Till Death Do Us Part

George Moraitis, M.D.

In this article, the termination of analysis is examined from the vantage point of the analyst. The nature of the bond that analysts form with their patients is explored, as well as the extent to which this bond interferes with their capacity to facilitate the process of terminating the analysis. Patients with severe psychopathology cannot be expected to terminate their analyses the same way neurotics do. Both analysts and patients must come to terms with their unrealistic expectations of themselves and of the healing powers of psychoanalysis in order to avoid an interminable and unproductive process.

A few years ago, I closed my analytic practice. I planned and implemented my decision very methodically. After my seventy-first birthday, I stopped taking new analytic patients and, for six years, I worked very diligently with my last five analytic patients until all of them completed their analysis by mutual consent. I did not set a date for closing my practice until all my analytic patients had terminated their analyses.

Analysts do not usually retire; they slow down and gradually fade away. There are, of course, many exceptions, but most of these pertain to those whose retirement was imposed upon them by the state of their health. I am among the few who decided to retire. Most of my colleagues found it hard to believe that I would really do it. Some tried to dissuade me from my decision. With very few, very notable exceptions, I had the sense that they felt sorry for me, even when they congratulated me for my courage.

The process of saying goodbye to my patients was by no means easy. At times, I had my own doubts about my decision, and I did a good deal of reflecting and introspecting. That situation was further complicated by my wife’s illness. But I stayed the course and now, more than two years later, I am glad that I did it.

Many of my readers may wonder why I wanted to retire. I can best answer this by reversing the question. Isn’t the aging process a good enough reason to make all psychoanalysts consider retirement after the age of seventy? By and large, professional people have ambivalent feelings about retirement. After they pass the age of seventy, however, and given the right circumstances, retirement becomes very appealing. In contrast, most psychoanalysts act as if they perceive themselves as ageless. It is not accidental that, before too long, the average age of training analysts will be seventy-three, and 30% of the members of the American Psychoanalytic Association will have reached the age of seventy (most of them, probably, with no plans to retire).

It can be argued that the practice of psychoanalysis does not require physical effort, and is therefore not subject to the physical constraints of other professions. Such arguments do not take

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into account the emotional toll that psychoanalytic practice extracts from its practitioners, and the difficulties analysts of advanced age have in dealing with the tensions generated by negative transference, suicidal threats, acting out, and other complexities of analytic practice. Analysts work in isolation, and rely entirely on their own assessment of their capacity to cope with the stresses of the analytic profession. If they wait too long, they will be the last ones to find out when their mental functions are no longer intact.

Kurt Eissler (1993) explored the possible effects of aging on the practice of psychoanalysis, and found both positive and negative contributions. On the positive side, he referred to the analyst’s reduction of ambition, a decreased tendency toward activity, increased tolerance, and greater capacity to empathize with the patient’s childhood experiences. However, Eissler did not fail to recognize the damaging effect aging has on the practice of psychoanalysis. He refers to the biological factor that in aging progressively takes over the immediate control of the psychological process. Furthermore, the impoverishment of the analyst’s love objects and the possible compensatory cathexis of the patients as love objects imperil the analytic process.

In reference to the patient’s concerns about the analyst’s age and the possibility of death, Eissler writes (1993, p. 330): “Once the analyst’s age passes the sixth decade ... the objective probability of seeing his analyst in good health after his last analytic session shrinks with the progress of time. Therefore, it is necessary that the analyst tell the patient to whom to turn for advice and treatment should the analyst die.”

At no point does Eissler consider the analyst’s retirement as an option. Instead, he assumes that the analysis will proceed “till death do us part.”

It is not only aging analysts who adopt this attitude toward their patients. In our times, many analyses are conducted within the bounds of the “till death do us part” mentality, as a result of which termination has become a relative term, and there is little consensus about what constitutes a proper way to end an analysis. Several institutes in this country no longer demand a terminated case for graduation, and the notion of an interminable analytic process is becoming acceptable—if not appealing—to a number of analysts. Accordingly, analyses have become increasingly longer, and often without an end in sight.

