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NECESSARY AND UNNECESSARY LOSSES

THE ANALYST'S MOURNING

WE WERE IN what seemed to me to be a particularly productive phase of the treatment. At long last (from my point of view) the patient was recognizing narcissistic aspects of her character that had hampered her in developing an enduring relationship. At thirty-five she was, I felt, really ready, for the first time, to engage in a deepening intimacy. Her whole life had been a momentous, courageous struggle with physical disabilities. Now she seemed ready to emerge more fully from the constraints of her psychological limitations. It was over the weekend that I got the message that she had suddenly died.

My experience of losing this patient was extremely painful, but I know I am hardly unique in having sustained such a loss. How do we bear these losses? What effects do they have over time, on our personal and professional lives?

Of course, the loss of a patient is usually less dramatic than this example. Patients terminate treatment, sometimes abruptly, sometimes with measured preparation. What is the accumulated impact on us, over the years, of living through so many endings? How can we best bear the sorrows that accompany a life in this rather peculiar profession?

Describing some peculiarities of the analytic relationship, especially in its termination phase, Nina Coltart (1996) writes,

The totality of the ending, which seems to go against the grain of all our work on love, loyalty, object-constancy, and intimacy, is reinforced by the austere prescription of no social contact thereafter. Thus we create an arbitrary situation that has much in common with a death. [p. 151]

This description is no less apt for the analyst than for the patient. We take it for granted that over the years we will suffer the loss of countless people who have been our partners in an intimate emotional exchange. However we lose contact with these people, the loss is usually total and final.

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In an attempt to separate the unavoidable from the avoidable pain of these experiences. I suggest that the negative impact is exacerbated by:

- (1) Inhibitions (implicit in how we conceive of our roles) against full acknowledgment of the depth of some of the losses.
- (2) Obstacles, intrinsic to the nature of the analytic relationship, to our benefiting from the normal mourning process.
- (3) Other, more subtle forms of loss that are also frequent occurrences in the professional life of the analyst.

Our training does not adequately prepare us for dealing with these losses. Part of the reason is that the treatments we conduct under supervision are generally in their beginning phases, so intensive study of the termination phase is limited. This rational reason, however, does not entirely explain how ill-equipped many of us are to explore our repetitive losses usefully. Once again I agree with Coltart, who suggests that analysts are reluctant to examine the similarity between treatment termination and death because

even a mature, level-headed, and commonsensical person may have an almost superstitious fear of talking about death, and this would certainly include any comparative reference to death in connection with such a frequent phenomenon as ending a treatment in our own professional lives. [p. 148]

I begin this essay on our loss experiences with some comments on the situation for the analyst when the patient dies during the course of the treatment, either through suicide or natural causes. Of course, analysts are not alone in experiencing deaths, but here I suggest some of the ways the death of a patient in analysis is an unusual situation. In order to delineate some of the obstacles to healthy mourning for the analyst, I describe what I believe normal mourning requires.

Deaths comprise a small portion of the losses the analyst sustains. I discuss the analyst's experience of planned and abrupt terminations, and why we often fail to register their impact fully.

More subtle, pervasive losses than the actual death or departure of a patient abound in our worklives and, I believe greatly exacerbate our acute grief experiences. These chronic demoralizers include losses of dignity, integrity, and conviction, due to the impact of aspects of the

wider culture, such as cynicism about analysis, managed care, and an overemphasis on pharmaceutical solutions to emotional problems. Eventually this can lead to a loss of involvement in analytic work or "burn-out." This extremely painful condition, I argue, is not unlike severe depression in its effects on self-esteem, energy level, creativity, attitudes about the future, and the experience of leading a meaningful life.

Although much of this discussion could be considered under the rubric of countertransference reactions, I suggest that some of the difficulty for the analyst in the situations I describe derives from how he has been taught to conceive of his role. Thus, these unnecessarily prolonged, painful experiences are partly a product of the culture of analysis (Buechler, 1988, 1992) as well, of course, as a product of the particular character issues and life experiences of each analyst.

