Ending Therapy

The Clinical Logic of Termination

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This discussion has so far remained on the clinical level, but a premise that underlies this work is that the clinical and social levels must be integrated if we are to understand the meaning of termination. This chapter will serve as the transition from the purely clinical discussion to one that integrates the clinical and the social levels. The concept of a clinical logic touches on both.

What do I mean by clinical logic? The term does not refer to particular psychodynamic or metapsychological formulations, or even particular theoretical stances. Rather, the clinical logic becomes apparent only from a historical vantage point, from which it is possible to view a pattern that is repeated with each of the major innovations that have shaken the field of psychoanalysis and psychotherapy since Freud. The pattern goes something like this: (1) Clinicians, often because they are examining a new clientele, or seeing a familiar clientele for new reasons, hear a new set of complaints or symptoms. (2) The new list of symptoms is related to new or revised diagnoses. (3) New theory is generated to explain etiology and guide treatment. (4) New therapeutic techniques are devised. (5) The criteria for termination and the management of the termination phase of therapy are altered accordingly. (6) It is argued that the technique and the approach to termination are now the specific indicated treatment for this particular diagnostic category.

How does this clinical logic touch on both the clinical and social levels? The logic is clearly reflected in the clinical literature, as I will illustrate with the work of Heinz Kohut. In terms of the social level, recall the line Freud (Freud and Breuer, 1895, p. 305) drew between "neurotic misery" and "common unhappiness," and my contention in the introduction that clinicians have been steadily moving that line, ceding to the realm of neurotic misery (or newer varieties of psychopathology) much of what once might have been considered part of everyday unhappiness. The movement of that line is a social phenomenon, even if clinicians believe it is merely a matter of their capability to treat more symptoms with their greater understanding of psychopathology and more advanced therapeutic techniques. There are social roots to developments in the field of psychoanalysis and psychotherapy, and social implications to the widespread practice of therapy. Indeed, the clinical logic of termination is the mechanism whereby the

line is moved. I will discuss the clinical logic in this chapter; in chapter 5 I will examine a contradiction inherent in the logic regarding the assignment of clients to brief or long-term therapy; and in chapter 7 I will explain how the clinical logic serves as the mechanism for larger social developments.

At this writing, a debate is raging at the national level of the American Psychiatric Association: Should the APA endorse the report of its Task Force on Treatments of Psychiatric Disorders, which "develops treatment principles for major diagnoses, discusses areas of agreement and controversy, and discusses the goals as well as pros and cons of various modalities in treating patients with these disorders?" (APA, 1987a). The pros of endorsing the treatment manual are that naming indicated treatments, such as brief therapy for posttraumatic stress disorders, medications or cognitive therapy for depression, behavior modification for phobias, or long-term supportive psychotherapy for borderline character, would permit more objective peer review and effective allocation of treatment resources. The cons touch on the same points: insurance companies will deny payment for treatments not indicated in the manual, thus undermining the clinician's judgment in each case, and patients' attorneys will cite the manual in malpractice suits. Whatever the outcome of the debate, the point is that the clinical logic leads to the idea of a manual that designates specific treatments for each of a growing list of emotional disorders.

I will discuss each of the six steps of this clinical logic. I could use any of the major turnings in therapeutic approach that have occurred since Freud. For instance, Wilhelm Reich (1933) expanded the expectations as well as the number of potential candidates for psychoanalysis by suggesting, in direct contradiction to Freud's early view that the analyst cures only the neurosis and leaves the analysand with the same underlying character structure, that character can be changed by analysis. What would be required, of course, would be a deeper analysis, one that would get to the core of the "character armor." Since Reich, analysts have been analyzing clients with ever more serious character disorders, and the analyses have grown longer in the process.

Or I could use Melanie Klein's innovations in theory and technique to illustrate the logic of termination. Where Freud would not treat psychotics because he felt their extreme narcissism made it impossible for them to direct enough energy toward the treating analyst to make the transference analyzable, Klein (1948) treated psychotic patients and created new theory in the process. In doing so,

she moved the prototype for therapy back from the oedipal stage of development to the earliest infant-mother relationship and searched for infantile defense mechanisms in the transference relationship. Her position that the conflicts of the early months of life must be analyzed before termination could be considered also resulted in longer analyses.

