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Table of Contents

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Philip Rieff (1968), in discussing "the triumph of the therapeutic," writes: "At its best, psychoanalytic therapy is devoted to the long and dubious task of rubbing a touch of that analytic genius into less powerful minds" (p. 30). Today, it is more often psychotherapy, not psychoanalysis, that carries on the task. Therapy, because it is less expensive and less time-consuming, is accessible to more people, and many would say that intensive, long-term therapy, when it is informed by psychoanalytic theory, can accomplish as much as psychoanalysis. I will begin by briefly explaining what I mean by psychoanalytically informed therapy. With so many varieties of therapy available today it helps to clarify. I will first demonstrate how psychoanalytic principles can guide a psychotherapy, then present a case, and finally continue the clinical discussion of termination that I began in the context of psychoanalytic thought. The context, however, will have shifted from the psychoanalytic to the psychotherapeutic consulting room. By way of illustration, I will present two additional cases. I will conclude the chapter with a brief discussion of countertransference and termination.

Up to this point, I have presented clinical issues and cases drawn mainly from the professional literature. This is because I am not a psychoanalyst. A psychiatrist, I was trained by analysts to practice psychotherapy, and I will illustrate how psychoanalytic theory continues to inform my practice. But I cannot present a firsthand account of psychoanalytic practice. Psychotherapy is a different matter. From now on, I will present my own understanding of how therapy is practiced, and my own cases.

If, because of variations among schools of thought, it is difficult to describe trends in psychoanalysis, it is doubly difficult to portray how therapy is theorized and practiced, there being so many idiosyncratic approaches and no official institutes to foster orthodoxy. Therefore I will attempt to describe what I understand to be trends among practitioners. This means that many of my formulations do not reflect any particular body of literature, since, for the most part, practitioners tend to borrow from various schools of thought. Also, most therapists do not publish their own work and ideas, making it even more difficult to assess what occurs in the average therapist's practice. Nevertheless, I will attempt to present principles of termination in terms general enough to make sense to practitioners of various theoretical persuasions. In

this chapter I will discuss long-term, open-ended therapy. Brief therapy is also informed by psychoanalysis, as I will explain in chapter five.

Psychoanalysis and Psychotherapy

The majority of contemporary therapists borrow from psychoanalysis, adapting it to the idiom of the face-to-face encounter. Frieda Fromm-Reichmann (1950) states the goal of intensive psychotherapy:

> "Alleviation of patients' emotional difficulties in living and elimination of the symptomatology, this goal to be reached by gaining insight into, and understanding of the unconscious roots of patients' problems, the genetics and dynamics, on the part of both patient and psychiatrist, whereby such understanding and insight may frequently promote changes in the dynamic structure of the patient's personality." (p. x)

There are discussions among psychoanalysts about what differentiates psychoanalysis from psychotherapy (Nemetz, 1979; Wallerstein, 1969). Ticho (1970) identifies three significant differences: the free-association technique and couch employed in psychoanalysis foster deeper regression; the analyst is "neutral" and avoids becoming a model, whereas the therapist is more of a model, is more active in the encounter, and does a certain amount of "reeducation and the analyst makes only insight-producing interventions, while the therapist might also give advice, be supportive, and so forth. According to Ticho, psychotherapy can accomplish as much in terms of symptom reduction but results in less resolution of unconscious conflict and less autonomy. Merton Gill (1954) suggests that the crucial ingredient that differentiates psychoanalytic psychotherapy from other therapeutic approaches is the therapist's persistent focus on interpretations of the transference. Lifschutz (1984) agrees with Gill, and would even call all other forms of therapy by some other name, for instance, "counseling." My own view is that in many cases psychoanalytic psychotherapy can incorporate more varied forms of intervention and still accomplish as deep and lasting change as can psychoanalysis.

Wallerstein (1969) describes a continuum, with psychoanalysis at one end and supportive psychotherapy or counseling at the other. In the middle is expressive, or insight-producing, psychotherapy, which is the same as psychoanalytically informed psychotherapy. Kernberg (1984) employs the same continuum. Robert Langs (1973, 1974) presents a concise and rigorous outline of technique, though I find his instructions rigid in places, and his style more formal than my own. Dewald (1964) and Malan (1979) present quite accessible guides for the practitioner.

As an example of how a psychoanalytic principle can inform and be adapted to psychotherapy, consider the link Freud made between idea and affect. In his essay on the unconscious, Freud (1915) explains that affect cannot be repressed. Only the idea or memory trace of an experience is repressed and lodged in the unconscious. If the analyst guesses what resides in the analysand's unconscious and tells the analysand about it, the insight does little good. It is merely an intellectual observation. When the analysand is able to connect idea with affect, what was unconscious becomes accessible to consciousness, and the analysis proceeds. This is the analytic principle.

Any therapist who has worked with a bright and highly intellectual client knows that this task is not as easy as it might appear. One such client, a man in his mid-thirties, listened intently during one session as I explained to him how his early feelings of neglect and betrayal by a self-indulgent mother might have something to do with his current problem in sharing his feelings with a woman. He thought about what I said, seemed to make some links with conflicts that were troubling him in a particular relationship, and left my office seeming less anxious than when he had arrived. A week later he walked in and announced that everything I had said the week before was true, but not helpful, since it was all "purely intellectual." He told me he did not think he was making much progress in therapy with me, and he was thinking of quitting and going to see another therapist who did "body work." "At least that's not so intellectual and unfeeling."

I asked this client how he felt about my being so "purely intellectual." He began to tell me that it might be helpful for some people but that he had already done a lot of thinking about himself, and he did not think my interpretations added much new. I asked if he might not also be feeling misunderstood. After all, he was pouring out his heart to me, and all I was giving him back were intellectual interpretations. He agreed, and seemed to relax a little. Then he listed some other complaints he had about me: I was too formal at the beginning of sessions; I never answered with much content when he asked me how I was, while I expected him to come forth with all kinds of "deep emotional problems" ; and I never really gave him much advice about what to do about his problems—I just made those interpretations.

