Therapy in Pieces

Ending Therapy

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Does brief therapy represent a countermovement to the tendency I discussed (chapters 2 and 3) for therapies to lengthen? Is it just that the health-plan administrators and insurance adjusters have found a way to justify reduced payments for psychotherapy? Certainly the advent of brief therapy does these things very nicely. But it does something more. The brief-therapy modality has arrived at just the right time. Where psychoanalysis might be conceived of as a once-in-a-lifetime endeavor, psychotherapy is not usually consumed at one sitting. The average therapy consumer probably undergoes relatively brief stints of psychotherapy at several different times in his or her lifetime. More and more, clients enter therapy wishing to work through one or another circumscribed issue, end the therapy when they feel satisfied with the immediate results, and then return to be in therapy again when another crisis arises. It is hard to say which came first, the brief therapy or the pattern whereby more and more people begin to utilize therapy in pieces over a lifetime. Whichever it is, the whole meaning of termination changes.

The Moment of Ambivalence

There is a moment in just about every therapy when the original symptoms that brought the client in have diminished sufficiently for the client to pause to consider whether further therapy is needed. Some clients are entirely ambivalent about therapy in the first place, for fear of stigma, because they have no knowledge of what to expect, or because the prospect of a deepening relationship with the therapist frightens them. They are likely to take the opportunity abruptly and unilaterally to discontinue the treatment. Others are willing to talk about their ambivalence, or their lack of clarity about what more therapy might accomplish and why they should continue to attend. Sometimes, when the client is ambivalent about leaving therapy, and until that ambivalence is resolved, the therapist must simply dig in his heels and interpret the client's resistance to a deepening therapeutic relationship. I did so with Alan.

Alan

Alan, a forty-one-year-old professional man, came to see me seeking help. "I believe I love my wife.

I'm having an affair with my secretary. I think I love her—maybe even more than I love my wife. My wife is starting to catch on. She's getting really upset and making all kinds of demands. I'm a wreck, and I don't know what to do!" I asked this father of three children how he felt about all this, and he replied, " I don't know how I feel. That's the problem. And I don't know what I want to do. That's why I've come to see you."

He had been a great success at everything. A star athlete and "straight A" student in high school, he joined a fraternity in college and married his college sweetheart before going off to graduate school. She became pregnant immediately—later he admits that she was pregnant when they were married, and he often thinks about what his life would have been like if they had not married so young. The young couple adopted a pattern that lasted from then on: he studied or worked, she raised the children and attended to the house. He went to prestigious schools, developed good "connections," and became successful and wealthy.

As he talked about his "connections," it became clear his associations with people were mainly pragmatic. He was unable to identify for me any real friend he could rely on. He assumed that since he basically was using people to get ahead, they were all using him too. In fact, the only person he really trusted and talked to about anything of significance was his secretary, June.

"I never had an affair until now. I don't want to let go of June—she's fast becoming my best friend and confidant. Susan [his wife] is really being unreasonable. She stamps and screams at me, she can't sleep all night, she refuses sex, and by now she's guessed it's June I'm seeing and insists I never see her again. I try to assure her that I'm not going to have sex with her again." As he completed this part of his story, he sank back in his chair, sighed, and said, "This whole business has been blown out of proportion. I feel like I've lost all control of my life. I just wish it would all go away."

On the first visit, Alan did not look depressed. He was very energetic in his attempts to tell me his story and convince me that though he was confused, the real trouble was the women and their unreasonable feelings. By the third visit, after he had committed himself to undergo some ongoing psychotherapy, he began to demonstrate some sadness and admit to being depressed. " I feel empty. I don't want to leave my wife because that would mean leaving the children. I'm scared to be alone. June is fifteen years younger than me. I think I love her, but I feel silly robbing the cradle like that, and besides,

there's too much of a gap in experience and sophistication between us. It would never work. I'm really bummed out."