Heinz Kohut's self-psychology, a more recent innovation that has received attention among therapists, also illustrates the logic of termination. In what follows, I will explain Kohut's theory in greater detail than any of the others. This is not to say that I think Kohut and his followers have found the single correct way to practice therapy. Rut his ideas are very helpful, and his formulation about termination happens to illustrate the clinical logic very nicely. Therefore, as I list and comment upon the six steps of the clinical logic, I will explicate just enough of Kohut's theory to illustrate each point.

1. *Clinicians hear from clients about a new set of symptoms*. In Freud's day it was likely a paralyzed limb, a debilitating obsession, or an inability to get out of bed that brought someone to see a psychoanalyst. Today, therapists' practices take them to more varied settings: the schools, courts, prisons, and workplaces. Every time they enter a new situation they hear different sets of complaints: about learning disabilities, disruptive behaviors, violence, or work disabilities. And in their private practices, therapists frequently see clients who are highly functional people who are just not happy with their lives. At the same time, therapists are seeing more severely disturbed people than did early analysts. In those days, people with severe character disorders would have been considered poor candidates for treatment. With all these changes, the list of complaints therapists hear and aim to treat grows ever longer. For instance, in the private consulting room, with more people choosing to undergo therapy for relatively subtle problems, the therapist hears a lot about troubled intimacies, inability to be creative, feelings of inner emptiness, and so forth. The new symptoms Reich heard about involved rigidity of character, while Melanie Klein heard about severe mood swings and attacks of mania or paranoia.

For Kohut, the new list includes more subtle hindrances to intimacy and creativity. He realizes that many of his analysands are undergoing psychoanalysis for reasons directly related to their narcissistic personalities. Many demonstrate the narcissist's self-centeredness, tendency to exploit others, insensitivity to others' needs and feelings, addictive patterns, need for sexual conquests to bolster self-esteem, and/or rageful response when others criticize or refuse their demands. But he thinks the

narcissist's bravado is merely a cover for another, possibly more significant list of symptoms: low self-esteem, depression, feelings of inner emptiness, hypersensitivity to slights, a lack of vitality and creativity, loneliness, experiencing repeated failure in their relationships, preoccupations with bodily or psychosomatic complaints, and a recurring feeling of fragmentation.

Once he found this list of depth symptomatology in his narcissistic patients, Kohut began to discover that other patients, many of whom did not come to treatment with the typical outward appearance of the narcissistic personality, also complained of these same symptoms. Kohut's discussion turns to the narcissistic traits we all might have: there's a narcissist in many of us, even in those of us whose problem seems the opposite of narcissism, that is, an inability to muster enough of the aforementioned bravado to be self-assertive.

2. *The new list of symptoms is related to a new or revised diagnosis*. As therapists leave the private consulting room to venture into schools, prisons, and other settings, they hear new lists of complaints from the clients they encounter there, and begin to create new diagnostic categories. They diagnose hyperkinesis or attention-deficit disorder in the schools, impulsive dyscontrol syndrome or conduct disorder in the prisons, and work inhibition in the workplace.

Meanwhile, in the private consulting room, clients are always bringing in new lists of complaints, and therapists inventing new diagnoses. Therapists rarely examine someone and conclude there is no identifiable psychopathology. There is always a bit of neurosis, a character disorder, or, in the most current psychological terms, a borderline or psychotic core lying somewhere deep inside even the most sane-appearing individual.

For instance, where once the women seen by analysts were likely to be housewives or not working, today's therapist sees many successful professional women. As these women complain of insecurity, fears that they are just fooling someone about their competence and will soon be found out, and ambivalence about the pressures of work life, a new diagnostic category is invented: "the impostor complex in high achieving women" (Clance and Imes, 1978).

There are official diagnoses, and there are unofficial ones. The impostor complex is still unofficial, as is the midlife crisis (Jaques, 1965). The official list grows; each successive edition of the *Diagnostic and*

Statistical Manual (APA, 1980, 1987b) lists many more categories than did the previous one. And some of what were unofficial diagnoses become official. Thus, posttraumatic stress disorder and panic attack made it into the last revision, amid much publicity, and accompanied by conferences and continuing education courses for therapists on how to diagnose and treat these newer conditions. Other unofficial diagnoses, even ones as well known and widely applied as the "as-if personality" (Deutsch, 1942), never make it onto the official list. Whether the diagnosis makes the official list or not, this step in the clinical logic is the same: new symptom lists are linked with new diagnostic categories.