In a final section of this essay I offer some ideas about how we can best bear our inevitable, necessary losses, and limit the frequency and impact of the unnecessary ones.

The Death of a Patient

Each death, of course, carries its own very personal, individual meaning; but I feel there are some experiences that analysts often have following the death of a patient by suicide or natural causes. These experiences can be extremely painful and, in some ways, bizarre.

If he attends a funeral, the analyst may come in contact, most likely for the first time, with the patient's closest relatives. It can be very hard to find words that feel at all appropriate, and yet we may be expected, and may expect ourselves, to be especially interpersonally adept at handling this sensitive situation. The analyst has the sense of intimately, profoundly knowing all the parties involved, and yet they may never have met or spoken before. The relatives and friends, dealing with their grief, may be dis comforted by the presence of the analyst, whose role in the patient's life they may have long resented. They may blame the analyst in some way for the death, or they may feel that for years they have been judged by the analyst, without any opportunity to defend or explain themselves. The relatives and the analyst may all be carrying an enormous load of conflicting feelings, without any store of positive memories of relating to each other to draw upon.

The patient I mentioned earlier comes vividly to mind. She was an unforgettable woman who touched many lives with her determination

and lively spirit, and I know that my sense of loss was more than matched by many others. But I'm not sure they understood, as I felt I did, how hard she had recently been fighting for a better life. To see her die at such a young age caused me indescribable pain. Unlike others who mourned her, I had no one I could really talk to about these feelings. Her relatives and friends were not mine, and I would have felt it inappropriate for me to discuss the treatment with them. Some of the mourning of an analyst proceeds in solitude.¹

Healthy Mourning

Before further discussion of the experience of the analyst whose patient dies, I would like to comment on the nature of the mourning process. Freud, of course, in "Mourning and Melancholia" (1917), strove to discriminate the emotions that normally accompany loss from the pathological, depressive state. In so doing he defined normal mourning as a process of adjusting to loss by gradually shifting cathexis from the lost object onto new, available objects.

From another perspective, emotion theorists (Izard, 1971, 1972, 1977) have defined sadness as a universal part of human experience in response to loss. It is contrasted with depression, which is considered a complex rather than a fundamental emotion, in that depression includes sadness as a component but has other emotional aspects as well, depending on the life experience of the person. Sadness is the emotional pain it is temporarily natural to feel when a meaningful loss or blow is incurred. Depression, on the other hand, generally involves a loss of self-esteem, a narrowing of the range of other emotions, and an overall constriction in living.

Not all theoreticians conceptualize sadness as a healthy, functional, self-limited response to loss and depression as its pathological alternative. Some (e.g., Bonime, 1982) see the core of depression as anger rather than sadness, and envision the "practice" of depression as a characterologically based, destructive way of life. Spiegel's work (1960, 1965, 1967, 1968, 1980) suggests that the specific emotions contained in any particular individual's depression may differ, so it is always important

¹ For many years of lessening that solitude I would like to thank the members of my peer supervision group: Drs. Mark Blechner, Richard Gartner, John O'Leary, Allison Stern Rosen, and Robert Watson.

clinically to make no assumptions about what depression "is," and to carefully inquire into the nature of each patient's depressive experience.

But for those interpersonal psychoanalysts who see depression as an unhealthy version of sadness, the two states can most easily be distinguished by looking at their effects over time, because sadness heals and passes, whereas depression repeatedly disrupts functioning. The difference between sadness and depression is well captured by Arieti (1978).

Common is the sorrow that visits the human being when an adverse event hits his precarious existence or when the discrepancy between the way life is and the way it possibly could be becomes the center of his fervid reflection. In some people this sorrow comes and goes repeatedly, and in some others, only from time to time. It is painful, delays actions, and generally heals, often but not always after deepening its host's understanding and hastening his maturation.

