Termination: A Case Study

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Abstract: In this article I posit and examine certain criteria and qualities for ending an analysis. The case study* describes the end phase of a four-year psychoanalysis in which the patient's decision to move to another area forced the end of his analysis. We continued to explore and work through his core neurotic conflicts that included issues of competitive rivalry, dominance and submission, control, and anxiety about birth and death. A shift in the transference from me as a negative father to me as a supportive but competitive older brother was also examined in the context of ending treatment as well as other aspects of the transference. In addition, we analyzed the meaning of his ending treatment based on an extra-analytic circumstance. In discussing this phase of treatment, the definition and history of the term "termination" and its connotations are reviewed. Various criteria for completing an analysis are examined, and technical observations about this phase of treatment are investigated. It was found that while a significant shift in the transference occurred in this phase of the patient's analysis, conflicts related to the transference were not "resolved" in the classical sense. Terminating treatment was considered as a practical matter in which the patient's autonomy and sense of choice were respected and analyzed.

> What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from.
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> —T. S. Eliot, "*Little Gidding*"

Freud's metaphor of the psychoanalytic process as a game of chess allows us to speak of the end phase of treatment as an entity with its own criteria and characteristics. The idea of termination was intro-

*The case has been disguised so that the patient cannot be identified.

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duced into the psychoanalysis through the case of a stalemated analysis, named the "Wolfman." Freud's forcing an end to treatment by setting a time limit was a tactical maneuver that attempted to break through some difficult resistances. Such a technique is perhaps not what today's experts would advocate. In this study, I posit and examine certain universal criteria and qualities for ending an analysis.

The development of a concept of termination has been a post-Freudian contribution (Blum, 1989). One early idea about termination had to do with the resolution of the transference neurosis. Through understanding and working through the genetic determinates of the illness, a patient got better. This achievement supposedly corresponded with symptom relief and an improved sense of well-being. A topographical descriptive aphorism involved "making the unconscious conscious" (Freud, 1917, p. 280). A structural maxim was "Where it was, there shall ego be" (Freud, 1933, p. 80). Psychological growth has tended to be measured in terms of an improved capacity to work and love. As our thinking evolved, the idea of ongoing self-analysis also became an outcome (Freud, 1937, p. 249).

This case study of Mr. B describes the phase of an analysis in which a patient's decision to move to another area required that his analysis end. It forced a treatment of over three years into its final stage. The patient and I continued to work as analytically as possible under this particular circumstance by continuing to explore and work through his core neurotic conflicts. Dreams, life experiences, and other material dealing with issues such as life and death, competitive rivalries, dominance and submission, and control were examined more directly. A shift in the transference from me as a negative father to a supportive but competitive older brother was also noted and considered. The meaning of his decision to end treatment based on an extra-analytic circumstance was also analyzed. Elucidating the patient's fantasies about birth and death, connection and loss, and relationship with me were an integral part of this phase of the analysis.

INITIAL CONSULTATION AND TREATMENT SUMMARY, YEARS 1 TO 3

Mr. B was a 26-year-old Christian man from the South who presented for treatment shortly after moving to New York City to attend medical school. He had been given my name by a senior colleague, after specifically requesting psychoanalysis. At the time of the initial consultation,

he appeared anxious although his demeanor was friendly and engaging.

He complained of feeling worried about starting medical school in an unfamiliar city. He expressed uncertainty as to whether medicine was the right career choice for him and worried about being separated from his fiancée, who was completing her medical studies overseas. Presenting symptoms included feeling restless and irritable, being easily fatigued, and difficulty concentrating and falling asleep. Such symptoms had persisted for about two months. Over the past several weeks, he noted that his mood was depressed and that he took less pleasure in exercise and other activities previously enjoyed. He thought these symptoms might interfere with his schoolwork and affect his relationship with his fiancée and others. Once the initial consultation was underway, he disclosed that his anxiety was also manifest in his picking at his arms and face. He was concerned that the resulting marks might be noticed by others, and on second glance, they were to me. When feeling especially anxious, he might also "pick on" his pet cat. For example, if the cat's behavior violated Mr. B's rules, he might hit or throw it. These impulsive, violent actions against the cat had begun during a stressful period shortly after acquiring it and recurred since moving alone to New York City. He was not aware of any self-destructive thoughts or feelings and reported no other compulsive or impulsive behaviors. He did not pick at himself during the initial consultation. Mr. B wondered what deeper issues lay behind these behaviors. None of the above symptoms were due to the effects of drugs or alcohol, and he used alcohol only socially during weekends. He had no history of abusing animals as a child or other pathological behaviors.

The present episode was not Mr. B's first experience with anxiety and depression. The initial onset, he recalled, was during another change in life circumstance, his freshman year of college. At this time he had had difficulty adjusting to being "a small fish in a big, prestigious pond." He also felt upset that his father moved out of the house for reasons that were unclear at the time and, thus, left the family. His father returned home after several months, but during this period Mr. B felt depressed and hopeless. His picking at himself worsened, and he felt negative and isolated. He did not seek treatment at this time but overcame his depression by forming a close relationship with his female superior at a volunteer program. This woman was currently his fiancée. Mr. B also mentioned feeling "blue" during adolescence. At that time, he apparently had severe acne which distressed him, and he would spend hours in the bathroom "picking at" his face. His father would say, "You look like shit," and his mother would pretend not to notice the blemishes.

He felt hurt by his father's remarks and found his mother's avoidance unhelpful. He fantasized about running away to a secret place and that causing his parents to be distraught.

Mr. B did well in college and graduated in three years with high honors. He wondered if his academic performance was a way of keeping his parents together by making them proud. When his girlfriend started medical school, he followed her without much sense of his own self-identity. Through her activities, he became interested in medicine and fulfilled his premedical requirements. She was also in psychotherapy. After listening to a pop psychology lecture on "healing the inner child," he became interested in pursuing treatment and entered into a weekly psychotherapy with a psychiatrist. His father denounced this endeavor as quackery and refused to assist with the fees. Mr. B described his father as using money to control the family's actions. For example, his father refused to lend him any money for an engagement ring in order to express disapproval of his engagement to a non-Jewish woman. Mr. B felt in need of treatment and arranged to be seen at a reduced fee and to work overtime to pay for it.

Mr. B described his father with ridicule as "a rugged dude, a charmer with red-neck appeal." He could be humorous but his main emotion was anger. Mr. B also saw his father as a perfectionist and self-made man. However, he was chronically dissatisfied with his work as a small businessman and had difficulty getting along with his partners. His mother, on the other hand, he described as the polar opposite: "a nudge, vulnerable, caring, a good boy's mom." She worked as a teacher. Mr. B was the middle of three siblings. His brother, who was three years older, married and became a businessman like his father. His sister, who was two years younger, was still looking for herself. He wondered if his sister was gay. Mr. B felt that he was favored by his parents, especially his mother. He described himself as "the golden boy, the apple of her eye" because he was smarter and a better athlete than his siblings. He did not report any aims or aspirations from childhood beyond doing his best in school. When asked about his interest in medicine, he described following in the footsteps post-college of his fiancée, who was pursuing a path in medicine.