In this article, I will focus on the nature of the bond analysts form with their patients, and the extent to which this bond interferes with their capacity to facilitate the process of terminating. I take into account that not all analysts cathexis their patients the same way, and each analyst cathexes each of his or her patients differently. Within the bounds of this large spectrum, we can identify, at one end, those whose feelings and attitudes toward their patients resemble those of the surgeon and, at the other end, those who turn their patients into love objects, essential to the maintenance of their self-organization. In one or another, however, all analytic patients are important objects that are essential for the satisfaction of the analyst’s psychological needs.

There are great differences in the degree to which analysts allow their patients to enter their private space. Early in the history of psychoanalysis, when analyses were short, Freud used the metaphor of the surgeon with some degree of justification, despite the fact that Freud himself was by no means like a surgeon vis-à-vis his patients. In our times, given the changes in psychoanalytic clinical theory and practice, it is almost inevitable that the patient will enter the analyst’s personal space and become an important object that cannot be easily replaced or relinquished.

For some time now, the analytic community has become aware of the need to study the analyst’s input into the analytic process by focusing on the analytic dyad. The first efforts were based on Freud’s concept of countertransference, which has been further elaborated and broadened.

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There have been new conceptualizations as well. Winnicott’s (1957/1963) concept of the holding environment, Modell’s (1993) concept of the shared reality, Gedo’s (1984) concept of a shared language, Gardner’s (1983) references to parallel self-inquiries of analyst and analysand, as well as the advocates of intersubjectivity (Stolorow and Atwood, 1992), all clearly convey how personal is the analyst’s input into the analytic process and the strong sense of mutuality that characterizes the analytic dyad.

In most of these propositions, however, there is a presumption, at least, of an asymmetry between the analyst’s input into the process and that of the patient. This is the way to recognize that one of the partners of the dyad has requested assistance and the other provides it. Accordingly, although patient and analyst share a good deal within the analytic dyad, the functions and psychological needs of the participants are different.

Not all investigators agree about the asymmetry within the analytic dyad. Howard Bacal and Peter Thompson (1984) have postulated that the analyst’s self-object needs are identical to the self-object needs of the patient. According to them, every analyst brings his or her self-object needs into the relationship with the patient and, ordinarily, these needs are responded to by the patient. When this mutually satisfying relationship is disrupted by the actions of either of the participants, a “relatedness reaction” is triggered, the severity of which depends on the degree of disruption.

Bacal and Thompson recognize a common mirroring self-object need for the therapist, and assume that the self-object needs of the therapist and of the patient are the same. I believe that the symmetrical relationship described by these authors occurs only in pathological situations in which the more archaic psychological needs of the analyst intrude into the analytic dyad. Under such circumstances, the bond of the analyst to the patient may indeed be no different than the patient’s bond to the analyst.

Generally speaking, analysts do not bond with their patients the same way their patients bond with them. The patient’s bond to the analyst is based on the transference, through which past experiences with the caretakers are reenacted in the clinical situation. In contrast, the analysts’ bonds with their patients are based on their professional function and on the internalized models of psychoanalysis that shape this function. Most of what analysts do, say, think, and feel in the clinical situation is mediated through these models, which provide them with established references to understand their patients’ communications. The use of such references not only informs the analytic work, it also protects the patients from the analysts’ unbound use of their idiosyncratic notions.

To be sure, the analysts’ use of psychoanalytic models does not necessarily render them objective. As I have discussed elsewhere (Moraitis, 1984), such models are not immune to the psychological needs of those who develop and use them. This is particularly true when models become ideologies, an issue that I will address later on in this article. Nevertheless, the use of psychoanalytic models is essential because they provide the clinician with guidance and structure, and to an extent they shield the patients from the more archaic needs of their analysts.

Early in their analytic training, analysts become attached to their “control cases” with great intensity, because their experiences with these patients enable them to take a position on the other pole of the analytic dyad in identification with the function of their analysts. Their work with these cases facilitates their idealization of psychoanalysis and becomes the proving ground of who they are and who they aspire to be. When they present them to their supervisors and in seminars, they do not only present their patients, but themselves as well, a process that creates a blurring of boundaries. Candidates’ experiences with their control cases become deeply in-
grained reference points, which inevitably influence the way they castepth other analytic patients later on.