Less common—but frequent enough to constitute major psychiatric concern—is the sorrow that does not abate with the passage of time, that seems exaggerated in relation to the supposed precipitating event, or inappropriate, or unrelated to any discernible cause, or replacing a more congruous emotion. This sorrow slows down, interrupts, or disrupts one's actions; it spreads a sense of anguish which may become difficult to contain; at times it tends to expand relentlessly into a psyche which seems endless in its capacity to experience mental pain; often it recurs even after appearing to be healed. This emotional state is generally called depression. [p. 3]

What allows us, if we are characterologically capable of it, to mourn a loss and go on living productively? What is it in the way we live our losses that distinguishes normal mourning from pathological depression? Gaines (1997) suggests that healthy mourning encompasses *two* tasks: the detachment that Freud's drive theory emphasized, and the equally important task of creating continuity by maintaining and building on the connection to the inner object. Creating continuity is, as Gaines describes, a very interpersonal endeavor.

The creation and maintenance of continuity is not easily carried out alone. For many people it is difficult to maintain the internal image without opportunity to express it aloud and share it with others. Partly, this has to do with the role of language in preserving memory. Both the expression of feelings and images in words and the repetition and sharing of those narratives with others are known to enhance memory. Also, the very act of communicating one's experience of a lost relationship has the effect of

"bringing it alive" that is different from inner contemplation. Further, other people's appreciation of the lost object validates and enriches the solitary mourner's inner image. Other's observations about the mourner's relationship to the lost object can add to an understanding of what the relationship consisted of, what it meant for the individual, and how it is relevant to his life now and in the future. The availability of other people with whom to share the connection to the lost object helps mourners to bring the relationship into the present context, making it part of their shared ongoing lives. In a very important way, inner construction of objects draws on shared social construction of those objects. [p. 559]

The Analyst's Unresolvable Mourning

This description of the interpersonal process of mourning highlights what is often missing for the analyst when his patient dies. Even if the analyst is characterologically capable of a healthy mourning process, the interpersonal context is not conducive to it. He may never be able to communicate with anyone about the patient, which may make it difficult to maintain the patient's image internally. Without the opportunity to talk about the patient, especially to others who also knew the patient, the analyst has only his own resources in his effort to understand what knowing and losing this patient meant to him.

But I believe that some of the role expectations embedded in our analytic culture interfere even more profoundly in the essential mourning process. As analysts we are part of the wider culture, but are also members of an analytic subculture, with its particular mores, injunctions, and assumptions (Buechler, 1988, 1992). The analytic culture dictates, sometimes in subtle ways, the emotional reactions deemed "appropriate" and acceptable. Although we might not be able consciously to formulate all the "rules," we could probably listen to a colleague's case presentation and agree on whether his involvement with the patient seems "excessive."

I feel that there are times when these mores inhibit the normal mourning process. I will break this process into its components, to suggest the specific elements of the normal healing process that are unavailable to us as analysts.

Healing requires recognizing the fact of the loss. Denial of the reality and meaningfulness of the loss interferes in normal mourning (see, for example, Riviere's, 1936, discussion of the relationship between denial

and depression). Thus, to whatever extent our analytic culture discourages our seeing ourselves as personally invested in our relationships with patients, we may have difficulty admitting to ourselves what the loss of a patient means to us personally. In other words, any characterological tendencies we might have to use denial are enhanced in this context.

Mourning is complicated in the presence of unresolved aggression toward the object before the loss. (This, of course, was spelled out by Freud in his 1917 essay). To the extent that, as analysts, we ask ourselves to contain negative emotional responses to the patient, at least until it seems therapeutically appropriate to share them (Winnicott, 1949), we accept the burden of carrying our unresolved negative feelings during much of the course of the treatment. If the patient dies or terminates abruptly, we are left with these feelings.

The process of mourning is furthered by hearing about what the loss meant to others, and by maintaining communication with other mourners over time. This allows the mourner to create needed continuity in his relationship to the inner object (Gaines, 1997). All of this would generally be prohibited by the constraints of our roles as analysts. The absence of ongoing communication with anyone about what the patient meant to us may complicate our response when the patient terminates treatment as well. We do not see ourselves as needing any ongoing process, but seem to expect ourselves to behave as though patients are interchangeable, and the loss of one can be erased by the appearance of another.