Mr. B offered little sexual history spontaneously. He had limited physical experiences with women during high school, and his first ongoing relationship was with his fiancée. He reported having a couple close friends in high school and college but did not elaborate on those relationships. When asked about his parent's relationship, Mr. B recalled how his father would insult his mother in front of the family, and she would not respond. He could no longer see his father's insults and attitudes toward women as funny. He recognized they hurt his mother.

From his limited description, she came across as anxious and mildly depressed herself. The father left pornographic magazines and movies lying around the house in plain sight. Mr. B found it stimulating to gaze at pictures of women when he masturbated and saw the images as something to conquer and control. He described how his mother's hugs and kisses made him very uncomfortable and mentioned dreams about having had sex with her that supposedly expressed his deepest desires. After telling of his interest in pornography and incest, he characterized his sexual relationship with his fiancée as poor, specifically with the frequency and quality of intercourse. Mr. B recalled how once when she became aroused in bed, he laughed in a devaluing way, which made her more distant.

My initial psychodynamic formulation of Mr. B was of an intelligent and likable man who was seeking a psychodynamically oriented treatment to deal with anxiety and dysthymia. He had uncertainty about his professional choice to become a physician as well as with his fiancée. His good behaviors and sense of humor covered over negative feelings of resentment and hostility. He was afraid his impulses might lead him to express anger in abusive ways like his father had. Instead, he tended to act in compliant ways or withdraw and be passively provocative. The intensity of his Oedipal conflicts also tied in with his mother's having turned to him as a replacement mate. Mr. B hoped that more insight and understanding would help him to feel better and also be more assertive.

In terms of beginning a psychoanalysis, I was concerned about certain career and relationship issues as well as the difficulties of pursuing this intensive course of treatment during his medical training. I thought that a psychoanalytically oriented psychotherapy would be a good initial treatment for Mr. B. If this phase of our work together proceeded therapeutically, then we might further consider psychoanalysis. When I discussed this recommendation with Mr. B, he seemed slightly disappointed in not getting what he wanted but also pleased that we would be able to work closely together and possibly proceed with an analysis. He requested that I see him three times per week, and we were able to settle on a fee satisfactory to us both. He felt appreciative of the opportunity for treatment.

During the first year of treatment (three-times-per-week, psychoanalytically oriented psychotherapy), the patient focused on problems in school and with his fiancée. He tended to repeatedly discuss subjects in his present life. His tone was obsessional, distancing him from underlying, affectively laden material. However, by working on these manifest issues in psychotherapy, Mr. B was able to better understand and affirm his decision to become a physician. He was also able to clarify

his commitment to his fiancée and move forward with their marriage plans. In addition, Mr. B became more aware of how he experienced issues in his present life as an expression of underlying conflicts such as competitive/aggressive feelings toward his father and older brother. He began to see how understanding these and other issues in terms of his relationship with me, and whom I represented to him, could be useful in resolving them.

Toward the end of the year, we revisited the idea of his being in psychoanalysis. At that time we discussed not only the use of the couch and the increased frequency of the work but other differences between the types of psychotherapy. Namely, we would focus even more on Mr. B's unconscious mental life and try to understand it by examining his associations, fantasies, defenses, and other aspects of his inner life in the context of the transferences that emerged. Mr. B was excited about the prospect of working more analytically together but also anxious. He imagined that he might provoke me to behave like his reprimanding father or that he might become more aggressive himself. He thought about laying on the couch and how he might experience not looking at me as a loss and had ideas about being looked at like a patient such as being pathologized. We considered that such possibilities were potentially useful for helping him to better understand himself and decided to proceed with this form of treatment.

During the second year of treatment (four-times-per-week psychoanalysis), Mr. B continued to move forward in his medical studies and his relationship with his fiancée. He began to examine how he eroticized different medical situations based on paternal identifications from the overly stimulating household of his childhood. His conflicts around looking and being looked at came more directly into focus in the psychoanalytic situation where, at times, he felt like the object of my desire. The transference was primarily erotic. While it shifted among the various significant others of his past, he tended to experience me paternalistically as picking on and criticizing him for his own impulses, wishes, and desires. Examining this aspect of his psychic life more deeply helped him to be more comfortable with himself and his choices. The effect was that he was better able to perform his duties as a student-physician in a professional way. Near the completion of the second year, he married his fiancée, and they lived together again in New York City.

To elaborate, his medical school curriculum had a yearlong physical examination and diagnosis course. He was very concerned about examining patients and turning them into sexual objects for his erotic desires. He feared losing control of his impulses as with his cat. Playing "doctor" meant crossing a boundary, breaking a taboo. He felt anx-

ious and guilty about such concerns. For Mr. B the physical examine was like a sexual experience, to examine patients a pornographic act. It shifted his orientation from passive complacency to active looking and exploration. He saw being a doctor as an empowerment in the sense that he could do "forbidden" things and the patients would comply. He found it exciting like his father's apparent power in relation to him and his mother.

The rectal exam was a particular preoccupation. His anus had been a "battle ground" of his early childhood like when his mother took his temperature rectally. We explored issues having to do with wanting to be in control. For Mr. B his struggle for autonomy as a young physician was based in this earlier struggle for personal control. He recalled an incident from around age four in which a babysitter humiliated him by making him wear diapers. I observed how he expressed conflicts around control through his body. After a pause he recalled having to be disimpacted in an ER for retaining his stool when his parents were away. Like a dependent child exerting "power," he had gotten attention angrily, and someone else cleaned up the mess. His associations to my interpretation suggested that this experience had the meaning of a feminine identification. He also mentioned a recent dream where he had breasts and got something shoved into his behind. As the meaning of these negative Oedipal aspects to his psychology was better understood, he became more sexually assertive with his wife.

Being looked at also made him feel turned into an object of my desire. He experienced the analytic situation as one in which he was revealing himself to me. He imagined, uncomfortably, me sitting behind him masturbating in response to what I saw in him. I interpreted his experience of the analytic situation as like a physical exam. He replied how he felt sexually vulnerable in my examining him. He went on to elaborate on his relationship with a priest that culminated one evening with the priest's hugging him while inviting him to do more. While Mr. B recognized that the priest had acted unethically, he also considered his own role in the seduction. The patient began to see that behind his concern that I might seduce him was a desire that he might seduce me into breaching our professional relationship and crossing a sexual boundary. Mr. B recalled how toward the end of his previous treatment, the psychiatrist had given him a hug. He feared and desired that one of us might similarly cross a boundary.