This client's report is accurate. I do not say much when a client asks how I am, I try not to give much advice, and I try to offer useful interpretations. I acknowledged all that. Then I explained that our task

was to look at his situation. If I used his time with me to express my problems and conflicts, wouldn't he feel he was not getting my full attention to his concerns? And wasn't it more important for me to help him decide what course he wanted to take rather than what course would please me? I repeated that I understood his concern that I was not present and attentive in more than an intellectual manner. During the ensuing discussion, he reminisced about his father's tendency to pretend to be listening to him, while really thinking of other things, and then to give him advice that usually turned out to be wrong, or at least not matched very closely to his experience. The client spontaneously made the connection between the current tension in our therapeutic relationship and resentment toward his father that he had been suppressing for years. I reminded him of his complaint that I was too intellectual and pointed out that what was not merely intellectual was the set of strong feelings he had about me, and the feelings about his father that were called up. Was I, like his father, offering him advice that would turn out to be wrong? The link with the transference is very often what makes it possible for a client to connect idea with affect. The "here and now" (Strachey, 1934) experience with the therapist touches conflictual or repressed memories of very early experiences with important others, and since the here-and now experience involves affects as well as ideas, real contact with the repressed idea becomes possible. This is just one example of how psychoanalytic principles inform the practice of therapy.

But therapy, no matter how informed by the psychoanalytic approach, is not the same as analysis. Consider, for example, the question of eye contact. Some clients refuse to look the therapist in the eye. The therapist must decide whether and when to mention this. If the therapist says something too early, the client might feel she or he is intrusive. The therapist can alter the boundary arrangement significantly by looking directly at the client or looking away. When a client is ready to examine how she or he distances the therapist, the therapist can diminish the distance by maintaining eye contact. When a client's ego seems fragile and the therapist's direct gaze seems to heighten the client's anxiety, the therapist might choose to look away. The whole phenomenon can occur without discussion, or can be examined as another instance of the client's conflicts about trust and closeness. Therapy is no less a "talking cure" if, in the midst of the conversation, or during the silences, the therapist is aware of how eye contact or lack of eye contact intensifies or relaxes the encounter, and how certain clients need more or less intense interaction at one or another moment.

The therapist learns from Freud, and then adapts what has been learned to a new context.

Whatever the modern therapist's style—rand mine is reflected in the cases presented here—where there are gaps in Freud's method the therapist must improvise. For instance, Freud (1913) admitted: "I cannot bear to be gazed at for eight hours a day (or more). Since, while I listen, I resign myself to the control of my conscious thoughts, I do not wish my expression to give the patient indications which he may interpret or which may influence him in his communications" (p. 134). It is one thing for the analyst, sitting out of view behind the couch, to hide actual personal reactions so that he or she can ascertain how the analysand on the couch fantasizes the analyst might feel. It is quite another for a therapist to try to hide feelings while sitting face to face with a client, particularly when the client complains: "My father always pretended he wasn't angry even when I knew he was, and then later, still denying he was mad, he'd say something sarcastic. I knew I could never get a straight answer out of him about how he was feeling." While it is unfair and counterproductive for the therapist to burden the client with the full force of his feelings and unprocessed reactions, the client's demands for a more human face are also important.

It would simplify matters greatly if someone were to prove that therapists who sit impassively and rely mainly on interpretation are the most effective, while those who show their feelings, those who empathize and actively support, and those who chat and give outright advice are less effective. But no one can really show this to be the case. The direct transposition of psychoanalytic principles into psychotherapy does not necessarily result in the most effective therapeutic practice. Each therapist evolves his or her own style. Still, the lessons of psychoanalysis do apply, so that even in the midst of expressing feelings, talking, making self-revelations, supporting, advising, or even cajoling, the therapist repeatedly discovers anew that the greatest therapeutic gains occur when affect and idea are connected through the interpretation of the transference. A clinical vignette might prove useful here.

Sandra

Sandra could not tell me a precise reason why she was seeking therapy. "Things are just not right for me." She told me during our first session that she felt more comfortable when I asked questions. At thirty-six, she had built a successful professional career for herself but was concerned because she had never been in a lasting primary relationship and in fact had no real friends. From the start I found that I could ask any question I liked—about her sexual fantasies, thoughts about suicide, envy of her sister, or resentment toward me—and she would give me a frank, revealing answer. But the answer would be curt

and to the point. Then she would revert to silence. She offered very few spontaneous utterances, in spite of my requests that she tell me what was on her mind.

During the first several months of therapy, I asked many questions. I found that to be the only way to keep the conversation going, and when there was prolonged silence, her anxiety level rose and the distance between us grew. She seemed to be training me to ask the questions and then, possibly because this convinced her she had some control in our encounter, she was able to be quite candid. (For a discussion of silence, see Masud Khan, 1963.)

After this pattern had become clearly established, I told her I found it remarkable that she required me to ask all the questions but then would be willing to tell me such intimate things about herself. She thought about this for several minutes, then said: "As long as you ask we aren't really talking about what's on my mind. I'll answer all the questions you want." She might as well have added: "But I won't let you know which ones really matter." Characteristically, Sandra's perceptions proved that though she was silent, her mind was rarely still.

Sandra had always felt ignored by her parents. "They treated me like a piece from their fabulous art collection, parading me out to display to people who came to see their expensive collection. But they never cared how I felt the whole time." Sandra feared that if she shared what was on her mind she would be humiliated, as she was when her parents and their guests ignored what she said, or laughed at her when she said something inappropriate. I ventured: " So you prevented your being made into a dead piece of art by disappearing from the room, becoming silent." She agreed. In the months that followed, she began to answer questions more spontaneously, to interject more thoughts into the silences, and to accept more responsibility for maintaining the flow of our conversations.

We explored her feelings about the fact that her mother never viewed her as a separate, unique person, with her own rights, feelings, and wishes. She had to be "mother's good little girl," or her mother became icy and distant. She decided early to comply and be "mother's good little girl." (For a discussion of the ramifications of this kind of compliance, see Miller, 1981). She did well in school, joined all the right social cliques so that she was viewed as a "popular girl," and followed the rules about curfew and dress code. She did break some of the rules—for example, when she drank and became sexually active in her

mid-teens—but her parents never found out about that. She remained in their eyes the model child, and her success in her profession was proof.

Intellectual exchanges with her mother were a " disaster."

> She would take me to a bookstore, and I would look around. Each time I selected a book I liked, she would laugh in a mocking way and say, "That book is really pedestrian!" Then she'd show me a book she thought I would like better. I learned to just accept the books she wanted me to read, and forget about my own taste. At least then she wouldn't make fun of me. Even now, when I go home to visit, she buys me books that she thinks are worthy, usually that I don't like, but I read them while I'm there, and then when I get back here I put them in a box in the closet and read what I like. But when I go back for another visit I hurriedly read a few of the books she bought me so she won't get angry.