A common component of mourning is identifying with the lost object, thus compensating for the loss (Freud, 1933; Jacobson, 1971). But this may be difficult for those analysts who maintain emotional distance as part of the frame.

The position of mourner requires temporary acceptance of passivity, which might be difficult to integrate with some analysts' conceptions of their role.

Thus, if we view mourning in Gaines's (1997) terms, as a process of both detachment from the object, to make room for new ties, and continuity, to preserve the meaningfulness of the ongoing inner connection, our roles as analysts interfere much more with the maintenance of continuity than with detachment. Our interpersonal context, which does not include anyone else who knew the patient, is not conducive to sustaining the inner tie. Our roles mandate some distance, encourage us to

contain negative feelings about the patient, and heighten any tendency we may characterologically have to delimit appreciation of the personal significance of the departed patient to our own lives. Our workdays, lived in forty-five-minute segments, may encourage the illusion that we can emotionally "move on" every time the buzzer sounds. The analytic role may also exacerbate the discomfort we otherwise might be prone to have with the passivity of being a mourner. Our position, of having many other patients with pressing needs, seems to justify, even to enable, moving on. This encourages whatever defensive processes in us that might tend toward denying the impact of loss. It is as though our roles make it seem possible that we could "skip" some of the normal human mourning process. If we have any tendencies in this direction characterologically, the role reinforces them.

My experience analyzing, supervising, and informally talking to analysts over the years suggests that many of us have suffered the deaths of patients without making an active effort to process the loss in a meaningful way. We have no institutionalized rituals for dealing with these losses. It is as though the fact that the person was a "patient" makes a ritual unnecessary. We would be unlikely, if a colleague, or friend, or relative died or permanently left, to expect ourselves to "move on" without grieving. But because, in some fundamental sense, our role encourages the denial of the personal impact of our relationships with patients, we also deny the personal meaning of their death or departure.

There are added complications if a patient's death was the result of suicide. There is no question that a patient's suicide can haunt the analyst for life. Among other feelings, there can be a vague, guilty sense that the analyst might have prevented it. Most writers on the subject of mourning suggest that guilt, or any factor that could lower self-esteem, interferes in normal mourning (Arieti & Bemporad, 1978). Perhaps, like the patient's relatives and friends, the analyst is likely to mentally inspect every recent interaction with the deceased, looking for clues to the patient's desperate state that the analyst may have missed. But unlike friends and relatives, the analyst is, supposedly, an expert at reading human behavior. Unfortunately, of course, our expertise does not guarantee that we can always predict what a patient may do. But as analysts, perhaps especially if we look back and see ourselves as having been unwilling to extend ourselves for this patient, we may feel a special sense of responsibility and guilt.

Terminations, Planned and Abrupt

Even the well-planned termination involves several kinds of losses for the analyst: the loss of a partner in a significant relationship, an economic loss, and the loss of a reflection, that is, someone who could help the analyst assess his own professional progress. The literature on termination (e.g., Ferenczi, 1927; Freud, 1937; Reich, 1950) deals mainly with its timing and impact on the patient and focuses less often on the analyst's losses.

As all of us can do, I see, in my mind's eye, a parade of former patients. I would love to know what happened to them, if only out of natural curiosity. Of course, ours isn't the only field in which the practitioner works toward his own obsolescence. Consider foster care, and even parenthood. But for those of us who feel posttreatment contact should be very limited there is a unique kind of loss at the termination of an analytic treatment. Never to hear what became of someone you have known so intimately is an incredible loss. Yet it is a regular occurrence in our professional lives. Loss comes with the territory.