Over time Mr. B was able to further explore aspects of his own manhood in contrast to that of his father. He began to talk more openly about his use of pornography and his sexual fantasies. Especially arousing for him was a tape of two women undressing and playing with a dildo. He became more aware of some of his own feminine identifications and

homosexual yearning. A number of times he said how it was hard to speak about gay feelings. He wondered if I would be critical of him like his father. I interpreted how he experienced talking about this uncomfortable aspect of his sexuality as being sexual with me.

The transference shifted frequently—me as older brother pinning him down, me as a sexually stimulating mother giving him a rectal, me as a powerful and desired father—but whoever I was to him in the moment, the transference was primarily erotic. He imagined that under the guise of "understanding," we were getting naked together. The analytic situation as a homosexual experience was a threat. I interpreted how homosexual feelings were threatening to him because "if he felt it, he was it." As we better understood this aspect of our relationship, his communication with his wife and their sex life improved further. As he became more comfortable feeling close to me, he expressed his wants and needs with others more clearly. His sexualization of medical situations also decreased. He was better able to focus on his role as a student-physician and perform his duties in a professional manner.

In the course of his third year of treatment (four-times-per-week psychoanalysis), Mr. B's Oedipal conflicts came more directly into play in his daily life and the analytic situation. He saw his becoming a physician as surpassing his father, both professionally and economically. He saw becoming a "real doctor" as bettering me and fancied being a physician and analyzing a few patients on the side. He even looked into the possibility of analytic training for non-mental health professionals. Interpretation of these competitive strivings lead to his becoming more focused on work of genuine interest. He began to explore a career in family medicine, where he felt he would be able to find fulfillment of his vision of becoming a physician.

As the treatment progressed, Mr. B felt more frustrated that his wife was always working and not "there" for him. He wanted her to be more admiring of him as his mother had been. As a third-year medical student, he felt less important than his physician-wife. While his evaluations in his clinical rotations were good, especially in his interpersonal skills and clinical rapport, he felt disappointed not to excel more. He blamed his performance on his "education," indirectly referring to analysis. As he came to recognize his actions as those of someone who was frustrating others and himself rather than of a frustrated victim, he felt less resentful about doing the work of becoming a physician. He also came to better understand his tendency, when faced with competition, to retreat passively as he had seen his mother do. He discussed his frustrations with his wife, and she was responsive to his concerns.

A few months into the year on a visit home, his mother told him, in confidence, that his father was having another affair. She intended to

divorce him. Mr. B was distressed about the "break-up" of his family as he had previously been during a similar episode his freshman year of college. He now had even more of his mother's attention, and she turned to him for support and guidance. So he was doubly the victor and anxious about it. He confronted his father who acknowledged his adulteries. Mr. B felt morally superior. With his new position in the family established, he became mildly depressed. He found ways to potentially undermine his own success and to punish himself for his progress, such as showing up late to work. I interpreted how his actions represented a masochistic need for punishment for his success. In association, he reminded me of his father's comment, "All physicians are assholes." He took it to mean, perhaps rightly, that his father felt diminished by his success.

While starting his psychiatry rotation, Mr. B had a series of dreams that brought his issues about competition with me more directly into play and helped to illuminate the underlying Oedipal conflict. In one he felt he had killed a man while camping with his family. In another he was shooting strange animals that represented patients on the ward. Winning was not a harmless activity. He saw becoming his own man as lessening or killing his father. The patient wondered if the animals also represented his father and me. He was concerned about raping or killing someone. After listening to his associations, I interpreted that if unrestrained, he imagined becoming out of control and wild. Mr. B looked relieved and spoke more directly of his competitive feelings toward me.

Later in the year, during his surgery rotation, Mr. B frequently needed to miss sessions because of his intensive work schedule. This professional commitment allowed him to put me down and put our work together in its "proper place." Surgeons were powerful and did important work. His connection to them helped him to feel stronger. On the other hand, I did not "do" anything. He wondered if my professional choices were a reflection of my own problems and psychopathology.

Mr. B performed well in his clinical rotations, especially medicine, pediatrics, and a primary care elective. Despite his concerns, he was professional in his approach to patients and their care. His fears about controlling his impulses and acting out his fantasy life in sexual ways were not manifest in problematic behaviors. He was concerned that I would be disappointed in his not pursuing a career in psychiatry. I interpreted the father transference and reminded him how he had felt criticized by his father for not following in his footsteps. In addition, these competitive issues were used in the service of distancing himself from homosexual feelings in the transference. He wondered about feeling closer to me but also choosing to be different. Such concerns suggested early termination issues.

As the summer break approached, Mr. B began to think about the ending of his analysis. He began to look toward internship and residency, with their time commitments and constraints. He might even be moving to a different city. The patient got relief from the idea that the analysis would end soon. It ending, he imagined for example, meant freedom from his homosexual feelings and conflicts over intimacy. By talking about leaving, he was also testing me to see what interests I might have in continuing to work with him. While wanting a vacation from analysis, he also felt angry about the separation. The issues became difficult for him to discuss, and he felt "less like a man." Among other subjects, I suggested that his homosexual feelings were left for us to explore further.

CLINICAL MATERIAL FROM YEAR 4 OF TREATMENT EMPHASIZING TERMINATION PHASE

During his fourth and final year of treatment (four-times-per-week psychoanalysis), Mr. B decided to pursue a career in family medicine. He thought that this specialty would allow him to have ongoing relationships with patients and to be involved in their overall physical and mental health. His relationship with his wife continued to improve, especially regarding their communication and sexual life. They chose to have a child. Mr. B still was inclined to see feelings of vulnerability as weakness, and in his mind "like a woman." His discomfort with vulnerability and perceived femininity tended to bring up conflicts around homosexuality, that he defended against in various ways. He was aware of this issue and knew he had not fully worked it through. However, in contrast to earlier in the analysis, he no longer felt as intense a need to devalue the analyst or himself.

About three months into his fourth year of medical school, Mr. B began to talk more about the possibility of having to end his analysis and the concerns that it presented to him. At first this issue came up only indirectly through his being more negative, reserved, and cautious in speaking with me. He talked about not measuring up to his wife and his tendency to avoid uncomfortable situations. He agreed readily with my interpretations. I commented how his modus operandi was to be passive and avoid talking about uncomfortable subjects with me. He focused his attention on his patients and on one in particular who did not get a procedure finished and was angry with him. He felt intimidated by the patient who reminded him of his father. I observed how he tended to displace his anger toward me onto physicians or patients

at the hospital. His associations were to situations where he felt out of control, such as once when a babysitter put an elastic diaper on him. He recalled an extra-analytic incident, not previously mentioned, where he had seen me at the hospital. He said that I looked preoccupied, "a kooky shrink who talks to himself."