Sandra was terrified that in the presence of anyone she let really matter to her, she would be treated like a piece from her parents' fabulous art collection. Her dread was circular. In order to avoid what she dreaded, she reproduced it. She assumed I was just like her mother and would make her into another specimen in my collection of successful cures—if she let me. So she would not give me an opportunity to prove I was trustworthy. Every time I guessed what might be occurring in her inner world, she refused to respond, maintaining an icy silence. I had to ask more questions and receive more curt replies. I ended up feeling that I was being negated, my feelings ignored. She was doing to me what had been done to her, out of fear I would do the same again to her.

Once, while I was in the midst of a painful argument with my wife, worried about a crisis in a son's life, and feeling insecure about the quality of therapy I was practicing, I made an interpretation that I was quite sure hit the mark. Sandra said nothing, and there was no change in her expression. I asked; "Why do you refuse to let me know how my interpretations affect you? Even if they're wrong, I know you must have some reaction."

She did not respond. I felt impotent, humiliated, and angry. Because I was not coping too well with my own worries and insecurities that day, I failed to analyze my own countertransference first, and instead responded in anger: "You use your silence to defeat me. You want me to feel as impotent as you!" I knew as soon as I said it that this was a retaliatory attack, and though quite likely true, not a usable interpretation. Sandra was silent for the rest of the session, and we both felt very uncomfortable.

The next week, Sandra came in and said she felt angry and hurt after the last session. This was the

first time she had opened a session by spontaneously expressing feelings, and probably the first time she took responsibility for maintaining continuity in our encounter by referring back to something that occurred in a previous session. I had thought about the way my countertransference had interfered with my work during the previous session, and I had independently decided not to make any more angry accusations in the guise of interpretations. When she told me about her feelings, I thanked her for doing so, said she was right, and apologized. Sandra seemed to relax and told me she had thought about what I had said, and I was right, too. She did have trouble acknowledging my helpful interventions. But she felt threatened. The more she trusted me and the closer she felt to me, the more she dreaded total failure and humiliation—and then there was the ultimate trauma that was always hanging over our relationship: if she really let me matter, someday I would leave her and it would really hurt. For the first time, the termination issue was consciously seeping into our work: if she showed me how the therapy was benefiting her, and how much improvement there was in her everyday life, then I would say the work of therapy was done and we must part.

Nothing changed dramatically, but in the ensuing sessions Sandra spoke a little more spontaneously, and we were able to talk about how hard relationships were for her—and partings. Yet she was so tired of being totally alone. Sandra's course in therapy is a good example of how precedents of termination issues surface right from the beginning of therapy. Before proceeding to a presentation of the termination phase of Sandra's therapy, I will make some general comments about the termination of psychotherapy.

The Termination of Psychotherapy

David Cooper (1970) offers a useful metaphor for the termination of psychoanalytic psychotherapy:

> At the commencement of therapy the room may hold hundreds of people, principally all the person's family over several generations, but also significant other people. Some of the population inevitably includes the therapist's internalized others—but the guarantee of good therapy is that the therapist is familiar enough with the machinations of his internal family and has them well enough tamed. Bit by bit in therapy, one identifies the members of this vast family and all its extensions and asks them, appropriately enough, to "leave the room," until one is left with two people who are free to meet or to leave each other, (p. 5)

Everyone experiences repeated losses and separations throughout life, and each person evolves a

personal style for coping with the inevitability of loss. Generally, the individual's reasons for seeking therapy have something to do with an unbearable loss, real or imagined, in the past or threatened in the future, or the reasons have something to do with what is dysfunctional or disturbing about the personal style of coping. Some people are so frightened of being rejected or deserted that they withdraw from all meaningful intimacies and consequently feel isolated and alone. Others keep their intimacies superficial in order to avoid the pain that would otherwise follow loss, drift from one superficial relationship to another, and then complain to therapists that they feel empty inside and are bored in all their human encounters (perhaps including this one with the therapist).

Others act helpless, chronically sick, or hopelessly depressed, clinging to whoever comes close, as if hoping that some very powerful and loving individual will come along who will take care of them forever. They might fall apart when a loved one, feeling engulfed, leaves them. Or they might complain to a therapist that they feel merged and lack autonomy and a sense of self. Thus a woman client complains to me that she feels she is merged to a clingy man, lacks her own identity, and gives herself away too much to him, but is afraid to establish more appropriate boundaries for fear she will lose him and be all alone. Others become anxious, dysfunctional, or even psychotic when confronted with a real or potential separation. And others are so consumed with rage toward loved ones who have disappointed or deserted them in the past that they bring into every new relationship an intensity of hostility and ambivalence that precludes the establishment of real intimacy.

Whatever the client's idiosyncratic issues and defensive maneuvers, she or he will bring them into the therapeutic relationship where, one hopes, they can be examined and worked through. The client does not encounter the separation issue only once at the end of therapy any more than one ponders the experience of death only once at the end of life. In regard to death, it is the mortifying losses, the unbearable pains, and all the other little deaths that occur throughout life that provide the conceptual building blocks for our ideas about what awaits us in the end. Likewise, in therapy, the little separations and betrayals that occur during the course of therapy present the client and therapist with an opportunity to understand and work through the client's troublesome issues with separation and loss. A harsh criticism by the therapist, a betrayal, or a rejection will hurt—and probably hurt in the same way as formative unbearable criticisms and rejections once hurt. The criticism might be a figment of the client's imagination projected onto a therapist who was truly not feeling critical at that moment, or the therapist

may for some reason have been critical. The sense of rejection might occur when the therapist announces a vacation, or the betrayal might involve the therapist's inability to make life easier for the client fast enough. The real basis of the client's feeling is not the only issue. The therapist must also help the client learn to survive and live fully in face of this risk of disappointment and pain. Then the client will be better able to shed outdated defensive maneuvers. In this way the client prepares for the real loss—of the therapist—that awaits at the end of the therapeutic encounter.

Margaret Mahler (1972) identifies the paradox of termination: in order to individuate, the individual must separate from the parent. Her formulation of the rapprochement subphase of the separation-individuation process is usefully applied to the termination of therapy. She explains how the toddler, excited about the newfound freedom to explore that comes with upright locomotion and a new level of cognitive development, first reaches out and explores the environment with great enthusiasm. Then, as if suddenly aware of the growing separation from mother, the toddler becomes very concerned about where mother is and how she is reacting to his or her explorations. The child experiences separation anxiety. If the mother responds by encouraging the child to explore and to conquer new challenges, the child transcends the anxiety and explores further. If the mother becomes depressed that the child has left her lap, excessively anxious about dangers connected with the child's explorations, rageful when the child falls or makes a mess, or just plain inattentive, the child is left feeling conflicted about new adventures, growth, and independent strivings.