Our first three or four sessions of therapy were filled with Alan's anxiety. He became almost exhilarated in telling me about his romantic situation. But he quickly concluded that leaving his wife for his newfound love would not work. Because of the difference in age, he was afraid that their affair would end and he would find himself all alone. The following session focused on his fantasy of dropping everything—career, family, possessions—and going off somewhere far away. He decided that would not work either. He began to seriously reconsider the wisdom of leaving his wife. He cried for the first time in many years.

In the following session, all the progress we had made locating Alan's feelings seemed to be lost. He was stiff, distant, and unable to tell me what was going on. I asked, "Could it be that you have regrets about sharing your tears with me, that you are afraid that now other uncomfortable feelings will emerge if we go on in therapy?" He flatly denied there was any validity in such questions. He continued to attend, but he seemed more numb, more the dispassionate storyteller.

After two months in therapy, Alan decided to stay with his wife. His anxiety diminished. He began to settle back into his prior state of numbness. Meanwhile, after responding very well to interpretations in the first several sessions and seeming motivated to look at his life and make changes, he began to disregard my interventions, and on several occasions seemed intent on devaluing me. For instance, he commented about the mediocrity of my taste in clothes and speculated that many of my other clients were probably "dependent types."

Though Alan did not say anything direct about it, it was clear that by this point in his therapy the crisis was past and he was thinking about terminating. Meanwhile, I was thinking about how I would respond when the question came up. Alan was in something of a midlife crisis when he first came to see me. It was not just the affair. Not every affair is a midlife crisis, and many people experience midlife crises without acting them out sexually. It was his barely awakening realization that he did not know what he felt, did not know his own desires, and that this state of affairs was no longer tolerable. He experienced a deep dissatisfaction with his life and his relationships—a dissatisfaction that, after two months of

therapy, he realized was deeper than sexual frustration.

But Alan also presented with an underlying character disorder, a narcissistic personality. It was not only his conflicts about relationships, his tendency to use people, and his dread of being used by others. He would also tend to idealize me at times—like when my interpretations hit home—and then there were those times when he swung around and completely devalued me. Linked with such fluctuations in his appraisal of my worth was a running evaluation of his own. When he was complimenting me on the perceptiveness of my interpretations, he said he felt safe being in therapy with me and felt more competent and powerful at work. When he was criticizing my wardrobe, he was also thinking he was really only as successful as he was because he was fooling people, manipulating them into thinking he was competent at what he did. And he seemed incapable of real mourning. When a friend betrayed him, ending the friendship, he would write it off: "The guy wasn't really important to me anyway." But Alan was only interested in resolving his ambivalence about relationships with two women when he entered therapy.

Should I focus on Alan's immediate crisis, and as soon as he resolves his ambivalence terminate the therapy, considering it a successful brief therapy aimed at resolving a midlife crisis? Or should I insist that the crisis represents only the tip of the iceberg, interpret his wish to terminate as a resistance to the deepening of our therapeutic relationship, and use my influence to persuade him to continue in long-term therapy with the aim of characterological change? Here is a situation where a therapist might be colluding with a client's resistance to therapy by agreeing to a brief time limit. By the time the twelve- or twenty session limit is reached, someone as closed off to feelings and frightened of intimacy as Alan might be just beginning to open up. If I agree to cut the therapy short, I might well be colluding with his defensive need to end this therapeutic relationship before it gets threateningly close, and an opportunity would be lost to examine why this man short-circuits every deepening relationship. Of course, if Alan's financial situation only permitted twelve or twenty sessions, my clinical opinion about all this would be irrelevant.

Before I had this question resolved in my own mind, it became apparent that Alan's motivation to continue in therapy was waning. Still he said nothing direct about the issue, so finally I commented: "Now that you've given up the idea of leaving Susan, you probably want all your dissatisfactions with

married life to disappear, and you're probably even thinking about dropping out of therapy."

"Yeah, you're right! How'd you know that?" My ability to come up with a correct interpretation seemed, for the moment, to put an end to the devaluing.