This denigrating attitude marked a shift where he was more openly competitive but worried how I would respond. He talked about feeling judged by me. He showed off his knowledge about medicine and acted like a superior doctor who was no longer in need of me. His self-assertions had the transferential meaning of cutting parental figures down to size and not wanting to be in a position where he could be criticized or hurt. He experienced stopping treatment (or at least cutting back) as an attack on me, which made him feel vulnerable, and so experienced what I said as an attack on him. I commented that his schedule next year might require that he cut back or stop treatment, but that doing so had meaning, which was relevant to explore. He experienced the possibility of not coming to see me as being liberated from an authority. It was gratifying for him to miss a session since he was "too busy doing other important things." In terms of the transference, I was like his father, whom he could now reduce to being powerless and ineffectual.

The patient's hostile attitude toward analysis made him feel more powerful in relationship to me. Over several weeks I found myself feeling annoyed and frustrated with Mr. B. Although I felt he was appreciative of how useful analysis had been, I experienced his missing several sessions for work-related reasons and interviews as minimizing the treatment. He talked about putting a down payment on an apartment but said that he had no money to pay me. He complained about my not caring or being "involved," but experienced me as having power over him. His being desired by various postgraduate programs helped him feel more confident, and he expressed hostility toward me by missing sessions. He discussed his sense of debt and obligation toward me, which related associationally to his "whiney and dependent" mother whom he did not want to visit. I said that perhaps he resented me too. He discussed his sense of guilt in owing me for the treatment and used anger to distance himself from the feelings of guilt and loving appreciation. He said how for him getting angry at something was a way of disconnecting from it. I pointed out how his attitude of obligation (i.e., having to come to treatment and talk about difficult aspects of himself) came up in relationship to leaving and being separate from me.

Over the next couple of months, Mr. B continued to do well in his life. His finances improved, his work hours were reasonable, and through the grapevine he heard that his first choice of postgraduate program had ranked him highly. His thoughts tended to drift toward how diffi-

cult and lonely his father's life had become. Mr. B thought about how in getting into a prestigious college he had taken someone else's position and how he now wanted to beat out a friend for an award for clinical excellence. I commented that he saw it as a zero-sum game in which his "winning" meant his father's "losing." He responded negatively saying that he did not need to be "force fed canned interpretations that taste like limp cabbage soup by an Oedipal father." He described feeling forced to do things against his will—jury duty, medical school, and social obligations—and I added analysis to his list. Mr. B's self-analysis had a self-assertive quality. He felt that explaining the Oedipal basis of his psychodynamics was a way of taking more ownership of his mood.

However, over several weeks he began to complain more during the sessions. His mood remained dysthymic. When I stated the obvious—"You spend a lot of time being unhappy"—he got angry and frustrated with me. He protested that I was not doing my job to make him better. Rather than accept the work of this phase of analysis, he complained about it like his father would about his work. I interpreted how being like his father was a way of staying connected to him. Mr. B said that he was afraid to be less like his father (i.e., give him up) because he would be a "pussy." After reflecting a moment, he said, "That's totally it. If I reject my father, I'll be less a man." His being less simply accepting of my interpretations and even openly critical of me had the meaning of his not being passive and feminine, which was related associationally to his being a pussy. Being open and expressive meant being weak. When I interpreted this conflict to him, he commented that it was "true but formulaic." He laughed in recognizing that his response further validated the point.

His anger at me allowed him to maintain some feeling of superiority and masculinity. His depressive stance was a way of defeating me and maintaining a sense of power. The dilemma was that fighting analysis meant he felt like a man, but it did not in-and-of itself advance his self-understanding. Further deepening the analysis meant giving up power and control, that is feeling like a woman. His associations were to urinating on himself, his father's angry tirades, and to getting punched in the nose. He received the benefit of feeling masculine at the cost of being angry, depressed, and not doing well emotionally. Becoming a physician meant "giving into them," and this dynamic did not permit him to do as well as he was capable of. I continued to interpret how he saw being angry and resistant in analysis as a way of exerting his manhood and how being more emotionally open meant being feminine and vulnerable. As he gained insight into how these personal senses of "being a pussy" were within him, he found himself feeling less dysthymic. He also became more assertive in relationship to his work, choosing to

design his schedule more according to his liking and responsibilities, and less the demands of other people.

After spending a week on vacation and away from the analysis, Mr. B focused even more on its termination. Old issues began to recur where he felt that I was criticizing and examining him. He moved further into a separation/depression mode. The patient talked about me in terms that related to his own issues—as being lonely, needy, and with a sense of loss. He projected his helpless and dependent feelings onto me and then experienced me as like his father in terms of being deficient and troubled. His dependent position was, in part, a defense against his hostility and vice versa. I observed how his negative feelings and anger toward me followed from his having talked about separating and missing me. This response gave him the message that his hostility was understood and would not evoke a counter hostility on my part. He described how wanting to be closer made him feel vulnerable and want to get away. If he were even more open emotionally, he imagined he would lose control and become "subject" to my will. He went on to discuss both feelings of anger and closeness toward me. He felt that the couch had both freed him to express fantasies, thoughts, and feelings but also limited how close he could get to me.

Mr. B recognized many of the positive gains he had made. One was that he had become more assertive. For example, he expressed himself more directly to colleagues and peers. Also, his relationship with his wife became more intimate and open. Still, he intellectualized about various subjects such as what defined a "cure." Over several sessions, I became aware of a feeling of boredom that seemed to be more than my usual tiredness from the late hour of our sessions. He seemed content to run out the clock by talking about how he was not talking and not feeling or expressing his feelings. Since analysis is about talking, once he said, "I know I'm resisting" it was as if he had fulfilled his analytic responsibility without having to go beyond his resistance. For him being intellectual was connected with feeling powerful and masculine in the sense of figuring things out. I observed how leaving treatment stirred up many different, strong feelings that were covered over by this intellectual style. Mr. B became more emotional and described how when he cried his father would yell, "Crying is for wimps." Unveiling his tears, he described times when he felt hurt and cried, and how he felt vulnerable and scared at his father's angry response.

About six months into the year, Mr. B matched at an internship program that required his moving to another place in the New York area. This effectively forced the ending of his analysis and brought a number of important conflicts to the forefront of our work. My general approach was to handle this phase of his treatment like the rest of it, ana-

lyzing whatever issues were present in terms of the transference and, in particular, the meaning of his treatment ending. Correspondingly, Mr. B began to enjoy a more healthy sense of competition and take pride in his accomplishments. He came to experience his separateness not as abandonment but rather as a new opportunity for mature relationships and cooperation. In more fully resolving certain Oedipal and sibling issues, he gained a newly found sense of autonomy and confidence. His sense of being an adult was reflected in his view of the analyst as a collaborative peer.