But we have only scratched the surface when it comes to the losses analysts bear. Aside from planned terminations, there are the abrupt departures. I would wager that no analyst completes his career without encountering at least one mystery patient who leaves in the middle of the work, giving circumstantial but insufficient reasons. Freud (1905) set an example for us in his open expression of pain and frustration in response to the abrupt departure of his patient Dora. As a graduate student, I remember watching a taped interview in which an "elder-statesman" analyst, commenting on mysterious terminations, said that "pieces" of these patients always "stuck with him." For the analyst, the story never ends; it remains unfinished. He can always wonder if he could have done something differently to make it possible for the work to continue. In addition to feeling responsible for any "mistakes" he committed, the analyst may not be able to absolve himself entirely of what he might have thought of.

Analysts who work with children often experience the exquisite pain of having the parent withdraw the child from treatment as soon as there is progress (from the analyst's point of view). The parent-child-analyst triangle is inherently complicated, and I will not belabor its difficulties here, but I can attest to the tremendous pain, most especially evident in young, idealistic therapists, who may deeply identify with their child pa-

tients, and must watch them return to abusive or neglectful family situations, with no recourse unless evidence can be presented that warrants intervention.

My comments on abrupt termination are meant to be evocative, not definitive. Each such event has its own particular impact. But unless our training and later experiences encourage us to self-examine how we are affected by these departures, I believe they can contribute to the destructive state of burnout I discuss in a subsequent section. Although each patient's treatment and departure has its own meaning, if an analyst reflects on her experience, it may be she will find that she does have a characteristic way of responding to abrupt terminations. For some of us, self-blame and a strong sense of guilt may predominate, while for others, shame and a painful feeling of inadequacy may prevail. Still others may experience mainly anger directed at the patient. Unless we find a way to face and truly deal with these experiences, I feel they can affect our commitment to the work and our faith in ourselves.

Culturally Based Losses and "Burnout"

Without much effort, most of us can describe some of the array of losses experienced by analysts as a result of managed care. In many cases, we and our patients are put in untenable positions. We must either collaborate with a system that often shows no respect for the basic assumptions of our profession or risk losing, for our patients, reimbursement they need. Whether or not the treatment gets reimbursed can depend on the verbal skill of the "provider," who must couch the patient's "illness" in terms acceptable to the company. The losses for all concerned are too numerous to list, but too many times they include losses of dignity for both patient and analyst. Whatever choice the analyst makes, whether to "play the game" and try to guess the words that will bring reimbursement, or simply to report the facts or opt out of the system, patient and analyst have been forced into potentially troublesome roles with each other. The analyst's verbal skills, willingness to stretch the truth, political attitudes, resourcefulness in finding time for paperwork, and the like should not determine whether the patient gets reimbursed; but these and other equally absurd factors often make the difference.

So many analysts come to consultations or supervision having lost enthusiasm for the field, partially because of today's bottom-line-driven climate. Younger ones, just entering the field, wonder if they have chosen

their profession wisely. Will there *be* analysis in ten, or twenty, or thirty years? How can they develop decent practices if that part of the public mind that wishes deep-seated problems could be eradicated with a magic pill, or in eight forty-five minute sessions, is given official sanction? Middle-aged analysts feel it is too late to change professions, and see their incomes and opportunities to use their skills dwindling, at the time of life when they expected to be reaching their professional peak. Older analysts look with increasing dismay at what has happened to the field to which they have dedicated their life's work.

So far, I have described the analyst's experience of loss from deaths, planned and abrupt terminations, and the demoralizing climate. Cumulatively, these experiences can, I believe, contribute to what is often called "burnout" (Cooper, 1986). For an analyst, burnout is symptomatic of the greatest loss of all—the loss of faith in the profession and in oneself. The burnt-out analyst no longer believes in the worth of what he does for a living. He feels, for whatever economic or other reasons, he must continue to go through the motions of doing treatment, but it has become an empty exercise. I believe that cumulative losses are one important source of burnout, although other factors, such as the unique stresses of the work and the individual analyst's particular character issues, play major roles.

In burnout, it is as though making the work not matter could offer solace, relief from repetitive experiences of stress, pain, and loss. If what I'm doing has no meaning, then losing patients and the discouraging climate would not hurt so much. Unconsciously, cynicism offers an illusion of protection from pain. Better to deaden oneself than to be continually assaulted by loss. Of course, this is not a real solution, and the burnt-out analyst has suffered the greatest possible loss—the loss of faith in the worthwhileness of what he can accomplish.

