather, for recognition of the significance of attachment and the real relationship. She says, "And when we are truly in touch with what we have lost, we might, as I did and do, at least wonder why on earth anyone would want to end" (p. 209).

Bergmann (1988, 1997, 2010) links the value of the transference to relational configurations when he observes that a patient's transference relationship with the analyst is often the best love relationship they have ever had. He states the practical issue that for people, who are single or unhappy in a relationship, there is less for the patient to gain by leaving analysis and "it is easier to terminate an analysis if the possibility of a newer love relationship or a reordering of an older love relationship is realistically possible" (2010, p. 31). Salberg (2009) echoes Bergmann as she questions why a patient would want to end "a relatedness that may be more satisfying than has been the case with other relationships" (p. 704).

Glennon (2010), struggling to justify work with a patient that has not reached termination, questions if the relational turn has made analyses harder to terminate; she adds her voice to those that question the cornerstone of termination. Few people would

willingly end relationships that are loving and supportive and meaningful "even if more therapeutic work is not deemed necessary" (p. 257). She wonders if she has "gone too far in the direction of mutuality" (p. 265) with a patient who does not want to leave analysis after 21 years. In her exploration of her work with this patient she writes: "I have not yet encountered, with the exception of Bergmann's speaking of transference love, a discussion of a nonsymptomatic, nonpathologized reluctance to leave based on the intensity and profundity of the new, real relationship with the analyst" (p. 271). Her paper highlights the dilemma that historical and contemporary literature reaffirms an ideal of termination, but in some cases, clinical experience disproves the accepted wisdom. In a statement that speaks to the purpose of the current study, Glennon writes that she would welcome dialogue regarding the conundrum of termination in relational psychoanalytic work.

Mourning the Loss of the Therapy Relationship

The three tasks of traditional termination that I have chosen to focus on are not discrete from each other; they overlap and relate to all other aspects of treatment. The resolution of the transference, as reviewed in the previous section, is concerned with the nature of the therapy relationship, while mourning the loss of the relationship is the task most related to affect. Of the three tasks, the experience of loss at the end of the therapy relationship is the one that the literature increasingly addresses most frequently. Loss is the experience underlying mourning and is an important issue throughout most therapy treatments because of the patient's losses in life, as well as losses revived and felt by both the patient and therapist, especially when their work together inevitably ends, whether the treatment has been short- or long-term. If there is not a defined termination, there will be

an inevitable stopping point because of changes in the life of the patient or therapist, or illness, or death.

As with resolution of the transference, the shift from traditional to relational formulations has altered perspectives in the literature on the theoretical and clinical relevance of loss at the end of the therapy relationship. Traditional formulations emphasize the patient's loss of the transference relationship while relational perspectives focus on mutual loss of the real, personal relationship.

In this section I review literature that discusses termination from perspectives of grief, death, and mourning of the transference relationship, past losses in the patient's (and therapist's) lives, and loss of the real therapy relationship. I review journal articles and three studies about analysts' post-termination experiences of loss. Of the three studies, Tessman's (2003) is the only one that discusses a particular participant's experience in long-term treatment. At the end of this section, I will show that a small amount of literature questions the assumption that the end of analysis needs to be mourned.

Mourning as the patient's task.

In his classic paper, "Mourning and Melancholia" Freud (1917) did not refer to the end of the analytic relationship as something to be mourned. Freud's focus on mourning has to do with the real experience of the death of a loved one. Some other early analysts did associate mourning with termination; the mourning was not related to death but to the loss of the transference relationship. In keeping with the traditional emphasis on illusions in the transference relationship, Ferenczi (1927) wrote that when the patient realizes that the analytic relationship deals with fantasy only, he slowly mourns this

discovery and then moves on to "more real sources of gratification" (p. 85). Annie Reich (1950) and Michael Balint (1950) brought their perspectives to the theme in observing that patients mourned the loss of the transference relationship at the end of analysis, though the mourning does not last long: "As with mourning, a spontaneous recovery takes place, we might say a recovery from the abnormal situation of analysis" (Reich, p. 182). Balint compared the feelings in termination to a kind of re-birth with deep emotions of grief and mourning, as well as happiness, for both the patient and analyst.

Rudolph Eckstein's (1964) perspectives on mourning at the end of analysis have to do with the patient's loss of symptoms and pains of the past. His ideas are portrayed in a dramatically memorable paper in which he compares the epilogue of a play to termination. Symptoms that the analysand brought into analysis are like actors in a play that reappear, in order of importance, when they take their final bows; "the curtain rises again and again" (p. 61). Eckstein writes that conflicts about whether or not to end are resolved by a mourning process at the end of analysis in which "the loss of the past may then be the gain of the future" (p. 62). The themes of the drama, the "actors," will go on to repeat their performances at a higher level and become the new prologue for life after analysis. He also likens the mourning of termination to a painful Thanksgiving in which hard tasks have been accomplished in order to live with plenty; pain, mourning, and plenty prepare us for the uncertain future.

A two-person perspective.

Judith Viorst (1982), using a two-person lens, examined loss at termination from the perspective of the analyst. In a landmark study, she interviewed 20 analysts about their experiences of loss at the end of analytic work with patients. This study radically

shifted the conceptualization of loss from past experiences of the patient to include the real relationship between the analyst and patient. Viorst notes that the study provided an opportunity for analysts to openly express strong emotions that they contained when they were with their patients. Because of the isolation of analytic work, she writes, it was a relief and pleasure for the analysts to discuss the topic: "Anger and guilt and frustration and disappointment, along with sorrow, were openly manifested as we spoke of loss at the end of an analysis" (p. 401). Virtually all of the analysts Viorst interviewed experienced significant loss with termination. While not usually traumatic, there was a sense of loss in all terminations. Analysts spoke about some patients who are especially hard to let go of because they are pleasing to work with, lively, humorous, creative, or "who give me a view of life I might never otherwise have gained" (p. 405). In themes that carry into subsequent termination literature, Viorst suggests that experiences of loss can serve as tools in the work with the patient. Relevant to the central issues in the current study, Viorst asserts that, left unanalyzed, the analyst's countertransference can lead the analyst to avoid loss by holding the patient in treatment too long. Here is what Viorst says about the analyst's losses and why he or she might be reluctant to end the therapy relationship; the first loss refers to the actual relationship:

> The loss of a whole, real object; the loss of a healing symbiotic relatedness; the loss of some especially pleasing role; the loss of a host of professional and therapeutic ambitions; and the loss of the analyst's dream of his or her own perfection. (p. 416)

Leowald (1988) states that mourning is the most important aspect of termination. What the patient mourns, he advises, is not only his past and its impact on current life

relationships, which the analyst recognizes and interprets, but also the loss of a cherished relationship. Loewald, like Viorst, recognizes the value of the real relationship: if the patient and therapist participate together in the mourning process of termination there is a sense of something shared and attained that provides more access to the experience of a transformed self.

Nina Coltart (1996) also writes about the value of the real relationship; at the same time, she is unambiguous about termination. She believes patients need to go through the mourning of the therapy after termination, away from the therapist. She considers that long treatment might have things in common with reflections on death and dying: it is odd that we end at all—analytic relationships are rich, important, and central in a patient's life—but we do end and it can be experienced as a death sentence. Ending, however, is not an arbitrary choice for Coltart. Here are her reasons that make it necessary for patients to end treatment: so that too much of the therapist's real self is not imposed on the vulnerable patient, the strength of internal objects are reinforced, and patients are free to resolve the transference and all problems that remain on their own (p. 151).

In a study on the prevalence of mourning after termination, Heather Craige (2002) mailed questionnaires to candidate members of the American Psychoanalytic Association about their overall experiences of the termination and post-termination phases of their analyses. Of the candidates who received the mailing, there were 121 who had terminated their training analyses and responded to the questionnaire. The candidates' analyses ranged in years from one to sixteen, with an average of five and a half years. The time lapse since ending their treatments ranged from one month to 21 years, with a mean of

two years. Craige's questions focused on the amount of loss experienced by the candidates with the termination of the analytic relationship. The questionnaire produced the following findings about ending therapy: The loss of the unique relationship with the analyst was felt more strongly than a general sense of loss, a strong sense of loss was felt especially at the end of a positive experience of analysis, and "candidates in longer analyses experienced a more painful loss and felt more uncertain about their readiness to stand on their own" (p. 517). Relevant to the current study, Craige states that the findings on longer analyses merit further exploration.

Respondents to Craige's (2002) questionnaire were also asked if they would participate in an interview and 20 respondents were selected for telephone interviews. Craige's comments about the interview phase of the study indicate that, while the loss of the analytic relationship can be anticipated at the end of treatment, it is only fully felt and mourned after termination. After analysis ends and the patient mourns the loss of the relationship with the analyst, the patient "may come to feel enriched rather than impoverished by the loss" (p. 539). However, Craige found, the positive feelings may be challenged if the patient experiences the loss of the analyst as a repetition of earlier traumatic losses, if new transferences related to the analyst emerge after termination, or if the patient is overwhelmed by too much internal or external stress. "The benefits of the entire analysis may be undermined or consolidated during this phase, depending on how the analysand negotiates the work of mourning" (2002, p. 539). In a more recent discussion about her study, Craige (2009) endorses a "two-person" model in which patient and analyst mutually experience and acknowledge the struggle to let go of the relationship, suggesting that this helps the patient to better metabolize the loss. She

discusses patients who experience complicated mourning after termination and who need to know they would be welcomed by the analyst to return if necessary. She writes that some patients return to full treatment; "Others, with just a few sessions focused on the meaning and affects related to the loss of the analyst, may be able to progress again on their own to a resolution of mourning" (p. 113). A finding that she elaborates from her study is the importance for the patient to develop a self-analytic function after analysis; the first test of which is how the patient is able to "leave home," grieve both old and new losses, and bear the pain of separation and ending.

Tessman (2003), whose study of analyst's experiences of their own analyses after termination is reviewed in the previous section, writes about her findings having to do with mourning. Similar to Craige, Tessman writes that the way an analyst and patient approach the question of mourning affects how the termination is experienced. Mourning the loss at the end of analysis is a unique opportunity, Tessman points out, because unlike other life experiences, "the very person whose loss is being mourned—that is, the analyst—is initially still present to receive and respond to the emerging affects" (p. 235). Relevant to the distinction between the transference relationship and the real relationship between patient and analyst, Tessman notes, there is a difference between interpreting the loss of the transference relationship and helping to bear (not interpreting) the loss of the real relationship. She also notes that while most analysts of every theoretical orientation accept that mourning is part of the end of treatment, it is not the response that all people have; for some, the primary feelings at the end of analysis are mastery, fulfillment, and energy, rather than pain and sorrow.

Most of Tessman's (2003) participants reported having deeply satisfying analyses and painfully missing their analysts after termination, although some reported less satisfactory experiences with their analysts and felt painful disappointment rather than painful loss. One of Tessman's participants described her process that seems in accord with what most authors mean by mourning the end of analysis:

> It was like a real mourning for a very, very long time until one day I noticed that I had gone through the day without thinking about him the way one does in mourning. It was more than a year, and it was less than two that I thought about him that much. But it was a very difficult time. (p. 246)

In a demonstration of a patient in long-term treatment that is relevant to the current study, Tessman (2003) reports a dialogue with a participant who has been in analysis for an extended period of time and finds the idea of terminating very painful. Discussing whether this participant could envision ending, Tessman states: "You were telling me last week that you have come up with what seems like the nicest solution to the pain of termination, which is to say, 'I'm not going to do it'." The participant responds: "I think that's right" (pp. 255-256). The dialogue continues with a discussion that shifts back and forth from the participant's own analysis to her work with her patients. The participant comes to the realization that reaching a state of equality with the analyst is very important to her. She suggests that when this happens the work might end for patients, with a formal termination. In a comment that is similar to some of the long-term literature I reviewed earlier, the participant added: "You can terminate with their neediness. . . . And then later they might come back. On a completely different footing" (p. 256).

I include the following works that address loss and mourning at the end of treatment to emphasize the depth of meaning associated with this task of termination and its implications for thinking about long-term treatment. Irwin Hoffman (1998) asserts that avoidance of termination reflects the patient's or analyst's maneuver to avoid the issue of death. Steven Cooper (2009), like Hoffman and numerous other authors, considers death a central theme of termination: "Death is always in the background of analytic work but during termination it symbolically and affectively moves more into the foreground" (p. 592). Also like Hoffman, Cooper believes that treatment does need to end; however, Cooper emphasizes uncertainties surrounding the ending of analysis, such as the fact that treatment often ends with wished-for but unresolved aspects of the work still present, and it is often unclear when to stop. The main focus of Cooper's paper provides a relational perspective, that is, when analysis does end, the patient grieves the loss of the therapeutic dyad as well as loss of the analyst. Termination provides the patient the opportunity to grieve the relational patterns habitually enacted in the relationship as "the way we were together" (p. 602). Shelley Orgel (2000) writes that mourning is intrinsic to psychoanalysis and the finiteness of analysis revives memories of loss and unrealized opportunities. Mourning can be the primary reason for patients to reenter analysis, sensing that their previous analysis was unfinished. Relevant to this study, Orgel states that although analysis might last a decade or more, sometimes patients reenter subsequent analyses and the sense of mourning and analysis seem interminable; ultimately, "every analysis is a multidirectional journey toward a termination" (p. 723). Davies (2009) offers a fully unambiguous view of grieving the loss of the real relationship in analysis when she asks if there is any difference between analytic love and "love in its more familiar

iterations" (p. 735). She questions if tragic experiences with grief in the analytic relationship are unusual or different from the way we love in life. "Isn't all love ultimately tragic?" (p. 735).

K. R. Eissler (1993) suggests that some aging analysts might want to hold onto relationships with their patients as they face impending losses at the end of a long career. He writes that an aging analyst's loss of contemporaries may lead to a greater investment in his professional life with his patients; the "optimal distance between the analyst and the patient may be lost and because of the undue gratification the emotional atmosphere may lead to the patient's fixation on the treatment situation" (p. 327).

Challenges to necessity of mourning.

Some authors question if it is necessary for the patient to mourn, or lose, the therapy relationship. Skolnick (2010) advocates benefits of termination as an important process in analysis but he challenges the traditional assumption of mourning as a necessary component. He disagrees with the conceptions that link termination to death and mourning; no one has died at the end of most analytic work and, furthermore, relational analysts offer the possibility for renewed contact after termination.

Glennon (2010) asks if patients need to mourn the loss of the analytic relationship. She considers that a person has many opportunities to face great losses in life: deaths of loved ones and losses experienced in aging and deteriorating health. She cannot say if the loss of the analyst is a necessary experience toward managing other losses: "Who is to say that having had the experience with the loss of an analyst, one is more prepared or more practiced at handling loss if that experience is gone through with the analyst?" (p. 268). Beside, she points out, in the relational mode, patients know they

can see their analysts after termination if they are in need. She considers if the relational turn in analysis has changed the traditional focus on mourning of the lost therapeutic relationship.

Development of the Self-Analytic Function

A colleague recently told me of a friend who feels very conflicted about wanting to return to see her therapist, with whom she terminated some years ago, because she feels she should be able to perform her own self-analysis and returning means that she has failed. The patient's development of the self-analytic function, the last of the three tasks of termination, deals with the fate of the relationship with the therapist at the end of treatment. More than the ability to engage in self-reflection, self-analysis refers to the patient's ongoing internal relationship with the therapist and the internalized psychological functions of the therapy after termination. This self-analytic function is sometimes considered in light of the patient's ability to solve problems, resolve crises, interpret one's own dreams, and conduct their lives in a more mature or nuanced way than they would have prior to therapy. My colleague's friend suffers from the burden of the "requirement" of the completion of this task, as if her need to return to her therapist imputes a failure in the self-analytic function.

The literature reveals that the meaning of "self-analysis" has been a complicated process to pin down. It might be an analytic function that the patient develops through *identification* with the analyst, which leads to increased capacity to analyze oneself separate from the absent analyst, to see situations in a new light, and create new insights beyond those discovered during analysis—in essence, the patient becomes her own analyst. Another definition views self-analysis as *internalization* of a sense of the analyst

that leads to increased capacity for self-regulation independent of the presence of the real analyst. Patients might develop *either* identification or internalization, or *both*. It is not clear if self-analysis functions consciously or unconsciously and whether it is more likely to develop in patients who are therapists than non-therapist patients. Is it a necessary byproduct of a successful analysis or therapeutic endeavor and if it is missing (and the patient remains, or returns to therapy), has the treatment failed? Is self-analysis even possible? The meaning of "self-analysis" in this body of literature remains unclear. The importance of the concept for the present study is to get a sense of what long-term therapists might think about self-analysis, however they define it.

Freud attempted self-analysis throughout his lifetime and voiced doubts about its efficacy and validity. Harold Blum (1989) notes that Freud wrote to Fliess in 1897 saying that he realized he could not analyze himself without the objective help of others. Furthermore, true self-analysis was not possible, Freud explained, because if it were, there would be no neurotic illness (Blum, p. 278). Blum suggests that Freud's self-analysis could not pertain to termination because, acting as his own analyst, Freud could not "take leave of himself" (p. 279). Despite Freud's earlier doubts, in "Analysis Terminable and Interminable" (1937), he delineated a form of self-analysis as a continuing process for analysts after their training and formal analysis has ended. At this time, near the end of his career and life, Freud writes about self-analysis:

> We reckon on the stimuli that he has received in his own analysis not ceasing when it ends and on the process of remodeling the ego continuing spontaneously in the analysed subject and making use of all subsequent experiences in this

> newly acquired sense. This does in fact happen, and in so far as it happens it makes the analysed subject qualified to be an analyst himself. (p. 249)

Willie Hoffer (1950) is often credited as the first to identify the self-analytic function as a psychological criterion for termination, which functions for some but not all patients. He defines self-analysis as a process that occurs during treatment in which the patient comes to identify with the ego functions of the analyst, which leads to the following abilities in the patient after termination: "to interpret for himself derivatives of his unconscious, to spot and to remove resistances, and finally to understand and within limits to control the acting out within the social setting" (p. 195). Hoffer acknowledges that some patients conform to this picture but some do not, and he states, but does not elaborate, that sometimes other provisions have to be made.

Following Hoffer's (1950) tradition, Leon Grinberg (1980), Jack Novick (1982) Shelley Orgel (2000) are among authors who affirm the importance of self-analysis as part of termination. Grinberg emphasizes the patient's search for truth about himself as of primary importance and criteria and goals as secondary. He does stress, however, that self-analysis is an important goal. Grinberg writes that his point of view coincides with those who hold that mental growth is "interminable" and continues after termination in the form of self-analysis, which occurs through internalization of the psychoanalytic process. Relevant to my colleague's friend, who was conflicted about returning to therapy, Grinberg says: "This process, once it has been started, goes on forever and use will be made of it in all future experiences although, for different reasons, it may need the help of a new psychoanalytical experience" (p. 27). J. Novick's depiction of self-analysis is not as a separate and distinct goal but as an indication that the patient has developed a

function or tool to resolve the transference and mourn the loss of the analyst while entering the post-analytic phase. Like Hoffer, Novick states the following are unknown: whether self-analysis develops in all patients, the degree to which it functions post-analytically, and how much it might contribute to improvements. Novick echoes Freud's statement when he suggests: "In one sense the criterion of self-analysis may be an ambitious formulation and one that is more applicable to candidates than to patients" (p. 358). Echoing Novick, Orgel writes about termination as the result of resolving the transference (and countertransference), mourning the loss of the analyst, and developing the self-analytic function. According to Orgel, internalization of the analytic process, not identification with the analyst, leads to psychic change in the analysand (and analyst) and creates structures in the mind that evoke the analytic relationship and process after analysis ends. He quotes Loewald (1973): "What results at the end of analysis is emancipation, not identification, if the feelings of mutual abandonment can be analyzed, and the relationship rather than the object is internalized" (pp. 9-10). Relevant to the current study, Orgel also writes that analysis can last a decade or more; patient and analyst share numerous stages of life with each other and developmental changes might produce long periods with no apparent progress. A willingness to be patient in the work, however, can produce new levels of organization and mastery.

Maria Kramer (1959) raises questions about how to define and discern self-analysis. She considers that it may occur only on an unconscious level, an observation that is reprised by others in subsequent literature. Kramer writes that she could not discern active self-analysis after the termination of her own analysis and endeavors to comprehend how she could analyze her patients but fail in her capacity to analyze herself.

She concludes that she had been unaware that her capacity to analyze herself probably occurred on an unconscious level and was therefore out of conscious control.

Gertrude Ticho (1967) writes that the importance of self-analysis in the lives of former patients is controversial. As with Kramer, Ticho's "self-analysis" can be conscious or unconscious and insights are often not verbalized so they remain outside conscious awareness and not clearly formulated. She endorses the importance of self-analysis however, arguing that at the least, the ability to conduct it is a prerequisite for practitioners of psychoanalysis. In sum, this is how she describes the process: After termination ends there is often a period characterized by feelings of accomplishment and increased inner freedom, followed by a period of disappointment when unexpected conflicts cause discomfort. If the patient is able to handle the discomfort constructively, this will lead to a phase of remembering the analyst's interpretations, and more automatic continuation of self-analysis can occur. Relevant to this study, Ticho argues that if the patient does not achieve separation and independence and remains in contact with the analyst, self-analysis will not develop.

Julia Grinberg de Ekboir and Ana Lichtmann (1982) join authors who question the meaning and viability of self-analysis. They consider whether the concept refers to the first analysis, that is, Freud's attempts at self-analysis, or if we are using the same term to describe different processes. Is self-analysis a process of new insight, which implies identification with the analyst, or introspective continuation of working through ongoing neurotic conflicts? The authors discuss their examination of three clinical examples of analysts who developed inner conflicts after their own analyses ended. The authors conclude from their examination that patients do not acquire new insights without

presence of the analyst. They resolve that self-analysis proper is a process of understanding conflicts with new insight that develops through the lifting of repression and integration of split off parts of the ego, and this can occur only in the presence of the analyst. Therefore, post-termination self-analysis is a misnomer; it is actually introspection about what has already been accomplished with the analyst. They refer to Freud's (1937) recommendation that every analyst should resubmit to their own analysis every five years or so, concluding "Thus, it may be inferred that towards the end of his life Freud was inclined to ratify the view he had advanced 40 years before: 'Genuine self-analysis is impossible' " (Grinberg de Ekboir & Lichtmann, p. 76).

Several studies on the outcome of psychoanalysis and psychotherapy examine the meanings and test the validity of self-analysis as a post-analytic function. In the follow-up study conducted by Kantrowitz et al. (1990b), discussed above in the section on resolution of the transference, the authors, like Grinberg de Ekboir and Lichtmann (1982), state that self-analysis is the capacity to reflect upon and understand one's own feelings, behaviors, and fantasies *in a new light*. The authors distinguish between depictions of self-analysis in which the patient acquires insight and achieves adaptation, and another analytic process in which the patient feels less overwhelmed and finds comfort. In interviews five to ten years after termination, 17 patients were asked to describe their use of self-analysis. Thirteen said that they had the ability to use self-analysis and four said they had not acquired the self-analytic capacity. Of the 13, four could give illustrations of their statements and two of the four could describe new adaptations; five patients described a process of self affect-regulation, rather than insight or adaptation. The others were not able to describe their self-analytic processes. Seven of

the 13 who reported the ability to use self-analysis were mental health professionals who suggested that their training contributed to their self-analytic abilities, although only one was able to provide examples. The authors note that mental health professionals might assume interviewers would understand the principle without examples or "that their confidence in their self-analytic capacities were more a product of wish than reality" (p. 643). The authors conclude that it is complicated to collect data on self-analysis that is reliable. Their study was not designed to focus specifically on self-analysis and they suggest that further studies are needed to examine the capacity. They state they cannot assess how much self-analysis affected the psychological life of the patients in the study but, nevertheless, maintain the belief that self-analysis is an indicator of successful analysis and an important function for continued growth. Like others, they qualify self-analysis as an "essential capacity for analysts, [but] its importance and the role it plays in the post-treatment life of analysands who are not involved in the analytic field is less clear" (p. 639).