Matching at his first choice of postgraduate training program bolstered Mr. B's confidence, and he felt stronger in relationship to me. It meant he would become "a real doctor" at a top-notch hospital. He felt glad and expressed appreciation about how I had helped him to be more comfortable with himself, more assertive, and fulfill more of his potential. During one session, he focused on his disappointment about my starting the appointment late. He wanted me to know that he too had gone out of his way to accommodate me and had done so on many occasions. Everything he said was true. He had a realistic complaint and was better able to articulate his upset. I felt some discomfort and guilt about having occasioned his reproach and acknowledged my error. But the question still remained as to what my lateness meant to him in terms of his own psychological issues. His associations were to a visit from his mother and her boyfriend where he felt displaced, to his father's reminding him of the costs of his son's success (i.e., "I sacrificed so you could go to private school"), and to how his first choice program appreciated him. Listening to himself, he recognized that he experienced my lateness as my not valuing him. In the context of terminating treatment, he also wondered what I thought of him after having heard so much of him and his life.

His wanting to be appreciated also had as one of its meanings defending and coping with his competitive feelings toward me in the father transference. His satisfaction in becoming a real doctor, in contrast to how he saw me, continued to carry with it some sense of superseding his father. His moving forward in this regard meant surpassing me, as both a real and transferential figure. He wondered how I might feel about his becoming a real doctor, but felt less anxious that I might do things to hold him back. I pointed out how he experienced these events as triumphs over me rather than as "shared" accomplishments. This notion helped to assuage his guilt in moving forward with his life and to deal better with feelings of separation and loss regarding me.

Additionally, it brought another aspect of the transference more into focus, namely me as his older brother with whom he was also competitive. He felt anxious about having a child and achieving other things

that he imagined I had not accomplished. At the same time, Mr. B became less devaluing of psychoanalysis and me, and expressed a more realistic view of the work. Rather than seeing it as a miracle cure and psychoanalysts as perfect people (or the opposite of this extreme), he came to see our work as useful in helping him to better understand himself. He dealt better with the psychological conflicts that interfered with his working in a more satisfying way toward his personal goals.

A dream introduced the themes of the final weeks of Mr. B's analysis: "I was tunneling up through a hill in the woods. The trees were like sticks. I had a place of my own there. Then the scene shifts, and we're looking for a place to live in a flophouse with a nice lobby. Some clown is mistreating my wife, calling her honey." The tunneling up he saw as a metaphor for his growing up. He saw himself as bigger now so that the trees looked like sticks. He needed to see himself as big and strong in order to leave me. Climbing out in the sense of emerging was in contrast to an earlier dream where he saw climbing as a dangerous activity in which he was struck down. His association to the clown was to "an intimidating, loud, imposing, and tall man like you." Mr. B still needed to see me as demanding, but he no longer felt afraid. He now saw me in a more benign and ineffectual way. I observed how seeing me as less powerful and denigrating me made it easier to leave the analysis. He said how he used to idolize psychiatrists, but now he saw us as human beings with our own faults and foibles. He felt that he now saw me as more of a colleague, although being on equal footing (i.e., seeing me/standing up to me/getting off the couch) felt uncomfortable.

In the next session, Mr. B reflected further on the image of "tunneling." He mentioned that a friend of his recently had a baby, and after a pause commented that he and his wife had been trying to have one too. In fact, they had not been using birth control for the past month. When I expressed surprise, he thought about why he had been hesitant to discuss it. He wondered if I would react jealously like he felt his older brother had to the news. He wondered more about my motivations for taking him into treatment and keeping him as a patient. My needing him at the time as a training case meant he had a special place. Mr. B felt he was being replaced/displaced by other patients, and that he was not valuable to me in the same way. His having a child displaced him further. He felt dispensable in that his wife no longer needed him as a stud.

Matching at his residency program meant Mr. B would not be able to continue on in analysis with me. It brought to the forefront issues related to this circumstance, which we used to further his self-understanding. For example, he experienced getting accepted to a residency as putting him out of reach of the demands of authority, both the medi-

cal establishment's and my own. Mr. B felt an impulse to rebel, either by not doing the work of his remaining clinical rotation or coming to sessions. The patient felt relieved that he could accomplish his goals despite his wish to rebel. He had not just made it but had "made it after all," that is with the wishes he had. I observed how he tended to see himself as a competitive child rather than as an adult on equal footing with his peers. In association, he recalled a recent dream in which I was disguised as his good-looking, older brother. About the dream Mr. B reported, "I kick your ass and pull your arms out." He still tended to see our relationship as a competitive one, although felt strong enough to beat me.

Mr. B looked toward graduation and said that he felt ready for his analysis to be over. He commented that it did not matter much if he came for the last couple weeks. I observed how he minimized the emotional meaning of our relationship and its conclusion. He talked about how vulnerable he felt lying on the couch and how he was insecure about being able to fulfill the responsibilities of an adult life as a father, a homeowner, and a physician. He felt uncomfortable lying down on the couch in a different way, "like mom tucking me into bed." He imagined getting off the couch and looking me in the eyes, face to face as a man. His associations were to his mother's giving him a kiss and to his brother's titillating attacks.

A few sessions before his analysis ended, Mr. B dreamed of a Lucite cutting board that stretched across the kitchen sink. Water running from its faucet was too hot and melting the board. His cat was underneath, and when he went to pull her out, she was sticky and gooey. His associations to the cutting board were to his old fears and concerns about analysis and how the couch was like a cutting board (anatomy table). The board reminded him of a tombstone and the impending "death" of his analysis. Like a penis, the board went from being stiff and hard to flaccid and gooey. He recalled how the night before he had masturbated but could not bring himself to orgasm. Regarding the cat, he expressed concern about potentially being abusive to his child. I reminded him of how previously he expressed feeling like a pussy with me. He appeared moved to tears. He had always, he said, felt a need to cover up his feminine side. The cat also represented his soft underbelly—being intimate, crying, showing his fears.

Mr. B's stopping his analysis became even more affectively charged. He cried when talking about "giving me up" for his adult life. The tears were heartfelt. He complained about his work and new responsibilities that served as a cover for his sense of loss. One patient did not have a wristband on for identification. His initial association was to not having chosen yet a name for his baby. He commented that termi-

nating the analysis was also a kind of rebirthing in terms of letting me go. Next his thoughts turned toward doctors who did not know their patients' names. Mr. B remarked about my not having used his name. He described two supervisors with whom he had worked, one who praised him and his work and the other who was more critical. My patient wanted me to give him a kind of verbal diploma. I interpreted his wish that I call him by his name and tell him how well he had done. He talked about his wanting me to validate him and his analytic accomplishments over the past four years by giving him "a certificate of self-awareness." We explored the dynamic and genetic determinants that underlie that wish, including his competitive feelings toward his father and siblings.