I would argue that for most analysts, most of the losses I have described usually evoke temporary sadness. The burnout reaction is, I believe, closer to depression than sadness (see the descriptions given earlier of the differences between the two). A definite loss of self-esteem is involved in burnout, and it is likely to be pervasive and extended, rather than a temporary response. Why do some of us burn out while others lead long, rich professional lives? As with any depression, underlying character structure is key (Jacobson, 1971). But I also believe that those of us who are involved in training have an obligation to talk and write openly about our loss experiences, so that younger analysts will feel free to reflect on and, if necessary, get early help dealing with the losses they

encounter in the work. If we keep to ourselves what it is personally like to lose patients in one way or another, year after year, we don't offer an invitation to our younger colleagues to pursue these issues openly.

The Well-Borne Loss

Although repeated loss experiences are unavoidable in our work, we can learn to bear the losses as well as possible. Aside from permitting ourselves awareness of the meaningfulness of the losses, so that denial doesn't complicate the mourning process, we can turn, more often, to colleagues, to make these losses into shared experiences. We can also become more aware of the potential these experiences have for furthering our personal and professional growth.

I hope that by writing of the potential positive uses of these experiences I will not be misunderstood as making light of them. But I do feel they can contribute to the analyst's emotional life. Of course, I don't mean by this that losses should be sought. But we must collectively study how they can be borne in such a way that the analyst avoids burnout.

With every year I feel deeper appreciation of Sullivan's statement that we are all more simply human than otherwise. Participating in the painful moments of others' lives I have come to know how the most seemingly inexplicable behavior may, at bottom, be a convoluted expression of a grieving that is quite basic and universal. The intense losses that are part of everyday life, losses of loved ones, of health, of faith, of ideals, of dreams, are always near to the analyst. He knows of loss vicariously, through patients' experiences as well as through his own.

This heightened awareness of the pervasiveness of loss is not only a burden. It can also be a tremendous inducement to savor every waking moment. It can teach the same lessons that any brush with tragedy potentially affords. It can enhance appreciation of the smaller and bigger miracles of life, the ordinary pleasures so easily taken for granted.

Sadness is an emotion that potentially binds us together. It bids me to stretch to understand that which is initially alien. When I first began working as a therapist I was assigned to see a patient who was a member of the American Nazi Party. His beliefs were especially repugnant to me, and, initially, I had doubts as to whether I could treat him. But something pulled me to listen further, and, in hearing the story of his unbearably sad childhood, I found a human being I could connect with.

I could feel sorrow for his losses, for the gentler, saner childhood that would never be his. I could understand how it warped and embittered him, though I would never embrace the "philosophy" he developed. Eventually he came to repudiate that philosophy and its defensive strivings for absolute domination and superiority. Eventually we understood some of the complex determinants of his politics. Of course his party affiliation was more than merely a response to a severely abusive childhood, and cannot be so simplistically explained away. But without engaging in reductionism, I do feel that genuine sorrow for some of his early losses enabled me to empathize with aspects of his humanity, and to bear being with him long enough to get to know and help him.

Sadness eventually cleanses, allowing us to return to the fray. It acquaints us more nearly with all it means to be a human being, binds us to each other, and sharpens our appreciation of joyous moments. It lends perspective to the ordinary and the extraordinary vicissitudes of life. As an analyst, it is necessary that I develop a strong tolerance for sadness and loss, for they will always be close at hand.