Another study by Fredrik Falkenstrom, Johan Grant, Jeanette Broberg, and Rolf Sandell (2007) was conducted in Sweden to increase understanding of how psychoanalytic patients continue to work on problems after treatment has terminated. The study consisted of data derived from questionnaires and interviews of ten psychoanalytic and ten psychotherapy patients that were used from a larger, longitudinal study (Blomberg, Lazar, & Sandell, 2001). Falkenstrom et al. discerned two post-termination categories from the data that echo Kantrowitz et al.'s (1990b) findings: self-supporting strategies, which have to do with internalization of the analyst; and self-analysis, which has to do with identification with the analyst and insight that was not achieved while in

treatment. The authors' conclusions are similar to Kantrowitz et al.'s findings: self-analysis seemed to develop in some patients and not others, it was not clear if the self-analytic examples represented new insights or old conflicts worked on during therapy, and, it is not easy to determine how much of self-analysis is a conscious or unconscious process.

Craige (2002) conducted a study of mourning and self-analysis after analysis ends (reviewed in the above section on mourning) in which 121 post-termination psychoanalytic candidates were sent questionnaires and, in order to explore the subject in more depth, 20 of them were also interviewed by telephone. A description of self-analysis that Craige derived from the candidates' interviews falls along the lines of internalization and self-regulation.

> Craige (2002) asked these questions about self-analysis during the interviews: What structures have you created in your life or in yourself that have taken the place of the analysis? What gains or new developments occurred after termination because you terminated? And finally, describe your inner relationship with your analyst, your view of him, and the way you imagine he views you. (p. 520)

Three groups were created from the 20 interview transcripts: Group A, consisted of 11 candidates who reported an overall positive experience in analysis and post-analysis. Four candidates comprised Group B; they had good-enough experiences in analysis and termination but struggled, post-analysis, with feelings of depressions, anger, and abandonment. Group C's five candidates experienced their analyses negatively and they ended in stalemate. Craige states that for the purpose of this study, she focused on the experiences of groups A and B.

Craige (2002) found that most candidates from Group A reported missing their analysts and wished to return to analysis but did not do so. Some wrote letters and/or returned for an occasional single visit and one entered case consultation with his former analyst. They "spoke of their struggle to figure things out on their own or to engage in what analysts typically refer to as self-analysis" (p. 527), which for this group meant sensing the analyst's presence internally, evoking the image of the analyst to have internal conversations, and internalizing the analyst's attitude toward them, which created a source for self-esteem and self-regulation. Craige states her finding that the first task of self-analysis with this group was to negotiate the experience of mourning the loss of the analytic relationship; the group proceeded from loss to "creating sustaining internalizations, establishing a new sense of equilibrium, and liberating energy to invest in other relationships" (p. 530). The difficulties that the candidates in Group B reported included emergence of a strong negative transference toward the analyst, realization of unresolved merger with the analyst, reenactment of early trauma, and intense grief. Each of these candidates returned to their analysts or resumed with another analyst for brief treatments that addressed problems that were brought on by the termination.

In her discussion, Craige (2002) surmises that the capacity for self-analysis is related to the patient's positive internal image of the analyst and suggests that post-termination should be considered a time of vulnerability that depends upon the patient's capacity for self-analysis. She emphasizes that the patient should seek additional help if needed. Like many others, Craige considers whether candidates, being mental health professionals, have greater intellectual preparation for self-analysis.

In the conclusion of a more recent article, Craige (2009) writes that standard views on termination were developed in a one-person psychological climate and should be reconsidered in the newer light of a two-person model, such as the recommendation from her study (2002) that analysts encourage patients to return to treatment if they are in distress after termination and need support implementing the self-analytic function.

In a commentary on Craige's (2009) article, Kenneth Frank (2009) states that his ideal is for the patient to terminate and internalize two functions: the interpretive activity of the analyst, which relates to self-analysis, and the compassion, sensitivity, and acceptance of the analyst, which refers to self-regulation. Frank reasserts Craige's concern that, when studying self-analysis, we should keep in mind that candidates and analysts have different experiences than non-analysts. Mental health professionals use their own analysts as role models and they "experience their analyses from two sides of the couch, as it were, with their overall experience and especially the developing self-analytic function being enhanced by didactic elements of their training experience in addition to the training analysis itself" (p. 138). Frank argues that Craige does not go far enough in her recommendations for the end of analysis—she recommends a return to analysis if the patient is distressed and unable to function self-analytically—while Frank submits more options for ending, including tapering sessions, trial terminations, follow-up sessions and, under special circumstances, friendships. Relevant to this study, Frank does not go as far as some others because he does not recommend or refer to the option of ongoing treatment.

Regarding authors who question the reliability of the self-analytic function, I return to Estelle Shane (2009). Shane rejects the idea of general criteria for termination

demonstrating her shift from a one-person to a two-person lens. Describing an earlier article, co-written with Morton Shane (M. Shane & Shane, 1984), she points out that they endorsed self-analysis as a criterion for termination, along with the resolution of the transference and mourning the loss of the analyst. She notes in her 2009 article that the earlier paper was written from a classical, one-person perspective. She currently views analysis as an endeavor that is nonlinear, never completed, and not generalizable across analytic dyads. According to E. Shane, the attempt to generalize "by establishing normative criteria seems highly mistaken" (p. 168).

Rucker (1993) writes that in efforts to consolidate treatment goals and promote self-analysis, the analyst might miss the patient's need for ongoing dependence. The patient in turn might respond to deprivation and empathic failure by adopting a false self (Winnicott, 1996a). "Under these conditions, self-analysis becomes a dehumanized, functional substitute for human warmth and involvement" (Rucker, p. 165). Bergmann (1997) submits that we do not know ahead of time if any patient will be able to conduct self-analysis as a way of continuing inner development; some patients are not able to "replace the analyst" (p. 170). He writes that many patients develop the capacity for free association, using transference interpretations, and analyzing their dreams but they may not be able to terminate because they cannot replace the experience of the analyst with self-analysis. More recently, Bergmann (2005) notes that self-analysis can be useful for solving problems of everyday life, "such as finding a lost key or remembering a forgotten name, but it is seldom up to the task of solving a serious crisis" (p. 250).

Tessman (2003), in her qualitative study of analysts' experiences of their own analyses (reviewed in the above sections on resolution of the transference and mourning)

writes that the classical criteria for termination—resolution of the patient's transference neurosis and development of the patient's self-analytic function—have ceased to be seen as reliable as the transference is never totally resolved and the capacity for post-termination self-analytic function varies greatly with the individual and life situations that arise. In interviews with analysts that addressed post-analytic feelings about their analysts, Tessman found that self-analysis varies with the way the patient experienced the analysis; some who have had a good experience with the analyst might bring the analyst to mind, have internal conversations, and experience the absent analyst in an ongoing manner; but others who have felt damaged by analysis, might gain "some hard-won sense of mastery through self-inquiry" (p. 264). Tessman seems to be saying that when patients feel damaged by the analyst, whatever post-termination mastery they arrive at does not feel enhanced by an internal connection to the absent analyst—it might be "self-inquiry" but not what is thought of as "self-analysis."

"Self-analysis," long considered a criterion of termination, is barely mentioned in recent literature on termination from relational perspectives. In *Good Enough Endings: Breaks, Interruptions and Terminations from Contemporary Relational Perspectives* (Salberg, 2010a), it is interesting to note that the concept of "self-analysis" is referred to in the index only two times, both references to Salberg, the editor of the text. The first is a historical review in which Salberg (2010b) refers to Bergmann's (2005) mention of self-analysis as a criterion of termination. The second is to Salberg's (2010c) paper "How We End: Taking Leave," in which she asserts that the analyst's concern that he or she has not done enough for the patient in order for self-analysis to occur can be a crisis. Analysts might fear more—than the fears that both analysts and patients share that they will never

be able to replace the closeness they have had—that some patients might not be able carry on the work themselves, without them. "As a consequence, I believe ending treatment can create for many patients and for us a kind of crisis—the crisis of having to end and say good-bye" (p. 109).

The concept of self-analysis, and the long tradition of attempts to define it, has virtually disappeared from this recent collection. Instead, post-termination formulations are portrayed as internalized experiences that are unique to each dyad. Neil Skolnick (2010) talks about internalization of the "coconstruction" of patient and analyst that is subject to the risks of the passage of time after termination. He submits that this is stressful for the analyst and patient and raises the question, "Will the illusion of their dance together survive the separation?" (p. 239). Skolnick advocates autonomy and improvements that patients make on their own after analysis ends and, relevant to this study, does not mention the possibility of uninterrupted, ongoing analysis as an alternative to separation risks. Bass (2010) writes that for the patient, treatment ends with the recognition of an internalized process that continues "which often includes an ongoing internal dialogue with the analyst" (p. 288). The time to end treatment, Bass contends, is rarely experienced with certainty; instead it usually occurs with consideration of what has been left undone and includes the possibility of the patient returning to work with the analyst if he or she chooses.

Empirical Research Studies

A number of studies cited so far in this review have focused on research that has to do with the aftermath of termination—"outcome studies." I will now review three studies that differ from the others in that their research questions asked analysts and

therapists to consider issues related to termination and long-term treatment. These studies and discussions range in dates from the late 1930s to the late 1990s and address concerns about termination and length of treatment that are relevant to the current study. Findings from the studies reveal unanticipated long treatments, reluctance of therapists to discuss long-term treatments, the importance of ongoing treatment in the lives of patients, and calls for therapists and analysts to communicate with each other about issues of long-term therapy and termination.

Glover's Study and Discussions on Termination

In 1938, Edward Glover conducted a study of British practitioners' technical difficulties in psychoanalysis. Results of the study, and Glover's discussions, were published in his book, *The Technique of Psycho-analysis* (1955). Glover's research gave questionnaires to twenty-nine analysts whom he identified as representing the "British Group" in experience and orientation; he received responses from twenty-four of the analysts. Glover described his research as having "the merit of being the first and moderately successful attempt to penetrate the curtain of uncommunicativeness behind which psycho-analysts are only too prone to conceal their technical anxieties, inferiorities and guilts" (p. vii). The topic of termination composed one section of his study.

Participants were asked the following questions about criteria for termination: "What are your criteria for (a) Symptomatic, (b) psycho-sexual, (c) social? Are your criteria mostly intuitive?" (p. 327). The majority of respondents favored symptomatic relief and a number admitted to using intuition. Glover writes that one third of the participants did not answer the question and he attributed this to "considerable diffidence" (p. 327).

Another question addressed how long analysis should last: "Have you an average period for all cases? In this matter do you differentiate between (a) anxiety, (b) obsessional, (c) characterological, (d) psychotic, (e) normal cases?" (p. 328). He received responses from two thirds of the participants and writes: "Most preferred not to be specific about duration" (p. 328). Results showed the average to be three and one half years although numerous treatments exceeded seven years, and some lasted 10 years or more. One respondent suggested that time should not be a factor and another, with many years of experience, had not yet terminated a case "but hopes to do so some day" (p. 328). Glover observed that analysts were reluctant to admit to very long cases and surmised that this might be due to analysts' guilt and concern that it reflected on their technique. Glover writes that there were fewer answers to length of treatment with different types of patients and they varied. Some participants responded more time is needed with character cases, one person said obsessionals, another replied that he could make no distinctions, and another said that we are sill too ignorant to differentiate. Glover states that there was a good deal of uncertainty and diffidence in these answers and notes that the answers were "cautious and to some extent a play for safety" (p. 328).

Responding to a question about whether analysts set the date for termination, one third stated that they did set a date but added that they did not tend to adhere to the time that was set. Glover commented on the finding that some patients see to it that analysis ends and it is possible for the analyst to leave it to these patients to terminate when original symptoms have ceased. He noted that it would be interesting to explore how many analysts exert pressure by raising the issue of stopping at various times. Glover

concluded that uncertainty about when to terminate relates to doubts and lack of sound judgment about criteria of cure.

Glover's book also contains his summary of papers presented at a symposium of the British Society in March of 1936 on the topic of criteria for success of treatment in which Glover presented a paper on termination. Regarding length of time in treatment, he stated, "the longest cases often have the worst results symptomatically but sometimes are conspicuously successful in other directions (character changes)" (p. 334). He argued that a detailed list of indications for termination was needed, with variations for clinical types and advised that this could be accomplished when broad general principles could be agreed upon, which had not yet occurred in the profession. His discussion cautioned analysts to be aware of a tendency to idealize a preconception of the complete analysis; in order to save the analyst's self-doubt and the patient's time and money, an analyst needs to be able to admit that a case has gone as far as it can.

Wallerstein's Study of Psychoanalysis and Psychotherapy

The Psychotherapy Research Project (PRP), under the leadership of Robert Wallerstein began in 1954 in conjunction with the Menninger Foundation clinical community, a large group private practice of psychotherapy and psychoanalysis. Wallerstein (1986) presented the research and outcomes in his book, *42 Lives in Treatment*. The design of this longitudinal research was to study the nature of everyday clinical work. It's purpose was to learn more about *what* changes occur in psychoanalysis and psychoanalytically oriented psychotherapy (the outcome question) and "*how* those changes come about through the interaction of what constellation of factors or variables

in the patient, in the therapy and the therapist, and in the patient's ongoing life situation (the process question)" (p. 5).

Over a four-year period, 42 patients were selected for the study from intake information and psychological testing. The patients who came to the Menninger Clinic had experienced failed outpatient treatment in their home communities and were considered to have more severe degrees of psychological illness than the usual private practice patient. Those selected for the study were divided into three treatment groups, according to presumed suitability of treatment modality for each patient: psychoanalysis, expressive psychotherapy, and supportive psychotherapy. Twenty-two were assigned to psychoanalytic treatment and 20 to expressive or supportive psychotherapy. The therapists were trained in psychoanalytic methods and expressive psychotherapeutic modes, aimed at gaining insight and analyzing resistance and defenses to uncover conflict, and in supportive psychotherapy, directed towards strengthening defenses and ego-functions.

This was a naturalistic study in that patients and analysts were not told they were part of a research project until the termination phase of the study. The data consisted of three phases of research: the initial study, the termination study, and the follow-up study. Extensive case studies were written for each patient, which consisted of psychological tests and therapists' progress notes during the stages of treatment; termination interviews with patients, significant others and therapists; and follow-up interviews.

Regarding length of time, the treatments were to be of indeterminate course and length although patients were expected to be in treatment "reasonably long-term (from 2 years to indefinite)" (p. 85). Terminations were studied as they occurred up until 1964

(10 years after the project began); at that time the treatments actually ranged in length from seven months to over ten years. In 1982, when Wallerstein began writing his book, he contacted therapists from the study and found that four out of the 42 patients were still in psychotherapy, with therapy lasting between 25 and 30 years. He refers to these cases as "therapeutic lifers." Wallerstein writes that 12 of the 22 psychoanalytic cases converted to psychotherapy during the course of treatment, including two of the four long-term cases. According to Wallerstein, patients in psychotherapy would be more prone to continue indefinitely because "in theory psychoanalysis should always come to some natural resolution" (1986, p. 194).

In addition to the four patients who remained in treatment, most returned to formal psychoanalysis, psychotherapy, or varieties of post-treatment supportive contacts following termination—there were only three for whom there was no record of further therapeutic or supportive treatment. Wallerstein writes that "with the kind of 'sicker' patients represented in the PRP sample" (p. 607), as with medical patients who have chronic illness, psychotherapeutic contact can be regular and lifelong:

> The goal is not one of cure, in the sense of restoration of reasonably complete functional autonomy and well-being, but of life management with ongoing help and support at a significantly better functional level than would be possible to the patients on their own. (p. 632)

Wallerstein comments that the patients in the "therapeutic lifers" category "have been grouped among those with better therapeutic outcomes" (p. 640). For the majority of the PRP patients, once they became involved in analysis or psychotherapy, a psychotherapeutic dimension became an aspect of their ongoing lives in a far longer time

span than anticipated. He submits it is undetermined if this might be generalized "to the wider population of more usual patients in more usual outpatient psychoanalysis and psychotherapy" (p. 641).

Two Studies by Firestein

In 1966, Stephen Firestein conducted research at the New York Psychoanalytic Institute to examine the topic of termination. His book, *Termination in Psychoanalysis* (1978) is based on the study of eight analyses that were conducted by candidates at The New York Psychoanalytic Treatment Center. The cases were under supervision and were expected to terminate within two years. The data consisted of clinic records and interviews with the analysts, the supervisors, and the patients, as well as follow-up interviews of patients one year after termination. Firestein found that "Separation reactions are experienced by both members of the dyad" (p. 215). A summary of his discussion of findings follows.

There was a distinct period related to the end of the working relationship between patient and analyst when the focus was on ending and would not have been the same without the anticipation of termination. Affective reverberations of termination were "psychically enervating" (Firestein, 1978, p. 205) and included anxiety, separation rage and separation elation, disappointment, sadness, grief, and mourning. Some patients' wishes and fears included the desire to become a psychoanalyst, wishes for rebirth, desire to see the analyst after termination, including two occurrences of brief resumption of analysis after termination. New symptoms did not generally surface although increase of old disturbances did arise, which was often seen as a desire to continue and forestall the impending loss of a significant object. There were a couple of cases in which a

termination date was set by analysts because of the degree to which the analyst was idealized or hostility was directed toward the analyst as a defense against termination anxieties. Both of these cases were perceived as having positive outcomes regarding the ability to accomplish termination.

Following termination some patients made phone calls or sent letters to let the analyst know his or her progress and several sought further help from other therapists and analysts. Firestein (1978) noted that the invitation to the follow-up interviews seemed to open up "at least transient resumption of the work of termination" (p. 213), and some seemed reluctant to the possibility of re-experiencing painful feelings.

The impact of termination on the analyst included anxiety about the results of the work, the timing of the termination, and gradations of grief over the loss of the relationship with the patient.

Firestein (1982) conducted another study 15 years later in which he sent questionnaires to almost a dozen senior analysts in his community. His findings include the following statement, which a respondent made as his notion of the criteria for termination: "If the analytic work has become fallow, and the patient continues because of attachment to the analyst, then naturally the focus of the investigation shifts to that adhesiveness" (p. 487). On the other hand, Firestein found that a number of respondents described working with patients when significant change did not occur until many years into treatment—20 years in a number of cases. Firestein reports that one respondent revealed he needed to be the one to raise the topic of termination with most patients or they stayed on unless some negative reality factor caused them to leave. In a commentary about the difficulty of conceptualizing termination, Firestein urges analysts to overcome

discomfort they might feel about discussing the end of treatments with other practitioners: "Considering how very long it takes for any analyst to accumulate much experience with termination, it would be unfortunate if we refrained from exchanging these clinical experiences as part of the instruction we are able to offer" (p. 497).

Similarly, in a new edition of his book, Firestein (1998) concludes his discussion with the observation that divergent views on termination reveal "nobody can claim monopoly of the truth, and that numerous questions await further study" (p. 241). He cites statements by Rangell (1980) and Bergmann (1986) that try as we may, termination is largely an arbitrary event.

CHAPTER THREE: METHODS AND PROCEDURES

The focus of this study is to learn how therapists think about their work with therapy cases that last 15 years or longer. The following questions are central to this study: How do psychoanalytically oriented psychotherapists conceive of their work with long-term cases? Do therapists think about long-term cases in relation to the concept of termination, and how do they understand those thoughts? What theoretical concepts guide therapists about the nature of the therapy relationship and the course of treatment as they work with long-term cases? In this chapter on methods I shift from preliminary questions about long-term treatment and information gleaned from psychoanalytic literature to the process and techniques that guide my study of the phenomenological data.

Design

My approach to this research is qualitative, with the goal of exploring therapists' thoughts and feelings about particular clinical phenomena. A qualitative research approach is considered most appropriate to explore data derived from participants' personal experiences and for exploration of under-examined clinical phenomena, which is the case with long-term psychotherapy treatment.

The qualitative research method—defined by Anselm Strauss and Juliet Corbin (1998) and more recently elaborated by Corbin and Strauss (2008)—uses procedures such as interviews to invite thinking, explore meaning, and discover data embedded in respondents' subjective experience. Michael Quinn Patton (1990) describes qualitative interviews as open-ended and "revealing respondents' depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences, and their basic perceptions" (p. 24).

Interviews in this research were conducted in a semi-structured style. Elliot Mishler (1986) describes unstructured interviews in which respondents are invited "to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their responses" (p. 69). Donald Polkinghorne (2005) elaborates a style that is semi-structured in that the interviewer knows what experiences he or she wants the participant to cover and will have prepared questions to guide the participant in a full account of the phenomenon that is being studied.

The personal experiences revealed in interviews with therapists who have long-term therapy cases created the data for analysis and interpretation. The method I used to analyze the data and generate theory is based on grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The term "grounded theory" denotes that concepts are "grounded" in the data that is derived from the interviews, and "theoretical constructs [are] derived from qualitative analysis of data" (Corbin & Strauss, 2008, p. 1).

Participants

Nature of the Sample

The qualitative research design of this study was chosen in order to produce a wealth of data from a relatively small number of people. Samples were chosen "*purposefully*" and studied in depth (Patton, 1990). A purposefully selected sample allows for the study of data that is information-rich and "from which one can learn a great deal about issues of central importance to the purpose of the research" (p. 169). The method of sample selection is in keeping with the focus of the study in which therapists

were asked to speak in their own voices to contribute their thoughts and feelings on the research topic.

The sampling in this study was derived from interviews with seven participants. Patton (1990) writes that relatively small samples in qualitative research allow for indepth illumination of the questions being studied. The number of study participants depends upon how much information is gathered to sufficiently address the research questions. The size of the sample can be determined by reaching "the point of redundancy," a phrase Patton attributes to the 1985 work by Lincoln and Guba (cited in Patton, p. 185); redundancy occurs when continued sampling ceases to produce new information. Corbin and Strauss (2008) refer to "saturation" as a determinant of sample size. Sampling is an open and flexible process in which questions and concepts derived from one set of data drive the questions and concepts to be examined in the next round of data collection; this proceeds until the research "reaches the point of *saturation*," that is, the point in the research when all the concepts are well defined and explained" (p. 145).

I selected participants that represented "*maximum variation sampling*" (Patton, 1990, p. 172) in order to interview psychoanalytically oriented therapists who cut across a range of professional categories and theoretical orientations. According to Patton, a varied sample stands to yield high quality descriptions; on the one hand, it provides the potential for uniqueness and, on the other hand, illustrates common patterns that are shared across the sample. "Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impact" (p. 172). When maximizing variation in a small sample, the researcher

identifies the characteristics and criteria that represent similarities and differences in the sample.

Criteria for Selection

The participants selected for this study have seen one or more patients for 15 years or longer and are experienced psychoanalytically oriented psychotherapists. They have been in practice for 15 years or longer, which allows for the length of treatment central to this study.

Variation among participants stands to yield a range of exposure to training and psychoanalytic literature that pertains to the phenomena under study. In order to have the widest variation in participation, I did not control for gender, age, or other demographic variables. I selected potential participants from different mental health professions and theoretical orientations that are psychoanalytically oriented, licensed in California, practicing as clinical social workers, clinical psychologists, marriage and family therapists, and psychiatrists. By maximizing these variations in selection, I attempted to have a broad view of how psychoanalytically oriented practitioners address the questions central to this study.