"Well, I'm the one you've told all your inner thoughts to. You said you told no one else, certainly not your wife, how much you loved June. You told me all about your dissatisfactions, how unbearable the boredom in your life is. Now that you're considering patching things up at home, it makes sense that you want to be rid of me." At this point, Alan said he had been seriously considering ending the therapy but would not be closed to hearing what recommendations I had.

During our conversation, I decided that my influence was significant and that for Alan to drop out of therapy would be a mistake. So I shared that opinion with him. I told him that the acute crisis might be resolving, and that was to his credit, but that his dissatisfactions ran deeper. And he might as well spend some more time in therapy now with a good prospect of resolving some deeper-lying issues—for example, his ambivalence about trusting friendships—and maybe prevent some repetitions of this kind of crisis. Alan thought about it for a week and returned having decided to take my advice and enter into a long term therapy with the aim of resolving some of his underlying conflicts.

Sometimes, when that moment arrives, the crisis is past, and the client is more set on ending the therapy. Sometimes it is best for the therapist to make a quick and graceful exit from the client s life, hoping that the client will return at a later time if the need arises. This is what I did with Ann.

Ann

Ann was forty when she came to my office complaining of depression. As we talked, she shared with me the dissatisfactions she felt within her marriage (her husband was never affectionate with her and was likely having a long-term affair) and in her career (she had dropped out of a successful professional practice in order to have time to raise three boys, currently teenagers, and was worried that she would never be able to be successful again in the world of work). She had come across a book in a bookstore, *Men Who Hate Women and the Women Who Love Them* (Forward and Torres, 1986), and found she fit the picture of a masochistic woman who is all too willing to tolerate victimization by a misogynist. She wished

to get over her depression, she said, but not to end her marriage.

We talked about her situation. She explained that she was frightened of being alone and that fear pushed her to remain with her husband in spite of abuse she suffered at his hands. I helped her link that situation to her early ambivalence toward her father. She loved him dearly, but he was often rejecting. But then, in those moments of closeness—like when he hugged her after she had hit a home run in a girl's baseball tournament—she felt as if all the negative interactions were worth it. The rewards were infrequent, the criticisms and angry reactions from her father the more usual. She had real conflicts about the kind of relationship she was in now, a repeat of the earlier one, where the male partner is intermittently abusive but otherwise very nice, and for fear that she would otherwise never gain his approval and love, she is willing to stay with him to the bitter end. We talked about all this.

She began to stand up to her husband more. The first few times we met after she had stood up to him on some little point, she would typically enter the consulting room in a state of severe depression. Asked why she was so depressed, she would answer that she and her husband had just had a big fight. So, why wasn't she angry at him, why depressed? That turned out to be a good question. We talked about that. Gradually, she became stronger. We met weekly for about six months. Her depression had progressively lightened, though it would never disappear altogether. She wanted to terminate therapy at that point. Our discussion about that uncovered her wish to stop elevating the struggle with her husband. She had found a happy enough medium. She now knew when to compromise and when some point of contention was worth an angry battle. He backed off from her for fear of her anger—and maybe because he sensed she felt stronger and might actually leave him—and this created enough distance so that, even though he was still occasionally mean and never showed any real caring, the new equilibrium was manageable. Besides, with my encouragement, she had begun to spend more time with friends away from the house and family and was even thinking about part-time work.

Ann wanted to end the therapy immediately. In fact, she first told me about this over the phone, adding that she would not be coming to our next appointment and would not be coming in anymore. I convinced her to come in at least once more to talk about this. Interestingly, this woman had used my interpretations very often and aptly during the course of the therapy. As soon as she had decided to end treatment, she discarded that way of thinking altogether. She told me she had stopped writing down and

analyzing her dreams. And she had stopped selecting for friends people who "needed to psychologize everything." In other words, her use of "the therapeutic" was time-limited—she would spend just enough time pursuing the inner quest to resolve a crisis in her life—and once she regained her equilibrium, she would have no further use for it. I asked whether she would be willing to come to two or three more appointments so that we could sum up and talk about our parting. She agreed do to that.