Reich's new diagnoses included the character disorders, especially the obsessional, masochistic, hysterical, and narcissistic characters. The diagnoses that interested Klein were manic-depressive psychosis, schizophrenia, and the less severe but still problematic schizoid personality. W. R. D. Fairbairn (1941) and D. W. Winnicott (1965) made the last category a very familiar one in clinical settings.

Kohut's new diagnostic category is the disorder of the self. And Kohut's work nicely illustrates this step of the logic at work in the private consulting room. Narcissism is not a new diagnosis. Freud considered infantile narcissism a normal developmental stage and felt the psychotic was essentially regressing to that level. Lou Andreas-Salome (1962) pointed out the link between narcissism and creativity, and she cautioned that by too quickly pathologizing narcissism, analysts risked jettisoning artistic creativity in their construction of the "normal" personality. For a long time, analysts employed the diagnosis "narcissistic personality," but felt that psychoanalysis with these patients was not indicated or not likely to be fruitful. Then in the late 1960s and early 1970s, largely because of the work of Kohut (1971) and Otto Kernberg (1975), clinicians began to feel they finally understood narcissism well enough to offer effective psychotherapy.

While the narcissistic personality is not a new diagnosis, Kohut employs a diagnosis that is new, the disorder of the self. For Kohut, the self is both a psychic structure, "the center of the individual's psychological universe" (1977, p. 311), and the subject (the " I") who experiences and acts. Thus, frailty or fragmentation of the self results in a lack of cohesion and continuity of experience, problems with self-esteem, and a feeling of emptiness and lack of agency in one's life. This is the narcissist's dilemma. Kohut sees an unstable and very vulnerable self beneath the surface bluster of the narcissistic personality.

Once he has uncovered a structural disorder of the self at the core of the narcissistic personality, Kohut proceeds to identify the same kind of structural defect in analysands who would be less likely diagnosed narcissists on the basis of their surface appearance. Some people, for instance, suffer from "insufficient narcissistic libido," and their muted, attention-avoiding presentation and sense of themselves as boring is quite the opposite of the stereotypic narcissist's attention grabbing. Yet they suffer from the same kind of underlying disorder of the self.

Kohut sets up a spectrum of disorders of the self. At the most pathological end, the psychotic is someone with an extensively damaged, noncohesive self. The borderline states are slightly less damaged. According to Kohut (Kohut and Wolf, 1978): "Here the break-up, the enfeeblement, or the functional chaos of the nuclear self are also permanent or protracted, but, in contrast to the psychoses, the experiential and behavioral manifestations of the central defect are covered by complex defenses" (p. 415). Then, the spectrum includes the narcissistic personality disorders per se. Finally, there are the narcissistic traits, or "character types in the narcissistic realm frequently encountered in everyday life and they should, in general, not be considered as forms of psychopathology but rather as variants of the normal human personality with its assets and defects" (p. 422).

In other words, Kohut has reorganized all the diagnostic cubbyholes in order to make room for a category of psychopathology he invented, the disorder of the self. He is not the first to reformulate the diagnostic nomenclature on the basis of an innovative diagnosis. W. R. D. Fairbairn (1941) did the same, explaining the differences among paranoia, hysteria, and obsessional neurosis with reference to the different ways patients employ schizoid mechanisms. And Masterson (1976) tends to do the same thing, though not as explicitly. The borderline character diagnosis was once employed only in regard to patients whose lifestyle and capacity for reality testing were both so marginal that they seemed literally on the border between neurosis and psychosis. But Masterson diagnoses the borderline character in a broad spectrum of people: in successful professional people with families, whom he identifies as "better adjusted borderlines" with a neurotic presentation, as well as in lower-level borderlines who appear almost psychotic. Where Fairbairn finds schizoid mechanisms in many different diagnostic categories and Masterson finds borderline psychopathology, Kohut finds disorders of the self. Each then goes to offer a theoretical formulation about the diagnostic typology he has created.

3. *New theory is generated to explain etiology and guide treatment*. A wonderful thing about psychoanalytic theory is its constant evolution. When analysts encounter new problems, they first attempt to adapt old theories to explain the new findings. Eventually an innovator comes along and reformulates the whole theory to include, often to highlight, the new problems; there is a shift in paradigm (Kuhn, 1962). All the major schools of psychoanalytic thought began this way. Reich (1933) theorized the early development of character styles, how they are lastingly preserved in character structure, and the defensive functions of character. When the new findings are psychotic phenomena, the theory shifts the prototype to the infantile stage and stresses more primitive defense mechanisms. This is where Melanie Klein (1948), W. R. D. Fairbairn (1941), and D. W. Winnicott (1965) offer theoretical breakthroughs.