Here is a metaphor for the termination of analysis or therapy. The price of completing the tasks of therapy and "graduating" is that the client must give up regular contact with and dependency on the therapist. When the client's experience of separation-individuation as a toddler was traumatic, and conflicts or abandonment anxiety lingers, the trade-off can be less than appealing. Some clients worry that the therapist will be enraged, others are certain the therapist does not really care anyway. Some clients worry that they will fall flat on their face once separate from the therapist, and others that it is the therapist who will fall apart or sink into depression once they are gone.

Whatever the fantasy, the therapist must help the client identify it and work it through so that separations can be experienced in a healthier fashion and personal growth and independence do not provoke anxiety and conflicts. The therapist, during the course of the therapy, slowly begins to ask the

earliest others "to leave the room," so that the new other, the therapist, and the client can converse, during the termination phase, about how this new relationship might end on a more growthful note.

Sometimes therapy is interrupted for external reasons. These include the therapist's plan to move out of the area or cease practicing, the client's plan to move, the client's lack of financial resources to continue in therapy, and so forth. In discussing Burt's therapy later in this chapter, I will have an opportunity to say something about the shortage of financial resources. Here I will comment on the situation where the therapist is seeing a client in a clinic setting, perhaps as part of a psychology internship or psychiatry residency, and is about to complete a phase of training and leave the clinic. Eugene Pumpian-Mindlin (1958) makes some helpful suggestions on the management of this situation. Many supervisors suggest that in such a predicament, the therapist-trainee should wait until a few months before the time when the internship or residency is to end, and then announce his or her imminent departure. The rationale is that this leaves enough time to work through termination issues and does not create a situation earlier in the therapeutic encounter where the client might be hesitant to deepen the therapeutic relationship for fear of eventual abandonment.

I disagree with this teaching. It seems to me the therapist should assume the client knows more about his or her abandonment issues and separation anxieties than does the therapist. And the client's judgment, however compromised by the emotional disorder, should dictate the level to which he or she will permit the therapeutic relationship to deepen. If the client does not want to share certain personal thoughts, the therapist must respect the defense. If this is not always true with all clients, it certainly is the case in the particular circumstance where the therapist knows this therapy will end on a particular date. I believe, as a general rule, the therapist should tell the client from the beginning of therapy all she or he knows about the limit to the length of the therapy. Then the client can decide, given the time limit, how much to disclose and how dependent to become. Thus, if a therapist commences a therapeutic encounter in September and knows she or he will be leaving the clinic at the end of the following June, I believe the therapist is obligated to share this knowledge with the client. Some clients know they cannot tolerate a close relationship that will end in nine months. Others agree to the time limit but then always consider the time constraint when trying to decide what to share with the therapist and what not to share.

There are times when the therapist decides to discontinue the therapy before the criteria for termination have been met, not because of external considerations but because the therapy seems hopelessly stuck. This is essentially what happened in Frank B.'s case (chapter 2). There, the transference was erotized to such an extent that the analysis had to be terminated. The problem might be that the transference is erotized or that the analysis or therapy becomes so gratifying, for itself, independent of any amelioration of the symptoms, that the client resists growth in order to remain in this gratifying encounter. The therapist s task, in either case, is to interpret defensive aspects of the erotic feelings or the gratification from therapy—for example, the client makes this into a romantic relationship in order to seduce the therapist, as she did her father, into adoring her and never wishing to leave her. Or, the male client who enjoys the therapeutic relationship more than its healing effects uses the therapeutic relationship to escape from anxieties connected with establishing close relationships outside the consulting room. The therapist must make a serious attempt to help the client work through whatever resistances are present, but if, after a certain time spent confronting and interpreting the resistance, the erotized or overly gratifying relationship remains unaltered, the therapy might have to be terminated for the simple reason that there is insufficient clinical benefit to justify the therapist's time and the client's money. After the therapist tells the client that the therapy is to be discontinued, the task during the termination phase will be to examine the client's reactions to the therapist's decision to terminate, to help the client cope with the loss, and to maximize the benefits of the therapy. (For a discussion of erotized transference and how it is managed, see Greenson, 1967, and Ticho, 1966. For a discussion of stalemates in treatment, see Kernberg, 1984, pp. 241-53.)

When the therapy does reach the point where the criteria for termination have been met, the therapist and client agree upon a date for their last session, and the termination phase begins. Once the date has been set, the client's issues about termination emerge with renewed intensity. Even though each client experiences the ending differently, there are some identifiable patterns. Elsewhere (Kupers, 1981, pp. 196-212) I enumerate three: the client who so deeply resents what he experiences as rejection or abandonment by the therapist at the time of termination that he attacks the work of the therapy and undoes or fails to make use of the gains of treatment; the client who becomes so anxious and feels so helpless whenever the therapist takes a vacation or mentions termination that a regression occurs and the dependency seems interminable; and the client who refuses to become dependent on the

therapist in the first place, or denies the dependency that has developed, and is being truthful when, at the time of termination, she or he says, " It's OK I won't miss you." There are other patterns, and there are accompanying emotions. Roy Schafer (1973) writes:

> The potential for virtually every significant human emotion resides in the termination situation. . . . The ideal termination would explore all these emotions—for example, feelings of deprivation and longing, guilt and unworthiness, gratitude and envy, triumph and defeat, love and betrayal, disappointment and elation, rage and grief, from all levels of psychosexual and ego development—insofar as they were accessible and significant, (p. 146)

Whatever the particular pattern, the client experiences negative as well as positive feelings toward the therapist. And there are good and bad memories of the therapeutic encounter. Examples of good memories are the times the therapist was warm and understanding when the client was needy, or the times the therapist gave a helpful interpretation or piece of advice, or the times pleasant thoughts about a recent therapy session carried the client through a depressing period between sessions. The bad memories are of times the therapist seemed mean, unsympathetic, unhelpful, or rejecting. If the client denies the negative feelings, for instance, while idealizing the therapist, it is the therapist's task to help the client discover the negative feelings and tolerate a certain amount of ambivalence. Negative feelings tend to emerge, if they are not denied, when the therapist goes on vacation. They are often reawakened when the client realizes the therapy is about to terminate.