Recruitment

I recruited participants through recommendations from colleagues and from memberships of professional organizations in the San Francisco Bay area. I sent letters that describe the research project (see Appendix A) to colleagues, asking them to recommend potential participants. I placed advertisements (see Appendix B) in the newsletters of The Psychotherapy Institute in Berkeley, the San Francisco chapter of the California Association of Marriage and Family Therapists, and the Northern California

Society for Psychoanalytic Psychology, briefly describing the study and asking people who are interested in participating in the study to contact me by telephone or email. I then sent a letter to prospective participants whose names I received from colleagues or who had contacted me directly. The letter (see Appendix C) included a description of the research project and its methods. The letter was accompanied by an Informed Consent form for potential participants to review (see Appendix D) and a brief screening questionnaire (see Appendix E) that was returned to me by mail. I telephoned participants whom I select for inclusion in the study and established a time and location for the interview. I sent letters to any others who expressed interest but were not included in the study, thanking them for their interest (see Appendix F).

Data Collection: The Interview

Data for the study was collected through semi-structured, open-ended interviews. Mishler (1986) describes a semi-structured interview as a process in which two people address context and meaning in mutually constructed discourse. Interviewers formulate questions and respondents frame answers; meanings emerge and this leads to reformulations of questions and answers. According to Mishler, a question may be perceived as "part of a circular process through which its meaning and that of its answer are created in the discourse between interviewer and respondent as they try to make continuing sense of what they are saying to each other" (pp. 53-53). Patton (1990) defines open-ended interviews as a process of asking questions that respondents can respond to in their own terms. "The truly open-ended question allows the person being interviewed to select from among that person's full repertoire of possible responses . . . to describe their feelings, thoughts, and experiences" (p. 296). The styles of interviewing described by

Mishler and Patton lend themselves weil to the mutual construction of clinical meaning derived from unique descriptions of clinical experience, which makes them well suited to the focus of this study.

Procedure

I interviewed each participant for 60 to 90 minutes in the participant's office. I tape recorded the interviews and transcribe them afterward. I referred to my interview guide (see Appendix G) to insure that the participant and I discussed topics that I view as essential to the study. The interview guide was for my use only and was not intended to interfere with or direct the unfolding of the participant's thinking about the topic.

Before each interview, I explained the purpose of the study and issues of confidentiality. I asked the participant to sign a copy of the Informed Consent Form (Appendix D), which I sent prior to the interview. I then began the tape-recorded part of the interview asking the participant to being talking about her or his thoughts and experiences having to do with the research topic. The participant directed the course of the interview through his or her flow of thoughts and narrative about the topic. I asked questions at what seemed to be appropriate times during the interview if I wanted to probe an area to clarify or expand something the participant said or open an area of inquiry that had not occurred spontaneously in the narrative.

Topics of the Interview Guide

The interview guide (Appendix G) consists of a list of topics and questions that helped me attend to the areas of inquiry in this study. Early interviews suggested additional topics and questions as the research proceeded.

I reviewed the purpose of the study with the participant, emphasizing that the research topic concerns common clinical phenomena that have not been well addressed in the profession, so we were venturing onto unexplored ground. I reviewed issues of confidentiality with the participant and asked them to sign the consent form. I then began the tape-recorded interview. I stated that the research concerns the therapist's experience of working with long-term therapy cases, that I and many colleagues have such cases, and reconfirmed that the participant agreed to discuss this underexplored clinical area with me. I then asked the participant to share thoughts about the research topic. I followed the lead of the participant in allowing the narrative to unfold spontaneously. I referred to the topics below when I wanted the participant to share more information or explore an area that had not come up on its own. During the interview, my questions were not intended to reflect the order as it appears below; the use and order of the topics below depended upon how the interview proceeded.

How does the participant describe his or her current practice and theoretical orientation?

There were several purposes for this topic area. One was to discover the participants' length of time in practice and how long they had worked with their long-term patients. Another was to establish how the participants view psychoanalytic psychotherapy. Because this study is concerned with gaps between psychoanalytic theory and clinical practice, the topic brought into focus disparities between theoretical expectations and actual practice. The topic also allowed participants to consider how the personal contexts of education, training, supervision and peer learning have influenced their approaches to clinical work.

What is the participant's understanding and use of particular psychoanalytic concepts?

This topic explored the participants' relation to theory and practice in more depth and considered what psychoanalytic concepts the participants hold as important. An aspect of the current study is consideration of the course of therapy treatment, and this topic area allowed participants to begin to consider long-term therapy and termination.

How does the participant view the concepts of termination and long-term therapy?

This topic area allowed participants to discuss their views of termination in more depth, how they learned about it—in classes, training and supervision—and whether the participants had a supervised termination in clinical practice. Psychoanalytic literature says a lot about termination as necessary to successful treatment. The termination literature has particularly focused on the nature of the therapy relationship seen in transference and countertransference, the role of loss in patients' lives and in the therapy relationship, and the patients' use of the therapy relationship after treatment that ends.

In contrast, there is a small amount of psychoanalytic literature that explores and supports long-term therapy, and many therapists feel that it has been treated as a taboo subject. Participants discussed how they view long-term therapy compared to the concept of termination.

What is the participant's experience of long-term therapy in clinical practice?

This question is at the center of the current study. I asked the participants to talk about examples of long-term cases in their practices and allowed their narratives to

develop the topic. This topic area allowed participants to discuss their personal experiences with long-term cases, such as their own affect, commitment, affection, ambivalence, resentments, guilt, worries, needs, sense of isolation, etc. It also allowed participants to discuss whether they talk about long-term patients with colleagues.

In what ways is the participant an independent thinker about long-term therapy?

This topic considered how the participants manage when gaps in psychoanalytic theory do not explain enough to support work with long-term cases. It allowed participants to discuss how they make adjustments to commonly held psychoanalytic beliefs about theory and practice in their long-term work. This topic area also allowed participants to share how they get support and validation for their way of working, to discuss what else might help them in their thinking about long-term cases, and to consider if they would like to see long-term therapy addressed more in the profession.

Data Analysis

I analyzed the data from the interviews using Corbin and Strauss' (2008) "constant comparative method." In constant comparison, pieces of data are compared to other pieces of data within each interview, and between interviews, in a back and forth procedure; they are analyzed and categorized according to their similarities and differences. The data discovered in one interview influences the process of collecting data in another interview; ongoing interviews allow deeper and broader understanding of categories and themes, and further comparisons are made. The method is useful for generating knowledge from data that emerges organically as participants talk about their subjective experiences with the research topic.

Procedure for Data Analysis

I began my data analysis by making notes about my thoughts and feelings following each interview. This allowed me to immerse myself in the subjective experience of each participant and to summarize the themes that were raised. I then transcribed the audiotape of the interview. As I reviewed each subsequent interview, I discovered similarities and differences in themes, and the emergence of new themes. I continued interviewing and collecting data until I determined that relevant topics had reached a state of saturation.

The process of fitting data together to facilitate theory building occurred through categorizing particular phenomena in a series of coding methods, elaborated by Strauss and Corbin (1998) and Corbin and Strauss (2008). Coding occurs through overlapping processes of open, axial, and selective coding as discussed below.

"Open Coding" is the style of coding that breaks down the data through word–by-word analysis in order to identify and collect concepts found in words, clusters of words, phrases, and themes, and discover similarities and differences in them. At the same time, I qualified the concepts to develop and define categories in terms of their properties and dimensions (Strauss & Corbin, 1998). "Axial Coding" refers to the process of linking concepts and categories back to each. Axial coding cross-relates categories and subcategories, discovers connections between them, and adds structure and depth to arrive at more complete explanations about phenomena. In linking categories, I was also elaborating them (Strauss & Corbin, 1998). In their most recent edition, Corbin and Strauss (2008) no longer separate the processes of open and axial coding. They go hand in hand and are discussed together as "Elaborating the Analysis." "Selective Coding" is

the final process of refining and integrating categories toward the goal of theory building. As with axial coding, Corbin and Strauss (2008) have dropped the use of the term selective coding as used in their second edition (Strauss & Corbin 1998) and have replaced it with "Integrating Categories." The authors point out that the final step might not fit every study because not every researcher has the goal of theory building. This integrative stage seeks to say more, pull the threads together, and identify a core category in the research that represents theory development or movement toward further theoretical construction. I assessed for indications of this kind of integration and potential theory building as I elaborated my data analysis.

Presentation of the Data

I present the data in the final two chapters of this work. Chapter Four comprises a summary and overview of the data analysis and findings along with a description of the participants. I then describe and provide illustrations of the common features and variations in categories and subcategories that emerged from the data.

Chapter Five is devoted to a discussion of the implications and significance of the study, as well as its limitations. I discuss how patterns that emerged in the data relate to the research questions and to the literature.

Reliability and Validity

Qualitative research differs from quantitative research and requires different standards by which validity and reliability are determined. Qualitative research should be evaluated on its own terms and criteria related to reliability and validity can be adapted to address the design and scope of qualitative methodology.

With quantifiable research, "reliability" relates to the accuracy of the measuring instrument or procedure and "validity" refers to whether or not the study measures what the researcher intended to measure. There is an assumption that quantifiable research will reveal a valid "truth." Authors who have reexamined the standards for qualitative research have replaced reliability and validity with such terms as "credibility" (Corbin & Strauss, 2008) and "plausibility" (Mishler, 1986). With qualitative research, in which interviewing is the method, the "instrument" is the researcher who establishes credibility to interview a population and derives plausible data from the interviews. The researcher analyzes the data, interprets the findings, and speaks for the members of the population for whom the study was designed, so as to transmit the findings back to them (Strauss & Corbin 1998, p. 267). In the case of the current study, the findings were derived from the narratives of psychoanalytically oriented psychotherapists and related back to their clinical work. The study also has broader relevance to the relationship between psychoanalytic theory and practice concerning concepts of long-term therapy and termination. Applicability of the results of the current study to the stated purpose of the research, and to theoretical concepts, is discussed in the Chapter Five.

Patton (1990) writes that qualitative open-ended interviewing permits the researcher "to understand the world as seen by the respondents . . . [and] to enable the researcher to understand and capture the points of view of other people without predetermining those points of view through prior selection of questionnaire categories" (p. 24). To evaluate the quality of this kind of research, Mishler (1986) emphasizes the importance of care with which the research process is carried out in its various stages, including interviewing, analyzing, interpreting and documenting. Likewise, Patton

emphasizes the "methodology skill, sensitivity, and integrity of the researcher" (p. 11). In the end, what is important in qualitative research, according to Mishler, are not absolute truths but "assessment of the relative plausibility of an interpretation when compared with other specific and potentially plausible alternative interpretations" (p. 112).

CHAPTER FOUR - FINDINGS

This study explores how psychoanalytically oriented therapists think about and work with therapy cases that have lasted 15 years or longer. I collected the data from 60- to 90-minute interviews with seven therapists, which I audio-taped and later transcribed. I began the interviews explaining that I was interested in hearing participants' thoughts about working with long-term patients. I knew from my personal experience, conversations with other therapists, and my search of the literature that the topic of long-term therapy has not been well addressed in the profession; therefore, the purpose of this research was to explore how psychoanalytically oriented therapists think about and work with this particular clinical experience. I invited them to begin by sharing their initial reactions and thoughts about the topic.

I did not know ahead of time how the participants were going to address the topic and found that each began, and spent most of the time, talking about their work with specific long-term patients. For instance one began her interview: "So the one person that I was thinking about when you first called . . . " Another participant asked me to begin by asking her questions because she said she had not really thought a lot about it: "I had more of a sense that there would be particular questions you were going to ask me." I asked her how many long-term patients she had and she told me that she has two people she has seen 15 and one almost 22 years, "and I have . . . someone else that I saw for 21 years who stopped recently. . . . If you'd like me to say something about that I can." The participants clearly found their way into the material through narratives about their work with particular long-term cases.

During the course of the interviews I wanted participants to respond in their own terms. Without imposing too much structure on their narratives, I brought up topics and questions from the Interview Guide (see Appendix G) to help them address aspects of the topic that I was interested in. For example I asked participants to discuss their views on how people change, to make comparisons between their long-term cases and long- to short-term cases, to reflect on how consultation plays a part in their work with long-term patients, to consider how long-term therapy is perceived in the profession and how this might affect them, and to think about where the field needs to go in exploring this topic.

I proceed with a description of the participants. I will then give a brief overview of the findings; finally, I will present the findings grouped in the following major categories: working long-term, characteristics of long-term patients and therapists, the role of termination, and participants' thoughts about the profession.

Participants

The seven participants are experienced, psychoanalytically oriented psychotherapists in private practice in the San Francisco Bay Area: San Francisco, the East Bay, the Peninsula and Marin County. Two are clinical social workers, four are psychologists, and one is a marriage and family therapist. Four of the participants are women and three are men. Their ages range from 48 to 68, with a mean of 61. None of the participants are certified psychoanalysts although they are all psychoanalytically oriented. Some of the participants spoke of seeing patients in psychoanalytic style therapy, that is, three and four times a week using a couch or a chair; all see some patients more than one time per week. Five said they would like to have done a formal psychoanalytic training program but were not able to work that out during their careers.

All participate in various psychoanalytic learning venues and consultations. Some of the participants spoke of supervising and teaching therapists in training.

Throughout this chapter I will refer to individual participants as "A," "B," etc. to protect their anonymity and confidentiality. Following is a brief description of each participant that includes their stated theoretical orientations and the approximate numbers of long-term patients they have worked with.

Participant A is a marriage and family therapist who has been in practice for 30 years. She spoke about five long-term cases. She referred to herself as psychoanalytic and psychodynamic, relational, object relations and intersubjective. She sees some patients numerous times a week and some once a week.

Participant B is a psychologist with 25 years in practice. He has two long-term cases. One is an individual who has been in therapy with him once or twice a week and the other long-term case is a couple. The participant sees a lot of couples, as well as individuals. He described himself as psychoanalytically informed.

Participant C is a psychologist who has been in clinical practice for 35 years. She has three or four patients she has seen for 15 years or longer and some others ten plus years. "C" described herself as relational and psychoanalytic. She also consults with Jungian analysts and has an interest in Jungian perspectives. Although not a certified psychoanalyst, she sees some people in a psychoanalytic format—three or four times a week on the couch.

Participant D is a clinical social worker who has practiced for 30 years. She spoke of four long-term patients. She referred to herself as psychodynamic with an object

relations orientation and a "two-person" perspective, as well as interest in the "analytic third." "D" sees patients one or two times a week.

Participant E is a psychologist with 22 years in practice. He spoke about three long-term cases. He described himself as psychoanalytic, relational, and "eclectic." He sees some patients a few times a week and others once a week.

Participant F is a clinical social worker who has been in practice for 37 years. She spoke about three long-term cases. She described herself as psychodynamic, relational, and intersubjective, with an interest in the "nexus" between attachment theory, neuropsychology, and relational theory.

Participant G is a psychologist with 17 years in private practice. Earlier in his career he worked in a hospital setting. He spoke about three long-term cases. He described his theoretical orientation as psychoanalytically informed, psychodynamic, and relational, with training in developmental psychology, family systems, and cognitive behavioral theory. He works with children, adults, couples, and families and sees some patients two or three times a week.

Overview

The study revealed many similarities and differences in participants' ideas about long-term therapy and patients. Regardless of particular psychoanalytic orientations, they all consider long treatment to be a valuable container for patients to enhance the capacity for relational closeness and to foster more enduring change. These therapists stressed intimacy and familiarity as important values in long-term work, and only secondarily referenced the added benefit of not needing to fill as many open work hours.

Discussion about the course of long-term therapy revealed similarities across participants in how they talked about their thinking and experience; in addition, they also spoke to many variations in the unknowns and puzzling elements of treating patients for so long. One participant talked about unpredictability in patients' lives that leads them into years of therapy, and another talked about ongoing "puzzling" aspects of a long-term case. Some talked about the process and relationship being made safe and strong by the longevity and one referred to irreparable disruptions that can occur no matter how strong the long-term therapeutic container may seem to be. All the participants talked about therapy that is slow to start or has long plateaus, where it seems that not a lot is happening but trust is being established or therapeutic experiences are being integrated. One commented that there are times when a therapy actually might be "stuck." All the participants emphasized that talking to their patients about all aspects of the process is essential.

There are not conceptual roadmaps for therapy that lasts 15 years and longer and participants voiced their concerns related to external and internal pressures about the validity of their long-term work. They voiced concerns related to public and professional perceptions about long-term therapy; some spoke about aspects of shame for therapists and patients when working long-term. Countertransference was implied throughout the interviews: two participants discussed countertransference issues explicitly; some expressed worries about exploiting patients for their own personal and narcissistic needs; and most talked of fantasies that another, "better," therapist might have done a better job or made a particular treatment shorter. Participants' self-scrutiny became clear as they

talked about the importance of monitoring their long-term work, keeping it honest, and reassuring themselves of the validity of their work and it's value to their patients.

Participants' descriptions of their long-term patients varied widely, ranging from "mildly retarded" to high functioning and happy with their lives. Two participants did not explicitly describe or compare characteristics of patients, and one pointedly said she does not think about patients in terms of pathology. All participants described most long-term patients as having had very difficult early lives and also referenced that the same might be said for patients who are shorter-term because of how any therapy treatment might unfold. Among the patient population of people who have early deficits and trauma, some will become long-term patients and some will not. The therapeutic relationship itself may be the distinguishing element regarding who leaves and who stays long-term.

Participants talked about their own development. They described how, through their clinical experiences, their own therapies, and consultation, they gradually became more accepting of working long-term. Most of the participants are in consultation groups where they have long, deep, and trusting relationships with colleagues that they value highly as supporting their long-term work. Considering whether they can talk about their long-term work with colleagues, most said they feel especially able to in their long-term groups; although one said there is a little "edge" at times when talking about long-term work, and another spoke of being in one group in which she can discuss anything about her long-term work and another group in which she would be more guarded because of the perspectives of one or two of the other members.

While all participants spoke of strongly supporting the long-term therapy process, some also talked about the value of termination. Most described having experienced

termination with long-term patients, and two participants stressed that they might move certain patients toward termination, particularly those who have had considerable unresolved loss and have never experienced good endings. One participant said that patients can stay as long as they choose because there are always more things that can be worked on in life, whether there are "symptoms" or not, and one explicitly stated that she does not agree that termination is an important process for patients—she questioned why we feel we need to add more loss and grief to a patient's life when we do not have to. Many of the participants agreed with the therapeutic goals described in the literature review as the traditional criteria for termination. They discussed these criteria from their own perspectives and did not consider them to be in conflict with seeing patients as long as needed.

In terms of the larger profession, some participants talked about how managed care and the medical model has affected the profession negatively, that more education is needed about the benefits of long-term therapy, and that more research and writing would be helpful in opening up different ways of thinking and developing curiosity instead of judgment about what other therapists are doing.

Findings

I will discuss my findings in four sections. The first section focuses on what participants said about long-term treatment in light of their own experience with long therapy cases. The second section focuses on characteristics of long-term patients and development of the long-term therapist. The third section examines participants' considerations of the concept of termination. The fourth section examines participants' thoughts about the larger profession in relation to long-term therapy.

Working Long-Term

Findings in this section reflect participants' narratives about their work with long-term patients. I begin with the idea of long-term therapy seen as a "container"; then present findings about working long-term, beginning with the larger topic of the relational value of long-term therapy; next I will present findings related to the specifics of the course of long-term therapy relationships; and last, participants' questions and concerns about working long-term. In a study about long-term therapy, it is inevitable that there will be implications and comparisons to shorter-term treatment. I will note these when they occur in the findings. In a later section on characteristics of long-term patients, I will examine what participants said when comparing long- to short-term patients.

The participants are similar to each other in that they all identify as working long-term and using psychoanalytic theories; however, they differ in the particular psychoanalytic modality, i.e. object relations, intersubjectivity, etc., to which they subscribe. Despite differences, each participant supports the provision of a therapeutic process, or "container," that allows patients to remain in therapy as long as needed. Support for the long-term therapy "container" is influenced by participants' backgrounds, experiences, and personality differences. The endorsement of long-term therapy ranges from expressions of uncertainty about the long-term process, as seen in the words of "B": "Maybe, given her early experiences and early environment, I guess one can make a case for a longer therapy," to less ambiguous positions as seen in the observations of "G": "If it's helpful to an individual person, I think it's fine. I think some people really benefit

from being in treatment for their whole life and if they need that, then it's a good thing," and "A": "For some people therapy just takes a long time. It's what they need."

Mutual benefits.

One finding is that all the participants thought long-term therapy is a valuable endeavor for patients and therapists. Patients and therapists get to know each other very well through different stages of their lives and participants spoke about this as inherently valuable. "G" observed: "There's just a huge base of experience together," and "C" said: "When we see people this long, in a way, we're going through life with them" and it is a "privilege" to go through life with people.

The value I found expressed in the participants' narratives occurs in mutual experiences between patients and therapists. These experiences overlap for patients and for therapists; I will address the experience of each, starting with the patients' benefits.

Benefits for the therapy process and for the patient.

Benefits that participants described for the patient of the long-term therapy process are depth of closeness and intimacy, the best relationship in some patients' lives, stability in a long-term connection, and enduring change. These patient benefits can occur in in-depth therapy of any duration, long or short; long-term therapy has the advantage of more time spent in various phases of the work. "D" summarized what the progression from a shorter-term process to a deeper, long-term treatment might look like:

> The issues they brought in and the way they think of themselves and their access to their internal lives is different and yet they're still here. And sometimes they're still here because there is something that they're now ready to look at. It seems like that's been the stuff that brought them in and suddenly things deepen.

All participants spoke implicitly about depth and intimacy with their long-term patients and some talked more explicitly. "F" said: "In the long-term, really long-term therapies that I've done, I have found them to be incredibly rewarding and rich and in some cases extraordinarily deep." She illustrated the depth in her work with one long-term patient:

> It was so rich—her inner life was populating the room, kind of, and we had many wonderful images. And unconscious material was just accessed and available and we could work with it and understand it. There were dreams and there were fantasies and there was transference and counter-transference. It was very relational. We could talk about the present and what was happening between us. It was extremely rich.

"C" referred to depth in the therapy experience of her long-term patients in the areas of intimacy, interpersonal development and the ability to be vulnerable. About a sense of intimacy with a long-term patient, she said: "He's very close with his wife but he doesn't have a lot of close . . . he has friends but nobody that he talks to the way he talks to me about his inner world." She commented on development in the interpersonal realm: "When people feel mature in the work, it's progressive. [They can think] oh, we can have this other kind of intimate relationship where I can think about you, I can wonder about you." She talked about a long-term patient's ability to be vulnerable: "She only cries with me . . . she has people she's close to, but in terms of being really vulnerable and really letting people know what's going on with her, or telling a dream to, there's nobody but me."

Most participants emphasized that for some patients the therapy relationship is the best in their lives. Here is how "B" described the relationship with his patient: it is not perfect; they can be frustrated with each other, but she has developed the capacity to tolerate his weaknesses and limitations and the therapy is extremely therapeutic and beneficial for her. I asked him if he thinks the relationship is better than any other that his patient has had:

> Definitely. Because there've been a few other relationships where it's been more of a distant, idealized nature than anything more real and, other than that, the relationships that I know about, with her parents, with her husband, with people in her environment, they're all not very satisfying for her.

Similarly, "F" said about a long-term patient:

> F: He was a very bizarre guy, especially in the beginning and it was no surprise that he couldn't make connections with anyone—I may have been the first person he ever connected to. He was really young when I met him.
>
> J: And do you think that your relationship with him . . . was maybe the deepest he has ever had?
>
> F: Yes, without a doubt, including probably his wife.