When the new findings are subtle kinds of dysphoria in relatively high-functioning individuals, the theory focuses on nuances of the transference that were previously considered inconsequential. Kohut's theory is an example. He begins with an empirical observation: in analysis, clients with a narcissistic personality tend to be very attuned to the analyst's degree of empathy. He notices that when the analyst fails to empathize the analysand becomes depressed, rageful, or merely more lifeless. Then he identifies two kinds of transferences that typically evolve: the idealizing transference and the mirror transference. (He would later add the alter-ego transference where the analysand seeks sameness with the analyst [Kohut and Wolf, 1978], In the former, the analysand idealizes the therapist and then feels powerful because she or he is connected with such a powerful person. Or; in the latter, the analysand uses the analyst as a mirror, demanding the analyst's attention and praise and becoming angry or depressed when it is not forthcoming. Whether an idealizing or a mirror transference evolves, the clients seem very vulnerable to criticism and slights and have trouble remembering that they are worthwhile individuals.

Kohut theorizes that these transferences and the analysand s sensitivity to the analyst's failure to empathize represent the reactivation in the analytic situation of a conflictual phase of childhood, the period just after the one Freud termed infantile narcissism. During this phase, the child is supposedly no longer merged with an all-powerful parent and no longer feels the bliss of that narcissistic merger, but also is very hesitant to give it up. Psychologically speaking, one strategy available to the child is to idealize the parent, who by now is viewed as somewhat separate, and then: " Since all bliss and power

now reside in the idealized object, the child feels empty and powerless when he is separated from it and he attempts, therefore, to maintain a continuous union with it" (Kohut, 1971, p. 37). The child, grown into the narcissistic adult, attempts that kind of union once more with the idealized analyst. Another strategy for the child is to retain from the narcissistic phase a grandiose self and to demand from others recognition of that grandiosity—that is, to use others as a mirror of the self's greatness. These two childish strategies are what the narcissist reenacts with the analyst as the idealizing and mirror transferences.

Why do some people develop narcissistic personalities while others do not? Kohut's answer is that pathological narcissism (that connected with a disorder of the self) results from a parental failure to empathize, and that earlier and more extensive or traumatic failures result in more severe disorders, the worst being psychosis. In the normal case, there is a narcissistic stage of development, just as Freud said. The child does have a difficult time giving up the feelings of oneness, power, and bliss that are part of that stage. But the parents' empathic responses permit the child to make the transition to greater autonomy.

Specifically, the parent first allows him- or herself to be used by the child as a "self-object." "The expected control over such [self-object] others is then closer to the concept of the control which a grownup expects to have over his own body and mind than to the concept of the control which he expects to have over others" (Kohut, 1971, p. 27). The "good enough" parent (Winnicott, 1965) first responds empathically to the child's need to control him or her as a self-object, and then, in a phase appropriate way, gradually weans the child from this need for narcissistic control by disappointing the child in incremental steps that are more palatable to the child.

According to Kohut, in order to grow up with a healthy self, the individual must be sufficiently nourished in the narcissistic sector of the evolving personality. For instance, the very young child says a first word, takes a step, or sings a simple song, and the audience—parents and friends—claps. The child momentarily experiences being on center stage and enjoys the attention. Gradually the child learns she or he cannot remain always in the limelight. The teenager who sings a simple song and expects applause is courting serious disappointment or mockery. But the child who never has the experience of being thus on center stage grows up with "insufficient narcissistic libido" and experiences a lack of joy and a certain flatness to life.

In other words, the parent incrementally teaches the child that she or he cannot have constant attention and praise, but includes the message that the child is still talented and lovable enough, and will have attention and praise at least for certain moments here and there. It is parental empathy that guides the process and determines how big the steps of disillusionment can be without traumatizing the young and still very vulnerable child.

