ABSTRACT Endings in psychoanalytic psychotherapy are often problematic, especially in publicly-funded therapies. Endings may be premature or delayed - `too soon' or `too late'. This paper looks at some parallels between endings in literature and endings in psychotherapy; considers the gender bias in Freud's `Analysis Terminable and Interminable'; introduces evidence from psychotherapy research; and puts forward an attachment-informed approach to ending, based on the distinction between avoidant and ambivalent attachment and how this may be played out by both therapist and patient in the transference-countertransference matrix. A controlling therapist with an avoidant patient may end `too early', an over-empathic therapist with an ambivalent patient may end `too late'. Clinical examples illustrate these theoretical points.

In psychotherapy, timing is all. An interpretation delivered at the wrong time falls on deaf ears. A patient will only come into therapy successfully if the `time is right', and this principle applies equally to ending therapy, the subject of this article. Why do some patients end `too soon', others `too late'? What are the conditions that determine an ending? How may we conceptualize the process of ending? What is the nature of `timing' in relation to ending? These are the themes to be explored in this paper.

Poised between past and future, every ending encompasses both hope and regret, accomplishment and disappointment, loss and gain. The inherent ambivalence of endings tests our capacity as therapists to tolerate ambiguity, to encompass both optimism and sadness in the face of loss, and to hold onto a realistic appraisal of our strengths and shortcomings. In theory therapy will come to a natural end when the problems troubling the patient have been partially or wholly resolved. In practice these ideal conditions are not always met: endings `happen', sometimes unexpectedly, abruptly, or occasionally not at all as the treatment seems to drag on indefinitely. The central argument of this paper and its commentary is that the `fit' between the attachment style of the therapist and that of the patient is an important but often neglected determinant of which type of ending emerges.

The paper starts by a brief foray into endings in literature in the hope that this may animate the discussion and provide relevant examples. It then moves to discuss, as one must, Freud's views on termination; thirdly, some empirical findings relevant to termination are surveyed; finally, an attachment-based model of ending is presented, depending on the transference-countertransference pattern between patient and therapist.

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Endings in Literature

It seems likely that writers have as much trouble with endings as psychotherapists. The statement that poems are never completed, only abandoned, could be applied equally to analysis - and the more obsessional one is the more one may equate a parting with an abandonment. The writer has to be able to let go of his characters, and to help the reader with the inevitable feelings of sadness and loss as one comes to the end of a novel. There are of course various ways round the problem. One is to write an interminable novel - this surely was the enormously obsessional Proust's solution. Another way round the problem of ending is to embrace it from the start - to write short stories which, like brief therapies, trade ambition for a more economical but inevitably circumscribed set of aims.

Philip Roth's contemporary classic, Portnoy's Complaint, ends with the voice of the analyst: `So' [said the doctor], `Now vee may perhaps begin. Yes?' To end as you began emphasizes the way in which art provides a temporary escape from time's linear arrow - ultimately from the reality of death and finitude. For Freud the unconscious was outside time, shielded from the reality principle. Perhaps in a Jungian sense we can reify `the unconscious', seeing it as wiser than the conscious mind and so in touch with the cyclical nature of things, knowing that out of death comes new life. Alongside the sadness about the ending of therapy there is also often a sense of relief for both patient and therapist. The patient can get on with life, free at last to invest her time and money where she will; the therapist can look forward to a new patient, freed from the burden of worry and partial failure that each patient represents. At the end of a good book we feel a similar mixture of regret at having to part with the characters we have befriended, and satisfaction at completion.

Another device for ending a book is just that: a technique that will remind the reader that they have been immersed in what is only a story - a device - and that they are about to be returned to reality. One analyst, at the end of a very painful session, said gently to her patient: `I'm going to have to hand you back to yourself in a minute or two'. At the end of each session the patient crosses the boundary back to `real life'; ending therapy is a final version of that process of leaving the frame. In Conrad's Heart of Darkness, it is Marlow the storyteller - rather than the author - who takes the reader on a horrendous journey to the African interior. At the end we are returned to the dampness of a moored vessel on the Thames waiting for an ebb tide, while Marlow refills his pipe - it was only a story.