If the negative feelings do not surface during therapy, and especially during the termination phase, it is likely they will grow stronger after termination—the need to idealize the therapist or deny negative feelings lessens when the therapist is no longer around—and undermine the benefits of the therapy. Therefore, it is especially important for the therapist, during the termination phase, to help the client be in touch with negative feelings, particularly feelings of disappointment, so that the client can look at those feelings as well as the positive ones, and in the balance, decide that though there are the negative feelings, the therapy has accomplished a great deal. Myrna Holden (1983), in a study comparing the outcomes of brief therapies where the negative feelings are explored with otherwise comparable therapies where they are not, finds that the exploration of negative feelings toward the therapist markedly increases the likelihood that the gains from therapy will be significant and lasting.

If the therapy has gone well, when it is time to terminate the therapy the client is ready to mourn

the real loss, carry the therapist inside as a benign internalized object, and continue with life in a new and healthier way. This is the ideal. In reality, it seldom goes so smoothly. I will present vignettes that illustrate a few of the many diverse paths the termination of therapy can take, beginning with the termination of Sandra's therapy.

Sandra's Termination

As I have already mentioned, Sandra's termination issue was expressed early in the therapy. She believed that by refusing to share with me the gains in her life from therapy, she would avoid termination. If she let me know how much better she was doing because of our work, I would turn around and say: "Fine, that means we've accomplished what we came together for, and now it is time to end our relationship." As usual, there was a large kernel of truth in Sandra's formulation. We would someday end the therapeutic relationship, and yes, that would be when she had gained enough from our encounter. But this particular issue created problems in her relationship with me—a window on problems in her relationships with others. I found my interactions with her frustrating and unrewarding. I never heard about the changes in her life outside the consulting room, and all I got was icy silence. In addition, she never expressed any appreciation for what I did, and there were times when I just knew my interpretations were correct and useful, but she said nothing.

Sandra was reproducing with me a conflictual interaction she had with her mother. Beyond that, she was missing an important point about termination. Yes, when our work was done, we would part. That is the nature of therapy. But by the time that occurred, Sandra would be different in important respects, and one of those differences would be that she would better be able to tolerate separation and loss. And she would be ready to halt therapy and move on in her life. We discussed her shortsightedness in this regard and the way her failure to share gains and gratitude with me stifled our interactions.

Inevitably such discussions get around to the question of who decides on the actual date of termination. Sandra's original formulation was based on the assumption that the decision was totally in my hands. I would assess her improvement and tell her when we would terminate. Therefore she believed her only option was to hide the improvements from me, or refuse to grow altogether. Once we agreed that she would have a lot to say about the actual date of termination, she was able to share with

me some of the ways therapy was helping her in her life. And, at first very hesitantly, she was able to express some appreciation for my efforts, including my patience with her while she was so cold and withholding.

Sometime later, Sandra began to feel she had benefited a great deal from therapy and might be ready to terminate. By this time, she was in a relationship with a man that seemed to have a great deal of potential, had collected a rather impressive network of women intimates, was enjoying her work much more than she had ever before, and felt much more spontaneous in all of her endeavors. I reminded her of the time she had thought she would never want to terminate, and we laughed very tentatively about the turnaround. After hearing all the ideas and fantasies she could produce on the subject of termination, I responded that yes, I thought this was a good time to talk seriously of termination. Sandra was relieved, beamed proudly, and said that meant I thought she had accomplished the tasks of therapy and was ready to graduate.

The following week, Sandra returned depressed, and said she felt rejected by me, that I was trying to get rid of her and make room for someone else in my practice. Obviously, we had touched on another layer of issues she had about separation, and would have to work through those issues before terminating. It was not until several months later that we could mutually agree to set a date for our final session, and that date was several more months down the line. By then, we had spent enough time talking about Sandra's mixed feelings about our parting that we could end by merely sharing with each other how sad we would both be about not meeting regularly anymore.

Burt

Burt, by thirty-five, had done well in business. He was a vice president in a small but profitable corporation. Then the floor caved in. The corporation was bought by a larger corporation, the larger corporation replaced the top administration with appointments of their own, and Burt was offered a lower-paying job with less status. Rather than accept this humiliating demotion, he decided to quit. He cashed in the stock options he had been accumulating as a manager in the corporation, the equivalent of about eight months' salary. He thought this would be plenty of time to find an even better position as a manager. But when six months passed and he found no work that he felt was worthy of his talents, he

became disheartened. He began to lose sleep worrying about finding work.

Meanwhile he stopped seeing his friends, in part because he felt embarrassed about being unemployed. A single man, he had prided himself on being a playboy, and enjoyed dating and sleeping with several women in any given week. But by the time six months of unemployment had passed, he discovered that he was occasionally impotent, and since he could not predict when it would be, he stopped dating entirely. To make matters worse, he had by this time lost so much confidence that he was presenting himself poorly at job interviews and felt pessimistic about finding work. He decided to seek help from a therapist for the first time in his life.

When Burt first entered my office, he seemed meek and depressed. He told of a family with high standards, his father being a successful, self-made businessman, his older brother an attorney, and his younger sister a physician. His two siblings had always done well in school, while Burt was unmotivated and received average grades. He was more of a " regular guy," winning several varsity letters in high school, and then joining a fraternity in college and living "a wild life of boozing and womanizing." His parents never really approved of his performance until he entered a corporation after his college graduation and quickly worked his way up the management ladder. His father, who had never graduated high school and had always been intimidated by people with advanced degrees, was particularly impressed with the fact that Burt had more income than either of his better educated siblings. Obviously, the loss of his job was a huge blow to Burt's ego, and Burt's narcissistic personality made him quite vulnerable. The massive depression that followed immobilized him. Burt seems to have suffered a narcissistic injury (Goldberg, 1973).

I listened to Burt's complaints about the unfairness of the corporate merger, confronted him about his tendency to negate all he had accomplished in his life to date just because of this one setback, and talked with him about the pressures and high standards he, like his father, set for himself, and how unforgiving they both were. After a few sessions, his depression lightened.

We discovered a fantasy he had from an early age that, because of his innate talent and charisma, and in spite of performing poorly in school, he would one day finesse his way into a high-paying job and surpass all of those who had applied themselves more and had better credentials (this would include his

siblings, of course). The flip side of this rather grandiose fantasy was that the others he surpassed would be envious and would one day plot to deprive him of his status and power. The aftermath of the corporate merger seemed to fulfill his worst fears, including the corollary that he really did not deserve to be successful, and once exposed, would fall all the way to the bottom of the heap. Of course, this fantasy prevented him from developing any realistic goals while searching for work. At this point in our discussion, he suddenly realized that the jobs he was applying for were well beyond his experience and capabilities and that he was not seriously pursuing the jobs that were roughly equivalent to the one he had lost. With that realization, he proceeded to apply for a series of jobs and was offered an acceptable one.