Mr. B recognized that he had not fully explored certain aspects of his psychology, including some of his homosexual conflicts and his sexual fantasy life. His residency training would make it impossible from a practical point of view to continue in analysis with me. He wanted me to give him permission to leave and felt I would be judging him if he did not continue on in some form of therapy. In further exploring the meaning of losing me and separating from me emotionally, Mr. B discussed how scary the transition was for him. I observed how he seemed to want me to say it is okay for him to not come or to be in treatment any more, even though there were certain sexual issues and perhaps other subjects we had not fully explored. We discussed how conflicts involving dominance and submission were related to his dilemma about leaving. Bringing these issues to his attention helped him to feel freer to choose to end his treatment. He remained motivated to continue working to better understand himself independently, feeling he had acquired the tools to do so. Mr. B took pride in his graduation from medical school and in announcing his wife's pregnancy to his family: "It was a great moment for me. I said, 'the three of us want to thank you for being here.'" He felt that his father, other family members and friends, and I shared in his sense of happiness and accomplishment.

DISCUSSION OF LITERATURE AND CLINICAL MATERIAL

Definition and History of Terms

It is important to define what one means by "termination" as well as consider the history and use of the word in our psychoanalytic literature and practice. The word "termination" has in it the idea of bringing to an end or halt. It denotes a conclusion or end or result. It is derived from the Latin *terminare* meaning "end" (American Heritage

Dictionary, Second College Edition, p. 1254). In terms of its connotations, termination is an evocative rather than neutral word. We speak of terminating pregnancies and employment contracts and of terminal illnesses. It carries with it the sense of an ending that is abrupt and final. In Freud's classic paper "Analysis Terminable and Interminable," (1937) the German word *endliche* translates more as final, finite, or ultimate. Loewald (1988) defines termination as an ending of treatment that is "not crucially determined by extraneous factors in the patient's or therapist's life but appears as a natural outcome of the treatment process itself" (p. 155). This definition harkens back to the days when analyses were short and marriages long!

In a thoughtful paper on the subject, Pedder (1988) considers our use of the term "odd, unsatisfactory, and inappropriate" (p. 494) for describing the ending of an analysis because it fails to convey the positive hopes for a new beginning. He considers that it may be an appropriate word for a forced or premature ending. In terms of ending treatment, he applies Winnicott's analogy about breast-feeding, namely "the mere termination of breast feeding is not a weaning" (1953, p. 17). Alternative word solutions like "graduation," "separating," "ending," etc., have their own various meanings and resonances regarding concluding.

The term "forced termination" can have various meanings. Dewald (1966) introduced it to describe the ending of treatment that "represents an arbitrary decision by the analyst based on his own interests and needs, and does not take into account the potential impact on the patient, or whether the patient is ready for termination" (p. 105). He found that introducing this stressful reality into the transference situation often involved the repetition of infantile and childhood helplessness in the face of arbitrary parental behavior above and beyond the usual feelings of rejection and desertion. Such "forced termination" might occur, for example, with a geographic move. Martinez (1989) found that under certain circumstances deviation from classical psychoanalytic technique in terms of a purely interpretive stance can be valuable. More broadly speaking, one could see any ending of an analysis as having elements in which one person is being "forced" in the sense of submitting to the other. Even when there is mutual agreement about termination, fantasies on the part of the analysand (and analyst) involving dominance and submission, competitive victory, etc., may be present. The fact that it can involve a move on the part of the patient or the analyst may be of secondary importance to its psychoanalytic meaning. Likewise, even in an analysis that goes the distance, the same kinds of issues about who is forcing whom to do what often arise.

Mr. B's sense that he was "terminating" treatment had multiple meanings. For example, we explored fantasies about birth and death, dominance and submission, loss and being left. On the most superficial level, his ending treatment meant he had power over me and control over the analysis. He was leaving me and determining the ending date of the treatment. With Mr. B, termination was "forced" in the sense that he was requiring it of me based on his own professional and personal needs. As much as possible, I tried to analyze the meaning of his ending analysis. For example, we considered ideas about dominance and submission in the father transference. Analysis of this aspect of our relationship led to a notable shift in the primary transference. This was consistent with Davies's (2003) reflection that Oedipal and post-Oedipal process becomes more emphasized during the termination phase of analytic treatment. Rather than seeing me as his father, who had criticized and put him down, I was also experienced as his older brother, with whom he was competing. Examination of this aspect of our relationship allowed for Mr. B to come to see me more as a collaborative peer and feel more collegial toward me. Like his father who left for business trips or his older brother who tickled him until he peed, Mr. B now had his way with me. We were able to explore related fantasies about domination and submission in a collaborative way. Our relationship became a more mutual one.

Criteria for Terminating

In the 1950s, termination became the touchstone of a completed analysis. A terminated case was required for graduation at many institutes and for certification in the American Psychoanalytic Association. Over the last generation, it has been correlated with ideas about analyzability and outcome (Weiss & Fleming, 1980). There is also the notion that a generally successful analysis ends when the analyst concludes that the patient has achieved maximum therapeutic benefit (Firestein, 1969). This paternalist attitude can, at times, override the patient's own sense of what is right or necessary for himself. The 1969 Panel of the American Psychoanalytic Association on termination tended to emphasize the importance of the analyst's judgment in terminating treatment rather than being considerate first and foremost of the patient's sense of choice. Obviously, it is best if a mutual decision is reached by the analyst and analysand regarding treatment, but this agreement is not always possible. One at least hopes to be able to analyze the meaning

of stopping or continuing treatment and use it in the service of the patient's self-understanding.

Pedder (1988) summarizes the various positions analysts took as of that time with regard to termination. For Freud ideas about criteria for terminating involved overcoming the patient's resistances; the removal of infantile amnesia; making the unconscious conscious, which after 1923 was supplemented with the notion of sublimating "it" into "I." Jones (1936) also mentions confidence and well-being, a capacity for enjoyment and happiness, a more tolerant superego, unconscious affects being allowed into consciousness, and increased capacity to deal with aggression. Klein (1950) added a diminution of persecutory and depressive anxiety, analysis of both positive and negative aspects of transference, and an analysis of mourning toward the end of therapy. Balint (1950) tacked on the achievement of genital primacy and the ego strength to cope with both pain and pleasure. Rycroft (1985) sees the issue in terms of having allowed a healing process in which connections with previously repressed, split-off, and lost aspects of the self can be re-established. Simha-Alpern (2012) refers to both analyst and patient simultaneously negotiating multiple, complex states of self without fragmenting. The importance of the capacity for self-analysis as a criterion for termination varies depending on the author, but most analysts agree that it is helpful in the case of analysands becoming psychoanalysts. With all these ambitious ideals, it is little wonder that an analysis might be interminable.

