Discussion of Craig's "Terminating Without Fatality"

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Craig's concept of termination and the related concept of post-termination contact are based on Freud's early, one-person model of analytic therapy as a medical treatment for the cure of a disease. Post-termination contact was considered appropriate only if the patient needed additional therapy. Subsequent development to a two-person model of treatment, which recognizes the critical importance of the patient-analytic relationship, requires modification both of concepts of termination and of post-termination contact. I propose that whether there should be such contact, and what it's nature should be, is mutually decided by patient and analyst in the termination phase, based on their risk/benefit evaluation of such meetings. The intimate, loving patient-analytic relationship, which has enhanced the patient's development, should be able to continue in some form after the end of treatment unless substantial, unresolved problems of either patient or analyst proscribed such meetings.

A BRIEF HISTORY OF THE CONCEPT OF TERMINATION

The concept of termination, and the related concept of post-termination patient-analytic contact, should reflect the underlying conception of the patient-analytic relationship in analytic treatment. The term and the concept of termination developed in the context of Freud's early one-person model of analytic treatment. Neurosis was considered a disease, and Freud's goals were, first, to discover the cause of neurosis, and then, to cure it. Freud's ambitious search for the cause of neurosis, which he likened to the discovery of the Caput Nili (the source of the Nile) and his hope to develop a cure probably evolved from his recognition and admiration of the fame Koch achieved when he discovered the cause of tuberculosis. Freud was also much influenced by Darwin's *The Origin of Species*, devoted to the causes of speciation. Once the patient was cured, there would be no reason for subsequent contact between patient and analyst. Treatment would end permanently, be terminated. This presumption of no further contact was probably buttressed, as Craig notes, by the high value placed on independence and autonomy, which were believed contingent upon the absence of contact. No follow-up visit to check on the cure was included, although that was common practice in many medical treatments.

Subsequently, once analysts realized that even after successful analyses transference was not fully resolved, they began to abandon the notion of cure. Still later, as the one-person model of treatment evolved into a two-person model, with recognition of the importance of the intense, intimate patient-analytic relationship, the concept of termination began to be questioned. However, despite these modifications in the view of the relationship, the concept of termination remained...
impervious to change, and post-termination patient–analyst contact continued to be considered appropriate only for additional treatment. Other, nontherapeutic, forms of post-termination contact were assumed to be deleterious, likely to increase the patient’s anxiety, and to generate regression (Schachter, 1990, 1992), if not to open the door to ethical transgressions.

AN ALTERNATE CONCEPTION OF TERMINATION

Our concept of termination should be consistent with our view of the patient–analyst relationship during treatment. Thus, acknowledging the shift from the one-person model of a treatment of disease to that of a two-person model of enhancing adaptation calls for a fresh look at our conception of ending analysis. Although Craigie recommends “that our theory and technique of termination should be reexamined and revised in light of research and within the context of contemporary two-person theories of psychoanalysis,” the changes she proposes are too limited.

Consider Craigie’s title, “termination Without Fatality”; it sounds dour, dark, and death-like. In traditional psychoanalysis, life is often half-empty; it deals with loss and renunciation, renouncing our wish for the opposite gender parent, and renouncing our wish for the security of continuing with the loving analyst. Schirmeister (2004) describes it as follows: “We are always mourning for a desire that is always in the past, for a self we can never achieve, and perhaps, as well, for a lost sense of communal meanings and for the sureness that we belong” (p. 283).

Highlighting concerns about loss and renunciation creates a traditional psychoanalytic focus on the continuation of the transference after termination. The possibility that, after the last session, the patient may be interested in relinquishing patienthood in favor of collegiality with the former analyst is not considered an option. This focus on psychopathology prevents psychoanalysts from considering that termination could be viewed as one of those familiar rites of passage, like the bar mitzvah, college graduation, and graduation from analytic training. True, there is a sense of loss and anxiety about expectation and challenges. But there are also healthy, positive aspects in these rites of passage that traditional theory overlooks: the pride, the exuberance and excitement about moving into a world with limitless possibilities for development, growth, and achievement. These socially empowered rites, after all, are celebratory in character. Pizer (2004) writes: “Our five months of termination were both a celebration and a grieving and offered us much opportunity to recollect together, in the tranquility of now, our negotiation of impasses along the way” (p. 300, italics added).

Craigie’s traditional opening statements, “The psychoanalytic relationship is unique among intimate relationships in that its ultimate goal is separation,” and “the patient must cross uncharted territory alone,” focus on loss and are based on a one-person model of analysis. The European refugee analysts who became preeminent in the United States and formulated these views may have been responding to the exigencies of their lives. Perhaps what America brings to the psychoanalysis that originated in Europe is a much needed sense of optimism of the last frontier society (Layton, 2004).

The goal of contemporary analytic treatment is not separation, but rather the facilitation of the patient’s adaptation and comfort with self and others. That goal translates the question and nature of continued contact between patient and analyst into the value of keeping the dialogue open; the patient may not choose to be alone, and that choice should be considered and discussed. Because the analytic relationship fostered the patient’s development, only past theory
requires that the patient completely separate from that facilitatory relationship after ending regular appointments.