Unlike Alan, who wanted to know my opinion on the matter, Ann was set on terminating therapy. Clearly she was afraid that further exploration would threaten her tenuous marriage, and even if I said nothing about her needing to leave an unsatisfactory relationship, somewhere inside she knew that would have to be the next step if she were ever to be really happy. She felt it was a waste of time, knowing that, to be sitting for hours talking with me about how she feels about her life and how she is repeating patterns from her childhood with an abusive father.

I found myself, in those last few sessions, trying to get the message across to Ann that it was her decision to end therapy, just as it was her choice what she wanted to do about her marriage, but I wanted her to know she could return to see me whenever she felt a need. Obviously she was projecting some of her self-criticisms onto me and then assuming I disapproved of her choices. Rather than standing firm as I had done with Alan and confirming her projection that I would judge her negatively for ending therapy, I opted to interpret her projections and try to keep the door open for further work in the future.

Serial "Pieces of Work"

In effect, I did a piece of therapeutic work with Ann. Though we did not arrive at a termination date at the outset, and I did not stick to a focus the whole time, it was a brief therapy. The texts on brief therapy stress clarity about boundaries and time limits. They recommend setting a date for termination long in advance, and they even suggest that the client should not engage in any other kind of therapy for a certain period—perhaps a year or two—after the termination of the brief therapy, so that there will be an opportunity for the therapy to take effect, and perhaps for the therapist to assess the outcome.

In practice, things are rarely this clear. Studies show that clients go in and out of therapy quite frequently and move from brief to long-term therapy in other than the recommended way. Remember

Frank B. (chapter 2), who began therapy anew, albeit a diluted form of therapy, with another psychiatrist almost immediately after terminating his eight-year analysis. Patterson et al. (1977) found in their study of brief-therapy clients that sixty percent had previously undergone some other form of therapy and sixty percent would reenter some form of therapy within a year of terminating the brief therapy. This and other similar studies show that clients return repeatedly for one or another form of therapy as they experience the need. Patterson comments:

> Such data suggest that psychotherapy, whether long or short in duration, whether aimed at problem resolution or character change, is not constructed by the patient as a definitive and curative process, but one which has use and value at times of need. It is uncommon, however, for therapists to structure their relationships with their patients in a way that anticipates this pattern. Most commonly, such relationships are structured as closed ended, (p. 365)

In other words, the therapist is aiming for a resolution of the transference and a definitive termination for every therapy, but in many instances, the client intends to be in therapy only until the symptoms are resolved and might plan to return when these or other symptoms become a problem again.

Gerald Amada (1983) is pragmatic about this issue. He recognizes the pattern of client's entering therapy in crisis, quickly feeling better, and then not knowing what to do about ongoing therapy. He suggests that, in practice, many therapies that began as brief therapies go through an interlude after the crisis has died down, where the therapist and client fumble around looking for a focus and then proceed into a long-term, open-ended therapeutic relationship. He identifies the moment of transition: the originally sharp focus of the work becomes vague, the therapist necessarily shifts from an active interventionist during the crisis to a relatively more inactive role as facilitator of open-ended exploration, and the transference issues become relatively more important as time goes on. Amada's description fits the therapy I conducted with Alan.

Of course, many other clients, like Ann, drop out of therapy, to return, one hopes, when stresses once again overwhelm the capacity to cope. Unlike psychoanalysis, a complete psychotherapy is not usually carried out at one sitting. Of course, many clients go through several years of therapy with one therapist and then work hard on termination issues when the end draws near. This is important. When a client's lifetime pattern of therapy consumption consists of serial very brief encounters or pieces of work, a deeper therapeutic relationship is never experienced, and many of the " separation-individuation"

issues (Mahler, 1972) are never examined and worked through. The therapeutic relationship never really evolves to the point where termination issues might play an important role. In general—and this must be evaluated for every individual case—a relatively long course of therapy that gets to the separation-individuation and termination issues is useful somewhere along the way, and it often turns out that by undergoing such a therapy, the client reduces his or her need for some of the shorter pieces.