A therapy too can be seen as a story within a story. By the end the patient, we hope, is more firmly in possession of her own narrative, no longer needing the therapist, in Rycroft's (1985) words, as an `assistant autobiographer'. She can unmoor her vessel and sail freely, becoming, in Parsons's (1986) striking metaphor, the dove that did not return and who has therefore - or is this a therapist's wish fulfilment? - found dry land. The image of water is central to Heart of Darkness - the sea connecting the reader back in time to the Roman conquest of Britain, and through space to the heart of the Congo - like the unconscious, an unpunctuated continuum that transcends all man-made starts and finishes.

Erikson's (1968) model of psychotherapy was of the adolescent `moratorium', in which a young person is allowed to wander and explore both the world and herself, temporarily free from the grip of social obligation. Ending entails a return to the pleasures and duties of social and biological necessity: employment, marriage,
parenthood, responsibility. The beginning of the end of a successful therapy too is often marked by the establishment of a new relationship, or the renewal of an ailing one. Some patients may feel they must wait in therapy until they find the ideal partner they are looking for, and there is often much work to be done in unravelling that phantasy. The therapist will always be wondering if in the new relationship the patient has found a genuinely ‘transformational object’ (Bollas 1987) which can take over from therapy, and to what extent some aspect of the desire or disappointment which belongs to the therapy is being played out.

The nineteenth century novel, after its customary exploration of a series of moral or emotional dilemmas, also typically ends with a shift of state (‘Reader I married him’) - with one of the great sociobiological punctuations of arrival and departure that structure our lives: birth, marriage and death. The ambiguity of ending is nowhere more marked than in Dickens’ s Great Expectations with its two apparently contradictory endings, one ‘happy’, the other ‘sad’.

Dickens's first version ends with a fleeting meeting between the narrator-hero Pip (whose very name is, like the novel, recursive (Flint 1994)) and his love, the cruel and inaccessible Estella, in the centre of London where Pip is escorting his nephew, little Pip. Estella mistakenly assumes that the boy is Pip's son so, once more, there is a Hardy-like misunderstanding. The novel ends with the words:

I was very glad afterwards to have had the interview; for, in her face and in her voice, and in her touch, she gave me the assurance that suffering had been stronger than Miss Havisham's teaching, and had given her a heart to understand what my heart used to be. (1860-1, p. 482)

This straightforward but poignant ending suggests a task accomplished: the characters have been strengthened by suffering, misunderstanding has been overcome. Pip's dependency and fixation on Estella are finally broken, as his heart becomes whole. By finding a ‘heart to understand’ his heart he can at last let go. This can be compared with Fonagy et al.’s (1995) ‘theory of mind’ approach to insight, in which they postulate that the capacity for ‘self-reflective function’ (i.e. insight) arises out of a person's internalization of their object's internalization of them. Therapy begins - and ends - with finding a therapist ‘who understands how I feel’.

There is both a finality and a continuity about this first ending lacking in Dickens's later version. Here, in a dream-like return to the past, Pip and Estella meet in the garden of their childhood, familiar to them both, though all has changed. Once again they exchange vows: ‘You have always held a place in my heart’, they mutually confess. Then, in the final words of the book, while Estella announces that they will ‘continue friends apart’, Pip takes her hand and, with the mists rising, ‘sees no shadow of a parting from her’. It may be that Dickens's sentimentality and his commercial good sense got the better of him here - the public don't like unhappy endings (any more than purchasers of health care would like to be told that the aim of psychotherapy is to transform neurosis into ordinary human misery!).