MOURNING RESPONSES AND HISTORIES OF EARLY LOSS

Craigie expresses the “accepted” anecdotally based traditional analytic view that “individuals with histories of early loss are particularly vulnerable to intense mourning responses” during the post-termination phase.” She cites two cases in which analyses had who had suffered childhood loss/deprivation had great difficulty dealing with feelings about the loss of the analyst. This plausible, and widely accepted, hypothesis is contradicted by one of the relevant findings in her own study (2002): “Surprisingly, neither the sense of painful loss ... nor loss of the unique analytic relationship ... was significantly correlated with significant emotional loss in childhood or adulthood” (p. 818). Of course, the failure to find a statistical relationship doesn’t mean that there is none. On the other hand, the fact that it was a surprising negative finding, inconsistent with her expectations, suggests it should be taken seriously. Her positive finding was that “a strong sense of loss of a successful analytic relationship was associated with an overall positive experience during analysis and with a strong sense of achievement and positive progression during the post-termination phase” (p. 817). Thus, her data indicate that the variance in the sense of loss of the analytic relationship was a function of positive experiences during and after the analysis, recent experiences, rather than negative experiences of loss in childhood.

MOURNING TOGETHER

In further discussing mourning, Craigie addresses more specifically the implications of the two-person model of treatment when she writes: “I believe that if the analyst can somehow, in his own way, acknowledge 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” (italics added). Here, she recommends a significant change, indicating that she recognizes that the shift from a one-person to a two-person model of treatment does require substantial modifications in how we conceive the ending of treatment.

A DIFFERENT CONCEPT OF TERMINATION

To aid in forming a new view, consider as an alternative term to designate the end of treatment, graduation instead of termination. Graduation indicates that the patient’s successful completion of an exploratory program enhanced his or her development and increased capability to move forward to a more expanded status, which may include increased autonomy.

This leads to the following reasonable question: Why should a long-term, intimate, loving, helpful relationship arbitrarily be ended permanently, if a variety of patient–analyst contacts are possible after the end of treatment? It used to be said that the analyst’s interest in such meetings reflected a countertransference problem. If the patient–analyst relationship had been a mutually caring one, why wouldn’t the analyst naturally have such interest? In contrast, Craigie’s view is that
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sibilities of the somehow, in his ionally by the termin-

ations of the meeting, neither this expectation nor the experiences of contact seem to preclude mourning responses to the loss of regular therapeutic sessions with the analyst. Although I know of no comparative studies on the issue (a study would be of interest), it is my impression that the mourning responses of candidates are not distinguishable from those of noncandidate patients who do not expect to have contact with their former analyst unless there has been some specific agreement to do so. If so, there is no reason, arbitrarily, to assume a diminution or inhibition of mourning responses in noncandidate patients who have occasional, post-termination contacts with their former analyst. One clinical study has shown that, on occasion, such meetings enhance the mourning response (Schachter et al., 1997).

Although the patient–analyst relationship has unique features, it is fundamentally a loving human relationship, and I proffer the offspring–parent relationship as an appropriate analogy, which Craig also considers when she refers to termination as “leaving home.” The parent provides a long-term, intimate, loving, helpful, human relationship, and at some point it is appropriate for the offspring to separate to foster development and increase autonomy. But, obviously, that doesn’t mean that the offspring eschew all contact with the parent unless in need of help. In a mutual, loving relationship, it is natural that each member of the dyad would be interested in some continuing contact with the other.

RISK/BENEFIT RATIOS OF POST-TERMINATION CONTACTS

We can list a variety of potential benefits from the range of post-termination patient–analyst contacts. First, they may help the patient realize the need to return for additional treatment (Schachter et al., 1997). They may also provide an improved position from which to reevaluate idealization of the analyst. Further, contacts help to sustain the therapeutic alliance that played such an important role in the therapeutic gains.
Additionally, the most important benefit was described by Luborsky (Panel, 1989), who observed that psychotherapy patients who did not have post-termination contacts with their former therapists tended to lose some of their therapeutic gains, whereas those who had such contacts maintained their therapeutic gains. An example of such degradation of therapeutic gains was described by Craigie. She reported that “One participant in my study [who had not had post-termination contact] began to feel bitter about his analyst after termination and noticed that the good image he had held of his analyst had begun to sour.” Schachter and Brauer (2001) found that those analysts who think most frequently about their own former analyst are more likely to feel that their analysis helped them. Tossman (2003) (quoted by Craigie) reports the same observation: “The more satisfying the analysis has been, the more likely that the analyst’s inner presence remains vivid” after termination (p. 309). Further, Wzontek, Geller, and Farber (1995) conclude that “both constructive identifications with the therapist’s abilities and functions … and introjections that enable individuals to evoke conversations with their therapists, enable former patients to sustain the work of therapy in the absence of their therapists” (p. 407). In other words, post-termination patient-analyst contact may revitalize internalizations of the analyst that enable maintaining, consolidating, and extending therapeutic gains. Although Craigie recognizes that “Post-termination contact between patient and analyst influences and shapes the analyst’s internal image of the analyst,” she then refers only to corruption of good images by the analyst’s negative behavior. Acknowledgment that post-termination contacts may enhance the positive internalizations of the analyst is limited to her comment that the quality of such contacts “will continue to shape, for good or ill, the internal image of the analyst.”