Still, a life's dosage of psychotherapy is today more likely spread out over the lifetime in small pieces. For instance, one piece of work might be undertaken at the time of a divorce or business failure, another at a time when someone close dies and life becomes unbearable, and still another when the aging process seems overwhelming—for example, after a heart attack takes the wind out of one's sails. Thus, a college-educated middle-class individual reaching forty today is likely to have undergone one or two courses of personal individual therapy, has probably been in various group experiences from sensitivity groups to the more modern "trainings," perhaps has seen a couples therapist a few times while in the throes of a battle with a mate, probably has been given permission by the more important of the two individual therapists to return whenever there is need, and is likely thinking that is just what she or he will do.

Therapists create a whole new language to discuss the phenomenon. For instance, they speak of doing "a piece of work." Thus, with a client who is not motivated or cannot afford to go on in therapy past the time when the worst symptoms are somewhat ameliorated, the therapist might agree to halt the therapy—not exactly a well-worked-through termination, but a reasonable time to take a break from therapy—and might leave the client with the message that a nice "piece of work" has been accomplished, and the client might want to return for further therapy when difficulties arise in the future.

There is another important factor here. Psychoanalytic therapy has been diluted in the process of its popularization. There are all forms one can select. In Freud's day, there were no sensitivity groups, not even group therapy, no couples therapy, and no family therapy. Psychoanalysis was the only show in town. So the captive audience sat it out until the bitter end. Today, there is a whole culture built around therapy. The sensitivity groups and growth experiences of the 60s introduced a generation of consumers to psychotherapy. Since, there has been body work, co-counseling, peer self-help groups (including "twelve-step programs" such as Alcoholics Anonymous and Overeaters Anonymous), intensive growth

trainings like E .S.T ., and so forth. I am defining therapy very broadly now. But in the course of a lifetime, the individual is likely to come into contact with many different therapies, broadly defined. The lifetime work is essentially broken into pieces, some of which are accomplished in individual, psychoanalytically informed therapy, and some in other modalities.

Other developments have kept apace of this shift in the pattern of therapy consumption. Therapists are more numerous. Clinical practice is a popular career for sensitive survivors of the 60s—it provides a place to be honest and nurturing, and the work is paid. Also, there is less stigma today. Because therapy is commonplace, almost omnipresent in our everyday lives, it is easier to obtain, and there is more knowing support from intimates while one goes through it.

For these and other reasons, there has been a shift in the pacing of psychoanalytic therapy in consumers' lives. Certainly some analysands, such as the Wolfman, returned for repeated analyses, but as a conceptual ideal, psychoanalysis was a once-in-a-lifetime venture. Now, in its various diluted forms, therapy is consumed periodically, and therefore in pieces. Thus, when we talk about length of treatment, we are comparing a total of several years on the couch in the case of psychoanalysis to perhaps the same number of accrued hours in therapy in the course of a lifetime—the latter instance is of someone who has been in several shorter personal therapies, as well as logging a number of other hours in therapists' offices in groups, with a mate, or perhaps with a child when the latter seemed out of control. It seems that, if one wants to see evidence of the average tendency for psychotherapies to lengthen today, one must look at the total accrued hours of therapy in a lifetime rather than the length of any particular piece of work.

Not infrequently, the therapist is confronted by a client who unilaterally feels his condition is sufficiently improved for him to terminate the therapy. Instead of analyzing the way the plan to terminate contains important resistances to therapy, the therapist, being pragmatic and knowing about this modern trend, is more likely than analysts once were to agree with the plan, merely adding: "The therapy is not really complete. But if you feel you want to proceed without a therapist's help for a while, that is fine, as long as you remember you can always return if you feel you're ready to do another piece of work. " I have found that it is more when the client does not seem to get that message that the therapist will confront that client about resisting treatment. If the client gets the message, the therapist as realist

figures that the client will quite likely return when it is time to do the next piece of work.