However the key theme for this discussion is the idea that parting is only possible once both intimacy and autonomy have been achieved. If we feel truly understood - found a place in another's heart- then we can tolerate aloneness; conversely, once we have achieved a sense of autonomy then we can allow ourselves to get close without fear of engulfment or being destroyed by the other (Holmes 1996). Pip is no longer afraid to be either with Estella or without her and so his choices are widened, his horizons expanded.
Here then we find examples of a `right' ending, in which maturation has taken place, the
capacity for self-understanding installed firmly enough for the therapist to feel confident that
it will see the patient through the vicissitudes of life. Some sort of narrative closure has been
completed, which in literature brings the story to an end, and in analytic therapy represents
the establishment of a narrative of the patient's life with a sufficient sense of completeness for
the patient to close the book of their childhood and get on with their current life. Certainly in
literature and often in therapy there is an element of omnipotence about this, but sufficiently
tempered by reality for the completion to be `true to life'.

**Analysis Terminable and Interminable**

Freud's views on termination focused explicitly on this issue of the omnipotence aroused by
the wish for a perfect ending. One of the aims of therapy might be seen as reducing the
discrepancy between a person's real and ideal selves. On the one hand unrealistic self-
denigration will be reduced and self-esteem enhanced; on the other, omnipotent strivings will
be more tempered with realism and the patient will have a better sense of his strengths and
weaknesses, and be able to accept himself as he is. Freud (1937) argued that the length of an
analysis depended on three main factors: the extent to which trauma plays a part in the
neurosis (the more the influence of trauma the shorter the treatment, since the personality as a
whole may be unaffected), hereditary disposition, and what he called `alterations of the ego',
which we would now see in terms of character defences. Here he makes a specific point
related to gender which merits further examination. He starts with Ferenczi's assertion that

...Every male patient must attain a feeling of equality in relation to the physician as a sign that he has
overcome his fear of castration; every female patient... must have got rid of her masculinity complex
and must emotionally accept without a trace of resentment her female role. (Freud 1937, p. 251)

Freud comments:

I think that in this Ferenczi was asking a very great deal. At no point in one's analytic work does one
suffer more from an oppressive feeling that all one's repeated efforts have been in vain and form a
suspicion that one has been `preaching to the winds', than when one is trying to persuade a woman to
abandon her wish for a penis on the grounds of its being unrealizable, or when one is seeking to
convince a man that a passive attitude to men does not always signify castration and that it is
indispensable in many relationships in life. (Freud 1937, p. 252).

Thus Freud seems to suggest that rebelliousness and ingratitude in men can be traced to their
fear of passivity, while chronic depression in women has as its basis the conviction that
analysis is useless if it cannot provide her with the penis which she wants so badly. Freud's
vein of late life pessimism concludes that `the decisive thing is that the resistance prevents
any change from taking place - everything stays as it was'.

What is striking here is Freud's extraordinary double standard, even if we translate his
concrete thinking into metaphorical terms. For men the task is to see that passivity does not
equate with castration - to overcome a faulty cognition as the cognitive therapists would have
it. For women, however the aim is *not* to realize that one can be both active and feminine -
which would be a symmetrical task with that of men - but to come to terms with envy and
loss and the unrealizability of one's phantasies. To
translate this into today’s therapeutic terms, one might say that men have a relatively simple cognitive job to do; women a much more difficult ‘Kleinian’ one. Freud suggests that underneath these unrealizable desires and therefore interminable analyses lies a biological bedrock of bisexuality. It is as though for him it is a Darwin-given fact that women cannot achieve potency - ‘women don’t move’. But surely the bedrock - perhaps ceiling would be a better image - is social rather than biological. ‘Bisexuality’ is more a matter of habit than hormones. Today we celebrate female activeness and vitality just as much as receptiveness and, conversely, value ‘feminine’ qualities of gentleness as well as assertiveness in men.

Nevertheless, Freud is undoubtedly pointing to two important issues that can lead to ‘interminability’ in therapy. What he characterizes as fear of passivity in men is in attachment terms to do with vulnerability to attack. Only when patients, male or female, feel safe enough to give up their defences - to accept their helplessness in relation to the therapist, often symbolized by a move from sitting facing to lying on the couch - can they begin to progress towards an ending. Equally, a therapy can become interminable if the patient cannot accept loss, and let go of the past. For those who have been severely traumatized or deprived, it is asking an enormous amount to expect them to accept what has happened and that no amount of wishing it were otherwise can alter that. This in turn can lead to a similar fear of losing therapy and everything good that is projected into it, and the anxiety that when it comes to an end, and the projections withdrawn, everything will once more be destroyed.