Meanwhile, there were parallels in his fantasies about women. To begin with, we talked about the possibility that he might permit himself to occasionally perform poorly in a sexual encounter without assuming he was a hopelessly impotent man. In fact, the one woman he showed the most interest in found him more lovable when he was vulnerable in that way. After several months of therapy, Burt found a satisfactory job and felt much better about himself.

At the beginning of one session he announced that it would be his last. He was in difficult financial straits and would not be able to continue paying for therapy. He told me that I had helped him quite a bit but that he was doing fine now. Besides, he felt I was mainly helpful for people in acute crisis. I am very supportive. But if he were to continue in therapy, he would want to find someone who was "more confrontative, more probing." I felt the wind go out of my sails. He was demeaning me and the work I do. Taking a minute to recover from *my* narcissistic injury, I began to explore in my own mind, and then with him, reasons he might have to demean me and my work.

First, we talked about finances. Yes, he was having some difficulty paying his bills, and therapy was expensive. I did not try to minimize the possibility that he might need to halt the therapy for financial reasons. I suggested that even though that might be the case, perhaps there were also other reasons for his wanting to terminate. In other words, in response to the question whether it was really financial considerations or resistance that motivated him to terminate, my response was that it might be not one or the other, but both. When therapists interpret clients' claims that they cannot afford further therapy entirely as resistance, the client is justified in believing the therapist to be unsympathetic toward the

painful reality of his financial straits. Alternatively, when the therapist appreciates the financial consideration and suggests there might also be some hidden resistance, the client is more open to hearing the latter interpretation and might even then be able to find a way to continue in therapy. I suggested we momentarily postpone the discussion about finances and talk for a little while about other reasons he might have to terminate. Then, if finances were still the determining consideration, he could terminate with some better understanding of his feelings about therapy and about our relationship.

Burt admitted he felt some disappointment toward me and the limited results of our work together. He remembered liking my warm and comforting style at the beginning of therapy when he needed support. But then he began to feel that anyone who was as supportive as I was would not be able to challenge him enough to get beyond his defenses and manipulations. I acknowledged that I had been supportive in the beginning, and conceded that perhaps I failed to confront him sufficiently at one point. Then I pointed out that I had in fact altered my approach with him in the three most recent sessions, but that each time I made an interpretation he minimized it, either saying he already knew that or denying he felt the way I assumed he was feeling. He thought about this, agreed that he had been defensive and that, in fact, the interpretations I was referring to had been both accurate and helpful. But after denying them, he had been too embarrassed to return and tell me how helpful they turned out to be.

He also revealed that he tended to think less of me when I accepted his criticism and changed my approach accordingly. We were then able to unravel a link to his disappointment in his father. Though his father was a successful businessman, he tended to be passive at home, permitting his wife to run the household and permitting his children to manipulate him and get away with lying. We discussed the difference between my changing my approach in response to his feedback about what is effective and what is ineffective, and whether or not this is necessarily a sign of weakness on my part. In fact, he had often wished that his father, instead of becoming critical when confronted about something, had been more responsive to his wishes.

This led us to the link between his need to devalue me and the termination issue. If he could devalue me sufficiently, he would not suffer much loss when we stop meeting. After all, if he did not derive much benefit from seeing me, then why should he feel anything about leaving me? His response to this interpretation was strong. He cried. He talked for a while about how much he had always longed to

have a "heart-to-heart talk" with his father, and how impossible that was. His father could not even look him in the eye. Then he was able to see that his need to terminate therapy so precipitously was a way to avoid feelings of disappointment in me that would certainly arise if he continued to see me beyond the time when he was needy. He turned the conversation back to the question of finances and decided he could find some more money for therapy if he tried. We agreed to extend the time he had in mind for the termination phase of therapy—he had been thinking of ending after the day's session—and during the two-month time we agreed upon he was able to stay in touch with the grief he felt about terminating.

Janice

Janice, at thirty-four, had never been in a long-term relationship and had never held a job for more than a year or two. She began therapy by telling me how rotten all her lovers and bosses had been to her. Tired of complaining about all of them, she settled down, seemed almost to breathe a sigh of relief, and then changed the subject to depression. She was feeling bad about herself, wondering if it was really she, and not the lovers and the bosses, who was difficult to get along with and not very likeable. She cried, " I just get so lonely, sometimes I wonder if it's all worth it. Maybe I'd be better off dead."

After we talked long enough about whether or not suicide was a real danger, and Janice was able to assure both of us that it was not, she moved on to another important topic. She wanted more than anything to have a child. But she could not seem to stay in a relationship with a man long enough to accomplish that. She thought this was the main reason for her depression. She wondered, since all of her bosses were men, if the real difficulty might not be about relating to men. She had stayed away from men since the last man she saw—for two months—left her in a particularly brutal way six months before she commenced therapy. After several months of therapy, she began to feel better about men and decided to go out with a man her sister had been wanting to fix her up with.

She went out with the man. They slept together on the first date. Then he disappeared, failing to call and not returning the one phone call she nervously forced herself to make. She was more hurt than angry. During the next therapy session she cried. I made some brief statement I thought might be helpful —perhaps a lame attempt at an interpretation—and she pounced. Until this point in the therapy, it had seemed as if Janice could not stand to think of me as anything but the perfect therapist. She lauded my

therapeutic skills as well as my caring manner, claiming I was very different than all those other unhelpful " shrinks" she had seen. Now, suddenly, I was not the caring, competent therapist. I was a "vindictive man who enjoys seeing patients suffer." She angrily berated me for my insensitivity, and added: "Besides, this therapy isn't helping me at all with my problems. My affair with this man was just as much a fiasco as all the rest."

In the midst of the ensuing discussion about what I was and was not doing for her, Janice complained that I was not taking care of her enough. I was not "hearing what hurts and doing something about it," and she thought it was because I did not really care about her. The particular statements of mine she found unhelpful and objectionable were the ones where I interpreted or confronted her about something she was doing rather than sympathized with her about the pain she was feeling. Thus, she found my questions—for instance, if she might not have waited longer to sleep with that man—to be very insensitive and uncaring.