In this context, brief therapy is not so much a shortened variety of therapy as it is an opportunity for people who are not familiar with "the therapeutic" to have a well-bounded trial package. Then too, it is a modality that serves well for doing the periodic "piece of work." Interestingly, when the brief therapists first arrived on the scene, more traditional psychoanalysts dismissed their outcome studies by saying that what they had achieved was a "transference cure" or a "flight into health," and that sometime after termination of the brief therapy the still unresolved deeper-lying conflicts would surface anew, displaced into a new set of symptoms. The brief therapists aimed, in their early outcome studies, to rebut this traditional analytic critique. Empirical studies did eventually show that the analysts' concern was not well founded.

Peter Sifneos captures that debate in his description of a 1956 case discussion (Davanloo, 1978). The patient complained of phobias and was concerned that his upcoming wedding would be ruined by his symptoms. The brief therapy was successful, and the man married without incident. Sifneos recalls:

> This case was presented to our staff, and we were told that we had a "flight into health." Someone disagreed and said, "No, that was a transference cure." Someone else said that this was a symptom substitution and that there was a chance this fellow was going to relapse. We have a follow-up of three and a half years for him. He still had some occasional twinges of anxiety when he entered closed spaces, but he said, "I know what these things mean, and they don't bother me as much. I have learned to live with them, I am happily married and I have two children, (p. 82)

Meanwhile, the advent of brief therapy brings the triumph of the therapeutic into new classes and contexts. Then, if clients do not want to end therapy after a brief course, but want to explore their psychological make-up more deeply, and if they can afford private fees, they can go on to longer-term therapy. Brief therapy serves to recruit from among the ranks of people who never before believed in the efficacy of the talking cure, and motivates them, sometime later in their lives when financial constraints are less, to pursue a longer course of therapy, or even to join those who regularly resort to therapy whenever problems in their personal lives seem out of control. The therapeutic that triumphs takes many forms. Lengthier and deeper probing therapies are not the only method for the therapeutic to enter the interstices of the individual psyche and the social fabric. Brief therapies that reach into the lives of a broader spectrum of people, especially when the multiple brief pieces of therapy eventually add up to more hours in a lifetime than one course of the lengthier kind, carry the message just as well.

Now we can return to the critical question about termination: On what basis is the choice made of long-term vs. brief therapy? Clinicians, following the clinical logic of termination, would like to be able to say that clinical considerations—an individual's condition, motivation to change, progress in therapy, and so on—determine who needs and might benefit from one or another modality. In chapter 5 I showed that the ability to pay is probably a much more important consideration. But whether or not one can afford long-term talking therapy, there is another issue involved in the choice between the two modalities: what I term "abstract commitment to psychotherapy."

An Abstract Commitment to Therapy

What do I mean by abstract commitment? The commitment to be in therapy only in order to relieve a particular symptom, be it insomnia, depression, or a conflict about authority, is rather concrete. In contrast, it is an abstract commitment that motivates one to continue in the therapeutic process even after the symptoms are relieved, the rationale being that therapy will facilitate personal understanding and growth, even if the eventual outcome is not knowable at the beginning. Abstract commitment helps one remain in therapy longer and persevere through those inevitable moments when the therapy seems stuck, the therapist is off on a tangent, or the client is just plain disgusted with the lack of progress.