"A" said about a long-term patient who is in a "very engaged therapeutic relationship" with her: "I think I am her great love and she very much makes that evident." About the progress in this long treatment, "A" added: "there are other people other than me on the planet and she's getting it."

Three participants emphasized the value of stability when it was lacking in a patient's life and found in a therapy relationship that goes on for many years. "F" spoke

about the benefits of staying with a therapist through stages of life. She referred to certain long-term patients:

> . . . who have needed a stable constant object in their life and who really seem to thrive and go through multiple sorts of life transitions with something, with me or whoever is the therapist, kind of walking with them on that journey.

Similarly, "D" illustrated the therapist providing a stable relationship that was previously "missing in people's lives" over life's milestones:

> A relationship where there's sort of a good beginning that can take itself over time and that me, or anyone as a therapist, is there over a lot of milestones in their life—that the relationship can hold the ups and downs and that there is a stability of our connection that is really there.

"G" also referred to stability in his description of the treatment of his patient who died of cancer 14 years into her therapy: "I think there's a lot of ways of understanding it. But I think as a global way of talking about it, I would say it was a big source of containment and emotional stability for her."

In consideration of his long-term work, "E" spoke about the greater likelihood of lasting change when people are in longer treatment. He referred to his impression of an article by Jonathan Shedler (2010) on research comparing psychoanalysis to short-term treatment models: "There's an enduring effect that when people are in therapy longer—that change endures longer than in shorter term. To me that's very exciting."

Benefits for the therapist.

All the participants spoke about benefits they experienced as long-term therapists, including mutual generativity, intimacy, being well known by another, as well as more practical rewards.

Some of the participants emphasized mutual generativity between the long-term therapist and patient, who together create a therapeutic container that fosters personal growth and development for both. Describing his work with a long-term patient, "E" said: "What we shared together and what I've been to him and what we've had together, that actually had a very profound effect on both of us." "A" described a mutual depth of feelings with two different long-term patients: "I was so moved by both of them. I feel like they've been cooking for a thousand years. Their thoughts, the refinement—it's very powerful to sit with them." "C" spoke about the closeness she feels with her long-term patients: "I love the intimacy of these long-term relationships. I'm a person who likes a lot of intimacy. I get very close. I fall in love."

Three participants spoke implicitly and explicitly about the value they place on being personally and intimately well known by their long-term patients. "B" said about his patient: "There are I think a lot of ways that she knows me and she knows my weaknesses and strengths, how I am and what might be difficult for me . . . that's different from a lot of other patients." Similarly, "G" said that the patients he has seen longest know more about him than any of his other patients; though he has not necessarily disclosed more, they have known him through milestones in his life, such as births of his children and deaths of relatives: "They know things about me that most people that have even seen me for five years don't know." "C" talked about the level of

comfort she has with long-term patients because they know each other so well: "I feel so much freer. There's so much I can do, so many more risks I can take . . . because I know that we're solid, we're really solid."

A more practical reward for therapists that was mentioned in two of the interviews is not having to fill as many open hours when they see patients for a long time. Here is how "E" spoke about this: "There's a part of me that can want to hang onto them, and get all the good out of it, and not to feel rejected or have an open hour, and all those different things." "C" compared herself to some of her colleagues "who don't love the work the way I do . . . they don't like working with people who get too dependent on them." Echoing "E's" statement about an advantage to seeing patients for a long time, she added: "I don't very often have open hours."

The course of long-term therapy.

I will now present participants' perspectives about the course of long-term treatment. Overall, I found participants demonstrated that during the course of long-term treatment the ability *to talk with patients about the process* is, in most cases, enhanced by the time spent together. Also participants spoke to having a commitment to staying involved with the long-term therapy process no matter how complex it is, how slowly it proceeds, or how long it lasts.

"D" provides a good entrée into examining what participants said about the course of long-term therapy. She raises questions about what happens in the course of treatment and why some patients stay a long time: "It's always interesting to know what the situation is. I'm always interested in the trajectory of the treatment when people see people a long time. You know, what's been going on? Why?" In keeping with "D's"

questions, "G" depicted situations wherein life's unpredictability might set a person on a course of long-term therapy:

> And there's still a lot of things that would have to happen in a certain way for someone to stay in treatment for a long time. . . . Some people are just very unlucky. Like they, you know, like they have a treatment that works or things seem to be going better and life throws them something that just is really—it hits them right where there already is a fault-line and they're back in treatment, you know. So it's very capricious, I think.

I will present the other specific topics that the participants reference in the following order: a range of long-term therapy relationships, talking with patients about the process, experiences of time unfolding in the course of long-term therapy, countertransference in long-term work, and noticing what is happening during the course of long-term therapy.

Various kinds of relationships.

"E" captures a range of relationship variations that are part of a long-term therapy process. He stated that some patients make use of the therapist in a manner that is similar to a "rabbi or priest kind of relationship." With others, he said, "it's a necessary state of affairs. There's a certain kind of dialysis, an emotional dialysis. We can call it Bion's alpha functioning."

"E's" first variation refers to patients who were doing well to moderately well in their lives as they make use of the long-term therapy relationship. "D's" following description is an example of this. It is also an example of my earlier observation that participants found their way into the material through narratives about their work with

their long-term cases. "D" spoke about someone she has been seeing for approximately 20 years. She said that the patient has quite a successful life; she has used the therapy to gain compassion for others and to work on being a good mother, both of which were missing in her early development. In the therapy process, as the patient has been able to hear and take in the therapist's compassion for her, she has been progressively able to be compassionate toward others, and now "she's quite a good mother." The patient, however, has not been able to gain the ability to have compassion for herself. She continues to struggle with feelings that she is a "terrible person" as this long therapy continues.

"A" describes a patient who reflects more of "E's" "emotional dialysis." She said that her patient is not terminating because he needs to use the ongoing experience of having the therapist with him:

> I feel like what he takes with him from me is that I'm going through life with him. There's a way that he just feels safe, knowing I'm with him. He doesn't want to be separated from me in terms of termination and he doesn't allow himself, or even know how to allow himself, to think about me outside of sessions.

Talking with patients.

In studying their responses, I found that participants often emphasized that they can talk about the therapy process more easily with long-term patients because of the years they have been together. Two participants discuss how the course of therapy with long-term patients provides the safety to talk about what is going on, and one describes an exception—a disruption in long-term therapy that is unresolvable. "C" talks about relationships that are strengthened and protected by longevity:

> I don't know if it's so much the difference in how well I know them as how well we know each other; how free I am to say things. It's all the things when you don't see people as long you're more careful about—that I don't have to be so careful about. That I know if we have a fight we're going to work it out or, if I say something they don't like, I'm going to hear about it. Or if I'm on the wrong track, I'm going to eventually know I'm on the wrong track. I know we're in this together and we're not going to end on any kind of—you hurt my feelings, or call me up, I'm not coming back. . . . I mean, that's just not going to happen. So I think maybe with people I've seen a long time I might feel freer to say, you know, it's feeling to me like nothing is happening, what do you think is going on? As opposed to somebody who I don't know that well and I don't know how they'll react to something like that.

At another point "C" said about her work with long-term patients: "when I'm really wondering is anything happening, it might become our topic of conversation." Similarly, "G" described the course of long-term therapy wherein "there's a lot more trust and understanding":

> I feel like I have a lot more room to maneuver, because the relationship is so strong. . . . And so, I think, it gives me much more leverage to say things that I just wouldn't say to somebody that I treat for even five or six years.

"D" brought up an exception to the relationship being protected by longevity and talking about the process. She spoke about an "aberration" in her long-term work, which was a difficult and painful ending with a patient she worked closely with for 21 years. She said that she and the patient talked long and hard about her patient's objection to a

fee raise but in the end, they were not able to resolve it. "D" added that some therapists in her consultation group have had similar experiences "with a person they had seen for a very long time where it was an abrupt end, and quite painful kind of ending."

It takes as long as it takes.

I will present here what participants said about the developmental process for long-term patients, the pace of long-term treatment, and a brief statement about frequency of sessions.

All participants implied a developmental perspective in the course of long-term therapy—it takes 15 years (and longer) to raise a child. A couple of participants made explicit references to development. "A" referred to some patients who did not "get something at a certain age." She said: "I think in some ways that is how I have come to think about my long-term patients . . . very much in terms of development and the kind of work they needed to do to develop." "B" said: "Maybe some people it takes longer—well, for sure it takes longer when developmentally you didn't get that."

Participants spoke about how the course of long-term therapy might be unevenly paced. Their descriptions of years spent in aspects of the work provide more understanding about the course of long-term work. Some described therapy getting off to a slow start and taking years before a patient is able to work on underlying problems that brought them into therapy. A patient may be distant and hard to connect with or out of touch with feelings and memories. They might have difficulty developing trust in the relationship so that it takes a long time before they are able to discuss and process aspects of their lives.

"A" provided a summary of cases that are slow to start and take years before they could begin the needed therapeutic work. She said that some patients have intense longings to be close but feel so endangered and terrified that they put themselves in "exile from the self" and from everyone else, "so that it's almost impossible to find them. . . . and then if you begin to get at all close to their real selves, all hell starts to break loose." She referred to a long-term patient who distances himself from her when she attempts to explore what goes on between them: "I can ask him a million times, what do you think is going on between us. How do you think I feel about you? 'I don't know,' he'll say, 'I feel kind of detached.'"

Similarly, Participant D referred to a patient of 15 years who was "numbed out" and in denial for the first 13 years of treatment until she reached a state of trust and safety that allowed her to recall aspects of her childhood. "D" said some patients have no choice about how long therapy takes; sometimes "we can't move it faster." Here is what she said about a conversation with her patient:

> "So now," she said, "so now I'm in like year 15 and now I'm miserable? You know, I thought I was better and now I'm miserable?" . . . I talk to her about she's just beginning to feel what she will need to mourn . . . and I talk about how courageous she is to have opened this up and let this in. She says, "I look at my friends and they go to therapy for three years, or five years, that seems like a lot and here I am starting my 16th year. What the fuck is wrong with me?" And I feel with her, particularly, that I can see she just was shut down, frozen, locked in, and the feelings were split off.

Participant G had this to say about a long-term patient who made a suicidal gesture within the first few years of treatment and took a long time before the therapy relationship became stable enough for her to begin to work on her internal life:

> I don't think she trusted that I cared about her for the first four or five years of the treatment. And then there was a point where things actually really settled down . . . and I felt at certain times, that this is really, you know, she's like never settling down or this is never going to end. But the reality is that sometimes if you're patient enough things do settle down and people do feel contained and start to believe that you actually are not going to betray them and that, you might make mistakes, but you have their best interests at heart.

Similar to long periods before therapy gets off the ground, all of the participants spoke about times during a long therapy when it can feel like there is not much happening or it's not clear what the patient and therapist are doing. One participant referred to these times as "plateaus."

"B" describes being puzzled by what happens in the interpersonal process with his long-term patient. He said it is hard to talk with her about conflicts and the meanings of what happens between the two of them; the process can get "muddy" and "confusing" for him. He is "continually trying to figure her out" and this contributes to the long-term course of this treatment. He noted: "So maybe it's taken longer because, I don't know, I guess it takes as long as it takes sometimes. And it seems such a difficult thing to decide and to figure whether treatment is over. It's a puzzle."

Participants suggested that they often feel something is happening; even when it seems like nothing is happening. "D" referred to periods in any therapy, except

treatments that are really short, that are less actively engaging: "I sometimes think that's when things are getting kind of integrated and held and something's being worked out. Too much new stimulation is not going to be helpful." "F" referred to these stretches of time as plateaus when there is plenty to work on, "but there's some resistance in one or the other to doing it. And it's just comfortable for a while, or something." "G" spoke about phases of treatment with some patients that feel stuck but "there's clearly a place where we need to go . . . and we're just at this kind of rough patch . . . and you gotta stick it out." He described a situation with a patient whom he had been saying the same thing to over and over and it took a long time for her to be able to hear what he was saying: "Sometimes if you're patient enough over time, they eventually come around to it." "C" gave an example of the process with someone who has been coming for many years: "I feel like we do the same thing over and over and over again because the core issues don't change but it's not boring, you know, it's progressive." She added that there is a depth of understanding of the process in long-term work that does not necessarily occur with shorter therapies: "I can think of people in my practice that I wonder is anything happening, but they're not people who I've been seeing for years and years."

"E" raised the idea of frequency of sessions possibly affecting the length of long-term treatments. While frequency of sessions was not an explicit focus of this study, all the participants mentioned working one or more times a week with patients and some spoke of working more than two times a week. "E's" comments did not go beyond speculation as he described work with a patient gradually moving from three times a week to once a week because of the patient's financial situation. "E" wondered if more sessions per week might help this long-term patient move through therapy more quickly:

> I was thinking about this, after you posed this project that, with this particular patient, would it possibly make for a different outcome if he were to be able to come more often. I could see having a greater opportunity to get more depth, more into those psychic structures, if you will, because so much fades in between sessions that it's hard to get a kind of change that endures enough.

Countertransference in the long-term process.

Countertransference is inherent to any psychotherapy treatment and while participants used the term infrequently during interviews, it was implied throughout the descriptions of long-term cases. Most participants mentioned or implied boredom as a possible countertransference experience in the context of seeing patients long-term, although, in general, they noted they do not experience boredom. "E" emphasized, however, that he *does* experience periods of "boredom" sometimes when nothing seems to be happening. He qualified that his experiences are not about the longevity of the treatment but more about what is going on in the patient or in himself at that time:

> With these patients I can go through periods of really being bored and that's frustrating. Part of it goes with—it's just the nature of the beast; this is what I have to tolerate because of where they are . . . what is going on that I'm maybe induced to do this, or what am I bringing to the table that's making me do this? That doesn't happen in most of my other cases. So it's another facet I'm just wanting to emphasize—what goes on in the internal experience of these longer-term patients.

"A" spoke about times when she feels not bored but helpless, and, like "E," she relates these periods to the internal lives of her patients. She talked about times when you do not

know what is going on as being part of long-term work. She referred to these times as "really deep projective identification. You're getting the patient is helpless. You're no good. Nobody's any good. No one can help."

Noticing what is happening.

All the participants spoke about their involvement with the process and the attention they give to the course of treatment, even when things are moving slowly. In the words of "F": "If they want to stick around, it feels all right to me. But, it has to be really explicit what that's about." She clarified that she is interested in "being in the moment . . . and really being able to notice the process and what's happening, what's happening, what's happening." "G" echoed the importance of paying attention to the course of treatment, no matter how long it takes. I quoted "G" above saying, "you gotta stick it out" when you find yourselves in "rough patches." He also acknowledged the possibility that, when it feels like nothing is happening, the therapy process might actually be stuck: "I do think it's important that any treatment be dynamic and that it be moving in some direction and that it not be . . . kind of stuck or stale."

Questioning the work.

Participants voiced concerns about their long-term work that reflect questions asked throughout the history of the profession and speak to the heart and purpose of this study. Much of the work of psychotherapy, long-term or short, contains aspects of not knowing. Questions arise about the process and what a patient needs from therapy. Previous sections have shown how participants find significant meanings in the benefits, situations, process, and relationships of long-term therapy. Here I will examine participants' doubts and concerns—although they can understand and appreciate why a

patient continues in long-term therapy, questions still resound in their minds about the length of time for some treatments. "B" said at the end of his interview that we had covered his "ambivalence and conflicts" about his long-term work.

There are not good conceptual roadmaps for treating people so long, and this, accompanied by an underlying expectation that therapy should end in a timelier manner, seems to drive participants' doubts. "F" wondered about her work with a patient of ten years who was quite attached to her. The patient terminated because she moved away from the area. She kept occasional contact with "F" and although the patient tried, she could not find a therapist she wanted to work with in her new location. She moved back again and began to see "F" for additional work. "F" voiced these concerns:

> One of the things I think about and that I imagine other therapists do is, have I done her a disservice by not helping her terminate in a way that would allow her to go on to the next therapist and make a life in [new location]—that's the dilemma isn't it?

I found that participants' questioning serves a valuable purpose in exploring the long-term terrain. It is a way for them, not to dismiss the value of long-term therapy, but to think critically; to gauge and monitor their work and be honest with themselves about their conflicts. "E" said: "We never really resolve our conflicts, we just understand them better—we call it the depressive position."

In this section I will examine participants' conflicts, as well as understanding, about their long-term work from two perspectives: externally derived, and internally driven questioning.

Externally induced self-doubts about long-term work.

In the area of doubts and questions that therapists encounter from external sources, participants spoke about negative opinions of the public and respected colleagues about dependency and allowing patients to stay so long. "E" demonstrates in the following dialogue how he is able to rely upon the support of his own accepting community of colleagues; he also describes how negative public opinions about long-term therapy set off internal alarms earlier in his career:

J: Are there any colleagues that you would not talk about the length of these cases with?

E: No.

J: And do you feel you've heard long-term cases presented in public arenas—you know, professional public arenas?

E: Yeah, I have. Yeah, it hasn't felt like a dirty old secret. It hasn't felt like something to be ashamed of and kind of kept hidden. That hasn't been my experience. I've had that thought pop up in my own mind [though], or I think more once upon a time I would have had the feeling, like, oh, this person has been seen for 10 years—what's going on? What's wrong with that therapist?

"C" spoke about encountering and grappling with negative opinions expressed by respected teachers. The first example is when a teacher from her doctoral program was ending his own analysis and talked about it with his class:

I remember really clearly him saying in a very embarrassed way, he'd been in analysis for 14 years. I remember the number and he was talking about what a big deal it was that he was finally ending but he was saying how—he didn't say it but

there was an implication on his part, that he had stayed too long. And that he was kind of embarrassed, you know, he was excited, and embarrassed that he had been in analysis for so long. . . . I don't remember anything else except that it was 14 years. I remember it really stuck with me and I was in analysis at the time and I don't know how long I had been in but I was not anywhere near finishing.

At another point, "C" spoke about a former consultant who voiced strong biases against dependency in long therapy relationships, which felt to "C" like a criticism of her for her own analysis:

I had a consultant years ago who I adored and still adore who, when she knew I was in analysis for many years, she would start talking to me about other people who were in analysis for many years and say things like: You know so and so, she's been in that analysis for so many years; why doesn't she get out of that analysis? And I of course felt like she was talking about me. Whether she was or not she was certainly telling me about her bias.

J: Did she explain it or was it just—?

C: [She would say], oh, she's so dependent on this person. Almost like it's disgusting, you know. And then of course there's the notion that therapists take advantage of people by keeping them. You keep people tied to you; you milk them, you all that stuff. . . . If you feel like they're doing fine why don't you tell them it's time to leave? Why do you wait for them to say it's time to leave?

"D" voiced her own concerns and culturally driven challenges, as well as her learned perspectives and commitment to working as long as needed:

> Maybe you've had this experience as well, but there are some times when I'll say: Well I've been seeing this person for 18 years and it's like—what? As if, what am I not seeing? Like, what's wrong? . . . What could possibly take that long? That there's some sense, even with people that can be analytically trained, that there's something like, that's a little too long. Or there's some Woody Allen joke about will they be in for 60 years and will anything be different? Isn't there a point when they oughta' have gotten it by now?

She then reflected that this is not really the lens through which she sees the work, clarifying that her lens is to recognize that termination is hard and it can take a long time to work on the issues surrounding leaving before someone is ready to go.

Internally driven questions.

Participants spoke about their own questions and concerns about working long-term. The findings are that participants experience aspects of shame about engaging in long-term treatments, have concerns that hopes for patients and their own narcissistic needs might prolong the therapy process, wonder if another (better) therapist could help patients move more quickly, and question how their patients can meet "criteria" for termination but still want to remain in therapy. "F" makes reference below to "countertransference," which is something that is implied throughout the findings in this study in relation to participants experience of doing long-term therapy and, in some cases, in relation to patients. I did not use the term countertransference with participants but note that several participants did.

When I began the interviews for this study I wondered if I would hear about feelings of shame related to long-term work. I found elements of shame implicitly

expressed in all the participants' self-doubts and questioning, as in a statement by "C" that she *no longer* believes she needs to hide her long-term work, or any aspect of her work for that matter. "F" also spoke about hiding long-term work and she raised the possibility of her countertransference feelings of dependence affecting the length of treatment. "F" was the one participant who explicitly raised the topic of shame:

> Part of my background is that I've done a lot of study on the topic of shame. So I think that one of the reasons that long-term therapy, the length anyway, has not been addressed is because there is an element of shame involved.
>
> I do think there is a certain amount of shame around continuing to see somebody for 15 years or more where we end up sort of hiding a little bit. That we feel maybe, oh maybe I shouldn't be doing this; maybe I'm doing a disservice to this person and maybe they've gotten too dependent on me. Or maybe I'm dependent on them in that sort of countertransference. So I think it becomes a sort of more secret subject . . . also in the patients because sometimes they feel a little ashamed of, quote, needing to be in therapy for so long, because in the culture that's not very accepted.

At another point "F" implies countertransference as she elaborates self-monitoring questions about her needs versus patients' needs, illustrating self-scrutiny about her part in the process. Here she is considering her own ideas about what a patient needs to accomplish in therapy, which is to stay until they can work at a level of depth that is the patient's potential:

> F: And there have been some where it's always felt to me like we've never

quite reached a level of depth that I've thought was their potential but the life that they've wanted is there and they're going toward it and that feels great. So, now I have to think about, oh, is that my need?

J: What you know about what you've done with other people or what you have wanted in your own life.

F: Yeah, yeah exactly, exactly. And that can't be the definition of what's a good therapy. It can't be why I encourage people to stay—because I don't want them to go. I just have to know that's what I'm feeling, because that's me.

J: Your awareness of that. It helps you monitor it.

F: Yes, yeah.

Similarly, "E" demonstrates self-monitoring as he questions himself about what he and his patient are doing:

> Is there something wrong that I'm not addressing or seeing? . . . Is it because of my hopes, my goals, my desires, not being happy about where they are? Is it their defensiveness—not wanting to address something in a certain way? Is there a certain kind of wish to not have too much movement so that they can stay like this forever? These are thoughts that come to my mind.

"B" also questions his needs versus the patient's as he focuses on the long-term trajectory of a treatment. On the one hand, he feels that his patient needs more therapy to take in more of the therapeutic experience and, on the other hand, he is concerned that the therapy might be continuing for many years because of his own needs. "B" asks himself if they are recreating in the therapy what happens in his patient's life and if they will

remain stuck in this: "How much of it is sort of, as I said, my interest in trying to have my goals accomplished with her, you know, my own narcissistic needs?"

Five participants spoke spontaneously and candidly about concerns that can arise for them about whether another, "better," therapist could do a better job with their long-term patients. In the face of unknowns in treatment, feeling inadequate can occur during any therapy, long or short; participants demonstrate how these concerns arise for them in long-term work:

> I've thought about this one guy—with most of my patients I don't have this feeling, but with this guy I have really wondered if someone else would be more helpful. I don't know if you've ever thought this but I'm working with him and all of sudden I think, you should see a therapist (laugh). . . . I have thoughts about what the hell is going on and would they be better off with someone else (Participant A).

"B" voiced similar questions about work with his long-term patient:

> It's not that I think the therapy is harmful but is it not really useful to her anymore? Is she just clinging onto something that she'd be better served moving on from? And if she felt that she wanted therapy maybe it would be good for her to see someone else.

Participant D "holds" both sides—she questions and then provides a reassuring perspective:

> I just want to also say, there are plenty of times in these long-term treatments when I do wonder: would a better therapist have gotten there more quickly? Is there something I'm not seeing or not doing that is making this treatment be as

long? I mean, I can hold both—I can hold: well, of course, I understand why! But I think there is that pressure, in some ways. Even though when I'm in the room with the person I feel like I understand why, in a way that you can't measure on a statistical chart of how many times a person said what, or something. But I do think, as we do with all our patients, we have our doubts. Could somebody do a better job with this person or am I doing as good a job as anyone?