One approach that has been proposed in various guises is that rather than having rigid rules for when an analysis should be terminated and what the criteria should be that we have instead a few good guiding principles. For example: (a) greater mental health that might consider object relationships, the state of the ego (i.e., distinguishing better between fantasy and reality and a more accurate evaluation of each) and superego, the constellation of intrapsychic conflicts and defenses, etc.; (b) better functioning in one's life that might take into account resolution of symptoms, dealing more effectively with anxiety and other affects, further sublimating the need for immediate gratification, and other goals as defined by analyst and analysand; (c) personal growth as reflected in the psychoanalytic situation having dealt with and worked through conflicts that have emerged in the transference, adequate resolution of transference neurosis, and exploration and working through of treatment ending. Ideally, termination is introduced into the analysis by material that the patient brings up reflecting his readiness to consider this step. Often this material arises in relation to a life circumstance (i.e., a move, a graduation) or to gains in a patient's self or life (Firestein, 1969, p. 224). One hopes that the patient will at least have an improved

self-understanding that includes a realistic assessment of one's abilities, a reduction of childhood amnesia, improved insight, and perhaps some sense of the analyst and what has transpired in treatment.

Certainly, in the latter part of his treatment, Mr. B was functioning better at work and gained significant professional achievement matching at a prestigious postgraduate program. He settled down into a more fully satisfying relationship with his wife, and they chose to have a child. The patient was genuinely appreciative of how far we had gone together in the analysis. He had gained a better understanding of his Oedipal issues, sibling rivalry, and felt more comfortable with himself as a competitive and sexual man. At the same time, to a lesser degree he continued to see these advances as having a competitive meaning in relation to me and his successes remained a source of some anxiety. His choosing a termination date that made sense for him had the meaning of a competitive victory. However, it also was a positive self-assertion that meant his time and priorities were important too. As with his missed sessions and long weekends, it also served the purpose as Franz Alexander describes of "preparatory interruptions" (Alexander & French, 1946). For Mr. B what was most emotionally significant was being able to decide for himself and in a collaborative way about the ending of his treatment. The rest was analytic commentary from which to learn.

Mr. B recognized that he had matured and significantly improved. However, he felt some frustration that I had not made him even better. His unhappiness was both a connection to his father and a way of defeating me. Understanding the hostility in this investment of his energies allowed him to take more ownership for his state of mind and further separate from me. Bonovitz in his paper, "Termination Never Ends: The Inevitable Incompleteness of Psychoanalysis" (2007), posits that termination is always incomplete. Part of the challenge for analyst and patient is to deal with and accept the limitations of the treatment. It was difficult for Mr. B to both separate and remain emotionally open and vulnerable. He experienced this state of affairs as a threat to his manhood, which is as being like a woman. This insight helped him participate more fully in the end phase of his analysis. Rather than primarily seeing his success in terms of winning a competition, he came to appreciate and use it as an opportunity to further explore his own conflicts. He gained a healthier sense of competition such as with his brother in sports. His acceptance into an excellent residency and his having a child were achievements that he imagined further distinguished him from me. Examining the transferential meaning allowed him to see his various family members more realistically with their strengths and weaknesses and to be more forgiving of the faults in their

love. He appreciated that I might also take some pride and pleasure in his accomplishments.

Technique of Terminating

During the termination phase, a psychoanalyst hopes to continue to help the patient to better understand himself and the conflicts that are present for him by continuing to analyze resistances and transferences. So the basic technique of the psychoanalytic process remains fundamentally the same. Certain themes tend to be part and parcel of this phase of analysis. The actuality of ending treatment often brings to mind ideas about birth and death, separation and loss, etc. These motifs can be represented in dreams and fantasies. Grenell (2002) in fact points out that by paying attention to less crafted patient communications such as with reported dreams, the analyst may help the patient address complex feelings about the termination process. Loewald (1988) distinguishes two stages of termination: (a) when the patient with the help of the analyst arrives at a decision to terminate and (b) when the patient and analyst are in the act of terminating. In termination we are dealing with the actual separation of analyst and analysand and not just how the experientially related past is emotionally revived and reverberates in the present. Loewald considers the main work of termination that of mourning and internalizing lost objects as a way of furthering the process of individuation (pp. 156–157).

Initially, the possibility of Mr. B's termination brought up some old issues for him. Davies (2005) characterizes termination as a series of multiple good-byes that center on various traumas and developmental conflicts. Mr. B became more concerned about how I saw him in terms of his perceived faults, aggressive impulses, and sexual fantasies. He felt self-conscious and experienced me as "picking" on him. We were able to further examine how this experience was based in the father transference and his sense of himself as an adolescent flawed by acne and sexual turmoil. As we further explored these issues, he became negativistic and avoidant of looking at his thoughts and feelings about the possibility of treatment ending.

At times in this phase of the analysis, he devalued our work and me. He showed off his medical and psychodynamic knowledge to put me in my place. His anger protected him and helped him feel more powerful in relation to me as well as minimizing his loving feelings. His responses also facilitated his separation. Even these regressive defenses

demonstrated personal growth as he was more openly combative and hostile. Mr. B wanted to limit how deeply we examined the issues, fearing that I might force him to stay in treatment or that he would be left wounded. Mr. B's feelings are suggestive of Salberg's (2009) view that some significant, integrative work may only be possible in the context of termination. This often includes both the achievements and limitations of the treatment. So it is important to be realistic about a "good-enough" ending.

After matching at his first choice of residency, it became clear that Mr. B would have to end analysis. A dream introduced the actual termination of this phase of analysis and furthered a relationship to me in which he perceived me more as a real human being. Among other things, dreams are communications of what might not yet have become conscious thoughts and feelings. Around terminating treatment, it is not uncommon for patients to dream of departures, far-away places, funerals and/or of birth, reunions, new-found freedoms, etc. In Mr. B's first termination dream, the subject of birth was present, and one direction of exploration was along the lines of his own separation and individuation. He saw his ending treatment as a birthing, a movement toward emancipation. In Mr. B's second dream, his anxiety about leaving me and his Oedipal guilt and fear of castration were present and further examined. His leaving contained the idea that he was destroying me and the treatment.

Themes of birth and death were expressly present in the final weeks of treatment. His dream of "tunneling out" had in it his sense of being born as well as his wife's being pregnant. He imagined that I might be jealous of his various accomplishments but felt less afraid to forward his aims and ambitions. In ending treatment, he was also making a new beginning of his life, free from the bounds and perceived constraints of analysis. So in losing me and examining the death of our relationship, he also felt born anew into his improved life. His dream about the cutting board contained the sense of impending death and the couch as a final resting place. It also had in it a sense of comfort in being able to show me his feminine side and feeling accepted and cradled by me. He felt freer to express a full array of emotions in relation to me and treatment ending—triumph and loss, gladness and sadness, genuine appreciation.