Several years ago, as a member of the Committee on Certification of the American Psychoanalytic Association, I had the opportunity to read hundreds of case reports, and to interview a large number of applicants. Most applicants wrote up their case reports in a manner intended to illuminate the clinical theory that had been applied, rather than highlighting the patient’s personality and experiences, with which the theory may or may not have fit. For them, the patient had become the object upon which the idealized theory was projected.

Of course, many of the reports I read as a member of the certification committee were written with the aim of pleasing the reader, rather than out of conviction. Those applicants probably had a different theory in mind, which they idealized but which they felt was not safe to reveal. No matter which theory analysts adhere to, their bond with their patients is crucial in maintaining the idealization of that theory and of themselves as knowledgeable professionals.

Analysts are always in search of the elusive “ideal patient,” one with whom they can validate their convictions. When Freud’s patients failed to provide suitable material for his theoretical propositions, he used references from other sources. The Schreber case and the case of Little Hans are good examples of that. After Freud, however, it became extremely difficult to use such material for psychoanalytic theorizing, because it is not considered “psychoanalytic.”

Applied psychoanalysis has offered creative individuals a discourse other than the clinical situation with which to promote psychoanalytic knowledge. When the findings of applied analysis confirm existing psychoanalytic theories, they are usually well received. If, however, the investigator attempts to break new ground in psychoanalysis with the data of applied analysis, there is strong opposition. I believe the same is true of other nonclinical approaches to psychoanalytic studies, such as neurobiological research.

The exclusive reliance on the clinical situation for the validation of all psychoanalytic propositions makes clinical practice the *sine qua non* of the analyst’s professional identity and self-esteem. As it becomes increasingly difficult to find analytic patients, the analyst’s anxiety increases, especially when the time comes to consider the termination of an analysis. For many analysts, the ending of one analysis may mean the closing of their analytic practice, temporarily at least.

The word *termination* has a morbid quality to it. It conveys a sense of gloom and doom. The same gloom and doom is conveyed by the frequent references to Freud’s (1917) paper on “Mourning and Melancholia” when conceptualizing the termination process. Freud referred to mourning as the normal process of coming to terms with the death of a loved one, which could neither be controlled nor avoided. When used in the context of termination, it evokes the image of the dying analyst or the dying patient, as if death were the only way to part from each other.

The use of mourning as a metaphor in the context of the transference is understandable. The patient mourns the analyst as if the analyst were somebody else. Outside of that, its use is questionable. Termination is supposed to be a wished-for and willful act, which is not imposed upon the patient and the analyst by forces outside their control. There is no death involved, and the patient is hopefully in much better shape than she or he used to be.

Heather Craig, in her article, “Terminating Without Fatality” (another reference to death), refers to the “common practice among some classically trained analysts not to respond to patients’ contacts initiated after termination, including phone calls, letters, or e-mail messages.”

The thrust of Craig’s article is in her emotional appeal to analysts to reexamine their termination and post-termination practices, in order to remain available to their patients after termination.
She believes "that if the analyst somehow, in his own way, acknowledges to himself and to his patient that he too is affected emotionally by the termination, that he, too, is losing a partner in a mutual, though asymmetrical, libidinal relationship, then the analysand may not feel so alone in her grief."

I agree with Craige about the need to reexamine the termination practices, but this should not be limited to the "classical analysts." In our times, the "classical analyst" is often used as a straw-man in arguing for a certain intellectual position. The author's point of view is contrasted with a caricature in an effort to make it more convincing. I do not know who the analysts are that Craige has in mind, but I can think of nobody I know who would shut the door to the patients in the way Craige described.

In contrast, I can think of many analysts who have given difficulty parting with their patients and are caught in protracted process that does not seem to be getting them to any reasonable form of closure.