If this is done right, according to Kohut, there occurs a process he terms "transmuting internalization." By this Kohut means that the phase-appropriate disappointments in important others play a part in the formation of structures within the child's psyche— the precursors and building blocks of mature intrapsychic structures like the self and the ego—that permit the child to feel an inner source of strength, praiseworthiness, and vitality. The strength of the evolving self depends on the phase-appropriateness of the disappointments. Optimally, the child gives up its self-objects, its grandiosity, and its need for idealization, and in their place is constructed a self that permits autonomy, vitality, creativity, the capacity for an inner regulation of self-esteem as opposed to needing others' mirroring to feel good, and the capacity to be empathic toward others.

With this model of normal development, it is easy to see what goes wrong in the case of the narcissist. The disappointments are too large, occur before the child is able to tolerate them, or are not balanced with enough gratification to make them palatable. The parental failure of empathy is usually connected to the parents' own psychopathology—for instance, they are too narcissistic themselves to be capable of empathy, even for their children. Or events like the death of a parent might play a part, or some as yet poorly understood constitutional factor might be involved. But in any case, by extrapolating backward from the kinds of transferences Kohut observes with the adult narcissist, he develops a theory to explain the disorders of the self.

A clinical example: A young man came to see me in a panic about the breaking up of a three-year relationship with a woman he described as the most beautiful and exciting he had ever met. He was depressed. He had always wondered what she saw in him since she seemed to "have it all," and he felt quite dull and uninteresting in comparison. His mother was quite narcissistic, being a frustrated stage actress, quite dramatic and vain, and was interested mainly in the status of the men she (a divorcee) could attract. My client learned very early in life that his best chance of feeling close to his mother would

occur when she seemed depressed and he went to her and comforted her by saying something about how pretty she looked. In other words, there was no way for him to get her to pay attention to what was going on in his life independent of her.

In the first few therapy sessions, he had trouble finding material to talk about. He would start to talk about something and then stop and say it really was not worth saying much about. He was afraid he was boring me. We were able to link this fear to his tendency to attribute all excitement to his woman friend and to worry that he was boring in comparison, and his correct assumption as a youngster that his mother found her own problems much more interesting than his. By focusing attention on this theme while at the same time insisting I wanted to hear just what was on his mind, I was able to encourage him to talk a little longer about one issue and then another. Minutes later he brightened up and became enthusiastic as he told me about an essay he was in the midst of writing.

4. *New therapeutic techniques are devised.* I outlined in chapter 2 some developments in the field of psychoanalysis. Therapies tend to grow longer, delve more deeply into the psyche, use earlier phases of childhood as a prototype for the psychopathology as well as the transference, and focus on more primitive defense mechanisms. This is one major trend. Another is for therapists to claim more for their techniques and to begin to intensify the therapeutic onslaught so that certain conditions can be treated in a very short time. As I will explain in some detail in chapter 5, the advent of brief therapy also fits the logic of termination very nicely. Where the innovations of Reich, Klein, and Kohut result in a lengthening and deepening of the therapeutic venture, the brief therapists concentrate on more circumscribed symptoms and prescribe a more abbreviated treatment. Characteristic of both the trend toward lengthier and the trend toward briefer therapy is that therapeutic techniques are altered to fit newly discovered syndromes and diagnostic categories.

This makes sense. Why should therapists manage every treatment in the same way, always "peeling away each layer of the onion" as if they did not know, in line with their diagnostic impressions, what issues to expect and in what order? Generally, treatment strategies proliferate because clinicians gain experience with various emotional conditions and then feel they can better aim their interventions at the heart of the matter in ensuing treatments of like diagnosed individuals.

Continuing with the theories I have mentioned, Reich advises constant confrontation of the habitual patterns of defense—for instance, the idiosyncratic tone of voice or posturing that the client displays in the consulting room—that are typical of each character type; Klein advises early and constant interpretation of the earliest infantile conflicts, especially as they become reenacted in the transference; and Kohut stresses the therapeutic uses of empathy.

Again, I will explain Kohut's emphasis in a little greater detail. Kohut has shifted the attention of followers from the classical analytic theory of unconscious conflicts and disavowed wishes to the ways patients with disorders of the self attempt, through their narcissistic symptoms, to restore cohesion and vitality to their lives while actually experiencing deadness inside. Therefore his treatment strategy focuses on how the therapist might have to temporarily serve as a self-object to help the client get past that fixation and attain healthy relationships.