Assuming an equivalent ability to pay fees for private therapy, and assuming (as I have been throughout this discussion) that the client's mental condition is not so severe that some form of psychotherapy is mandatory, then the particular client's abstract commitment to therapy plays a key role in determining the length of the therapy and the terms of termination. For instance, one group of clients, such as busy executives or professionals who are in a hurry to get past troublesome symptoms and return to full functioning at work, may be interested only in a quick cure and may wish to terminate therapy as quickly as possible without exploring early childhood events, transference issues, or conflicts about dependency and termination. Another group of clients, generally college-educated with an interest in psychology and personal growth, demonstrate a sizable abstract commitment and undertake therapy as a growth experience as much as for the treatment of particular symptoms. Greenspan and Kulish (1985), in their study of premature (in the opinion of the therapist) termination of long-term psychotherapy, interviewed the ex-clients and found that they were relatively uninterested in the psychological roots of their problems, but rather felt most were due to external circumstances. And this abstract commitment is

not inborn, nor accidental. It is learned. Some people cultivate an interest in psychology by taking courses, reading, or being influenced by others who are psychologically minded. Most people develop the commitment as a result of a positive experience in psychotherapy.

A New Criterion for Termination

By being pragmatic about the client's lack of motivation to stay in therapy any longer, the therapist is inadvertently shifting the criteria for termination. Now, along with the usual criteria for termination—the amelioration of most of the symptoms, the resolution of the transference, the likelihood of continued psychological growth, and the therapist's confidence that longer therapy would not add anything to the client's potential in life—the therapist also insists that the client become attuned to the psychological sphere. Before giving their blessing to termination, some therapists require evidence that the client has internalized the therapeutic message sufficiently well to be likely to return for another course of therapy when the need arises.

Therapists even say this to clients: "After we part, I won't be entirely gone from your life—you will carry me around inside your head." In effect, the reason therapists are so often willing to give their blessing to a termination that is initiated by the client long before the therapist might feel the work is entirely completed is that, if the client has the capacity to internalize this message, in all likelihood the immediate ending will not be a termination at all, in Freud's sense, but merely a break in a process that is not completed—and that might go on over a lifetime.

The idea that the client internalizes the therapist is not new, of course. Freud would put the ego in control of the super-ego and the id, and consider the person mentally healthy. Gradually, the healthy ego was assigned the additional task of continuing the analytic work. A healthy ego would be one that could apply the uncovering of the unconscious to the problems of everyday life. The concept emerges in the contemporary literature as the "self-analytic function." For instance, Herbert Gaskill (1980) writes in the *International Journal of Psychoanalysis*:

> To the degree that the unconscious sources of behavior are understood and organized under the dominance of the reality principle, the analysand, due to internalization of *the self-analytic function*, is in a position to make more conscious and more informed decisions about his actions. This leads to the establishment of increased internal autonomy, the fundamental goal of analysis, (p. 15)

What Gaskill describes for analysts also becomes a prerequisite in order for the therapist to say that the therapy is complete. In other words, the new criterion for termination is that the client have sufficiently internalized the therapist or the therapeutic function that she or he will likely continue on her or his own the work begun in therapy, and will return for another course of therapy as the need arises.

There is even a newly invented diagnosis, unofficial to date, to fit those who are not able to demonstrate enough of the self-analytic function to make use of psychotherapy. Alexithymia is the disorder of people who are unable to speak symbolically about their inner life, are unable to express their feelings, and have an impoverished fantasy life (Sifneos, 1973). The condition is linked to psychosomatic disorders—that is, those who cannot express themselves verbally might do so through physical symptoms, and there is speculation about an organic base for alexithymia (TenHouten et ah, 1986).

Thus, without any explicit statement to this effect in the professional literature, the definition of mental health has shifted to include a certain amount of abstract commitment to therapy. Then, it is assumed by clinicians, again without explicit mention in quite these terms, that the criteria for termination have not been satisfied until there is evidence of this kind of abstract commitment. This development serves the therapy industry well. The healthy individual will spread the word, for instance, by introducing intimates as well as colleagues to the benefits of therapeutic work. The definition of mental health, and the perfect way to insure a continuing clientele for therapy, come together in one formulation about the proper time to terminate a piece of therapeutic work, and the possibility of doing further pieces of work at a later date.