Janice was expressing her belief that therapy is a place where the client is taken care of, where the therapist practically always satisfies the client's needs, within reason of course. At some point in our discussion, I made it clear that I do not see therapy quite that way. Of course there is a caring relationship wherein the work of therapy is done. But that work does not only, or even mainly, include support and caretaking. The therapist must confront the client at times and interpret what lies beneath the surface, and the interpretations might cause a certain amount of pain, or at least not be what the client would like to hear. I suggested that she might be angry about my doing that, precisely because her fantasy is that I will take care of her and never introduce any anxiety or tension into our relationship. But, I pointed out, my interventions are aimed at accomplishing the work of therapy, and I plan to make more like them. When I acknowledged that this might make her angry and mentioned that it takes a certain amount of courage for her to share with me that she is angry, she relaxed a little and admitted she sometimes just feels like having me take care of her, even though she knows that is not necessarily the best use of therapy.

This kind of exchange had to be repeated many times during the course of therapy with Janice. For instance, one time she was angry at me because she had called me the evening before and I did not answer her message until the following morning. We talked about her feeling disappointed. I

acknowledged that some of her disappointment was warranted—I might have answered her message the night before and saved her a certain amount of anguish. But she would not let the subject go. She kept returning to the fact that I did not answer her message. At some time during the session I repeated my speech about the difference between her view of therapy and mine, and added that the places where disappointments and betrayals occur in the therapeutic relationship are often the best places to do some work on the difficulty she was having with men—that is, here was an opportunity to examine in more depth this therapeutic relationship with a man.

Of course, Janice was one of the clients I dreaded telling of my upcoming vacations. She typically became angry, complained I was leaving her just when she needed me most, and either missed the session before I was to leave, or complained for several sessions after I returned about how hard her life had been in the interim. Repeatedly, I acknowledged her anger, pointed out the pattern in her reactions to disappointments and separations, and linked the whole issue to her constant fear while growing up of abandonment by her mother. Her mother was severely depressed and inattentive most of the time, and had been hospitalized for depression for two months when Janice was a year and a half old. In whatever words made sense at the time, and with reference to whatever hardships in her life she felt I abandoned her to, I repeatedly attempted to distinguish between our separation—an unavoidable facet of any relationship—and abandonment. The abandoner is by definition inattentive to the needs of the abandoned one—as her mother very definitely was at the time she was hospitalized—while the periodic separations that occur in any relationship are not necessarily due to insensitivity on the part of the one who leaves, and can be less traumatic when the two people discuss the scheduled break in advance and process some of the feelings involved. Thus, even though I unilaterally planned my vacations, and she did not have the power to prevent me from going, I did take care to inform her about it, assured her I would be back on a specified date, and then paid attention to her feelings and concerns about our separation. This kind of exchange occurred with each of my vacations, and gradually Janice learned that separations do not necessarily represent abandonments.

Even though this general discussion occurred repeatedly during the course of Janice's long and difficult therapy, Janice felt betrayed and abandoned anew when termination time neared. Any time I even mentioned the subject, Janice would become enraged, claiming I could not wait to get rid of her. She believed I would use her two hours a week to see a woman I preferred: "a prettier one, one who is easier

to get along with and is more in awe of you."

After several such exchanges, when therapy had proceeded for three years and Janice seemed to be doing very well, I again broached the subject of termination, this time in the context of reviewing Janice's impressive progress in therapy. She still was not in a long-term relationship with a man, but she was dating and optimistic about finding Mr. Right someday. And though she still became angry when I announced a missed session or a vacation, the anger was not as intense, she could talk about it rather than screaming or acting out, and she could let go of the subject after a brief discussion. She had decided somewhere toward the middle of therapy to enter graduate school and pursue a profession—an objective she was well on the way to accomplishing. And she had for some time been complaining about a lack of funds to continue therapy. Even though the time seemed right for a serious discussion of termination, she exploded more forcefully than I had seen for many months and renewed her accusations that I was just trying to get rid of her because I preferred to spend the hours seeing someone else.

When I raised the question of termination once again with Janice, she admitted that one of the reasons she did not want to talk about it was that she could not imagine my being absent from her life. She shared a fantasy she had that after therapy was completed, we might become lovers. Barring that, she would at least like to be good friends. The discussion turned to the different types of relationships two individuals might have and the choices that are made along the way. She had once told me about her ambivalence about sleeping with a close male friend of hers, how she feared the romantic relationship would not work out and then she would be losing her only close friendship with a man. I reminded her of that discussion and focused for a moment on the choice she had. Therapy involved a comparable choice. For the therapy to be effective, there must be a certain therapeutic distance in the consulting room. After all, no one wanted to be in therapy with a relative, a lover, or a friend. She agreed: "Of course not, you need more objectivity than that." I took advantage of the moment to point out the choice one makes when one enters a therapeutic encounter. Though the client might have conflicts about giving up the possibility of a different kind of relationship with the therapist—as friend or lover, for instance—there is the choice to designate this person as one's therapist. Even if attractions and romantic fantasies crop up during the course of the therapy, the choice is binding. In any case, much can be gained from a therapeutic relationship, making giving up the alternatives worthwhile. (This is an oversimplified

synopsis of a discussion that occupied three sessions and was punctuated with awkward silences, tears, and occasional outbursts of anger and resentment.)

Janice eventually agreed the time for termination was near. She and I spent several months—probably the larger part of the termination phase of her therapy—talking about the difference between a termination of therapy that is agreed upon by both partners, and abandonment, that happens when one person unilaterally leaves and the other person is not near ready to carry on by herself. Her affect during the first half of the termination phase was typically anger, and during the second half sadness. Remember, Janice's early idealization of me was a defensive attempt to avoid negative feelings. Only later, after I disappointed her by not being as sensitive as she would have liked when she felt abandoned by a man, did the negativity surface. Recall the general principle: if the negative transference is not brought to the surface and sufficiently worked through, the client is left alone after termination with a stockpile of unarticulated or unconscious bad feelings that will ultimately undermine the gains of the therapy. But if the negative feelings can be worked through, they can be seen in perspective with the positive feelings, and the latter can be preserved in lasting change. Eventually Janice was able to integrate the two, telling me at one point that she was finally able to see what I meant when I said a person could be angry at someone close, express it, and still appreciate the value of the relationship and mourn the loss.

