Counter-transference and the Termination Process

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"In the Room the Women Come and Go,

Talking of Michelangelo..."

Perhaps the ebb and flow of relationships, including the therapist-patient relationship, is what TS Eliot meant by these lines in *The Love Song of J. Alfred Prufrock*. Not only women, of course, but all those who consult us naturally come and go. They may leave psychotherapy weeks after beginning the process, or years after, with warning or without, improved or not. Since we cannot help but become intimately involved with our patients, we must exercise caution in managing our feelings as termination approaches.

The termination process in fact elicits any number of intense emotions in us, many of which might be viewed as shameful or unprofessional. Who among us has not felt deeply hurt, even abandoned, by the unexpected decision by a patient to suddenly leave the psychotherapy process? And what of the even darker emotions rarely discussed: Anger at patients' leaving during some crucial phase of the therapy relationship; relief to be away from those we find too frustrating; fear that they may seriously mishandle some aspect of their lives without our help; sadness that we will deeply miss patients that we have come to love; worry that we will suffer financially because of lost income. Because psychotherapy is an intensely personal process—more a structured transformation than a "treatment"—many complex feelings are to be expected during its end.

What then are we to do with such emotions, particularly the ones that strike us most powerfully? We process them as we would any strong counter-transference feeling encountered as part of psychoanalytic psychotherapy. We endeavor to derive the meaning that is beneficial for the patient and then to deliver it via confrontation, interpretation, or empathy.

But perhaps even more importantly, we must be on guard for the likelihood that our feelings as the relationship winds to an end often have more to do with our own psychology. Generally, counter-transference is elicited by a combination of ours and our patients' feelings, a manifestation of the so-called two-person model of psychoanalytic psychotherapy. But some counter-transference is more localized in the therapist alone, and terminations are particularly prone to this. This is because therapists find themselves in the more vulnerable role of the party being left; for most of the relationship, patients are in the more vulnerable position.

The best way to proceed when faced with feelings about a termination is to look inside and determine what nerves are being struck within us. Once we have delved into our own psychology, then our attention should turn back to that two-person model. The therapeutic dyad should then mutually explore the meaning of the desire for the termination. Here it is crucial to place most weight on the autonomous functioning of the patient. In my view, we should err on the side of honoring the patient's desire to terminate. But, in consonance with every phase of the work, we also explore the meanings of the

decision, which range from an accurate assessment that a piece of therapeutic work is completed to any number of destructive reasons for early termination. Sometimes patients quit in order to avoid encountering a particularly painful aspect of themselves, their relationships, or some other aspect of their lives. Sometimes they leave masochistically, having achieved all the positive gains that they can tolerate. Sometimes they grow tired of exposing and exploring their vulnerability.

Managing the termination phase requires great skill by the therapist: We must identify our own vulnerability; we must actively engage the patient in exploring the possible meanings of their decision; we must allow patients' their autonomy at a time when we may disagree with, and be highly emotionally impacted by, their desire to leave. We are left alone with some of our most intense emotions, ranging from triumph to defeat, from loss to joy, from anger to relief. Having invested heavily in time, love and care for these individuals, we end up alone. Here we should be seeking solace from our connections with our colleagues, our friends, and our family members. Perhaps we should apply the Buddhist ideals of neither clinging nor craving, thereby more freely allowing our patients, in TS Eliot's words, "come and go, talking of Michelangelo."