Termination and Psychotherapy Research

Proponents of brief therapy make much of the finding that, in publicly-funded psychotherapy settings at least, while the avowed aim of a clinic may be to offer longterm therapy, in fact the average length of treatment has been shown to be around 10 sessions (Garfield 1994). Many patients end ‘prematurely’, and consider themselves satisfied with the help they have received. Much better then, say the brief therapists, to plan time-limited therapy and to work towards an ending from the start, than for therapy to be cut short by patients who vote with their feet after a few sessions (like the patient who arrived at her sixth session to announce she was stopping, her hair newly cropped and in an unnervingly abbreviated mini-skirt).

This suggests a classification of termination in brief therapy into two types: (i) brief involuntary (‘too early’); (ii) brief planned. Equally long-term therapy can go according to plan, or drag on in a way that makes the therapist, and perhaps the patient, feel unable to terminate. So third and fourth categories would be (iii) longterm involuntary (‘too late’) and (iv) long-term planned.

Most psychotherapy research is based on brief therapies and has little to say about the longer term treatments and their termination that is the focus of this paper. Outcomes are almost always evaluated in terms of symptom reduction, rather than the kinds of personality change that long-term therapists are working towards with many of their patients. There are, however, a number of relevant findings. The first is the so-called ‘dose-response curve’ (Howard et al. 1986), which shows that the longer a therapy continues the greater the benefit to the patient. However, the ‘curve’ is not linear but negatively logarithmic so that there are diminishing returns in which there is a smaller incremental gain with each successive session. By session 26, according to this model, about three-quarters of all the total gain has been achieved. Severity is
a relevant factor too, and Shapiro (1995) found in the Sheffield Psychotherapy Project that longer therapy (here comparing eight sessions with 16) only produced more improvement in the more severely depressed patients, and that the less ill patients were no worse off with eight than 16 sessions.

For brief therapists one of the worrying findings of their work is that, despite very good results in the short run, long-term follow up shows that many patients tend to relapse. Thus in a major study of depression treated either with drugs or one of two types of psychotherapy, whilst nearly 70% of patients were recovered by the end of therapy and remained well at three months, by two years only 30% had not had further episodes of depression (Roth & Fonagy 1996). A further study looked at the impact of monthly ‘top up’ sessions of psychotherapy and found that these did indeed have a role in forestalling relapse: 60% of patients receiving them remained well compared with only 24% of those who did not (Elkin 1994).

There are complex research issues here waiting to be unravelled: to determine the impact on outcome of length of therapy, frequency of therapy, severity of illness, and the combination or otherwise of drugs and psychotherapy, not to mention the model of psychotherapy and skilfulness of the therapist. In the meantime clinicians will continue to terminate or continue with therapies based on experience and intuition, certain at least that procrustean models cannot be right, since the variety and uniqueness of experience is the essence of psychotherapy. Some patients need longterm therapy; others can be usefully helped with brief, or relatively brief intervention. Some need intermittent therapy - to come for a while and then return. In some cases termination can be planned; in others it needs to emerge as a theme for months or even years before it actually happens. Some people need to stop suddenly, while others do better with a gradual process of weaning. In the next section I shall look at different unconscious and conscious models of the termination process.

**Ending and Previous Loss**

An ending is perforce shaped by what preceded it. Therapists and patients will approach ending with preconceptions and phantasies about what it means to be separated. For the patient these will largely be determined by previous experiences of loss, as indeed they will be in part for the therapist who, in addition, will be guided by the models and metaphors of change which underlie her work.