Craige's recommendation to analysts to reveal their own feelings at termination is consistent with what the supervisor of my first control case advised me to do many years ago. I have followed his recommendation ever since, but not with the aim of joining my patient in his or her grief. My aim has been to help my patient recover from the therapeutic regression facilitated by the lengthy analytic process, so that she or he can experience the analyst's humanity not as a transference object but "as a partner in a mutual, though asymmetric relationship."

The self-revelations I have found useful during the termination process pertain to my feelings during some critical periods or events in the course of the analysis, which provided the opportunity to review the work that had been done. Often this led to a better understanding of what happened and why. Even more importantly, it helped the patient appreciate the personality change achieved with the help of our analytic work.

Naturally there is a sense of loss at termination, a feeling of losing a partner, experienced by both people involved to various degrees and, if genuine, the analyst should not hesitate to acknowledge it. In a successful analysis, however, the tears of termination have a cathartic quality, and make those who shed them feel better and experience a sense of relief. Actually, despite the sadness and tears it evokes, termination is a joyous occasion. It is this pride and joy that the analyst must help the patient experience. In order to do that, the analyst may have to address unanalyzed aspects of the transference. Consider this:

Several years ago, I analyzed a young woman who, at the end of a very successful analysis, became very distraught during the termination period. Her intense sense of grief clearly resembled a mourning process. The patient had originally come to me when she was divorcing her first husband, which was a very painful process for her. At the time of termination, five years later, she was happily remarried and expecting a child.

I responded to her grief by pointing out its paradoxical nature. Given the fact that all her wishes had been fulfilled, what was her grief all about? Predictably, the patient became angry at me, accusing me of being callous, uncaring, and of having betrayed her. Her affects and behavior were reminiscent of how she felt in the beginning of the analysis about her first husband, who had abandoned her for another woman. Obviously, she felt that I was doing the same to her. When she finally realized that, some new aspects of the erotized transference became conscious. She had the illusion that I was in love with her, an illusion that was dispelled by the termination process. Several years after the end of the analysis, she paid me a visit with her two daughters. We had a very warm exchange as we reminisced about the end of her analysis, which was what she mostly remembered about it.
I think it is essential that the analyst not join the grieving patient during the termination period. Termination is not a funeral but a graduation. If the patient is experiencing it as a funeral, some more analytic work needs to be done.

Unfortunately, it is not always possible to resolve the unanalyzed transference issues, as in the case I described. During the last few decades, and under the influence of the widening scope of psychoanalysis, many patients have entered analysis who are a good deal more disturbed than those carefully screened in the golden years of psychoanalysis in this country. In our times, severe character disorders, borderlines, and patients in an ananic depressive phase are often put on the couch and analyzed, assuming of course that they can keep their appointments and pay their bills. Many of these patients cannot terminate their analyses the way neurotics of the past used to. For the most part, given the nature of their needs, they experience the analyst not as a transference object but as a real caretaker.

After many years of analysis, some of these patients progress to a more advanced stage of self-organization, but many don’t, as a result of which they perceive the analyst as indispensable and the analysis as interminable. When, somehow, an end to the analysis is imposed upon them by circumstances, shame, or the analyst’s interventions, they enter into a type of mourning that can become pathological in nature. Under such circumstances, there is no joy or pride, only shame, anger, and depression.

Termination has been an important part of the clinical model of psychoanalysis, which must be experienced if the analysis is to be considered successful. Termination is, however, no consensus about what constitutes a successful analysis. As Zeno (1999) points out, “The successful termination of an analysis is determined by the observer’s theoretical conceptions” (p. 31). Analysts experience pride and pleasure only when the end of an analysis is consistent with these conceptions. If their conceptions are not met, they will try hard to prevent the analysis from ending.

During the times of ego psychology, the successful ending of an analysis was defined by the resolution of the oedipal conflict and the increased capacity for adaptation. More recently, new definitions have been proposed by all schools of thought in psychoanalysis. These new definitions emanate from what is conceptualized as the curative factor in psychoanalytic treatment, but there are no new instructions to clinicians as to how to proceed in order to make the termination successful. The implicit or explicit assumption is that, when the patient is cured or significantly improved, he or she will, on his or her own accord, provide the analyst with the necessary cues that will set the termination process in motion. All the analyst has to do is to be receptive to the patient’s messages and respond accordingly.