I turn a corner and "see" the patient I mentioned earlier, who died years ago. I realize how often this has happened over the many years since she died. At first I thought it would be a fleeting phenomenon, a wishful fantasy expressing how much I miss her humor and courage. I understand that these moments meaningfully reflect on personal aspects of my ongoing relationship to loss. But for these brief instants she is here again, and not just alive but well, walking, out of her wheelchair. The fantasy gives me a momentary break from bearing the sad reality. And then the person in the street comes closer, and I realize it is not my patient. The pain of her loss is no less now than it was when she died, and my feelings of regret that she didn't have more time are unchanged. What *is* different is that years of self-reflection have clarified some of the personal meanings of her life and death to me. Now I bring this greater clarity to each instance of actively mourning her loss. And cumulative experience has taught me something about how much she contributed to my personal and professional growth. Every current clinical and non-clinical moment that the experience of her illuminates increases my appreciation of her. Every time remembering her helps me in some way, the balance of what I gained from her versus what I suffered changes. I know much more now about what seeing her did, and still does, for me professionally and personally, and how I would like to use that growth. The sadness is doing its essential job, of binding me more firmly to life.

REFERENCES

- Arieti, S. (1978), The basic questions and the psychological approach. In: *Severe and Mild Depression*, S. Arieti & J. Bemporad. New York: Basic Books, pp. 3-10.
- Arieti, S. & Bemporad, J. (1878), *Severe and Mild Depression*. New York: Basic Books.
- Bonime, W. (1982), Psychotherapy of the depressed patient. *Contemporary Psychoanalysis*, 18:173-189.
- Buechler, S. (1988), Joining the psychoanalytic culture. *Contemporary Psychoanalysis*, 24:462-470.
- Buechler, S. (1992), Stress in the personal and professional development of a psychoanalyst. *Journal of the American Academy of Psychoanalysis*, 20:183-191.
- Coltart, N. (1996), *The Baby and the Bathwater*. Madison, NJ: International Universities Press.
- Cooper, A. (1986), Some limitations of therapeutic effectiveness: "The Burnout syndrome" in psychoanalysts. *Psychoanalytic Quarterly*, 55:576-598.
- Ferenczi, S. (1927), The problem of the termination of the analysis. In: *Final Contributions to the Problems and Methods of Psychoanalysis*, ed. M. Balint. New York: Basic Books, pp. 77-86.
- Freud, S. (1905), Fragment of an analysis of a case of hysteria. *Standard Edition*, 7:3-122.
- Freud, S. (1917), Mourning and melancholia. *Standard Edition*, 14:237-258.
- Freud, S. (1933), New introductory lectures on psychoanalysis. *Standard Edition*, 22:3-184.
- Freud, S. (1937), Analysis terminable and interminable. *Standard Edition*, 23:211-253.
- Gaines, R. (1997), Detachment and continuity: The two tasks of mourning. *Contemporary Psychoanalysis*, 33:549-571.
- Izard, C. E. (1971), *The Face of Emotion*, New York: Meredith Corporation.
- Izard, C. E. (1972), *Patterns of Emotions*. New York: Academic Press.
- Izard, C. E. (1977), *Human Emotions*. New York: Plenum Press.
- Jacobson, E. (1971), *Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions*. New York: International Universities Press.
- Riviere, J. (1936), A contribution to the analysis of the negative therapeutic reaction. *International Journal of Psycho-Analysis*, 17:304-320.
- Reich, A. (1950), On the termination of psychoanalysis. *International Journal of Psycho-Analysis*, 31:179-183.
- Spiegel, R. (1960), Communication in the psychoanalysis of depressions. In: *Psychoanalysis and Human Values*, ed. J. H. Masserman. New York: Grune & Stratton, pp. 209-222.
- Spiegel, R. (1965), Communication with depressive patients. Panel discussion: The management of depression in children and adults. *Contemporary Psychoanalysis*, 2:27-61.
- Spiegel, R. (1967), Anger and acting out: Masks of depression. *Journal of the American Academy of Psychoanalysis*, 21:597-606.
- Spiegel, R. (1968), Supervisory collaboration in the treatment strategy for masked depression. *Contemporary Psychoanalysis*, 5:57-61.
- Spiegel, R. (1980), Cognitive aspects of affects and other feeling states with clinical applications. *Journal of the American Academy of Psychoanalysis*, 8:591-614.
- Winnicott, D. (1949), Hate in the countertransference. *International Journal of Psycho-Analysis*, 30:69-75.

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