One patient had been in therapy for eight years when her therapist announced that he would be leaving to work in another town in four months’ time. Four years earlier- and coincidentally during a sabbatical break by her therapist - her husband, on whom, because of her severe depression and agoraphobia she was enormously dependent, had died. She had coped with this by partial denial in which she felt his presence around her and saw him as a guardian angel guiding her life. His death had, in fact, led to major changes in her life and she had established a much less dependent relationship with a new partner. In the session following the announcement she described how she had thought to herself that, having weathered her husband’s death, this ending was nothing to be afraid of, and was in any case what she had secretly been anticipating almost from the start of therapy. Nevertheless she felt unaccountably anxious and had been unable to sleep, and when she did sleep she had bad dreams - the previous night she dreamed that both her hands had been cut off. She saw this as an expression of her feelings of being unable to cope. She then described how she had been to her family doctor whom she had not seen for years, and how impressed he had been by the changes in her, telling her that a few years ago he had assumed that she would inevitably commit suicide. She then went on to say how amazed she herself was by how different she felt now, attributing
this mainly to the positive and cheerful personality of her nine-year-old daughter (she had entered therapy during pregnancy, convinced that the child would be taken from her by social services because she was so depressed), which she felt had rubbed off on her. She then described how, when she told her daughter about the therapist leaving, she had said ‘Oh, don't be so silly, mummy, just get another doctor!’ Finally she said that she was screwing up her courage to ask if she could still come to visit her therapist from time to time in his new post although she knew the answer would almost certainly be no.

This vignette contains many of the typical themes aroused at termination, in this case one imposed upon the patient by the therapist, which in 'third-party financed' practice is probably the commonest scenario. The patient at first denies the loss - as she did with her husband's death. Then she recounts some aspects of the mourning response - anxiety and insomnia. Then she seeks out a substitute - a doctor she had not seen for years. Then she begins to review the therapy in a profit and loss accounting way. Then there is a flash of anger - ‘Don't fool yourself into thinking it was your therapy that had done the trick, it's down to my daughter and I have still got her and can get myself another therapist thank you very much.' Finally, as with a bereavement, she begins to 'bargain' with the loss, hoping that it might not necessarily be irrevocable. In her dream she had lost both her ‘helping hands' - her first husband and her therapist.

Underlying all this are less conscious themes derived from childhood. Her mother had a severe puerperal depression and was in hospital for several months when she was three; both her parents were refugees from Hitler's Germany and no mention of their origins nor the past was permitted in the family; now she has cut herself off from them almost completely and wonders if her father sexually abused her during the separation from her mother; she contrasts her daughter's cheerful demandingness with her own feelings of rejection and lack of entitlement. Separation is a punishment, perhaps a torture, but it is what you deserve. There is nothing you can do about it, just stay passive and endure the bleakness as best you can.

For the therapist too the ending will inevitably have unconscious reverberations. If in therapy he has sought out the safe intimacy he finds elusive in ordinary life, then he may cling onto the patient 'too long'. If he has projected his own weakness and vulnerability into the patient, he may encourage termination in the illusion that his inadequacies will be cured or expelled with the patient, and this may lead to a termination that comes 'too early'. There may be a real sadness at parting, but also the excitement and hope of a new beginning.

An interpersonal perspective allows 'timing' to be theorized, since good - or bad - timing depends on the intersection of two or more inner worlds, each with its own rhythms. Bowlby and Winnicott saw in different ways the central paradox that one can
only be securely separate if one feels attached in the first place. For Winnicott (1958) the infant develops the capacity for solitude if he has been allowed to 'be alone in the presence of the mother'. Bowlby's mother provides the secure base from which the child can go out and explore the world. For Mahler the child has in the 'rapprochement subphase' to be able to rush back to mother when her love affair with the world becomes too overwhelming.

For Freud as interpreted by contemporary Kleinians (Britton et al. 1989), resolution of the Oedipus complex depends on the capacity to tolerate separation and loss, to adopt a 'third position' of contemplation which can allow parental intercourse without being compelled to either infiltrate or destroy it. Money-Kyrle (1971) states that analysis can come to a successful completion when the patient can see the breast as supremely beautiful, parental intercourse as supremely creative, and accept the inevitability of death. These can be translated as: being able to love without ambivalence, overcome envy, and be able to mourn. Freud saw identification with the same-sex parent as a vital part of grieving, and this idea reappears in the Freud-Klein model of mourning in which identification with the lost object and its 'reinstatement' in the inner world is a central aspect of coping with loss.