J: You get insecure about the work.

D: Yeah, and I think when it goes on for a long time and, especially in those periods when it may feel, I don't know exactly what to call it, but not as engaged—wondering. I wanted to make sure that got stated.

"E" echoes wondering if another therapist would do a better job and describes how he works to gain perspective about this concern. He said that feelings of helplessness, impotence and inadequacy can come up when working very long-term: "If I were a better therapist, this person would be in a relationship, better job, terminated, you know." He says that he uses his own therapy, consultation group and individual consultation to help him to deal with his concerns. He says, one of the things that "keeps me in my chair" is that the case would not necessarily move faster with another therapist. Part of what consoles "E" is that maybe another therapist could do a better job, but that it would be a different story line because "it depends on the nature of the two people in the relationship." "G" also wonders if another therapist would have done better and elaborates on how it depends upon the nature of the people in the relationship:

Looking at her history and where she's at, I don't really think somebody could do like a way better job than what I've done . . . incrementally it's just a lot better. I

think with somebody that's much more high functioning, I might have those same questions also of like, geez, you know, is there something I'm missing here? Or should somebody else—would they have done a little better?

Characteristics of Long-Term Patients and Therapists

In an effort to understand phenomena related to long-term therapy, it is important to gain a sense of who the people are on both sides of the "couch." In this section, I will first examine how participants spoke about characteristics of their long-term patients. Then I will explore how participants talked about their own growth and development as therapists who do long-term work.

The patients.

I was interested to hear how participants' spoke about characteristics of their long-term patients to see if we could better understand who the patients are that stay in therapy 15 years and longer. For this purpose, I also wanted to hear if participants' view of long-term patients differed from their view of short-term patients. A finding is that participants thought their long-term patients have experienced more neglect, relationship deficits, and early childhood trauma than other patients. However, the difference was not clear in participants' comparison of long-term to short-term patients because some patients who have had considerable childhood trauma leave therapy prematurely, in the therapist's estimation. Also some participants said that they generally do not compare their long-term patients to other patients. I will present findings related to patient characteristics in three sections: participants describe their long-term patients' painful childhoods, they differentiate between long-term patients as "higher" and "lower" functioning, and they consider comparisons between long-term and short–term patients.

Really painful childhoods.

As the participants discussed long-term therapy by talking about their cases, they referred to patients' early histories of trauma and neglect as the primary reason patients remain in therapy long-term. "D" captures this well:

> I think what they all share—although they're different ages and very different people—is such deprivation in early childhood: really neglected, really not seen, mothers who were depressed and in bed, mother who died when one of them was three months old, where . . . that basic sense of being sort of seen and held and cherished as a baby and a child was really missing. And in some cases they were victims of abuse or victims of sexual, physical, verbal abuse, but really, really painful childhoods.

"E" illustrates how painful childhoods led to the kinds of deficits in adulthood that have resulted in long-term treatment for some of his patients:

> A deficit model is one way of describing my thinking with these folks. All three had early trauma and because of that I think it's been really hard for them to kind of think their own thoughts, process their own feelings, relate interpersonally. For one in particular, it's almost like I can see him having to be in therapy indefinitely.

High vs. low functioning.

I asked participants to compare long-term cases in their practices to see if they would identify more patient characteristics than they portrayed in their spontaneous narratives. While reiterating their primary point that long-term patients have had extremely difficult childhoods, the therapists identified two different types of patients:

"high" and "low" functioning. These characteristics, however, could describe patients in any therapy practice and, like any practice, a couple of participants expressed a personal preference for working with one type of patient over another. Embedded in their descriptions of "high" and "low" functioning patients was a discussion of the kind of therapeutic approach that each of these types called for and the therapists' feelings about working with them. In this context, the therapists talked about what they felt they gained from working long-term and what they feel about their commitment even to those who are less personally gratifying to the therapists.

The higher functioning patients were described as being able to make use of insight-oriented treatment and continue to grow, even though they may have had serious early deficits. A few participants mentioned that some high functioning long-term patients are therapists themselves, although they did not reference whether they had experienced more difficulties in childhood than other patients. "G" indicated they might stay in therapy long-term because "they're interested in their own minds." Lower functioning patients were described as people who benefit from primarily supportive therapy in order to increase stabilization and manage their lives more successfully. "E" characterized the two types of patients and differentiated length of therapy within the category of "long-term patient," suggesting that the lower functioning patients tend to need and remain in therapy longer; this seems to be a common recognition among the participants:

> [One] patient, I think, has grown enough, healed enough, and added health to the pathology enough that he can kind of think, function, feel, process, handle well on his own, so that he would be able to contemplate terminating, and also doing it.

> As opposed to this other patient in whom there are such deficits and so many reasons: affects overwhelm him, impulses overwhelm him, there's really no way to imagine being able to kind of leave the nest.

While describing the difference between these two types of patients, and the two therapeutic approaches, two participants also talked about feeling more personally gratified working with higher functioning patients while, at the same time, expressing deep commitment to their work with both high and low functioning long-term patients. "C," for instance, indicated that she "cares tremendously" about a patient who needs more supportive than psychoanalytic work but she does not "find it very stimulating work." Similarly, "F" related her experience working with two very different patients who have both, after working long-term, terminated therapy. She also distinguishes her feelings about supportive work as compared with more in-depth work:

> I think we will be forever connected after that much intensive work for twenty years multiple times a week. And I had to really work with myself to be able to go through that process and let her go. . . . Now that's not always true. Because the other person I saw for many, many years, probably more than twenty, there was this certain relief, as well as sadness, because it was such a different kind of therapy. . . . It wasn't a therapy that had a lot of depth. It was, you know, supportive psychotherapy, and he changed enormously and was extraordinarily attached to me . . . but it wasn't the kind of therapy or treatment where I felt intimately brought into his inner world except in an observational way.

"G" provided a different perspective on working with "lower functioning" patients. He commented that "supportive" work "has kind of a pejorative feeling to it,"

implying that it is not typically sanctioned by the profession, but he indicated that he does not see it that way. For "G," both types of patients bring their relationship issues to therapy, so the work becomes more similar than different. He talked about his work with a "mildly mentally retarded" patient:

> I was very skeptical about taking her on as a patient but she had an emotional life like anybody else. . . . Basically, I imagine I'm probably going to treat her until one of us dies. And again, I think, she's definitely lower functioning than just about everybody in my practice. But it's interesting, she has the same kinds of issues—dealing with loss and abandonment and relationships and fighting with people and kind of accepting the fact that she's aging, and various health problems. So it's a little different, and an unusual treatment, but at the same time it's really [about] the relationship. Between the patients, thinking about what are the differences between them . . . I would say they're more similar than they are different.

However "G" does make a distinction in his experience of higher- and lower-functioning patients from another perspective, that is, his higher-functioning, long-term patients seem to leave therapy sooner than those who need supportive therapy. He puts it this way:

> In my experience, the people that are higher functioning, and maybe this is just my own clinical style but, often times, after a period of years, sometimes a long time, like ten years, they get to a point where they really do feel like they've accomplished what they want to accomplish and they decide to stop and I feel pretty good about it.

He compared this with his lower-functioning patients, whom he says tend to remain in therapy longer:

> Almost without exception, my really long-term patients tend to be more disturbed . . . really trying to regain some stability, avoid harm, things like that. So I would say, definitely, looking at the difference between, say, people who are in treatment up to about eight to ten years vs. more than that, most people that are in treatment longer are much lower functioning.

Comparing long-term to short-term patients.

To further clarify characteristics of long-term patients I asked participants to compare long- and short-term patients to see if they might identify differences between them. In response, participants talked about not being able to predict who would be a long-term patient. The finding is that participants thought that differences between long- and short-term patients are not very clear. Though they describe their long-term patients as having had more difficult childhoods, some indicated it is often unclear to them who will become a long-term patient because of how any treatment might unfold; some indicated they do not tend to make comparisons between long- and short-term patients. It appears that the therapeutic relationship itself my be the distinguishing element regarding who leaves and who stays long-term. With this caveat it would seem from what the therapists are saying that among the patient population of people who have early deficits and trauma, some will become long-term patients.

"A" defined short-term patients as people who enter therapy to do "very focused" work on a particular issue, as a patient who came in to resolve issues with her husband about starting a family: "she really got clear about it and was able to start a dialogue with

[her husband] and it changed their relationship." However, "A" says, some "short-term" patients evolve into staying long-term because of other issues that surface during treatment. Alternatively, many patients who might have become long-term patients leave therapy prematurely, before they can work on deeper problems, and it is not clear what work they could have done and how long they otherwise might have stayed in therapy. She gave an example of both scenarios with a patient who saw her short-term—for one year—and it felt to "A" like she ended prematurely. Five years later, the patient returned to therapy because her relationships weren't working out. When "A" said, "I wonder if there's a way that you feel you could make better use of me," the patient began to reveal her early molestation in her family. "A" said that until that time, she did not know what she was working with and, "I can see now that she may be in therapy for years."

"F" considered definitions of "short-term" and indicated she is not comfortable if a patient leaves after a few years when it feels there is more work to be done, but she is also comfortable with some patients leaving after only a few years:

> You have to define what not staying long is. So, for me that would certainly be under a year and, even then, that doesn't happen very often but occasionally it does. . . . Certainly under I would say three, I tend to feel a little like I failed because there was so much more that could have been worked on but I can understand it—why the person might want to step back.

I asked "F" to comment about patients who terminate after three or six years if it feels like the right time to them:

> There have been some of those people where I've felt it's been very rich and deep and I'm quite sad to see them go but also happy for them. And there have been

> some where it's always felt to me like we've never quite reached a level of depth that I've thought was their potential but the life that they've wanted is there and they're going toward it.

"G" indicates that it is hard to differentiate between characteristics of long-term and short-term patients:

> It's hard to predict how quickly someone's going to respond to treatment and also if they're going to stick with it and what their capacity to be in the therapy is. But also how well we're going to work together. . . . In retrospect, I think it' s hard at the time to predict who is going to stay a long time.

"B" considered that some patients leave "prematurely" instead of staying long-term, but he added he does not generally compare his long-term patient to other patients:

> A lot of times I'm feeling people are leaving prematurely and sometimes it feels better than other times. . . . I don't think I make such a dramatic comparison between her and other patients, even though, of course, I have been seeing her so much longer, but I don't think I do that so much.

In a similar vein, when I asked "D" to compare long to short-term patients, she responded by not comparing but reiterating the primary characteristics of long-term patients: "Well, as I said earlier, I think they have a certain kind of history." She was referring to her description of long-term patients, quoted above—"such deprivation in early childhood," and "really, really painful childhoods."

Development of the long-term therapist.

Findings in this section relate to participants' development as therapists who do long-term work. Throughout the narratives, participants portrayed their particular

capacities to imagine and provide therapeutic containers for long-term treatment: to sustain interest and immersion in therapy relationships, to know a patient very well and be well known, to tolerate strong affects as well as periods of calm and upheaval—for 15 years and longer. Here is how "F" described herself as a long-term therapist: "I have to tell you, for better or for worse, I am a person who likes and seeks the deeper realms, which is why I probably ended up doing this work." "C" compares herself to therapists who choose not to work long-term by stating: "[they] don't love the work the way I do . . . I've heard analysts who say that they don't like working with people who get too dependent on them." In this section I will examine what participants said about their growth and development as therapists who work with some patients long-term. I begin with how they described changes in thinking over the course of their careers. Then I will examine the role that consultation has played as containers for their development and long-term work.

Time and experience have altered perspectives.

Participants have undergone changes since they began learning and working as therapists, leading to their current perspectives on long-term work. Their professional development spanned the time in which the psychoanalytic zeitgeist shifted from a one-person to a two-person model of the therapy relationship, marking a movement of the co-constructed relationship of patient and therapist to the foreground. I will examine what they said about changes in their practice that resulted from clinical experience, professional discourse, their own reading, workshops and conferences, their own therapies and analyses, and consultation.

"E" summarized the kind of shifts in thinking that all the participants spoke about regarding patients "who have had serious trauma." He said he "reassessed the goals of therapy" as he saw certain patients struggle in their day-to-day lives and not move on to more rewarding jobs or satisfying relationships.

> There's a real kind of deepening awareness as I went through my career, of individual differences, internal struggles, people who can function very well on a certain level but have some real serious problems that aren't readily apparent but that would really interfere with a person's functioning; that would be the kind of thing that would make people be in therapy for a long time. Appreciating that is what has been my turn-around.

"G" also spoke about learning through clinical experience. He emphasizes the value of learning through mistakes, which can be recognized and utilized over time:

> When you treat somebody for a really long time, you make lots of mistakes and if you're lucky you kind of see, okay well with this person this particular approach doesn't work or these particular kinds of interventions don't work, or do work.

"A" described the clinical experience that precipitated her shift into a "two-person" mode, with implications for long-term work. Early in her career "A" was taught to interpret a patient's focus on the therapist's vulnerabilities as a projection of their own vulnerable feelings. She discovered through clinical experience that this one-person theoretical position, and interpretation, turns the patient away from the therapist. She came to recognize that some patients "don't know how to be in touch with somebody else" and their focus on the therapist reflects their desire to be in touch with and attach to another person, implying a potentially longer time frame for therapy.

"F" talked about movement from conventional thinking through clinical work, teaching, and supervising, and her evolved acceptance of long-term therapy:

> I think I feel less guilty about anything and ashamed of anything I believe about this [long-term therapy] or any other topic as a matter of fact, now that I'm at this place in my career. Because I've been doing this work, since I was what, 25 years old or something. So that's a long time and I feel more liberated from the conventions and the "shoulds." And I've taught for so long and supervised for so long now that I really can see that there's no absolute right or wrong . . . so I don't give myself a hard time now.

"C" also commented on her role as a supervisor. She refers to a process that all participants spoke about: over time she has strengthened her resolve about the value of long-term therapy and has striven to "undo this training we've had that people shouldn't stay [long-term]." She supervises therapists in training who "worry about exploiting people after six months or a year . . . it's like not being able to own the value of what they're doing because they're so green." "C" recognized that all therapists have struggled with that at times; however, she added, "I just don't feel like I struggle with that so much anymore and it's been a long time." At another point, "C" referred to working with her consultant to confront "hiding" how she works: she said she will defend long-term work but she used to also feel "defensive about it. I didn't want people to know what my stance was but I don't feel that way anymore."

Four participants referred to the importance of their own therapy experiences in their lives and professional development. Here is how "C" spoke about the experience of long-term therapy enhancing her clinical work: "My own analysis was so transformative

that I feel like I can take people there, or I can help people get something of what I got, that you can't do in short-term work."

Consultation as the therapist's container.

The finding has to do with participants' value of good consultation when working long-term; both group and individual consultation provides a container for the therapists' process and development and enhances the ability to provide, in turn, a strong and flexible therapeutic container for the patient. In "E's" words: "I've learned that it's actually necessary for this kind of work to have somebody else you're connected with to talk about things." While almost all the participants made reference to their use of individual consultation at different times in their careers, the main finding in this section is that most participants discussed particularly satisfying experiences with long-standing consultation groups that, in most cases, provide safe, trusted and intimate settings for them to be open and vulnerable about their long-term clinical work.

A few participants described their experiences with individual consultation; two portrayed the consultations as helpful with their long-term work, and one said that he did not find it particularly helpful. "A" said that she has an ongoing relationship with a consultant whom she finds very helpful with her long-term patients and with her work in general. "C" spoke about how she has developed a preference for consultation that is from a Jungian psychoanalytic perspective: "I think it's because I feel there's a kind of openness, you know, it feels less rigid to me." "B" talked about an unsatisfying experience when he sought individual consultation about challenges of his long-term case. He said he was "reenergized" by the consultation but that it did not help him significantly with how to think about his patient who "remains a bit of a puzzle."

However, "B" sought and found some psychoanalytic reading that was more meaningful in his thinking about the patient.

Regarding group consultation, five participants talked about their long-standing consultation groups as safe places to discuss their most sensitive clinical topics. In consideration of controversy in the field about long-term therapy, I asked participants if there are situations in consultation or presentations when they or others might choose not to talk about long-term work. Two participants described some exceptions to feelings of safety in clinical consultation groups. "C" said she would not talk about her depth of connection with long-term cases in one of the groups she is in because she would feel too vulnerable with one or more members. She feels this has to do with personalities of therapists: "I think there's at least one person in that group with whom I would get into an argument." Similarly "F" implies minor group discomfort with the long-term topic:

> Maybe there's always a little edge, but in the two groups that I have right now, or three that are either consultation groups or study groups, where we do present cases, they have been so long-standing and we know each other so well and I feel so well held in them that I really don't hesitate.

Other references to participants' use of consultation groups to discuss their long-term work were extremely positive. "G" talked about the value of his peer consultation group that has been together for almost 20 years. I asked him how it would be for him or other group members to present very long-term cases:

> I think it would be very fine—very easy. I don't think we've talked about it as a topic, per se, but we've definitely presented cases to each other. Actually, both of the patients I was describing to you I've discussed in a consultation group at some

> length over the years. At the point where my patient was dying of cancer and I was considering going to visit her, we did, we talked about it. It was always very helpful. Theoretically it's helpful but I think even more in terms of maintaining your own balance and sanity, I think to have some kind of group where you can, you know, share your mistakes, and not feel like, everybody's going to judge you harshly or disrespect you in some way, but just to kind of feel like you can really be more vulnerable professionally.

Likewise, "E" talked about being in a long-term study group where they bring in different senior analysts to provide consultation on cases that group members present:

> Two long-term cases I've been referring to that aren't terminating are ones I've presented a number of times because of this wondering about a stuck quality. . . . So that's been a really important venue to get help and get reality checks for that. Colleagues in the group, I would say it's a similar kind of thing . . . it's usually the ones that I'm struggling with that I'll present—a patient that I need their help with. At times it's been these long-term [cases].

At another point, "E" referred to his learning from presentations when therapists have talked about patients they have been seeing for a long time where it has "normalized" and provided a "kind of modeling that this is part of what we deal with here." He said this has helped him to talk with patients "about the enormity of what they have to do and put it into context," because being in therapy for 15 years or longer "can be filled with humiliation" and pain for patients.

"C" is in two clinical consultation groups and one group for clinical supervisors. In one of the groups she presented a long-term case that has stopped and started three times:

> I just wanted to talk about it and they were so respectful of what we were doing and it was such a gift to me that I didn't have to defend it and that they really got that we were on this journey together, and it's a journey that has taken a long, long time. . . . The point is that it was a really unique experience for me to have all these people get how profound this is and didn't pathologize in any way.

Similarly, "D" is in two consultation groups that she feels "fortunate" to have. She described her group experience as consisting of a "particular intentional community . . . I consult with and who I talk with and who my colleagues are," where working long-term feels "ego-syntonic." She said therapists need "to talk about our work and make sure that we're not off the mark." "D" especially emphasized getting consultation to talk about "our work" so "we're not in some kind of solipsistic, really isolated bubble—just you and the patient, for a long period of time."

The Role of Termination

Examining participants' thoughts about the concept of termination and its clinical use were central to the research question; long-term therapy might imply opposition to the idea of ending therapy, and vice versa, so I was interested to hear participants' points of view about the role of termination in the context of the study. Participants had multiple perspectives about the importance of termination and its functions in relation to long-term therapy. They all said or implied that termination is inevitable and a component in every therapy, long or short; what they did not agree on was the importance that termination

plays in the course of their long-term cases. Some thought termination is an important aspect of long-term therapy, one thought it is not important, and some did not state an opinion about its importance to long-term therapy. Not only did participants differ from one another about the use of termination, but individual participants also expressed different points of view about the importance of termination with different patients in their practices.

Participants reported few formal complete terminations. They noted that long-term patients who have terminated often keep in touch through cards and calls, occasional sessions or regular therapy sessions. Participants implied that talking with patients about the meaning of ending therapy, whether a patient actually terminates at that time or not, matters as much as the actual ending. I did not explore if this also occurs with their short-term patients, but participants did say that long-term therapy relationships are especially close, intense, and hard to end for both patient and therapist.

In this section, I will examine a number of topics that participants addressed about termination. First I will examine what they learned about termination during their careers. Then I will address how complicated termination is in long-term therapy, the timing of termination and, finally, ways that participants consider long-term patients' readiness for termination.

Learning about termination.

Participants reported that they learned most about termination on the job with their long-term therapy relationships. When I asked them what formal learning they have had about termination, most said that, other than some reading in graduate school, there has not been very much. Two participants spoke about termination involving theoretical

constructs that serve as points of reference when thinking about their work. Most of the others did not elaborate using theory as a reference point for termination.

"D" and "F" talked most about using theoretical concepts of termination in their work. "D" said she has had a particular interest in termination throughout her career. She read about it and wrote a paper on it in graduate school and regards it as an important phase in many treatments. "F" said that, as a clinical supervisor, she has taught termination classes. In recent years, she took a workshop on aging and life-issues where they talked about "the importance of termination really helping us work through issues around our mortality and endings," and it has helped her think about certain cases. "C" said that it is not her style to read much about theory in general. She implied that she learns mostly through clinical experience and does not give a lot of credence to termination as a phase of treatment. She does not recall if she ever took a class on termination but does remember reading "things on stages of termination." When she was concerned about the length of her own analysis, she read an paper on termination by a Jungian analyst, which helped her relax about termination in general.

Ending is complicated.

Most of the participants have at least one long-term patient who has terminated and they all spoke about termination as complicated because of the many varied situations, the people involved and years spent in the therapy relationship. Participants described some terminations as being like a hard won rite of passage, and related that some patients stay in long-term therapy by choice, even though they have already reached certain therapeutic goals.

Participants spoke about times a patient wants to leave before the therapist thinks the patient is ready and other times when a therapist might think a patient is ready to leave but the patient does not. How this is viewed and handled by different participants depends upon their styles and the process of the therapeutic dyad. They all described talking with their patients about what is going on in the therapy that relates to leaving or staying. "A" described a situation with a patient who had to work through anger that he could not be friends with her after termination; it helped him to know that he can return to see her as his therapist if he wants.

Within their discussions regarding termination and its complications, the issues of its import and its initiation arose.

How important is termination?

Some participants spoke about termination as an important stage in the therapy process although one maintained it is not that important. "A" said she feels it is important for people to terminate when they are ready. She noted that she had been in therapy with someone who retired before she could go through a termination phase. As though she missed a personal rite of passage, she said she "envied at times people's ability to terminate with their own therapists." "D" expressed the strongest view about the importance of termination as a therapeutic construct: it is "what has to happen if there's going to be movement and growth." She summarized how she sees growth occurring in the termination phase of long-term patients:

> I think when you work long-term with people you have really deep and intense relationships. I've terminated with people who I did spend a long time with and it felt like the termination was reflective but [because of] the intensity of the

> relationship, we took a long time terminating. There was a lot of acknowledging what had changed and how the treatment had been helpful, what their fears might be to not have this thing in their lives. But it felt like a very collaborative, connected, related ending.

Similarly, "E" described a significant experience during a termination phase. A long-term patient wanted to terminate before "E" thought he was ready so they began discussing it:

> A few months ago, [the patient] started questioning what he was doing here, what there was left to really do, how life did feel, all things considered? That's when we started looking at maybe you've done what you wanted to do here, at least for now, and then it led to very rich ways of really incorporating more deeply what he's done, from whence he came, what our relationship has been like, in ways that he wasn't able to really think about [before] very directly or very often. . . . It actually moved us to this thinking about ending and all these feelings back and forth coming up about that—the dread—all those things.