The patients of the widening scope may need a good deal more than that in order to handle the anxieties of termination. When archaic issues are the focus of the analysis, the analytic dyad becomes, in many respects, a symbiotic state. It is unrealistic to expect the patient to break out of this bond without the explicit help of the analyst and the analyst’s conviction that the end of the analysis is an indispensable part of it. I agree with Modell (1933), who believes that it is the analyst’s responsibility to “conduct” the analysis, and of course conduct its termination as well.

I do not suggest the “heroic” approach that Freud (1937) applied in the analysis of the Wolf Man, in which he set a timetable. It is the patient’s conscious or unconscious perception of the analysis as interminable and of the analyst as indispensable that makes this unanalyzable. I do not suggest that termination can become thinkable and doable in the patient’s mind. In order to help their patients to come to terms with the sensitive issue, analyses need to deal with their own unrealistic expectations of themselves and of the healing powers of psychoanalysis. When the analysis falls short of the analytic dyad, the patient even when psychoanalyzing the patient, his or her insights are not in the context through a biological process.
short of the wished-for results, a strong sense of shame is experienced by both members of the analytic dyad, which often is not revealed by the patient nor interpreted by the analyst. Instead of analyzing the painful feelings of shame, it often becomes more convenient to do more of the same, even when there is little hope that it will produce the desired results.

Psychoanalysis is inevitably a lengthy form of treatment. Providing the patients with insights into their psychological issues is not enough to produce the desirable changes, even when such insights are accurate. The novel input generated by the interpretations made must be rediscovered in the context of the transference, as well as outside of it, during the lengthy process of "working through." This process is the sine qua non of psychoanalytic treatment for both psychological and biological reasons. In a recent publication, Gedo (2005) writes:

There is universal agreement about the necessity of working through to achieve therapeutic success. It is not widely understood, however, that such a process is not merely a matter of mastering the displeasure of facing the truth: behavioral change is contingent on the establishment of new neural networks (though novel activity patterns), thus disestablishing automatic reliance on those previously available [p. 13].

Termination is the final part of the working through process in which the changes in the patients' self-organization will be solidified psychologically and biologically under the influence of the impending dissolution of the analytic dyad. Without the benefit of termination, analytic patients would never be sure to what extent the newly acquired skills and functions belong to them or have been borrowed from their analysts.

It is essential to distinguish the working through process from an impasse. Working through is a period of rediscovering that gives rise to powerful affects such as excitement, fear, amazement, anger, and laughter. Despite the repetitions involved, both patients and analysts have a sense of participating in a meaningful and constructive experience in which the power of the unconscious becomes evident.

In contrast, an impasse generates feelings of boredom, anger, guilt, and shame. The patients' thoughts and affects and, to some extent, those of the analysts, are fixed in a certain position with great tenacity. Accordingly, there is no sense of novelty and discovery; instead, there is gloom and doom.

Analysts who defensively fail to make the distinction between working through and an impasse collude with their patients in maintaining the impasse and the illusion associated with it.

During the last few years, I had the opportunity to be the consultant in a few cases of analytic impasse, and to interview both the patients and the analysts involved. I cannot, of course, draw any general conclusions about impasses in psychoanalysis, nor use this experience to reduce the complexities involved into a few simple propositions. Nevertheless, I was impressed by the tenacy with which both analysts and patients were attached to each other, despite the intensity of the patients' rage and the abuse the analysts had suffered because of it. The cases I refer to were long analyses (more than ten years in duration) with no end in sight. Termination was not an option in the minds of any of the participants, despite the fact that they all felt trapped and with no way to escape.

The patients' feelings can always be understood within the context of the transference and of the therapeutic regression. But that does not explain why their analysts tolerate such abuse and do not help their patients put an end to an impossible situation. Some analysts rationalize their feelings by means of theoretical preconceptions that render them indispensable to their patients. More
likely, patient and analyst have entered into a collusion in which both feel indispensable to each other.