All these themes appear in the contemporary literature on ending (Bateman & Holmes 1995). Pedder (1988), from an interpersonal perspective, dislikes the term 'termination' with its overtones of abortion and finality. He is critical of the uncompromising view of the ending of therapy as an absolute break, akin to a death, which the 'successfully analysed' patient must be expected to undergo. He compares the ending of therapy with an adolescent leaving home who may need to come and go several times before independence is finally achieved and argues that the therapist should be tolerant of these fluctuations of involvement and disengagement as therapy draws to a close.

One of the hardest therapeutic tasks is to differentiate these premature 'trials of termination', in which the patient appears to be experimenting with leaving but is not really ready, from the real thing. Like any loss, ending therapy produces a period of psychological instability in which the patient is both drawn forward by the prospect of autonomy and freedom, but held back by anxiety at the loss of the intimacy and security which the therapy represents. He may try to distance himself from his feelings of abandonment by belittling the therapy, failing to turn up, or arranging to be away at times of sessions. Alternatively he may regress, with a recurrence of old symptoms and anxieties, implying that he is damned if he will leave until he has had his money's worth. He may immerse himself in a new relationship as a substitute for therapy now that it can no longer be relied upon to be there indefinitely. There may be an obvious identification with the lost object, if the patient decides to train in psychotherapy or counselling. At the same time there will be a taking stock, reviewing the progress of therapy, of satisfaction at what has been achieved and disappointment at what remains undone.

The therapist meanwhile will need to be able to accept attack without justification or retaliation, to hold onto a sense of what has been positive in the therapy without denying faults and limitations. She will need to resist the temptation to impose an idealized view of therapy, which may subtly suggest that the patient has failed, or that he needs to continue indefinitely so as to protect the therapist from disappointment. The therapist may well feel envious of the patient's creativity and new-found sexual energy, and must resist the temptation to undermine or intrude upon them.
Attachment theory arose out of object relations theory, but with an emphasis on security rather than sexuality, and a determined attempt to marry the objective findings of developmental psychology to the more intuitive findings of psychoanalysis (Holmes 1993). From an attachment perspective, the aim - or `end' - of psychotherapy is to help create a secure base, both in reality and as an internal representation within the patient. A secure base arises partly out of the responsiveness and attunement provided by the therapist, partly from her capacity to accept and metabolize protest and anger. From the former arises the rudiments of intimacy, from the latter the capacity for autonomy (Holmes 1996).

A `good ending' is possible once a secure base has been established. In less disturbed patients this may simply mean the repair of one that is temporarily damaged often by trauma, and therefore the process can be relatively brief. In borderline patients there may never have been the experience of security and so the base has to built up from scratch. This inevitably takes time.

Two basic pattern of insecure attachment have been described: avoidant and ambivalent (see Goldberg et al. 1995). The avoidant individual shies away from passionate contact with his attachment figure, hovering warily on the fringes of life, for ever keeping a safe distance. His childhood experience has been of unresponsiveness and rebuff in caregivers. When asked to give an account of his life he finds it difficult to remember or to elaborate. The ambivalent individual, by contrast clings to attachment figures, fearful to let them go lest he be abandoned for ever. His caregivers have been inconsistently responsive, one minute ignoring him, the next intruding while he is happily playing. His self-narratives tend to be rambling incoherent affairs, bogged down in past pain with no structure or objectivity. Some individuals, perhaps potential borderline sufferers, show incoherent or mixed ambivalent/avoidant patterns.

From an attachment perspective, these different styles of anxious attachment evoke differing therapeutic strategies. For avoidant individuals holding is perhaps the key ingredient in successful therapy. Only when they feel securely held can these patients begin to confront their inner world and to put emotion-laden thoughts into words. Conversely, ambivalent individuals need a firm and consistent therapeutic frame if they are to feel safe enough to express the anger and protest that can lead to a sense of autonomy. Autonomy is possible on the basis of a secure inner world - we can go out on a limb, stand our ground, make our own choices, and tolerate separation if we can be sure that intimacy is available when needed. Conversely, intimacy is possible if the loved one can be allowed to be separate: we can allow ourselves to get close if we feel autonomous enough not to fear engulfment or attack, and also know that separation does not mean that our loved one is lost forever.