"C's" perspective was that termination is not that important. As mentioned earlier, all the participants support patients remaining in therapy as long as needed, and four stated or implied that patients can stay as long as they choose. "C" had the most to say about patients choosing to stay: "It's like you wouldn't say to somebody you shouldn't go to acupuncture if acupuncture helps your back or whatever." She stated that she has grown to feel that the role of termination is "manufactured" and generally not that important. She said "mainstream people—generally mainstream analysts—believe that by 15 years people should have terminated" and she does not follow those "rules" any longer. At one point she questioned my asking her "what makes people able to leave." She felt it was a

judgment implying pathology. Her point was that people have the right to stay as long as they choose without being pathologized for staying:

> I think we pathologize people way too much in general. . . . There's something about these rules—that we have to diagnose, and then we have to pathologize, and then we have to figure out a treatment plan, and then we have to end. It's more and more foreign to me as I get older.

"G" also spoke in support of patients staying as long as they choose:

> For all of us, there are always more things we can work on. You know, you can say well, somebody doesn't have any symptoms. Well, okay that's nice. But you could have less constriction in your life, you can think of yourself in a more complete way, you can have deeper, richer relationships with people. So, you know, there's a lot of other goals that are worthy.

In terms of talking to patients about staying or leaving, "G" said at another point that if therapy feels "very, very stuck and like it could go on forever," he would not necessarily "kick somebody out of treatment" but he would talk much more about what is going on in the therapy.

Who initiates termination?

Regarding who initiates the topic of termination in the course of a therapy treatment, all said in general that patients should be the ones to bring up the idea, with two exceptions: "D" and "F" said they will initiate the idea of termination with patients who would benefit from a good ending in their lives but are forestalling leaving. What can forestall moving toward termination are the patient's fears of being abandoned or abandoning the therapist and losing the valued relationship, a desire to become friends

with the therapist, or to have a different kind of therapy relationship where they discuss things like books and movies. None of the participants said they believe in having friendships with patients after termination, although they also said that most patients who have left remain in touch or return for sessions at a future time.

"D" emphasized her particular awareness of clinical situations when people are "avoiding termination." She gave a clinical example when a patient of 15 years "manufactured" a crisis because she was having a hard time leaving, "like it might be hard to leave home for a college student." "D" initiated the idea of termination with her and they "had to make a few runs at it until we actually got to the point where she could really accept it."

> We really had to look at why the manufactured crisis, what was the fantasy about being friends? And if we couldn't, was this the way that she could have regular contact with me? What does it mean for her to hold that she really is ready and own that and honor the work that she'd done? I think there are some people around termination—and I can say this whether it's long or short but I think you can feel more in long-term just because you have a deeper relationship over time with people—that there's something about, if I'm leaving, am I abandoning the therapist? The relationship becomes so intense for some people that there's a feeling that maybe I shouldn't leave, maybe I need to be here, and you can keep helping me. But I think it's really some worry about who's abandoning whom? That comes up.

I asked "D" to consider what would have happened if the patient had still not wanted to leave after that time:

> Well, I think we would have continued looking at that because that was a really important part of the work. You know, having somebody staying just because they don't want to leave doesn't feel to me like them having to stay without interpreting it or trying to understand it. Then I would have felt like it was almost taking her money under false pretenses—paying for her to like coming to see me, or something, or being in our relationship without really having it be therapy.

"D" said that her patient stays in touch with her by occasionally sending a card. She does not feel that there is "something that was not analyzed" and her patient really was ready to leave, but "it's just her way of wanting to just drop in for a bit." "F" talked about how much initiation of the idea of termination varies—many times it's mutual, sometimes the patient brings it up when they have the feeling they might be finished, "at least for now," and sometimes the therapist gets a "clue" that they might be approaching the end and brings it up. Similar to "D's" case, "F" talked about a patient she felt especially needed to experience a good ending in her life because of early traumatic losses. "F" brought up terminating, but the patient was having a hard time letting go and talked about her fantasies of wanting to discuss books and movies with "F." Here is how "F" described an ambivalent termination process, followed by a renewed connection:

> The point was that we were pretending, or we were in denial, and I was colluding with her in that denial of our own mortality. Some day I'm either going to be retired or she's going to move away or one of us is going to get sick, one of us could die, and then it's going to be a repetition of this very traumatic history. And if I didn't say to her, look, I think we need to acknowledge that we will have an

ending and that if we avoided a termination process we weren't helping her and that I wasn't being the best therapist I could be for her.

"F" said that they talked about it for months and the patient eventually did leave, and then returned. "F" felt that the patient still needed her as a "touchstone" and, with the trauma in her early life, not allowing her to touch base would have been way too wounding:

Within a year, probably, she called me wanting to come back in with something she needed to talk about. . . . She's still coming in every month or six weeks. So we haven't really ended. I mean we did and we didn't, kinda, you know?

"C" demonstrated her different approach to termination in a situation where her own agenda was not the same as a long-term patient's. The patient was moving and it was going to be further for him to travel to see her. "C" felt he would be "fine" if he stopped therapy so she brought up termination, but he wanted to continue:

C: He just assumes, I mean, I don't know whether he ever thinks about my leaving, my retiring. That actually doesn't come up.

J: So, does the fact that he's staying come up as a conversation or do you . . .

C: I've brought it up but the truth of the matter is it's my agenda, not his. It's not an issue for him.

Timing is everything.

"Bottom line, [patients are] the best judge of when they are ready to go or when they want to stay" (Participant G). This comment suggests a perspective that, in the end, it is the patient who drives the timing of terminating or remaining in therapy, more than the therapist. At another point, providing insight into patients' involvement in the timing of termination, "G" spoke about discussing with his consultation group how long their

own therapy experiences have lasted or will last: "at what point do you end your own therapy?"

"C" talks about the timing of two cases, wherein she considers whether her style of not moving toward termination is an exploitation of patients. She assures herself that she is able to support the termination of a patient when the timing seems right. She talked about a patient who is terminating after 11 years and it feels very clear that it is the right time. She has another patient who after 11 years wants to leave but "C" feels that it's not the right time and more work needs to be done. Relevant to working long-term, here is what "C" said about her experience of knowing when it is time to end:

> When this woman said to me, it's time for me to go, I was so aware that I was so able to let her go, and I felt it was time for her to go. For her sake, not for me. I didn't want her to go. She knows I don't want her to go and I got teary and she got teary. . . . I was also in the middle of somebody else who I've been seeing about that time who keeps telling me she wants to leave and I know it's not time for her to leave. But there was this part of me that was worrying, am I just trying to keep her when really she does need to go? So the experience I had with this other woman was really validating for me. That when we do it well, and when it's right, I don't want to try to keep people who don't want to be here or who shouldn't be here. It was very validating of my own psyche and that I'm not exploiting people.

At another point, "C" mentioned a friend whose analysis ended when her analyst had an untimely death.

> When she was having some stumbles I said to her, have you thought about going back into therapy and she said, well, I did analysis for eight years and . . . I was just about done anyhow. Well, I know she wasn't just about done . . . but, you know, the eight years, that's an important number. I did it for eight years, as if eight years means you were getting ready to end.

Continuing to consider the timing of ending long-term treatment, "B" spoke about his patient giving cues that it might be time to talk about termination but, when he does try to talk about it, his patient backs off:

> One of the ways that I brought it up is in the situation where she was saying that maybe she wanted to take a break. And so I might raise the question, why a break? Is this a way that you're somehow trying to communicate to me that you'd like to stop but are having a hard time with that? . . . There are other times where she would bring it up . . . we've talked a bit about, again, a bit, about the possibility of terminating. But I have to say that those discussions have been short-lived. They've not really produced much clarity so it's been difficult to really assess, um, whether or not she feels, whether or not there's been a part of her that's wanted to leave and couldn't for various reasons.

Readiness for termination.

As a way of hearing more about participants' thoughts on ending long-term therapy, I asked them to consider questions related to how they might determine if patients are ready for termination. In this section, I will examine what they said about how people change and about criteria for termination and will limit my presentation to participants' views that relate to long-term patients.

Change.

Some participants spoke about change that occurs in more functional aspects of the patient's life, such as "D" who described patients being able to recognize that things are different and "they have the tools and feel equipped to get a better handle with things." Looking at long-term patients, "D" argues that they do not have to remain in therapy to accomplish all they want to change:

> It's not that you stay in until you feel everything is absolutely resolved. Then people would be in therapy until they die because there is always something else to deal with. But if you feel a better internal sense, a sense of choices, a sense of knowing oneself pretty well.

"B" and "G" spoke about change in terms of emotional experiences their long-term patients have with them "that translate into something outside of therapy" (Participant G). "B" said a patient's emotional contact with the therapist leads to the patient developing the capacity to value herself, adding that it takes longer when people did not get this emotional contact earlier in life.

Criteria.

I asked the participants what they think about the criteria for termination that are often referred to in the literature: resolution of the transference, mourning the loss of the therapist, and development of self-analysis.

"E" provides a good summary of a long-term patient having reached a point when the criteria are more resolved. He implies all three criteria in his description:

> It was a new experience to imagine not having me, which was powerful in that he got to miss me and at the same time got to experience what he had with me. This

> was a great opportunity to, you know, you don't know what you have until you don't have it but you still have it cause you're talking about not having it. It's this being able to do it in the moment, which then, again, consolidated what we shared together and what I've been to him and what we've had together that actually had a very profound effect on both of us. It just felt like it helped. You could just see his internal abilities consolidate that much more in this kind of thinking and discussion. It was really very powerful. It's a rare termination process to have this. It was very moving to me to have this with him and help facilitate that. . . . The process itself was really heartfelt.

"F" considers that criteria for termination might occur in a long-term therapy but does not always lead to ending:

> That's how you, I guess you know that the potential for ending or termination is right there. Because all these things have sort of been worked through. Just these three [themes], exactly that you're mentioning, and then some of these people, they still want to come. So what do you do with that? It can be confusing. Like it's never quite clear to me, well, what are we working on? What is this therapy?

Mourning the loss of the therapy and relationship is the traditional criterion for termination about which most participants were particularly thoughtful. They spoke about how loss is felt by the patient when long-term therapy comes to an end. Here is how "G" spoke about this:

> I think that not all but the vast majority of the work we do is helping people with mourning that's gone awry in one fashion or another. . . . I really spend a lot of energy on that; especially with a patient I've seen for quite a while to have as long

> a termination period as I feel we're going to need because I think it's really important to address that. . . . You know, but it's a weird kind of mourning because there is this idea that they can come back. So, you know, they might decide to do that [come back] so it's not like I'm dead to them. But the relationship really is coming to a close.

He also said about grieving when therapy ends: "I think not having that phase is kind of a missed opportunity in some ways."

"C" was the one participant who did not agree with the others that termination provides a valuable experience for patients toward dealing with loss. She said life is so full of grief and loss, "why add one more when you don't have to?" She argues that mourning the loss of the therapist it not an important component of therapy:

> To me that whole notion of how long should it be before you start a termination phase, or what does it mean if you're not terminating, what's not happening that should happen, or people need to learn to deal with the loss of the analyst, I think it's all bullshit. I really do. I mean, not that there aren't people who need that, absolutely, but most people have dealt with a lot of loss. If they don't want to leave the therapy, you know, ultimately one of the people is going to die or the therapist is going to retire, or something is going to happen where they're both going to have to deal with the loss. But it feels manufactured to me that people have to terminate. You have to learn how it is to be independent or on your own? You know, most people have some experiences being on their own and feeling independent, and still have these supports in their lives.

At another point, "C" gave the example of not needing to experience loss and grief when she ended her own analysis:

> I felt like this person is in me and this person is there for me and I don't have to feel grief and loss. I lost my mother, I lost my father, I lost my best friend. I could tell you all the people I've lost in my life. . . . This is not a relationship I've lost. It's a relationship I decided I wasn't going to maintain . . . I know she's there. I know I'm going to see her. I didn't lose.

A number of participants spoke about the loss of the relationship from the therapist's point of view; what the loss feels like for them when a long-term patient terminates. "D" said: "I think that's the hard thing about people leaving, that we miss them, that we don't get to be in their lives anymore. "A" talked about her experience of mourning after long-term therapy ends: "I just had somebody terminate last Thursday who I had worked with 19 years so that's still kind of bonging in me like a gong, still kind of reverberating." About his experience, "E" said: "If I didn't have a sharp feeling about this particular patient leaving after 17 years, I wouldn't feel good at all."

In terms of patients developing a self-analytic function as a criterion for termination, "E" summarizes what most participants said long-term patients take with them when they leave. Speaking about a long-term patient who is terminating, he said:

> I see it as partly being able to take with him the function, or the role, I've had for him in being able to kind of work through his own thinking, his own feelings, on his own; taking with him what we've been doing, that kind of self-analytic function. There's also another aspect of being able to do, in a way, with others what he has been doing with me. So taking that relational component on the road.

At another point, "E" made reference to his patient being able to leave in part because he has gained the capacity to be "dependent and to carry with him our work." "D" talked about what a long-term patient was taking away with her at termination:

> We talked a lot about the ways that she really did have me with her. She would say, you know, I think about what you would say about this, or I can hear your voice saying . . . and that she didn't need my physical presence; that it was kind of time to be launched. . . . She could be launched and still hold onto me.

"C" again presented the one differing perspective. She said about termination and self-analysis:

> The self-analytic function—first of all, yeah, I mean we want people to develop that but why do they have to develop that and then leave? What's the connection between—I mean it's almost like a punishment, you know, you've resolved this and this and this, therefore you go. . . . Your reward is that you don't get to have me anymore.

Participants' Thoughts About the Profession

The final section of the findings chapter describes participants' thoughts about long-term therapy as perceived within the larger profession and the general culture. They spoke about long-term therapy as not well understood in the culture and referred to biases against dependency. They also spoke about divisions in the profession between those who support and practice long-term work and those who oppose it, expressing a need for more awareness and communication in the profession about the practice of long-term therapy.

Here, I examine what participants said about perceptions of long-term therapy, effects of managed care on the practice of psychotherapy, and educating others in the profession about long-term work, including participants' ideas for possible further research on the topic.

How long-term therapy is perceived.

Participants spoke about ways in which long-term therapy is not well perceived in the culture at large and sometimes in the profession. "D" captured a cultural sentiment with an example of how people who are "outside of an informed community" have asked her about her work:

> Sometimes I get it from people who aren't therapists, they'll say, you know I've heard that Woody Allen was in therapy—Woody Allen is a big thing about this, you know. Woody Allen is still in therapy. And I'll say, well, you know, I see people for long-term. And they'll say, like 10 years? And I'll say sometimes twice that long. And there's, like, that person must be really sick or maybe you're not such a good therapist. . . . Woody Allen is seen as neurotic and screwed up, living with his wife's daughter and if that's what long-term therapy gets you, that's not very good.

"E" commented on cultural bias against dependency: "they see dependency as a bad thing," and overvalue independence. He commented that he thinks some in our profession are challenging this trend, particularly female and gay therapists.

"G" said about the profession that he has not come across cautions against long-term therapy in the psychoanalytic community. He did hospital work early in his career,

however, where the emphasis was on cognitive behavioral theory. Here is what he said about CBT:

> I actually think they have a lot of good ideas but they're so a-relational and they're so, sort of, tuned out to that part of treatment. . . . I felt like they're completely inattentive to transference, to the relationship between the therapist and the patient. And their feeling that they could just get in there and very quickly do things and get out, I just thought it was—it made no sense to me.

At another point "G" said that therapy is often looked at through the lens of the medical model. He argued that it is not the same as a relationship with a doctor who gives you advice and tells you what to do. "It's a different kind of animal."

Insurance and managed care.

Participants did not mention managed care when talking about their long-term cases and no one spoke directly about currently being on insurance panels though there were a few references to insurance when some considered the larger profession. Not surprisingly, they did not have anything good to say about effects that insurance companies and managed care have had on the profession and the ability for therapists to treat patients in a long-term therapy model. Some frustration was voiced about insurance companies and managed care. "E" lamented that though there has been some "normalizing" in his own work about certain patients needing long-term work, "try to convince the insurance companies of that." And "D" commented on a patient who was not able to work on early trauma until she was 13 years into therapy: "I see this in my long-term patients and it speaks to me as evidence-based, although you can't get an insurance company to pay for it." Here is how "A" talked about it:

> How I see psychoanalysis and long-term work is the way I see Barak Obama and the Republicans. It's like when managed care came along we just folded. . . . I wish we could really tell the truth about what psychotherapy is but managed care companies have essentially usurped the system and turned [therapy] into a product, and that's a lie.

She argued that she thinks we should fight managed care by not going on insurance panels.

Desire for change and suggestions for research.

When I asked participants where they think we need to go in the profession in terms of long-term therapy, they called for more openness, education, appreciation, and integration of different ways of working as well as further research of therapists' and patients' experiences of long-term therapy.

"C" said "first we need to not pathologize people who are in therapy for a long time, or therapists who do long-term therapy." She also said there needs to be more openness about different ways that people think and work and "a real curiosity about what other people are doing rather than a judgment." About divisions between Jungian and other psychoanalytic institutes, she said:

> There's so much elitism, there's so much rigidity. You know, it's interesting to think about it in this way. I've always thought that I wish that I could combine an institute like [local psychoanalytic institute] with an institute like the Jung Institute because they're each really missing something and together they could do something really great.

"E" noted: "We need to be educating people—insurance companies and the general public about analytic therapy and how it works." And "F" said about long-term therapy:

> I think it would be wonderful to have more written and talked about it. And some ways of beginning to look at, not whether or it's bad or good, but the meaning of it, how to work with it, maybe our own counter-transference stuff about it. So yeah, to be more out there.

Regarding ideas that some participants had about future research, "F" reiterated that it would have been interesting to do second interviews in this study and talk more about the therapists' countertransference with long-term work. "B" also suggested an additional component of the current study. He thought that it would be interesting if I could interview the participants' long-term patients as part of the study. "G" thinks research in the area of long-term therapy would be helpful to respond to the drive for efficiency and the message of the medical model that quick treatment is better. He recalled looking at outcome studies when he was doing his dissertation—"there were a lot of outcomes that were very simple and short and brief" that did not capture whether someone actually improved or not:

> To say that somebody got over their depression, therefore the treatment was a complete success and they did it in seven sessions kind of misses the point, I think, of what we're trying to do—and so I think to look at outcomes in a more subtle way and also to kind of make a case for the fact that there is evidence that what we do works . . . and I think to change the way that people think about [long-term therapy] would be helpful. Yeah.

This concludes the findings chapter. I will give a brief summary of findings at the beginning of the next chapter.

CHAPTER FIVE - DISCUSSION

This study grew out of an interest I have in long-term psychotherapy because of my own and other therapists' clinical experience. My purpose was to explore therapists' experience of a clinical phenomenon that occurs in psychotherapy practices but has received little examination in the profession and in the literature: how psychoanalytically oriented psychotherapists think about and work with therapy cases that have lasted 15 years or longer. Although there is not a definitive length of time that indicates "long-term," I chose 15 years because it stands in such contrast to therapists' experience of treatments that last six or even ten years. These long-term therapies have conceptually entered a kind of no man's land that does not have good roadmaps, although they are part of the clinical life of many therapists.

Several research questions were proposed: How do psychoanalytically oriented psychotherapists conceive of their work with long-term cases? Do therapists think about long-term cases in relation to the concept of termination, and how do they understand those thoughts? What theoretical concepts guide therapists about the nature of the therapy relationship and the course of treatment as they work with long-term cases?

The answer to the first part of the research question—How do psychoanalytically oriented psychotherapists conceive of their work with long-term cases?—depends very much on the context of the work with the patient and, to a lesser extent on the participant's theoretical orientation. Interestingly, participants' conceptualization of long-term therapy emerged through talking about work with patients, demonstrating that the topic draws more upon therapists' clinical experience than preconceived theoretical concepts. The answer to the second part of the question—Do therapists think about long-

term cases in relation to the concept of termination and how do they understand those thoughts?—surprised me in that the long-term therapists in the study think about termination quite a bit, whereas literature and commonly held beliefs I had encountered prior to the study seemed to regard long-term therapy and termination as mutually exclusive. The third part of the research question—What theoretical concepts guide therapists about the nature of the therapy relationship and the course of treatment as they work with long-term cases?—revealed the most variations among participants and was most relevant when participants talked about termination. Different psychoanalytic orientations among some participants led to different ideas about termination. Most participants, however, did not refer to theoretical concepts when talking about termination, but demonstrated they were guided mainly by the patient's process.

I will first present a discussion of the findings followed by an examination of the relevance of findings in relation to the literature reviewed in Chapter Two; finally, I will discuss limitations of the study and suggestions for further research.

Discussion of Findings

Findings from the study provide a unique window into what goes on in the labyrinth of long-term therapy and contribute to a dialogue and understanding of long-term clinical work. The findings also imply a conceptual roadmap for long-term therapy. I will discuss the findings within the four main categories presented in Chapter Four: working long-term, characteristics of long-term therapy patients and therapists, the role of termination, and participant's thoughts about the profession. I will then discuss the implications of long-term therapy as a developmental process.

Working Long-Term

Describing their work with patients, participants spoke about the transformative value of long-term therapy work for patients as well as mutual benefits that they and their patients experience. They described a depth of feeling and experience inherent in the long-term therapeutic container that tends to be greater than within shorter-term treatments. Patients in a long-term therapy relationships experience caring, intimacy, love, and stability over years of therapy covering several milestones in their lives—for some patients, the therapy relationship is the best they have ever had. Therapists, as well, feel personally connected to their long-term patients and benefit from the shared sense of intimacy and being well known by another, including the increased stability of having filled clinical hours.

The time element that stands in such contrast to shorter-term treatments was seen as relevant to each long-term patient's individual needs, and participants emphasized that no matter how long a treatment lasts, they pay careful attention to what is happening in the therapy process. They described different kinds of processes with patients: from those who are doing well, where the relationship might feel like a "priest" or "rabbi," to patients who are in more difficult situations and the therapy might feel like "emotional dialysis." There is often an uneven pace of long-term therapy; some patients take a long time before they are able to work on underlying problems, or they reach long plateaus, when nothing seems to be happening, but that are needed to integrate the therapy.

Long-term therapy is accompanied by therapists' own questions and concerns about the length of treatment time, and self-scrutiny is a way that participants monitor themselves in their long-term work. Their uncertainties derive from overlapping external

pressures and internal doubts. Externally, there are negative opinions in the literature and profession regarding long-term treatment, and a bias against dependency in the culture at large. Though participants do not agree with these pejorative views, they are affected by them. Internally driven questions—to some extent a response to external pressures—are more complex; these concerns focused on shame about therapy lasting so long. Participants also expressed worries that their countertransference—related to a personal attachment to patients' and their own narcissistic needs—might contribute to the length of some treatments. Surprisingly, all described moments of questioning themselves whether another "better" therapist might be able to move a patient through therapy more quickly.

One way participants tolerate their own uncertainties and reassure themselves is by recognizing that they experience doubt about their work with all patients—unknowns are a fundamental condition of all psychotherapy. Another way is by evaluating their work with long-term patients through clinical evidence rather than by a theoretical standard—they see that the treatment "works" when long-term patients change over the years and live more fulfilled lives. Participants also find it helpful to recognize that they are not "exploiting" patients because they *can* let patients go when they want to leave therapy.