He does not attempt to interpret symptoms in relation to the unconscious drives they symbolize. Rather, he allows the narcissistic transference, be it idealizing or mirroring, to evolve in the consulting room. The therapist must be empathic to accomplish this: "For long periods the analyst must participate empathically in the psychic imbalance from which the patient suffers; he must show understanding for the patient's painful embarrassment and for his anger that the act that has been committed cannot be undone. Then, gradually, the dynamics of the situation can be approached" (Kohut, 1971, p. 231). Kohut stresses that this does not mean gratifying the client's needs, except the need to be accurately and empathically understood (Baker and Baker, 1987). Rather, the therapist allows the narcissistic transference to develop and then helps the client understand that there are ways she or he uses the therapist as a self-object, and early memories make what is occurring between client and therapist seem very familiar.

There are moments in therapy when the therapist fails to be empathic. Kohut first noticed the consequences with Miss F., who not only refused his insightful interpretations but then angrily proclaimed: "You are ruining my analysis with these interpretations" (Kohut, 1971). At first Kohut, like a classical analyst, interpreted this as resistance. Then he realized he was failing to be empathic, imposing his interpretations on her situation. He learned two things from repeated incidents like this. First, he had to stop making the interpretations and permit the analysand to articulate her needs. Second, the

therapist's failures to empathize duplicates the early parental failures and sets off depressive or angry reactions in the analysand. Thus the analytic or therapeutic situation can reactivate the thwarted developmental process. If the therapist manages the moment of failed empathy correctly, he or she can facilitate inner structure building and a better-integrated self can develop, one that does not need to use people as self-objects but that can form much better relationships with others and can rely more on inner resources in times of need.

5. *The criteria for termination and the management of the termination phase are altered accordingly*. As therapists probe more deeply and link current complaints to earlier phases of childhood, they of course find more grist for the therapeutic mill. Then they insist that the new issues be worked through before therapy can be properly terminated. Thus Reich hopes to see lasting signs of real character change before terminating, and Melanie Klein insists that the conflicts and anxieties of the first year of life be worked through before agreeing it is time to terminate.

As I mentioned in chapter 2, the lengthening of the therapy and greater dependency on the therapist mean that at termination, separation and loss issues loom larger and require more attention. The opposite trend toward briefer therapies has another set of implications for termination: the date for the last session is usually set at the commencement of the therapy, and the client's reactions to the brevity of treatment become part of the material to be worked through (see chapter 5). In either case, the changes in symptom lists, diagnostic categories, and treatment techniques bear heavily on the conduct of the termination.

Kohut (1977) compares his criteria for termination with Freud's. For Freud, with neurotic patients, the question is whether or not the oedipal conflicts—that is, the conflicts among the ego, the id and the superego, all basically viable intrapsychic structures—have been resolved. According to Kohut (1977):

> When we turn to the narcissistic personality disorders, however, we are no longer dealing with the pathological results of unsatisfactory solutions of conflicts between structures that are in essence intact, but with forms of psychological malfunctioning arising in consequence of the fact that the central structures of the personality—the structures of the self—are defective. And so, in the narcissistic personality disorders, our description of the process and goals of psychoanalysis and of the conditions that characterize a genuine termination (under what circumstances we can say that the analytic task has been completed) must therefore be based on a definition of the nature and location of the essential psychological defects and on a definition of their cure. (pp. 2-3)

Kohut presents a series of cases and discusses termination in each. He stresses the way developments in the transference provide opportunities for gradual transmuting internalization and inner structure formation until the point is reached where a better-consolidated self permits the analysand to relate to the analyst as an autonomous object, not a mirroring or idealized self-object. By this time, the analysand is capable of experiencing joy and exuberance, has a capacity for internal regulation of self-esteem, is capable of empathy and therefore can be truly intimate, and has creative outlets.

Kohut (1977) generalizes the last item into the critical criterion for termination:

> The psychoanalytic treatment of a case of narcissistic personality disorder has progressed to the point of its intrinsically determined termination (has brought about the cure of the disorder) when it has been able to establish one sector within the realm of the self through which an uninterrupted flow of the narcissistic strivings can proceed toward creative expression—however limited the social impact of the achievements of the personality might be and however insignificant the individual's creative activity might appear to others, (pp. 53-54)

6. *It is argued that the technique and the approach to termination are the specific indicated treatment for this particular diagnostic category*. Each innovator believes she or he has discovered the correct way to understand the phenomenon under study and to treat the emotional condition. This kind of confidence is required if one is to publish the work and gain prominence as a teacher of the technique.