How is this relevant to ending? Ending can either be imposed from without, as in time-limited therapy, or can arise spontaneously out of the patient's wishes. This distinction can apply to any length of therapy. Some patients only want to come for a few sessions in order to resolve some outstanding issue, often, as Freud (1937) suggested, an unworked-through loss or trauma, and make this clear from the start. In others, as long-term therapy progresses it becomes gradually clear that an ending is on the horizon and by tacit or explicit mutual agreement therapist and patient begin to work towards it. In these situations the therapist is always following the patient's lead, attuning herself, working at the `zone of proximal development' (Vygotsky 1962).
helping the patient to work with the issue that is not so easy that he can grasp it unaided, nor so difficult as to be out of reach. In other cases the therapist will offer the patient a time-limited contract from the start, or in longer therapies set a date for ending. Which strategy is used will depend ideally on the needs of the individual patient. Thus the avoidant patient needs an attuned, `following' strategy; the ambivalent individual needs consistency, firm structure, and well-marked boundaries.

But therapists as well as patients have `personality styles'. Some will be good at attunement, less so at boundaries, and vice versa. At any given moment in therapy there will be a balance struck between attunement and limit-setting that reflects the transferential-countertransferential matrix between therapist and patient (Gabbard 1995). The `too early - too late' dilemma can be understood in terms of this matrix and the interaction of patient and therapist attachment patterns.

A key distinction in the literature is Racker's (1968) differentiation between complementary and concordant countertransference. In `complementary' countertransference there is a collusive `fit' between therapist and patient, in which the former is shaped to enact aspects of the patient's pathology. Thus the therapist may unconsciously be shaped via projective identification into a particular role that represents a fragment of the patient's inner world. The notion of `concordant' countertransference by contrast acknowledges that there will always be unconscious elements in the therapist's attitude and feelings towards the patient, but here the therapist is resonating more empathically with the patient's unconscious needs, in order, perhaps, to produce a corrective emotional experience. It is however a mistake to see complementary countertransference as `bad', concordant as `good'. A degree of projective identification if picked up by the therapist's self-monitoring will alert her to the key themes for the patient; conversely, a therapist who is perfectly attuned and empathic will provide no space for patient and therapist to learn from minor misattunements and mistakes.

Ideally such material will eventually be translated into interpretations and so enhanced self-understanding for the patient. But ending therapy is necessarily an action, not an interpretation - albeit one that is an important subject for reflection and discussion. It is an action that may be initiated unilaterally by patient or therapist, but of course preferably as a collaborative decision. The analyst must be able to evaluate the balance between the desire for ending as a valid expression of the therapeutic process and a transferential/countertransferential enactment. Thus in the latter situation the patient may decide to leave because of his own unconscious conflict or, via `reverse' projective identification, as an enactment of the therapist's unconscious conflicts. To complicate matters further, the therapist may unconsciously enact some aspect of the patient's unconscious, `picked up' by projective identification, which is then reintroduced by the patient.

Combining Racker's complementary/concordant distinction with the attachment ideas described above we can construct a four-way matrix relevant to ending (see Figure 1). Thus an avoidant patient with a therapist who over-emphasizes structure at the expense of attunement may end `too early', while an ambivalent patient with a therapist who is able to empathize but is weak on structure may end `too late'. Psychotherapy research (Roth & Fonagy 1996) suggests that good outcome with difficult patients depends on therapists who can combine firm-rootedness within their particular model of therapy (and it does not seem to matter too much which sort of model it is), with flexibility in the face of the particular patient's needs - i.e. a
combination of structure and attunement. Different therapies may tempt therapists in one direction or the other: analytic and cognitive therapies (strange bedfellows!) may overemphasize structure; humanistic ones might tend to produce an excess of empathy.