The reported risks of nontherapeutic post-termination contacts alluded to earlier are both specific and varied. I will cite several examples reported by Levine and Yanoff (in press).

**Example 1**

Analyst A unexpectedly encountered a former patient of his, C, in an airport. She came up to him to say hello and hugged him a little longer and tighter than he would have expected, which made A uncomfortable. C asked if they could have a cup of coffee and chat. A agreed, during which time C caught him up on her life, and then began to ask him some personal questions, such as how many children he had. A tried to reply simply and turn the topic of conversation back to C. He told himself that his reserve was technically justified to preserve the possibility that C might wish to return to analysis with him. He sensed that C wanted a fundamentally different kind of post-termination relationship, one that he felt had sexual overtones and felt too much like a “date.” A experienced C’s invitation as an activated transference wish to seduce him in order to prove her desirability and, at the same time, to test his capacity to maintain appropriate boundaries.

This vignette suggests that A and C had never discussed whether they would have post-termination contacts. The description does not enable us to discern whether the erotic attraction is entirely on the patient’s part or whether A also entertains some past and present troublesome erotic attraction. A, feeling uncomfortable in the airport, chooses, unilaterally, to return to the role of analyst, without discussing either his discomfort or his choice with C.

**Example 2**

Analyst B was reviewing his work with a former patient, R, while on vacation, for possible inclusion in a paper he was writing. B was happy and grateful for having had her as a patient, and told
friends and family about the paper while walking with them. B rounded the corner and unexpectedly found himself face to face with R and her family. Carried away by his positive feelings and excitement, B greeted her warmly and kissed her hello on the cheek. This was a far more visible display of affection than he had shown during her analysis. B felt R stiffen and he realized that she was taken aback by the kiss. Neither said anything about it; they chatted briefly and parted. B felt that there was much in R’s erotic transference to B that remained feared and muted, even at the end of her analysis. It would have been characteristic for her to minimize and disavow her erotic feelings should they meet by chance. However, this was an inappropriate display on his part, and B’s enthusiasm at seeing R probably also reflected the residue of his own unconscious erotic attachment to his former patient.

In this instance, as well, it sounds as though patient and analyst had not discussed the question of post-termination contact before treatment ended. In addition, I was also struck by the fact that B was considering writing about his work with R, without ever having requested her permission. Even more, in talking about his paper with his friends and family, he alluded to his work with B, committing a breach of confidentiality. Both may have been reflections of his own erotic attraction to R, which seems to have remained problematic.

I think that post-termination patient-analyst contact, either advertent or inadvertent, is much less likely to cause difficulty if the possibilities of such contacts have been discussed before the end of treatment, and a mutual understanding developed of how they are to be dealt with. My impression is that the risk of discomfort with post-termination contact is elevated if not discussed and if some substantial unresolved problems of either analyst, patient or both remains and is unacknowledged. Persistence of a substantial, unresolved difficulty on the part either of patient or analyst should be considered a contraindication to conducting post-termination contacts.

CONSIDERING THE POSSIBILITY OF “POST-GRADUATION” CONTACT

During the final phase of treatment, if the patient has not brought up the question of contact after “graduation,” the analyst should query why the patient hasn’t mentioned it. The original agreement or contract between patient and analyst to engage in treatment was presumed to be time-limited; the analyst had not specified that this was a life-long treatment arrangement. The presumed best interest of the patient, or, the analyst’s personal discomforts about such meetings, are essential subjects of analytic scrutiny. The analyst’s decision not to encourage or permit nontherapeutic, “post-graduation” contact is unilateral, arbitrary, condescending, and even arrogant. The Ethics Case Book of the American Psychoanalytic Association notes: “The treatment relationship between the patient and the psychoanalyst is founded upon trust and informed mutual agreement or consent” (p. iv, italics added).

When the treatment ends, the patient and analyst mutually recognize and articulate the change in their relationship and utilize this opportunity to negotiate a new contract dealing with the possibility of subsequent meetings. Explicitly, discussion of the various options—no contact, nontherapeutic contact, therapeutic contact, or an attempt to develop a friendship—can lead to a mutually negotiated final decision. After discussion, should the patient elect “no contact,” the analyst should respect that choice, as the patient should accept the analyst’s preference to limit the future relationship.
CONCLUSION

Although Craig does consider the implications of the two-person model of analytic treatment for conceptions of termination, she does not depart very far from a traditional view. Her central focus is on loss and mourning, and the patients' responses within a transference theory that emphasizes psychopathology. She does not consider that termination might be conceived of as a rite of passage, filled with pride and excitement, as well as with a sense of loss and of anxiety. During the closing phase of analysis, patient and analyst should discuss the fantasies and realities of possible planned post-termination contacts, as well as their nature. Then, a mutual, collaborative decision can be achieved.

REFERENCES


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