In order to understand the origin of the analyst’s feelings we must look beyond the confines of a few individual cases and into the broad picture of how analysts develop and maintain their professional sense of self.

As opposed to other professions, which have deep roots in our culture and have been established since antiquity, psychoanalysis as a profession is new and still struggling for survival. To be sure, many of Freud’s ideas have become household words and have been incorporated into our culture. Furthermore, there are many good friends of psychoanalysis in medicine, in academia, and in the arts. Nevertheless, as professionals, psychoanalysts are bound to feel very vulnerable. They can neither prove to a skeptical culture the reliability of their convictions through an experimental or intellectual discourse, nor can they prove the efficacy of analytic treatment. Furthermore, there is no way to define who is a bona fide analyst in a way everybody could agree on.

As a result, psychoanalysts have to rely almost exclusively on their own institutions for shelter and support. These institutions are isolated, and their members are sharply divided in their beliefs and their aims. For many years, psychoanalytic institutes provide a safe haven or, rather, a holding environment for their candidates, one that facilitates the development of the analyst’s identity as a professional. There is, however, a price to be paid. In a 1993 paper of mine, I wrote:

The highly personal nature of psychoanalytic training, however, combined with its intensity and length, makes the forfeiture of the candidate’s sense of autonomy as a thinker and as a clinician particularly dangerous. It gradually becomes part of the psychoanalytic paradigm of the young professional, as a result of which he develops a long-lasting sense of “student mentality” that is manifested by prolonging his training and his dependence on his teachers. Some psychoanalysts never outgrow this attitude [p. 342].

By and large, psychoanalytic institutes provide little support to their new graduates. Some of them are invited to teach, and a few become training analysts several years after graduation. There is hardly anything in the outside world that welcomes the arrival of a new analyst. Their only choice is to struggle to build up a private practice, most of which will, by necessity, be psychotherapeutic. There are, of course, exceptions but, generally speaking, it is inevitable that the idealization of psychoanalysis will be challenged, and the new graduates will have to develop a capacity for self-idealization in order to support their professional sense of self.

Gradually, psychoanalysts construct, out of what they have been taught and what they have experienced, an image of the analytic dyad and of their function within it, to which all of their perceptions in the clinical situation must be accommodated. Eventually, this image becomes solidified into a paradigm that defines the analyst’s professional sense of self. This paradigm has dual roots. Its more conscious part represents a shared belief system that emanates from the psychoanalytic theories and propositions the analyst adheres to. The other part is neither fully conscious nor conceptually articulated into an organized system of thought but, because of its highly personal and emotional quality, it has a profound effect on how the analyst will function in the analytic situation. This idiosyncratic aspect of the paradigm is seldom shared with others and, for the most part, is kept out of public scrutiny or even full consciousness.

Given the enormous challenges psychoanalysts must face, both from without and from within their professional world, it is relatively easy to defensively turn this paradigm into an ideology. I use the term ideology cautiously, because of the preconceptions associated with it. During the nineteenth century, ideology was understood as a set of beliefs that are shared by a group of people and that are used to justify their actions. In this sense, ideology is a form of self-justification that is often used by those in power to maintain their position and to suppress alternative viewpoints. In recent years, the term ideology has come to be used more broadly to refer to any set of beliefs or values that are used to justify particular actions or policies. This broader use of the term ideology has led to some confusion, because it is not always clear whether a particular set of beliefs is truly an ideology or whether it is simply a set of beliefs that are used to justify particular actions or policies. However, it is important to remember that ideology is not just a set of beliefs; it is also a form of self-justification that is often used by those in power to maintain their position and to suppress alternative viewpoints. Therefore, it is important to be aware of the potential dangers of ideology and to be careful not to allow it to become a form of self-justification.
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nineteenth century, Marx and Engels (Perry, 1962) conceived ideology as pertaining to any form of consciousness that expresses the basic attitudes and commitments of a social class. According to them, the ideological superstructure represents social myths, “the opiate of the people,” that have nothing to do with fact. This negative definition of ideology still clings to the concept, and it is important to distance ourselves from it, when the term is to be used in psychoanalysis.