Another important way therapists contain their emotional states and self-doubt is through consultation, particularly long-standing consultation groups that provide settings where they can discuss vulnerable aspects of their long-term clinical work. Participants spoke of these consultation groups as providing a container that parallels the therapeutic container they provide their vulnerable patients. I found it interesting, in this vein, that

one participant who did not refer to being in a consultation group expressed numerous uncertainties about a long-term case in a manner that suggested a personal style of learning through questioning and self-scrutiny. In retrospect, I wonder if it revealed the desire for more of a consulting container where long-term work can be supported and "normalized," diminishing the isolation and self-doubt of working alone with patients over many years.

On a personal note, one of the numerous ways in which I have gained from conducting this study is through the enrichment of my own long-term clinical practice. As I have been examining interviews and participants' experiences, my involvement with this group of therapist-participants has acted internally as consultation for my own work with my long-term patients. I am grateful for this and view it as a reflection of the value of the container provided by the consultation group and the importance of communication between therapists about our long-term work.

Characteristics of Long-Term Patients and Therapists

Participants described most long-term patients as having extremely painful childhoods with trauma, neglect, and relationship deficits. I asked participants to compare long-term patients, and long- to short-term patients in their practices; not surprisingly, they implied in their responses that the therapeutic relationship itself was the more distinguishing element, rather than characteristics of patients. Participants said or implied they do not usually compare characteristics of long- and short-term patients because it is unpredictable how any therapy treatment will unfold: some patients can enter therapy with a particular focus and stay a shorter time and, in these cases, participants may or may not feel that a patient stayed long enough. Regarding their long-term patients, some

participants commented that they find working with "higher functioning," insight-oriented patients to be more personally satisfying than those who need more supportive therapy, though they also expressed feeling deep commitment to all their long-term patients.

Participants helped me understand the characteristics of long-term therapists by describing their own development as therapists. Their individual paths to becoming clinicians who are comfortable with dependency and can sustain interest and immersion in a therapy relationship for a long time can be seen in their personalities and life experiences, professional learning, personal growth through their own therapies, and especially in their years of clinical experience; some said or implied that they "love" the work. Their clinical work has led to a deeper appreciation of patients' individual needs, strong resolves about the value of long-term therapy, liberation from old "rules" about treatment, and acceptance of themselves as long-term clinicians.

Disparities Between Long-Term Therapy and Termination

I wondered when I began the study whether therapists who conduct long-term therapy avoid thinking about therapy ending, but I found that participants are knowledgeable about termination and most probably are on a par with other therapist in that they have read about termination and some supervise therapists in training, including teaching about termination. When termination enters the therapeutic field with their long-term patients, they think about it, consider it, and talk with their patients about it. In this regard their approach to termination is not very different than with therapy that fits into to a more traditional time frame. What differs is that these therapists are sensitive to allowing patients to evolve according to their individual psychic needs and do not hold to

an expectation of termination unless and until the patient is ready. When therapists and patients talk about termination, therapy tends to deepen, following which some long-term patients remain in therapy and others take as long as needed to work through the experience of ending, during which they further integrate and consolidate the therapeutic experience. Many who terminate stay in varying degrees of contact with the therapist, they know that, in most cases, they can return if they choose, and some do return for further therapy. The findings imply that, more than valuing endings, participants value talking with long-term patients about feelings that arise and meanings they attach to endings.

Although all participants generally emphasized the patients' needs in the timing of termination, as well as returning if they choose, ending was the topic that demonstrated the most variation among participants—theoretically and clinically. They did not all agree about the value of termination as a component of long-term therapy. From one perspective, represented by participants who referred to psychoanalytic concepts, termination was seen as a hard-won rite of passage, with the long-term patient and therapist working through fears for as long as needed, incorporating the growth the patient has achieved during the therapy, thus bringing treatment to an end. From another perspective that included a Jungian point of view, termination was seen as a "manufactured" construct of mainstream analysis that is not important for patients to experience. Most of the participants, however, viewed termination from experiential, not theoretical, perspectives.

Participants' Thoughts About the Profession

Participants noted pejorative perceptions of long-term therapy and biases against dependency in the profession and culture at large; one remarked that Woody Allen represents long-term therapy for much of the public, i.e., that therapy is interminable and of limited value. A participant referred to the preference in the larger profession for cognitive behavioral therapy, which he described as working quickly so you can "do things and get out" and as being completely inattentive to the transference. Arguing against the current trend promoting cognitive behavioral therapy, participants said they have clinical evidence that long-term therapy works and wish for more openness towards long-term therapy in the profession, insurance companies, and the public, and suggest education as a way to achieve this end. They spoke of the need for further integration of different analytic ways of working, such as between Jungian and other psychoanalytic modalities, and increased curiosity—rather than rigidity and judgment—about how other therapists work.

Implications of a Developmental Model

My primary motivation in doing this study was to facilitate thinking and dialogue about long-term therapy in the hope of creating more understanding about this under-examined clinical experience. In addition to showing the benefits for patients who are able to mature in long, caring, intimate therapy relationships, the study also presents implications of a developmental roadmap that might be useful for therapists in thinking about the course of long-term therapy.

There is much about the study that suggests an implicit developmental model for therapists working with long-term patients and that corresponds with research into early

brain development. Development of self-organization and self-regulation in infant development depends upon early dyadic experiences of affect regulation between parent and infant (Schore, 1994). The findings show therapists providing predictability and stability, allowing patients to evolve according to their individual needs, "being with" patients, as per Winnicott (1996b), honoring patients' pacing, and not expecting them to terminate unless and until they are ready. Some participants noted emotional development as the most important change people make in therapy, with the caveat that it takes longer to achieve when someone did not have access to healthy emotional development early in life. Not surprisingly, there are parallels between psychic development that occurs during the course of long-term treatment and elements of actual child development—it takes 15 years and longer to raise a child, whether the child's development is going pretty smoothly, or is difficult and uneven. Participants referred to patients who remain in long-term therapy because of depth and richness of the relationship and dialogue, and enhancement of patients' lives; they also spoke extensively about some patients being immersed in processes that relate to problems with earlier developmental needs. The study showed that, in some cases, therapists can say things to patients for a long time, sometimes 12 or 14 years, before the patient can take hold and make use of the therapist's thoughts to move forward or deepen their exploration of early deficits. Patients can re-work development and repair dysfunctional early attachments in their own manner and pace that can easily last 15 years and longer.

Hans Loewald (1960) presents a developmental model that resonates with the process described in the study, wherein the essence of the work is "love and respect for the individual and individual development" (p. 20), and the analyst's focus is on the

redeveloping of early paths of development and the emerging core of the patient. Elaborating this model, he depicts a parent recognizing and fulfilling needs of the infant because, at first, infants are unable to recognize or fulfill their own needs:

> The parent-child relationship can serve as a model here. The parent ideally is in an empathic relationship of understanding the child's particular stage in development, yet ahead in his vision of the child's future and mediating this vision to the child in his dealing with him. This vision [is] informed by the parent's own experience and knowledge of growth and future. (p. 20)

Loewald also refers to "integrative experiences" in therapy when "experiences of interaction [are] comparable in their structure and significance to the early understanding between mother and child" (p. 25). This concurs with periods of time referenced in the study, when not much seems to be happening in long treatment and participants understand that patients are integrating therapeutic experience and consolidating growth before they began another period of activity—similar to times when a baby or child settles down and the "good-enough" parent, attuned to the developmental needs, settles down with the child. The study's implicit developmental model is further reinforced by a participant's reference to termination of a long-term patient feeling like a young adult leaving home to go to college—long-term patients who leave therapy often stay in touch or resume therapy again, similar to young adults returning home to continue valued relationships throughout their lives.

Relevance of the Findings to the Literature

Most of the literature contains arguments representing points of view that defend or disparage long-term analysis and psychotherapy. Arnold Goldberg and David Marcus

(1985), who focus on "natural" endings as opposed to "prescribed" terminations, point to Freud's Wolf Man case beginning the controversies. Freud maneuvered Wolf Man's analysis that threatened to be "interminable" by setting a termination date. The authors submit that this clinical tactic ushered in decades of deliberation over how and when to end treatment; termination, subsequently, became an aspect of analysis subject to rule making. My study shows that, despite arguments and controversies in the literature and profession, participants believe that long-term therapy has considerable therapeutic value for certain patients and is highly compatible with some therapists' clinical styles.

Little has been written that specifically addresses the topic of long-term therapy. There is a small group of psychoanalytic authors who have favored a patient's choice to remain in ongoing long-term therapy (Barish, 1991; Goldberg & Marcus, 1985; Leigner, 1986; Mendenhall, 2009; Poland, 1997; Rucker, 1993; E. Shane, 2009; Short, 2009; Tresan, 2007a, 2007b). I will first address length of therapy and then the issue of termination.

Length of Therapy

The literature describes long-term therapy as lasting anywhere from one year (Neale, 2008), to analysis lasting approximately six years (Doidge et al., 2002), which is more in keeping with commonly held assumptions about psychoanalytically oriented treatment. The findings contrary to the literature, however, show that participants do not believe six years—even 10 years—is enough time *for some patients* to accomplish their individual therapeutic potential. More in keeping with the study's findings, Robert Wallerstein (1986) reports in his longitudinal study that some cases lasted 25 to 30 years. He used the term "therapeutic lifers" to refer to these long-term patients and wrote that,

once they had become involved in analysis or psychotherapy, the psychotherapeutic dimension became an integral aspect of their lives and functioning for a far longer time span than he had anticipated. Warren Poland (1997) argues that the length depends on the "destination," which is based on the patients' needs, and therapists need to help patients make the most informed choices for themselves; this position is echoed by the participants in my study.

Authors endorsing long-term therapy describe characteristics of a type of therapist who works long-term that is in accord with findings in this study. Bergmann (2005) portrays these therapists as having patience and self-esteem that does not rely upon a timely "cure." Others describe the capacity for mature interdependence (Leigner, 1986; Rucker, 1993), comfort with uncertainty (Poland, 1997; E. Shane, 2009) and the ability to commit to and be energized by a long, mutually caring professional relationship (Tresan, 2007a). As study participants discussed their long-term work, they demonstrated capacities to provide a therapeutic container and sustain interest and immersion in a long-term therapy relationship for 15 years and longer. Some even spoke about developing a love for long-term work.

Related to the shift in the professional zeitgeist from a one-person to a two-person psychology and to their own clinical experiences, some authors speak of *growing* to endorse long-term therapy (Mendenhall, 2009; E. Shane, 2009). Estelle Shane compares her previous "one-person" formulations (M. Shane & Shane 1984) that termination was essential to successful analysis, to her current beliefs (E. Shane 2009) that therapy is a relationship of caring and a kind of love based on mutual respect and meaning that, in some cases, should not be terminated. As in the literature, some participants spoke about

changing from more traditional ways of conceptualizing therapy—and *learning* to value long-term work for their patients and themselves—primarily through clinical experience.

The literature depicted two types of patients in long-term therapy: those who are in therapy to work on difficult psychological and life problems, and those whose symptoms have subsided and are healthier but remain in ongoing therapy to enhance further maturation in a relationship that is unlike any other in their lives (Bergmann, 2005; Leigner, 1986; Rucker, 1993; Tresan, 2007a). These two types were also referred to by participants in my study—patients who are working on effects of having had extremely difficult childhoods and those who remain in ongoing therapy to enhance life and maturity in a valued long-term relationship. The study showed that participants did not assess their patients in regard to pathology. As discussed earlier in this chapter, when asked to, participants did not elaborate comparisons of their long-term patients to other patients, the implications being that the therapy relationship, not characteristics of patients, is the more significant factor toward increasing understanding about long-term therapy.

Literature that endorses long-term therapy provides a model of treatment that is attuned to lifetime developmental needs and the experiential contexts of patients lives, as well as each unique therapeutic relationship (Barish, 1991; Goldberg & Marcus, 1985; Leigner, 1986; Mendenhall, 2009; Poland, 1997; Rucker, 1993; E. Shane, 2009; Short, 2009; Tresan, 2007a, 2007b). Some authors highlight an open-ended, flexible process that promotes integration of *therapeutic goals* and *life goals* (Leigner, 1986; Rucker, 1993), unlike the separation of life and therapy goals that is prescribed by proponents of traditionally-lengthed therapy and termination (Ticho, 1972). Mendenhall (2009) writes

that patients in long-term therapy benefit from the deep connection and ongoing continuity that they have with a therapist who knows so much about the patient's life. Rucker (1993) discusses some patients' needs for an ongoing long-term therapy relationship that allows them to make significant changes in their lives and achieve a mature, mutually dependent relationship that enhances capacities for intimacy, healthy functioning, and reciprocity. This literature validates and agrees with my findings and the discussion earlier in this chapter, which present an open-ended, developmental model for working with long-term patients, where intimacy, i.e., being well known by another, and continuity over the events and milestones of life are seen to enrich therapeutic potential and enhance the lives of both patient and therapist.

Those authors who endorse long-term therapy (Barish, 1991; Goldberg & Marcus, 1985; Mendenhall, 2009; Poland, 1997; Rucker, 1993; E. Shane 2009; Short, 2009; Tresan, 2007b) highlight tensions between themselves and practitioners who favor traditional concepts of independence and autonomy. The long-term literature gives as much space to defending long-term therapy against denigration as it does to describing its strengths, in opposition to traditionally oriented authors who depict long-term therapists as exploitive of patients, treatment as stalemated, and patients as hanging on too long. Warren Poland (1997) writes that when practitioners express disdain and indignation at long treatment, for example depicting the long-term therapist as "stupid" or "a knave," they betray motives other than analytic thoughtfulness and curiosity and ought to question their own defensive moralism. In dueling journal articles, Jungian analysts Angela Dragosei (2007) and David Tresan (2007a) debate Dragosei's contention that long-term therapy is a futile, failed process that is frozen in indefinite waiting, against

Tresan's argument that it is a mode of therapy that has existed and been ignored for a long time by all analytic schools, with the long-term process being far from frozen—"these patients are the most supple I know" (Tresan, 2007b, p. 49). Barbara Short (2009) argues for more openness about the analytic process and focusing on the patient's developmental process rather than on a cure or achieving technical landmarks. She suggests that perhaps patients who remain in a sustained analysis can be seen as making valuable and legitimate use of the work and do not represent "shameful analytic secrets about which we neither write nor speak, or the dreaded 'interminable' analysand whom we talk about with derogation" (p. 21). In a similar vein, Samoan Barish (1991) asks therapists to consider whether they are masters or servants of their theories. The negative opinions about long-term therapy reported by these authors are relevant to the present findings in that they correspond with self-doubts expressed by participants who are aware of and have to grapple with these negative perspectives.

Termination

Traditional termination literature is historically critical of long-term therapy, therapists, and patients. Edward Glover (1955) studied analysts' "technical difficulties" and concluded that practitioners are reluctant to talk about long-term analysis because they struggle with concerns and "guilt" about length of certain treatments; he asserted that an analyst needs to know when a case has gone as far as it can in order to save self-questioning as well as the patient's time and money. A recent example of this critical position can be seen in Ronald Britton's (2010) work that is included in a collection of papers on relational perspectives on termination. Britton writes that he regards "interminability" as "a psychopathological feature of the personality and not simply a

prolongation of analysis" (p. 43). In a similar vein, Jack and Kelly Novick (2006) maintain that, although it is complicated to end a valued therapy relationship, termination is crucial to the psychoanalytic process. They contend that "interminable" therapy occurs when a patient refuses to enter a "pretermination phase" and is enmeshed in a "closed-system," static and sadomasochistic relationship with the therapist who has been "pulled into a relationship of enthrallment with the patient in an impossible search for perfection" (p. 11). These examples represent a long history of mainstream literature that has institutionalized termination as the necessary outcome of successful treatments and pathologized long-term treatments. As discussed above, this pathologizing of long-term therapy patients and therapists is relevant to the findings in that it that has contributed greatly to the hidden and shameful aspects of working long-term.

Three criteria for termination have commonly been used and examined through the history of termination literature (J. Novick, 1982) with the expressed conviction that these are essential to a successful termination: resolution of the transference, mourning the loss of the analyst and analysis, and development of the self-analytic function. The therapists in my study do not agree with the conviction that these, or any prescribed criteria, justify a termination phase. The findings do agree with literature that argues it is a mistake to generalize therapeutic treatment by establishing normative criteria (E. Shane, 2009), and that resolution of the patient's transference neurosis and development of the patient's self-analytic function are unreliable criteria for termination because these elements vary so much with individual patients and life situations (Tessman, 2003). My findings concur with literature that argues that the transference can be transformed but not resolved (Tessman), the patient develops an intense and profound real relationship

with the therapist (Glennon, 2010), and that the therapy relationship might be the most satisfying and best love relationship the patient has ever had (Bergmann, 1997, 2010; Salberg, 2009). Regarding self-analysis—often defined as identification with the functioning of the therapist and/or internalization of a sense of the therapist—some literature cast doubts as to whether patients continue to "analyze" themselves outside the relationship (Grinberg de Ekboir & Lichtmann, 1982), and if they can ever really replace the analyst or solve serious problems with self-analysis (Bergmann, 1997, 2005, 2010). The findings agree with this literature and argue that whether patients develop aspects of an internal capacity for self-analysis or not, the concept does not act as a legitimate criterion for a patient to terminate therapy and end the relationship with the therapist.

The traditional criterion of mourning is seen in some of the literature as one of the most, if not *the* most important aspect of termination and necessary for patients to experience for treatment to be a success (Davies, 2009; Orgel, 2000). While my findings do not agree with prescribed criteria for terminating, they do suggest that mourning is more relevant and more complicated than the other two criteria. My findings show much of the work in long-term therapy focuses on mourning that has gone awry in patients' lives. The study also agrees with literature that emphasizes strong feelings of loss for the patient and therapist when a valued therapy relationship ends (Salberg, 2009, 2010c; Viorst, 1982), which are even stronger in longer analyses (Craige, 2002). However, some of the literature, as well as some of the findings, argue that losing the therapist through ending therapy is *not* an experience that is essential to helping a patient handle other losses in life (Glennon, 2010). Furthermore, shown in the findings and some literature (Skolnick, 2010), is the argument that true mourning does not occur when therapy ends

because, in most cases, no one has died—and most contemporary therapists tend to offer the possibility for renewed contact after ending therapy. Another perspective in the literature suggests that avoidance of ending therapy and of mourning reflects a patient's or analyst's maneuver to avoid facing the issue of mortality (Cooper, 2009; Hoffman, 1998). This literature is relevant to the experience of several therapists in my study in that some of their long-term patients were avoiding ending because they were especially reluctant to face their fears of loss and mortality. Participants directed their attention to those fears and helped these patients through a process of ending, following which the patients remained in touch with the therapists or returned for more sessions. This concurs with the position that patients do not need to mourn the end of therapy *as they might mourn a death*; they can say goodbye and, in most cases, can come back and say hello again.

Some of the literature (e.g., Goldberg & Marcus, 1985) views termination from perspectives that regard all principles of traditional termination as secondary to the needs of the patient and that the patient is the best judge of whether to stay or leave; these perspectives are in agreement with the findings. Other literature on termination (Firestein, 1998) reveals that some patients do not show significant changes until many years into treatment—20 years in several cases, that no one has a "monopoly" on the truth about termination, and practitioners should not refrain from speaking about these clinical experiences. These comments also correspond with findings in the study that show participants wanting more open communication in the profession about practicing long-term therapy.

Limitations of the Study and Suggestions for Further Research

A limitation of the study is that I conducted only one 60 to 90 minute interview with each participant. If had spent more time with each participant or designed the study to include follow-up interviews, the results of the study might have been different. With more time, I probably would have asked participants to elaborate certain of their perspectives, which might have produced different emphases in the findings, including shedding more light on the ambivalent relationship between long-term therapy and termination.

Another limitation is that I chose to focus on the experience of psychoanalytically oriented psychotherapists and did not include psychoanalysts as participants in the study. I explored the clinical experience of a small group of therapists who have participated in psychoanalytic learning venues but have not received formal training and certification from a psychoanalytic institute, which makes their experience similar to mine. Other studies could be conducted that ask psychoanalysts the same research questions about how they conceive of their work with long-term patients. An aspect of their training that might lead to different results is that some institutes require termination of a control case before graduation; psychoanalysts might therefore receive more formal training in termination. Studies of psychoanalysts might be better conducted by researchers who are themselves analysts.

The study is further limited by geographical location. Participants all work in the San Francisco Bay Area. They have received training in psychoanalytic psychotherapy and conduct their therapy practices in the professional milieu that is available in this area. If this research were to be conducted in different geographical areas, results might differ

in relation to variations in theoretical emphases having to do with psychoanalytically oriented practice of long-term therapy.

Suggestions for further research have to do with continuing the dialogue about long-term therapy. When I asked participants where they think the profession needs to go in relation to this topic, some offered ideas about further research. One thought it would be interesting if, along with interviewing them, I were also interviewing their long-term patients. Another thought it would be useful for outcome studies to focus on evidence that long-term therapy works. One of the participants suggested a study that would focus more specifically on the therapists' countertransference in relation to their long-term work, which might shed more light on therapists' attachments to long-term patients, and their experiences of loss when long-term patients end therapy. A suggestion for further research that derives from the study has to do with perceptions of long-term therapy, which might be improved by explorations of theoretical foundations of the often-antagonistic relationship between termination and long-term treatment. In keeping with the qualitative design of the present work, studies could be designed to interview therapists about whether the theories they love enhance or interfere with long-term clinical configurations and how they manage possible discrepancies. Other research that would be suited to therapists who conduct long-term therapy—often senior clinicians—could explore how therapists think about and experience their own retirement in relation to patients they have been seeing long-term.

Afterward

After I had completed my study, I followed an online colloquium on termination for members of The International Association for Relational Psychoanalysis and

Psychotherapy in December 2011. I was interested to find only two entries that were specifically relevant to long-term therapy and surprised that these entries were not taken up and discussed by others—although one is a response to the other. I emailed B. Magid about his commentary, which suggests a lifelong developmental model for long-term therapy. He responded that he is interested in alternatives to the medical model as well as a separation/individuation model of termination. He welcomed me to refer to his colloquium contribution (personal communication, April 11, 2012):

> Within the developmental model, can we shift away from the picture of the infant separating & [*sic*] individuating or the adolescent becoming an adult and leaving home and consider the relationship of adult children to their parents, which is lifelong? Are there other metaphors like this that would respect rather than pathologize lifelong attachment and an open-ended analytic relationship?

I also contacted I. Philipson about her contribution to the colloquium, which was in response to Magid's entry. Her entry presents a social rationale in support of long-term therapy. She also welcomed me to refer to her thoughts (personal communication, April 11, 2012):

> What I increasingly am struck by is the profound loneliness and dislocation so many of my patients are faced with. . . . Termination, in its traditional sense, can mean returning people to lives of constant work, taking care of children and/or parents, commuting, worrying about their jobs, their financial futures. There is so little time for deep connection, reflective space. . . . Ideologically, each individual is to blame, is held responsible for him or herself; dependence is bad, weak. When [another contributor] asks if we are disavowing limits and the necessary process

> of mourning by . . . engaging in much longer treatments compared to a century ago, I think of how many of my patients know all too well about limits and mourning and grief. What they don't know about as well is having someone to turn to time and time again when they're in need.

These two commentaries fit well with my study in that they derive from therapists' clinical experience and reflections that privilege open-ended, ongoing therapy relationships over termination as a preconceived ideal. Magid's contribution supports the lifelong developmental model in long-term therapy that I developed in my interpretation of the findings. Philipson highlights a social context and the provision of a long-term therapeutic container, both of which are also found in this study. That Magid's and Philipson's contributions were not discussed by others in the colloquium seems to reflect the lack of communication in the field about long-term therapy and perhaps an underestimation of patients' needs for long-term, abiding, therapy attachments, lending further weight to the purpose and findings of this study.