The ending is not always as ideal as it turned out in Janice's case. For some people, the trauma of parting looms larger than any gain they can imagine getting from the therapeutic encounter. Consider for a moment the hospitalized psychotic patient who seems to do very well on the inpatient unit, quickly responds to medications and milieu therapy so that the hallucinations and bizarre behaviors that landed him in the hospital are under control, is a work leader in daily group-therapy sessions, is very attached to one of the staff who meets regularly with him, and seems motivated to make plans to live independently. Then his primary therapist arranges a job interview for him as part of discharge planning. The night before the interview, the psychotic symptoms suddenly reappear. The patient becomes violent and uncontrollable to the extent that he must be isolated in a security room and have his medication dosages raised. What happened? It seems the prospect of leaving the by now familiar and safe ward and its staff is more frightening than the prospect of holding a job and being independent is attractive. This, in a nutshell, is the dilemma of many people whose emotional symptomatology is less severe and who never

need hospitalization. But their intense dread of partings causes their therapies to misfire. Janice and I were able to work through this issue. Many therapies fail because it is too deep an issue for the client to transcend.

As therapists take on more difficult cases, such as those involving primitive character disorders, the termination issue looms even larger in the consulting room. And consequently, new strategies must be devised to treat clients for whom the trauma of termination seems to outweigh the potential benefits of entering into a therapeutic relationship. More attention must be given to termination issues, even early in therapy when precursors of the termination issue surface. Then, like psychoanalysis, psychotherapy with less disturbed clients follows the same path, deeper-lying recesses of the psyche are explored, and as a consequence termination is considered a more important issue to focus on. I will conclude this chapter on the termination of long-term psychotherapy with a discussion of the countertransference.

Countertransference

In chapter 1 I mentioned Freud's fear of dependency—his own and others'—and speculated that might be the reason he failed at the time of termination to work through with analysands their dependency on him. Since Freud, therapists have paid more attention to their clients' feelings about ending the therapeutic relationship. Longer therapies that probe for deeper-lying conflicts tend to foster more dependency, resulting in heightened termination issues, and consequently the modern therapist cannot minimize the client's feelings of loss as Freud attempted to do with the Wolfman.

Therapists have issues about termination, too. Laplanche and Pontalis (1973) define countertransference as "the whole of the analyst's unconscious reactions to the individual analysand—especially to the analysand s own transference" (p. 92). I am using a broader definition, including conscious as well as unconscious reactions. Some of the therapist's reactions are blatantly inappropriate, for instance, concern that when this client terminates the therapist will have difficulty filling the vacant time slot. In practice, concerns like this probably account for many overly lengthy therapies. The therapist, out of self-interest, colludes with the client's dependency and prolongs the therapy. Other sentiments are more honorable, but still must be suppressed or worked through privately by the therapist. For instance, the therapist might realize that he or she is overly identified with a particular

client, very fond of the client, or even secretly in love with the client, and will have great difficulty saying goodbye. Weddington and Cavenar (1979) suggest that the dearth of clinical literature on termination reflects the fact that therapists have difficulty coping with their countertransference feelings.

In relation to these very human feelings, the basic rule of psychotherapy, as of analysis, is that the therapist must keep a running account of the countertransference, attempt to understand the interface and crossings of transference and countertransference, utilize countertransference feelings to inform interpretations where appropriate—for instance, if there is reason to believe the therapist's feelings toward the client result from the client's projections or projective indentifications—and then work through the other countertransference feelings and issues privately in order not to burden the client with them and not to let them interfere with the progress of the therapy. Some therapists, for instance, have a need to foster dependency in their clients, or to collude with their clients' dependency needs, and if their countertransference is not worked through, therapies they conduct become ineffective and interminable.

One particular countertransference theme often emerges at termination and deserves mention. The therapist's task is to help the client transcend psychological constrictions and grow. When all goes well, there is gratification in the work, gratification that resembles the parent's when the child grows and flourishes. As the time for termination nears, the therapist, depending on what unconscious conflicts and fantasies there are about separation and loss, might experience some difficulty letting go of the client, just as the parent might when the child is ready to leave home.

David Malan (1973) describes the " social-worker syndrome" that is present for many therapists. The social worker takes care of clients better than she or he was taken care of as a child and vicariously identifies with the client who is receiving such good care. But then the social worker (or therapist, to the degree the syndrome is present) resents the client who is receiving such good care, care the social worker would like to have received him- or herself.

To the extent this syndrome is present in the therapist, there is a problem at the time of termination. The therapist derives a certain amount of gratification from the client's growth and success. As long as the therapeutic relationship continues, all is well. Then, when it is time for therapist and client to part, the

therapist might feel some resentment that the client has benefited from the therapist's best efforts, and then is going to leave, and will likely forget about the therapist soon thereafter. After all, the child remains connected with the parent after leaving home, but the termination of therapy is usually more final. Sometimes a client's idiosyncratic defensive maneuvers at the time of termination aggravate the therapist's countertransference feelings. This happens, for instance, when the client attempts to minimize feelings of loss by not recognizing and appreciating how much the therapist has helped. Ideally, of course, the therapist has worked through in a personal analysis or therapy the inner conflicts that lead to this kind of resentment.

Sandra's tendency to devalue the therapeutic relationship certainly brought out the social-worker syndrome in me. As the time of termination neared, she reactivated a defense mechanism I had interpreted earlier in our work together. She stopped telling me about the positive things going on in her life outside the consulting room and told me only about her problems. At the same time, she expressed no appreciation for anything we had accomplished in therapy, and even began telling me about a friend—remember, it was only as a result of our work that she would risk close friendship—who was able to enter a relationship with a man and become pregnant before terminating therapy. For a while, during the termination phase, our meetings were tense. I found myself confronting her on details—she would arrive a few minutes late, or fail to tell me a dream until two weeks later—but there was a bitter edge to my interpretations of her resistance. Sandra was of course trying to diminish her feelings of loss by devaluing me, and perhaps her unconscious fantasy was that if I was angry at her for her lack of appreciation, and retaliated with insensitivity and meanness (as either of her parents would have done), the parting would be angry, but easier. Eventually, I discovered the way her devaluing enraged the frustrated social worker in me, and I was able to put this into proper perspective with the loss I was feeling as termination neared. Only then could I point out, with the correct timing and dosage and without the bitter edge, that she was defensively minimizing the benefits of our work together in order to make the parting easier. She agreed, and her tears confirmed that we had successfully worked through an important part of the termination process.

There are as many countertransference themes at termination as there are transference themes. For instance, Martin and Schurtman (1985) discuss the therapist's feelings about loss of the professional role that had differentiated therapist from client during the course of the therapy—that is, when the

transference is resolved, the therapist is no longer idealized, and the two are more alike than different in the mourning they experience at their parting. Again, as David Cooper (1970) writes: "The guarantee of good therapy is that the therapist is familiar enough with the machinations of his internal family and has them well enough tamed" (p. 5).