Ideologies differ from scientific models and other intellectual propositions and deductions from established facts that can be rendered true or false by the use of logic, rationality, and experience. In contrast, ideologies are neither negotiable nor refutable. When a theoretical model becomes an ideology in the mind of the analyst, the ambiguities and metaphors contained within it are concretized and perceived as established truths. Furthermore, powerful emotions are generated that divide the believers from the nonbelievers. Under the circumstances, the perceptions generated by ideologies are a good deal more subjective than those generated from the non-ideological application of the theory. This, however, does not necessary render such perceptions false. The study of ideologies, in its essence, is a study in subjectivity, which is the basic tool in the work of the analyst, as well as a basic obstacle.

Ideologies are defensive positions. They produce a false sense of certainty and knowledge in order to obscure doubt and ignorance. Under the influence of ideologies, analysts will feel tempted to pressure their patients to produce evidence that confirms their beliefs. By and large, analytic patients comply with their analysts’ expectations. The termination process, however, loosens the symbiotic bond of the analytic dyad, as a result of which a more realistic assessment of what has been accomplished and what has not becomes possible. In a sense, then, termination is the time for reckoning, which will reveal illusionary beliefs and false idealizations. If properly handled, its therapeutic power is enormous, even when the therapeutic results are far below expectations.

There are, however, situations in which patient and analyst feel compelled to enact the scenario of a successful termination, and paper over the unresolved issues. Such illusions cannot be maintained for very long, and the patient’s grief and rage for what is perceived as unfulfilled promises will emerge. Sharing the patient’s grief is not likely to alleviate much of the patient’s pain, although it may be experienced as a kind of apology.

Not all analysts are ideological in their use of psychoanalytic model. Analysts who are free of ideological preconceptions are more likely to be creative in searching for new understandings of the clinical situation at hand and venture into new approaches to handling it. Improvising is an important aspect of the analyst’s work, given the uniqueness of the analytic enterprise and that of the personalities involved. This freedom of action requires the courage to cope with the anticipated disapproving response of their colleagues and the sense of shame that it can produce.

Clinical innovation should not be kept secret by those analysts who improvise them, but should be shared with their colleagues in a coherent and meaningful way. Such communications reduce the idiosyncratic aspects of ideology by turning it into propositions that can be openly discussed.

Contemporary clinical theories have facilitated the capacity of analysts to enter into the depth of their patients’ psyche. Dealing with archaic issues has become the sine qua non of a good analysis. When it comes to termination, however, nothing new has been proposed. Not much thought has been given to the fact that many of the patients of the widening scope cannot be helped with a classical termination.

Under the circumstances, it is up to the analyst and the patient, who struggle with their feelings of shame or humiliation, to improvise a workable solution, rather than resigning themselves to an interminable analysis.
When analysts undertake the analysis of severe character disorders and borderlines—not to mention psychotics—they should think well in advance about the strategy they would use when there is no way to produce an analytic closure. They need an exit strategy that is realistic and can help their patients regain some degree of autonomy, along with their pride.

Analysis should be open-ended, but not interminable. I believe that patients should be reminded of that when the analytic work comes to a stand-still. It can be an important “wake-up call” that can facilitate further growth.

Many patients with severe psychopathology will be in need of some form of follow-up. What kind of follow-up depends on the situation and on the ingenuity of the analyst. The most important part is for the analyst to help the patient assess with candor the progress of the analysis and the extent to which further analysis can be beneficial. The trauma of termination will be significantly reduced by such candor, which can also pave the way for further treatment at some time in the future, when the patient is in a better position to make the necessary changes in or her life.

Craigie (this issue) makes several references to the post-termination phase of analysis. I don’t know how long she thinks of this phase as being but, technically speaking, the post-termination period is the rest of the patient’s life. Indeed, some patients may need life-long care, which should be provided, but not under the label of psychoanalysis. “Till death do us part” is in the contract of marriage, not of psychoanalysis.

REFERENCES


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