APPENDIX A: RECRUITMENT LETTER TO COLLEAGUES

Jean Kotcher, MA
Marriage, Family & Child Therapist
License # MFC 25624
(415) 626-7945

Dear

I am about to begin the data collection phase of my doctoral dissertation at the Sanville Institute in Berkeley, and am writing to ask your help in recruiting participants.

My qualitative study is about the therapist's experience of therapy that lasts 15 years or longer, a clinical phenomenon that is not well addressed in the profession but occurs in many practices. The study will address the question of how psychoanalytically oriented psychotherapists think about very long-term therapy and what theoretical concepts they might find useful in this area of their clinical work.

I am looking for a small number of experienced psychotherapists from any of the mental health professions who identify themselves as psychoanalytically oriented, but who are not psychoanalysts, and who have one or more clients they have seen for 15 years or longer. I will spend about 60-90 minutes with each participant in an unstructured interview that I will tape record.

Can you think of someone who might be interested and appropriate for this study? If so, you could either tell them about it and suggest they contact me, or give me their names and contact information and I will get in touch with them directly.

My address and phone number are at the top of this letter. I can also be reached by email at jkotcher@mac.com. Please feel free to call me at the above number, or email me, if you have any questions. Thank you in advance for your cooperation and participation.

Sincerely,

Jean Kotcher, MFT

4214 18th Street, San Francisco, CA 94114

APPENDIX B: RECRUITMENT AD FOR NEWSLETTERS

Ads to be submitted to *professional newsletters:

1. SEEKING PARTICIPANTS FOR RESEARCH STUDY. I will interview experienced psychoanalytically oriented therapists concerning their thinking and experience of working with clients for 15 years or longer. If you might be interested, or would like to hear more, please contact me. Jean Kotcher, MFT, doctoral candidate at The Sanville Institute. (415) 626-7945, or jkotcher@mac.com.

2. SEEKING RESEARCH PARTICIPANTS: psychotherapists in private practice who have seen one or more clients 15 years or longer. 60 - 90 minute interview, Jean Kotcher, MFT, doctoral candidate at The Sanville Institute (415) 626-7945.

*Newsletters in which I placed ads:

San Francisco Chapter of California Association and Marriage and Family Therapists

NCSPP (Northern California Society for Psychoanalytic Psychology), San Francisco

The Psychotherapy Institute, Berkeley

APPENDIX C: LETTER TO PROSPECTIVE PARTICIPANTS

Jean Kotcher, MA
Marriage, Family & child Therapist
License # MFC 25624
(415) 626-7945

Dear

Thank you for your interest in participating in my doctoral research (or, I was given your name by _____because (s)he thought you might be interested in participating in a research study I am conducting.)

I am writing to give you some information about the study and to invite your participation. My study examines how psychoanalytically oriented psychotherapists think about therapy that lasts 15 years or longer. I am interested in understanding what thoughts, experiences, and theoretical concepts guide therapists who have this common, but under-examined, clinical experience.

Participation in the study means that I will interview you for 60-90 minutes, at a location and time that is convenient for you. I will tape record the interview. I might also follow up with a brief phone call if I need clarification of something that we discussed. If you choose to participate, I hope you will find the process to be helpful in clarifying your thoughts about the area of practice being studied and your own clinical experience. I will be happy to send you a summary of the study results if you wish.

I will treat the information you give me as confidential and will protect your anonymity, as well as that of any clients you discuss during the interview. I have enclosed a copy of the consent form for you to review and which I will ask you to sign at the time of the interview.

If you would like to participate in this research project, please complete the brief personal information questionnaire and return it to me in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding the possibility of your participation.

I hope this project is of interest to you. Please feel free to contact me at the above phone number or at jkotcher@mac.com if you have any questions.

Sincerely,

Jean Kotcher, MFT
Doctoral Candidate, The Sanville Institute
4214 18th Street, San Francisco, CA 94114

APPENDIX D: INFORMED CONSENT FORM

I,_____, HEREBY WILLINGLY CONSENT TO participate in an exploratory study of how psychoanalytically oriented psychotherapists conceptualize the phenomenon of psychotherapy that lasts for 15 years or longer. This doctoral research project will be conducted by Jean Kotcher, MFT, under the direction of Sylvia Sussman, PhD., principle investigator and faculty member, and under the auspices of The Sanville Institute.

I understand that my participation in this study will involve the following:

A 60-90 minute audio-taped interview will occur in a confidential setting to be arranged between myself and the researcher. If needed, the researcher may follow up with a brief phone call for clarification of something that was discussed. I will be talking about my thoughts and feelings as an experienced, psychoanalytically oriented therapist who has seen one or more clients in psychotherapy for 15 years or longer.

I am aware of the following potential risks involved in the study:

The possibility exists that I might experience emotional discomfort. Should that happen, I will be able to contact the researcher who will make provisions for me to receive professional help, up to three sessions, to resolve issues related to participation in the research study, at no cost to myself.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my anonymity and confidentiality, as well as that of any clients whom I may discuss, will be protected. The researcher will disguise information that would associate material I have provided for the study with my, or my clients' names or identities. The audiotape will be erased and transcripts of the tape destroyed at the completion of data analysis.

Signature_____Date_____

- -

If you would like a copy of the results of this study, please provide your name and address:

Name_____

Address_____

APPENDIX E: PERSONAL INFORMATION FORM

Name_____

Address_____

_____

Telephone (day)_____(evening)_____

Email address_____

Profession and year of licensure:

Marriage and Family Therapist_____

Psychiatrist_____

Psychologist_____

Social Worker_____

Do you have one or more clients you have seen15 years or longer?_____

_____

What is your theoretical orientation(s)?_____

_____

APPENDIX F: LETTER TO PROSPECTIVE PARTICIPANTS WHO ARE NOT INCLUDED IN STUDY

Jean Kotcher, MA
Marriage, Family & Child Therapist
License # MFC 25624
(415) 626-7945

Dear

Thank you very much for the interest you have shown in the research study that I am conducting as a doctoral candidate at The Sanville Institute. At this time I have recruited enough participants to begin the study and will not need to schedule an interview with you. If it becomes necessary to interview additional people I may contact you again to see if you would still be interested and available.

If you would like to know about the results of my study when it is completed, feel free to contact me.

Thank you once again for your interest.

Sincerely,

Jean Kotcher, MFT

4214 18th Street, San Francisco, CA 94114

APPENDIX G: INTERVIEW GUIDE

Introduction

Thank you so much for agreeing to this interview and to being a part of my research project. As you know, I am interested in hearing your thoughts about working with long-term clients. Many therapists, like you and me, see some clients for 15 years and longer. This has not been well addressed in the psychoanalytic literature even though long-term therapy is a reality. Many of us feel that the topic has been neglected in the profession. I am hoping you can help me understand some of the ways psychoanalytically oriented therapists think about and work with long-term clients. Let's begin by your sharing your initial reactions and thoughts about this topic.

Participant's Theoretical Orientation and Current Practice

1. Type of practice, kinds of patients. How many years in practice? How many patients have you seen 15 years or longer?
2. Education (including training and continuing education)?
3. What is your theoretical orientation?
4. Supervisors and mentors who have influenced you - their theoretical orientations?
5. Are you in a peer group or consultation group?
6. Other influences on your practice?

Participant's Use of Particular Psychoanalytic Concepts

1. What is your view of how patient's change?
2. How do you view the therapy relationship in terms of transference and countertransference?

Participant's Consideration of the Concept of Termination in Practice

1. How do you view the termination process?
2. How did you learn about the concept of termination (classes, training, supervision)?
3. Have you ever had a supervised termination?
4. How do you view loss and grief in relation to termination of therapy?
5. How do you view the patient's internalization of the therapist and the therapeutic function after termination?

Participant's Experience of Long-term Therapy in Practice

1. How do you think about the length of time your patients spend in therapy – do you think about it differently for different patients?
2. If you were to divide your patients into average length of time versus people long-term, can you summarize what has been true for the longer term, in contrast with the shorter term, patients?
3. Can you give me a synthesis of how two (or a few) of your long-term patients are the same, and different, from each other?
4. Has medication been used and has it been an issue with long-term patients?
5. Have you terminated any long-term patients and how did it go?

Participant's Use of Independent Thinking About Long-term Therapy

1. Do you discuss long-term patients with colleagues and what reactions do you get?
2. Have you ever attended presentations or ethics seminars that caution against long-term work?
3. Do you make adjustments to commonly held beliefs about theory and practice in relation to your long-term work?
4. Where do you look for support for your own point of view?
5. Where do you think this field needs to go in exploring this topic?

In Conclusion

1. Are there any areas of this subject that I have not covered that you think are important or would like to add?
2. Do you have any final thoughts on my questions or anything you would like to say about the experience of the interview?

APPENDIX H: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project Long-Term Psychotherapy: A Study of the Therapist's Experience

Principal Investigator: SYLVIA SUSSMAN, PhD
(print name and degree)

Investigator: Jean Kotcher
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__✓__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Sylvia Sussman, Ph.D. 10/13/10
(signature of principal investigator/date)

Jean Kotcher 10/13/10
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved __✓__ Approved with Modifications _____ Rejected _____

Gregory Bellow PhD Date 10/20/2010
Signature of representative of the Committee on the Protection of Research Participants/date

Whitney M Norton 10/20/10
(signature of dean & date)

REFERENCES

Aron, L. (1990). One person and two person psychologies and the method of psychoanalysis. *Psychoanalytic Psychology, 7*, 475-485.

Balint, M. (1950). On the termination of analysis. *The International Journal of Psycho-Analysis, 31*, 196-199.

Barish, S. R. (1991). A woman of her time (or was she?). In J. Edward & E. Rose (Eds.), *The social work psychoanalyst casebook: Clinical voices in honor of Jean Sanville* (pp. 91-110). Hillsdale, NJ: The Analytic Press.

Bass, A. (2010). "It ain't over till it's over": Infinite conversations, imperfect endings, and the elusive nature of termination. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 277-303). New York, NY: Routledge.

Bergmann, M. S. (1986). Transference love and love in real life. *International Journal of Psychoanalytic Psychotherapy, 11,* 27-45.

Bergmann, M. S. (1988). On the fate of the intrapsychic image of the psychoanalyst after termination of the analysis. *The Psychoanalytic Study of the Child, 43*, 137-153.

Bergmann, M. S. (1997). Termination: The Achilles heel of psychoanalytic technique. *Psychoanalytic Psychology, 14*, 163-174.

Bergmann, M. S. (2005). Termination and reanalysis. In E. S. Person, A. M. Cooper, & G. O. Gabbard (Eds.), *Textbook of psychoanalysis* (pp. 241-253). Washington, DC: American Psychiatric Publishing.

Bergmann, M. S. (2010). Termination: the Achilles heel of psychoanalytic technique. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 25-37). New York, NY: Routledge.

Bird, B. (1972). Notes on transference: Universal phenomenon and hardest part of psychoanalysis. *Journal of the American Psychoanalytic Association, 20*, 267-301.

Blomberg, J., Lazar, A., & Sandell, R. (2001). Long-term outcome of long-term psychoanalytically oriented therapies: First findings from the Stockholm Outcome of Psychotherapy and Psychoanalysis study. *Psychotherapy Research, 11*, 361-382.

Blum, H. (1971. On the conception and development of the transference neurosis. *Journal of the American Psychoanalytic Association, 19*, 41-53.

Blum, H. (1989). The concept of termination and the evolution of psychoanalytic thought. *International Journal of the American Psychoanalytic Association, 37*, 275-295.

Britton, R. (2010). There is no end of the line. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 39-50). New York, NY: Routledge.

Coltart, N. (1996). *The baby and the bathwater*. Madison CT: International Universities Press.

Cooper, S. (2009). Familiar and unfamiliar forms of interaction in the ending phases of analysis. *Psychoanalytic Dialogues, 19*, 588-603.

Corbin J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.

Craige, H. (2002). Mourning analysis: The post-termination phase. *Journal of the American Psychoanalytic Association, 50*, 507-550.

Craige, H. (2009). Terminating without fatality. *Psychoanalytic Inquiry, 29*, 101-116.

Davies, J. M. (2009). Love never *ends* well: Termination as the fate of an illusion: Commentary on papers by Jill Salberg and Sue Grand. *Psychoanalytic Dialogues, 19*, 734-743.

Davies, J. M. (2010). Transformations of desire and despair: Reflections on the termination process form a relational perspective. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 83-105). New York, NY: Routledge.

Doidge, N., Simon, B., Brauer, L., Grant, D. C., First, M., Brunshaw, J., Lancee, W. J., Stevens, A., Oldham, J. M., & Mosher, P. (2002). Psychoanalytic patients in the U.S., Canada, and Australia: I. DSM-III-R disorders, treatment, medications, and length of treatment. *Journal of the American Psychoanalytic Association, 50*, 575-614.

Dragosei, A. C. (2007). Frozen time and endless analyses: A response to David Tresan's 'Thinking individuation forward.' *Journal of Analytic Psychology, 52*, 41-45.

Eckstein, R. (1964). Working through and termination of analysis. *Journal of the American Psychoanalytic Association, 13*, 57-78.

Eissler, K. R. (1993). On possible effects of aging on the practice of psychoanalysis: An essay. *Psychoanalytic Inquiry, 13*(3), 316-332.

Falkenstrom, F., Grant, J., Broberg, J., & Sandell, R. (2007). Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy. *Journal of the American Psychoanalytic Association, 55*(2), 629-674.

Ferenczi, S. (1955). The problem of the termination of the analysis. In: *Final contributions to the problems and methods of psycho-analysis* (Vol. 3, pp. 77-86). New York, NY: Basic Books. (Original work published 1927)

Ferenczi, S., & Rank, O. (1969). *The development of psychoanalysis* (C. Newton, Trans). Madison, CT: International Universities Press. (Original work published 1925)

Firestein, S. K. (1978). *Termination in psychoanalysis*. New York, NY: International Universities Press.

Firestein, S. K. (1982). Termination of psychoanalysis: Theoretical, clinical, and pedagogic considerations. *Psychoanalytic Inquiry, 2*, 473-497.

Firestein, S. K. (1998). *Termination in psychoanalysis and psychotherapy* (rev. ed.). Madison, CT: International Universities Press.

Fosshage, J. L. (1997). Psychoanalysis and psychoanalytic psychotherapy: Is there a meaningful distinction in the process? *Psychoanalytic Psychology, 14*(3), 409-425.

Frank, K. A. (2009). Ending with options. *Psychoanalytic Inquiry, 29*, 136-156.

Freud, S. (1905). Fragment of an analysis of a case of hysteria. In P. Reiff (Ed.), *The collected papers of Sigmund Freud: Dora—an analysis of a case of hysteria* (Vol. AS 581V, pp. 21-144). New York, NY: Collier Books.

Freud, S. (1914). Further recommendations in the technique of psychoanalysis: Remembering, repeating, and working through. In J. Strachey (Ed.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. XII, pp.147-156). London, England: Hogarth Press.

Freud, S. (1917). Mourning and melancholia. In E. Jones (Ed.), *The collected papers of Sigmund Freud: Papers on metapsychology* (Vol. IV, pp. 152-170). London, England: Hogarth Press.

Freud, S. (1937). Analysis terminable and interminable. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud,* (Vol. XXIII, pp. 216-253). London, England: Hogarth Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Glennon, S. S. (2010). Relational analyses: Are they more difficult to terminate? In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 257-275). New York, NY: Routledge.

Glover, E. (1955). The technique of psycho-analysis. New York, NY: International Universities Press.

Goldberg, A., & Marcus, D. (1985). Some comments on ending analysis without setting a date. *Psychoanalytic Quarterly, 54*, 46-65.

Grand, S. (2010). Termination as necessary madness. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 131-144). New York, NY: Routledge.

Greenson, R. R. (1958). Variations in classical psycho-analytic technique: An introduction. *The International Journal of Psycho-Analysis, 39*, 200-201.

Grinberg, L. (1980). The closing phase of the psychoanalytic treatment of adults and the goals of psychoanalysis 'the search for truth about one's self.' *The International Journal of Psychoanalysis, 61*, 25-37.

Grinberg de Ekboir, J., & Lichtmann, A. (1982). Genuine self-analysis is impossible. *The International Journal of Psycho-Analysis, 9*, 75-83.

Hartocollis, P. (2003). Time and the psychoanalytic situation. *Psychoanalytic Quarterly, 72*, 939-957.

Hoffer, W. (1950). Three psychological criteria for the termination of treatment. *The International Journal of Psychoanalysis, 31*, 194-203.

Hoffman, I. Z. (1998). *Ritual and spontaneity in the psychoanalytic process: A dialectical-constructivist view*. Hillsdale, NY: The Analytic Press.

Kantrowitz, J. L., Katz, A. L., & Paolitto, F. (1990a). Followup of psychoanalysis five to ten years after termination: I. Stability of change. *Journal of the America Psychoanalytic Association, 38*, 471-496.

Kantrowitz, J. L., Katz, A. L., & Paolitto, F. (1990b). Followup of psychoanalysis five to ten years after termination: II. Development of the self-analytic function. *Journal of the American Psychoanalytic Association, 38*, 637-654.

Kantrowitz, J. L., Katz, A. L., & Paolitto, F. (1990c). Followup of psychoanalysis five to ten years after termination: III. The relationship between the resolution of the transference and the patient-analyst match. *Journal of the American Psychoanalytic Association, 38*, 655-678.

Kramer, M. K. (1959). On the continuation of the analytic process after psycho-analysis (a self-observation). *The International Journal of Psychoanalysis, 40*, 17-25.

Layton, L. (2010). Maternal resistance. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspective* (pp. 191-210). New York, NY: Routledge.

Leigner, E. J. (1986). The question of termination in modern psychoanalysis. *Modern Psychoanalysis, 11*, 5-18.

Levenson, E. A. (1976). The aesthetics of termination. *Contemporary Psychoanalysis, 12*, 338-341.

Loewald, H. W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psycho-Analysis, 41*, 16-33.

Loewald, H. W. (1962). Internalization, separation, mourning, and the superego. *Psychoanalytic Quarterly, 31*, 483-504.

Loewald, H. W. (1971). The transference neurosis: Comments on the concept and the phenomenon. *Journal of the American Psychoanalytic Association, 19*(1), 54-66.

Loewald, H. W. (1973). On internalization. *The International Journal of Psych-Analysis, 54*, 9-17.

Loewald, H. W. (1988). Termination analyzable and unanalyzable. *The Psychoanalytic Study of the Child, 43*, 155-166.

Mendenhall, S. (2009). From termination to the evolution of a relationship: A new understanding. *Psychoanalytic Inquiry, 29*, 117-135.

Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York, NY: Basic Books.

Neale, T. (2008). *Long-term psychotherapy outdoes short-term for complex mental disorders*. Retrieved from http://www.medpagetoday.com/Psychiatry/GeneralPsychiatry/11117

Norman, H. F., Blacker, K. H., Oremland, J. D., & Barrett, W. G. (1976). The fate of the transference neurosis after termination of a satisfactory analysis. *Journal of the American Psychoanalytic Association, 24*(3), 471-498.

Novick, J. (1982). Termination: Themes and issues. *Psychoanalytic Inquiry, 2*(3), 329-365.

Novick, J. (1997). Termination conceivable and inconceivable. *Psychoanalytic Psychology, 14*(2), 145-162.

Novick, J., & Novick, K. K. (2006). *Good goodbyes: Knowing how to end in psychotherapy and psychoanalysis*. Lanham, MD: Jason Aronson.

Orgel, S. (2000). Letting go: Some thoughts about termination. *Journal of the American Psychoanalytic Association, 48*(3), 719-738.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Pedder, J. R. (1988). Termination reconsidered. *The International Journal of Psychoanalysis, 69*, 495-505.

Pfeffer, A. Z, (1959). A procedure for evaluating the results of psychoanalysis: A preliminary report. *Journal of the American Psychoanalytic Association, 7*, 418-444.

Pfeffer, A. Z. (1961). Follow-up study of a satisfactory analysis. *Journal of the American Psychoanalytic Association, 9*, 698-718.

Pfeffer, A. Z. (1963). The meaning of the analyst after analysis: A contribution to the theory of therapeutic results. *Journal of the American Psychoanalytic Association, 11*, 229-244.

Poland, W. S. (1997). On long analyses. *Psychoanalytic Psychology, 14*(2), 183-195.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145.

Rangell, L. (1980). Some notes on the postanalytic phase. International Journal of Psychoanalytic Psychotherapy, *8*, 165-170.

Rank, O. (1957). *The trauma of birth*. New York, NY: Brunner. (Original work published 1924)

Reich, A. (1950). On the termination of analysis. *The International Journal of Psychoanalysis, 31*, 179-183.

Reich, A. (1958). A special variation on technique. The International Journal of *Psychoanalysis, 39*, 230-234.

Rucker, N. (1993). Analysis interminable reconsidered. *The American Journal of Psychoanalysis, 53*(2), 159-172.

Salberg, J. (2009). Leaning into termination. *Psychoanalytic Dialogues, 19*, 704-722.

Salberg, J. (2010a). *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives*. New York, NY: Routledge.

Salberg, J. (2010b). Historical overview. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 3-21). New York, NY: Routledge.

Salberg, J. (2010c). How we end: Taking leave. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 109-129). New York, NY: Routledge.

Schlessinger, N., & Robbins, F. P. (1975). Assessment and follow-up in psychoanalysis. *Journal of the American Psychoanalytic Association, 22*, 542-567.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Lawrence Erlbaum.

Shane, E. (2009). Approaching termination: Ideal criteria versus working realities. *Psychoanalytic Inquiry, 29*, 167-173.

Shane, M., & Shane, E. (1984). The end phase of analysis: Indications, functions, and tasks of termination. *Journal of the American Psychoanalytic Association, 32*(4), 739-772.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychological Association, 65*(2), 98-109.

Short, B. L. (2009). *Is termination a phase or a process? Creating a space for absence.* Unpublished graduation paper). Psychoanalytic Institute of Northern California, San Francisco, CA.

Skolnick, N. J. (2010). Termination in psychoanalysis: It's about time. In J. Salberg (Ed.), *Good enough endings: Breaks, interruptions, and terminations from contemporary relational perspectives* (pp. 223-240). New York, NY: Routledge.

Spence, D. (1987). *The Freudian metaphor*. New York, NY: Norton.

Strachey, J. (1934). The nature of the therapeutic action of psycho-analysis. *International Journal of Psychoanalysis, 15*, 126-159.

Strauss, A., & Corbin J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tessman, L. H. (2003). *The analyst's analyst within*. Hillsdale, NJ: The Analytic Press.

Ticho, E. A. (1972). Termination of psychoanalysis: Treatment goals, life goals. *Psychoanalytic Quarterly, 41*, 315-333.

Ticho, G. R. (1967). On self-analysis. *The International Journal of Psycho-Analysis, 48*, 308-318.

Tresan, D. (2007a). Thinking individuation forward. *Journal of Analytic Psychology, 52*, 17-40.

Tresan, D. (2007b). Time is a river without banks: A response to Connolly's 'Frozen time and endless analyses.' *Journal of Analytic Psychology, 52*, 47-49.

Viorst, J. (1982). Experiences of loss at the end of analysis: The analyst's response to termination. *Psychoanalytic Inquiry, 2*(3), 399-418.

Wallerstein, R. S. (1986). *Forty-two lives in treatment*. New York, NY: The Guilford Press.

Winnicott, D. W. (1996a). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 140-152). Madison, CT: International Universities Press. (Original work published 1960)

Winnicott, D. W. (1996b). The theory of the parent-infant relationship. In *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 37-55). Madison, CT: International Universities Press. (Original work published 1960)

JEAN KOTCHER Ph.D. 2012