In supervision, particular moments in therapy can be analysed using this matrix to help the therapist separate those aspects of the interaction that arise from his own pathology, from those which arise in response to the patient, both of which may be reintrojected by the patient.

**Clinical Example**

Real people do not fit neatly into predetermined categories and many, especially those suffering from borderline personality disorder, show features of both avoidance and ambivalence at different times. I will end with a clinical example, illustrating the possible use of the matrix in understanding the theme of ending in psychoanalytic psychotherapy.

Mary, a solicitor in her mid-thirties, came into therapy saying that she wanted to come to terms with the fact that she would never marry or have children. It was typical of her that she had prejudged the outcome - the ending - before she had even begun. She had grown up in a claustrophobic family with an alcoholic but loving father, and a depressed and highly controlling mother, whom Mary had learned to placate from an early age, and continued to do so. She was close to her older sister, but felt guilty about having done `better' and earning more than her. At 18 she had been kidnapped while hitch-hiking and had spent several utterly terrifying hours convinced she would be killed by her attacker who had sexually molested, but not raped her, and who finally let her go. She had informed the police, but not her parents about this, and had never spoken about it in any depth before coming into therapy. She had never trusted a man since.

Her narrative style was typically avoidant, starting each session with a rather unelaborated catalogue of the week's events, and finding it very hard to describe or show emotions. She controlled the session with great precision both with her eyes which she could not take off the therapist, and by vigilantly consulting her watch throughout, always making sure she brought the sessions to an end, usually leaving one or two minutes early, explaining that she `know how irritating it was when clients overrun their time'. Time and `watchfulness' became the central themes of therapy. She described the seemingly endless feeling of being trapped with her attacker, and how not being in control of the sessions was both what she wanted more than anything, and what she feared most of all.
Seeing her as avoidant, the therapist at the start made little comment on this and simply concentrated on affective attunement and responsiveness - on the mutuality of good timing, as opposed to the clock time by which she ran her life. But as she became more engaged and dependent on therapy, so it became safe to talk about her need to control the ending and her fear of what would happen if she didn't. The therapist no longer had to be a rescuer, and could challenge without it seeming like an attack. Gradually she began to leave her watch off, dared - at the therapist's invitation - to lie on the couch, and asked to come twice a week. The atmosphere of therapy became more lively and real. Mary then began to say how she felt she had 'enough' therapy and should stop. By now her dependency was much more apparent, and so the therapist was able, rather than to 'follow' this request, to interpret it in terms of her guilt about having more than she deserved, about lustily asking for 'more'. At the same time she began for the first time to express anger towards him, especially as he appeared to her to be unsympathetic when her beloved cat become ill. Had she stopped at that point it would undoubtedly have been 'too early', perhaps because the therapist was unable to tolerate her hostility.

After another 18 months of therapy and several transferential false starts in relationships, she found a suitable and available man, and began to talk again about ending, this time as though she meant it. As the end approached she began to have doubts about leaving and, as is so often the case, many of her old insecurities resurfaced but, feeling that it was important to affirm her new-found autonomy and her capacity to understand her own needs, the therapist accepted her plan. To have done otherwise would have run the risk of ending 'too late'. She suggested a follow-up session a few months later, which duly went smoothly, if uneventfully. Later still she wrote to say how well things were going and to announce that she was pregnant.

We often say that patients come into therapy with 'unfinished business' - a cliché perhaps, but it suggests that people seek therapy when they have been unable to make an ending - a trauma or loss that has not been mourned, or a dependency that cannot be resolved. Before patients can leave therapy they have first to find their object, then to attack the object and their need for it - and finally to let go. Before therapy Mary had not dealt with her attack; she had not extricated herself from her hostile dependency on her mother; nor faced the ambivalent sexuality of her relationship with her father. As these themes emerged and were at least partially dealt with in therapy, so ending became possible.

There is a constant dialectic in psychotherapy, as in life, between closeness and separation, attunement and challenge, attachment and loss. Ending is ever-present, long before the final separation, casting its shadow on therapy from the start and, when it comes, is a culmination of all the countless little endings that have prefigured it. In Rilke's words, 'So we live, forever taking leave'.

References