The debates between Otto Kernberg and Heinz Kohut are quite instructive in this regard. In his attempts to prove that his approach to narcissism is more correct, Kernberg (1975, 1984) spells out the differences between the two theories and tells how he and Kohut would practice therapy differently. In their responses to Kernberg's criticisms, self-psychologists (Ornstein, 1974; Wolf, 1983) are forced to clarify some of the imprecise points in their arguments. And by reading both sides of the debate (Adler, 1986), clinicians gain further understanding.

The same certainty characterizes the cognitive therapists, who argue that theirs is the best treatment for depression; the brief therapists, who argue theirs is the treatment of choice for adjustment disorders or posttraumatic stress disorders; and so forth. With each claiming to have the answer for treating one or more mental conditions, is it any wonder there is support in the mental-health professions for a treatment manual that outlines the indicated treatments for the particular diagnostic categories?

In its general outline, the clinical logic goes something like this: The more severe the psychopathology, the earlier the developmental trauma and fixation, the more primitive the defense mechanisms typically employed, the deeper the therapy must go to be effective, the longer the therapy is likely to run, and the more problematic the separation issues at termination. At one end of the spectrum is long-term therapy for the psychoses and severe character disorders; at the other, brief therapy for certain neurotic conditions and life crises. This is the logic.

Kohut's "The Two Analyses of Mr. Z. (1979) illustrates this logic perfectly. Kohut demonstrates that a psychoanalysis that is informed by self-psychology is far superior to a classical analysis when it comes to treating the narcissistic personality. Mr. Z. was in analyses of both kinds—both conducted by Heinz Kohut, as a matter of fact. Mr. Z. first entered analysis with Kohut in his mid-twenties, when Kohut "was viewing analytic material entirely from the point of view of classical analysis" (p. 3). That first analysis lasted about four years. There followed an interval of five and a half years, after which Mr. Z. returned to undergo another analysis that lasted four more years. Kohut conducted that second analysis with a "new frame of reference" : self-psychology. From his new stance, Kohut could look back and decide that although there was significant symptomatic improvement in the first analysis, it was really nothing but a "transference success," no real structural change occurred, and therefore it is not surprising that Mr. Z. would encounter enough difficulties to return for a second analysis.

In the second analysis, presumably because Kohut did not make oedipal and resistance interpretations but rather let the mirroring and idealizing transferences play themselves out, the analysis penetrated to further depths. Mr. Z. became aware of ways his engulfing mother used him as her object and never really responded to his needs, and ways his own masochism was an attempt to compensate for a weak and fragmented self. By the termination of this second analysis, he was able to forgive his mother and was better able to empathize with her plight. In other words, the first analysis did not reach deep enough and did not alter the inner structure of the self sufficiently to provide a lasting cure, but the second did.

In another context, Kohut (1977) claims that not only is a long-term analysis of the self indicated in the kinds of cases that he is treating, but it is actually predetermined that the analysis go on for as long as it does: "A genuine termination, it may be added here, is not brought about by external manipulation.

Like the transference, it is predetermined; correct psychoanalytic technique can do no more than allow it to evolve" (pp. 48-49).

Is it any wonder it starts to seem, to clinician and client alike, as if the client's condition, and the rate of progress of the therapy, determine a "correct" moment for termination—that is, as if all the two need to know is the condition being treated, and how well the therapy is progressing, to determine when it is appropriate to call a halt to the treatment. When the client asks the therapist whether it is time to end, the hope implicit in the question is that the therapist, basing his or her opinion on an understanding of all the latest theories and techniques, can give a definite answer.

As will become apparent in the chapters that follow, there are contradictions in the clinical logic. One is the discrepancy between clinical and fiscal considerations. According to the clinical logic, one's mental condition should determine the length of one's therapy. In fact, the much more important consideration is one's financial resources. Instead of offering longer-term therapy to the clients with the most severe disorders, the clinician is likely to advise the client with sufficient means to undergo long-term therapy and the one with less financial resources to make the best of brief therapy, even if the latter client suffers from a more severe disturbance than the former. In order to explore this contradiction—one rarely touched on in the clinical literature—I will turn from the discussion of long-term, open-ended therapy to the brief, time-limited variety. A discussion of brief therapy will also provide new perspective on the termination issue.