Mr. B's stopping treatment was based, at least in part, on external reasons. Its meaning contained aspects of a defiant victory, but it certainly was also a step toward his independence and self-betterment. Rather than seeing Mr. B's vacations and missed sessions simply in

terms of acting out and negatively self-assertive expressions, I also saw and explored them with the patient as testing of his growth and independence, an asserting of some of the psychoanalytic gains he had made. He recognized that the reality-based reasons for the decreased frequency of our meetings had meaning in terms of his relationship with his father and brother as well as our real relationship. Mr. B considered the competitive and sexual aspects of these issues. He also explored his sense of losing our relationship in its real and transferential dimensions. At the same time, the patient saw leaving me as an opportunity for forming new connections and finding his next level of independence. The ending of treatment was an opportunity to look at powerful underlying feelings and fantasies. During this phase of treatment, the analysis not only allowed Mr. B to separate from me but also to develop further the independence of mind and spirit that comes with becoming an individual.

While some of his core fantasies and associated defensives were constant, Mr. B was more able to reflect on them and continue to work through some key psychodynamic conflicts, which served to deepen his self-understanding. When I made observations about his being intellectual or obsessional as a way of not getting into things too deeply, he revealed his vulnerability and sense of fear about going out on his own. He took pride in his professional achievement but also expressed feelings of sadness and loss about ending treatment and leaving me. Mr. B's termination may reflect a similar dynamic to that referenced by Simha-Alpern (2012) in which both analyst and analysand participate in an Oedipal transference that facilitates the patient's growth into a reality-based, post-Oedipal state.

The idea of termination appears to have in it the sense that treatment should be final and complete. Classical psychoanalytic theory would seem to support this attitude, which predominated earlier in the history of our field. With wisdom borne of a few more years of experience, we have generally become more appreciative of the potential value of variations on traditional themes. Shane (2009) provides a summary of some more recent views analysts have with regard to termination. For example, some analysts find that post-analytic contact can be helpful in giving patients the opportunity to review the analysis, subsequent self-analysis, and life events post-analysis. In a panel discussion, Greenson (Robbins, 1975) reported inviting patients to return at monthly intervals for a few months after analysis. In fact, Shane (2009) argues against any overriding principle of termination and suggests a process that evolves in an ongoing way in the former patient after the analytic relationship ends.

Nevertheless, there remains a range of opinion about the value of tapering treatment at the end of an analysis (Feller, 2009). Some psychoanalysts find that tapering—or for that matter allowing the patient to return for more analysis after termination—interferes with consolidating analytic gains. Others find that termination is not a definitive ending and see it as part of a process without a definitive ending (Harrison, 2009). Interestingly, in the kind of termination that seems to be the classical ideal, we ask our patients to do what we as analysts seldom have to do, that is to completely give up the analyst (Pedder, 1988, p. 500). At least in part, the structure of psychoanalytic societies and organizations depends on the idea that candidates go through a training analysis and then become part of institutes that their analysts themselves participate in.

What then are the attainments necessary for a complete analysis and the completion of the psychoanalytic process? The problems involved in defining even the simple task of ending an analysis are complex and not unlike the issues we wrestle with throughout an analysis. For example, in terms of structural attainments, some analysts have considered that a task of the termination phase is to complete the resolution of the transference neurosis. However, in follow-up studies, the transference neurosis remained an active and permanent structure (Shane, 1984, p. 750). Additionally, other analysts (Blum, 1989) believe that the capacity for self-analysis is necessary in only those patients who themselves are becoming psychoanalysts, and one can have adequate autonomous ego functioning without it. We can also try to study the factors that correlate with outcome in analysis such as improvement during treatment, higher level of intrapsychic development at termination, or positive transference maintained after termination from a follow-up perspective.

Such studies tend to highlight the difficulty of assessing the gains and the reasons for them. Neither the patient's nor the analyst's assessment nor psychological tests at the time of termination are predictive of subsequent results (Schachter & Martin, 1993). Development may continue in several ways after termination constituting positive, ongoing results (Falkenström, Grant, Broberg, & Sandell, 2007). It is hard to generalize about specific case studies that might be relevant to decision making about treatment ending. In one study of 82 patients, Roe (2007) reflects the importance of terminating at the "right" time. This study found that 40% of participants reported that therapy ended on time, 37% that it ended earlier than it should have, and 23% that it ended later than it should have. In general, analysands who reported that termination was on time were more satisfied, terminated for less negative reasons, and had more positive feelings. Results suggest that people in treatment find terminating psychotherapy at the right time important

and yet difficult to achieve. S. Rittenberg (personal communication, 2000) suggested the interesting additional view that when an analyst does not have significantly more to add and when the patient has understood how the analyst has come to know the patient's conflicts and character, then that is as good a time as any to end treatment.

CONCLUSION

Whatever one's theoretical orientation, Freud's notion of termination as a practical matter is useful (1937, p. 249). Psychoanalytic treatment is a kind of partnership between analyst and analysand. Ideally, termination begins when both parties feel and agree they have gone as far as they can together for various reasons that may be intrinsic or extrinsic to the psychoanalytic situation or for that matter intrapsychic or interpersonal. As in beginning an analysis, a sense of choice on the part of both participants is essential in its ending. The psychoanalytic treatment is meant to be finite and limited. Achieving certain intrapsychic or life goals or reaching certain limits based in the analysand, analyst, the treatment, or external factors may define reaching this stage. The termination phase of treatment can present certain opportunities for analyzing intrapsychic conflicts and transferences that may not have come up so clearly or even at all in the rest of analysis. I am reminded of Samuel Johnson's observation, "When a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully" ("Epitaph on Goldsmith," September 17, 1777).

Psychoanalysis is a means to the end of a better and more fulfilling life. Even for us psychoanalysts, it ought not to be only an end in itself. It is important to coordinate the timing of ending an analysis with the needs of the patient. During the termination phase, it is our charge to continue to work with the patient to help him better understand himself. Our own personal labors include what it means for us to face the end of working with a patient. Such consideration can involve a sense of loss and mourning, a compromising of one's own therapeutic ambition, and other countertransference concerns. The various meanings that termination may have for the psychoanalyst impact the treatment. To the extent that ending treatment is a two-person decision, the analyst's subjectivity can have a significant effect on the patient's decision about termination. I tend to return to Freud's familiar maxim about mental health consisting of the capacity to find satisfaction in both work and love. In the end, as in the beginning, we work to facilitate the patient's overall health through understanding.

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