

Ending Is for Life

Andrew Powell

It is easy enough to talk about a therapy having ended. After all, it had a beginning, so why should it not come to an end? The author suggests this is true only in the concrete sense. No matter whether the therapeutic outcome is felt to have been successful or a failure, it can be argued that once psychotherapy has been set in motion, the process is genuinely 'without end'. An exception of a kind is to be found where the relationship is transformed from therapy to friendship; but is not true friendship also an opportunity for continuing personal development? Freudian, Jungian and group-analytic approaches are compared. The whole question of beginnings and endings is concluded with reference to the recurring nature of the individual lifecycle, which in this author's view is indispensable to a meaningful account of the evolutionary universe.

Great store is set by analytic psychotherapists on endings. Indeed, unless the therapist is prepared to be in loco parentis for life, he¹ will have the eventual termination of therapy in mind from day one.

Since the problems that cause the patient to seek help are generally more intelligible to therapist than patient, the asymmetry that results encourages and sustains a developmental metaphor in which the relationship of child to parent is given substance. The child is to some extent perplexed and distressed, the parent is correspondingly nurturing and enabling.

This experience of the patient is deepened and interpreted in relation to the transference, that set of unconscious assumptions and expectations projected onto the person of the therapist. There is, naturally, a two-way process in operation. However, since from the outset the analytic psychotherapist understands the nature of the task, he can for the most part set aside his personal emotions (other than in the service of the countertransference). Nor does he disclose the circumstances of his personal life, any more than the child should be witness to the sexual life of its parents.

As we all know, the theory at its most simple informs us that a new developmental process has been initiated, in the course of which points of fixation become unstuck, the patient's internal object world is restructured and a maturational change comes about which in time will close the gap between patient and therapist. By the end of the therapy, if all goes well, they can shake hands, symbolically if not literally, and each go his own way. The transference has been successfully analysed, truth has replaced illusion and the grateful patient has achieved emancipation from the yoke of childhood, not without a good deal of pain and suffering.

We also know equally well that it isn't really like this. Two people meet, the expectations of each about the other are shaped by various assumptions, some explicit and some not so explicit, one person talks about himself, his feelings, hopes and fears, the other takes a deep

interest, tries not to stand in judgement and offers his thoughts about how things might be seen and understood differently. A strong bond forms between the two, as it must when so much time is spent together in such intimacy. Tensions arise, and hopefully can be resolved, unpalatable truths are confronted and the patient is emboldened to face himself and his dilemmas with new hope and courage. He perceives many things about his therapist, some of them coloured by the transference, others not so. To the extent that he sees the truth, he will know his therapist to be, like himself, a fellow traveller in life, experiencing many of the same personal hopes and fears as himself and equally impelled by the need to feel that life makes sense before it is over and done with.

How much the patient is open to this I-thou encounter depends both on the extent to which he is self-preoccupied and whether his therapist invites such a relationship. Some therapists keenly feel a dilemma here; quite apart from the vicissitudes of the transference, might it not be unethical to take money from a fellow human being for something so akin to friendship? Further, how could such friendship ever end, except by a traumatic rupture?

Could it be that Sigmund Freud's famous 'mirror' (Freud 1912) served not only to elucidate the transference but also to maintain a certain decorum that owed its necessity to the promulgation of the psychoanalytic movement? After all, following his early case studies, much of Freud's clinical work centred on the analyses of colleagues who were to become the torch bearers of psychoanalysis itself. Only with Wilhelm Fliess and Carl Jung did Freud unbend. Unfortunately, both friendships ended in disaffection (Roazen 1975). Freud remained thereafter a reserved, even taciturn man, very much at the head of the table, whose intellectual brilliance continued to inspire reverence, a man who created an Apollonian ideal on which to this day many psychoanalysts model themselves.

The fare at this intellectual feast was none other than the elaboration of a highly structured metapsychology which, with various modifications and adjustments, such as object relations theory and self psychology, has advanced on all fronts to the point of presenting us with an all-encompassing model of psychic functioning.

Since metapsychology has derived from the clinical situation, not surprisingly it offers an interpretation of life, which can be framed between the bookends of the start and finish of the analysis. As the therapy proceeds, an internalisation of the therapeutic relationship is understood to be taking place and, *pari passu*, a process of structural repair of the psyche, rather like replacing the faulty electrical components in a complex piece of machinery. When the repair is adequate, if not perfect, the analysis is over.

This is, of course, a caricature of psychoanalysis. And yet there are certain dangers that are inherent. A general psychology has been founded on a bedrock of pathology, the understanding of which has, in turn, been derived from a situation in which great power is held by the therapist. Through his psychodynamic formulations, the therapist is able to diagnose the illness, which he then sets out to treat. However, since

the illness is in the mind and not the body, and the diagnosis is formed entirely in the mind of the therapist, the patient cannot give truly informed consent or challenge the therapist in the way that you might tackle your plumber for taking too long or charging too much. All depends on trust; how difficult when too much smacks of idealisation and too little suggests a negative transference!

These moral and ethical difficulties have been loudly debated by Jeffrey Masson (1988) and I will not expand here. But many problems about ending do occur in the context of therapies that have gone badly wrong, either because of mistakes by the therapist or irremediable psychopathology, and most often both together. Such 'therapy' will sooner or later have to stop, if only because the therapist cannot bear to go on forever. But it will certainly not end, for the patient will have become a complainant, whether the grudge is covert or acted on (psychotherapists would be inclined to say 'acted out').

We may concur that the therapist's fate is to have become his patient's bad object, possibly for life. On the other hand, the patient's experience is that he has been abused and psychically speaking it may be a matter of life and death to him to have the wrong righted. An impasse results, not generally alleviated by a period of further therapy with another analyst. This is because the patient is now behaving in a paranoid way, so that the second therapist is required to corroborate the grievance, or else is perceived as being in cahoots with his colleague. The possibility that the patient actually may have been paranoid from the outset only complicates the matter further.

There is, of course, a painful alternative to the paranoid development; that of the patient who becomes irrecoverably depressed. Suicide is one way of concretely both stopping and ending the relationship, for the patient at least. But for the therapist it is far from over. Unless he turns his back on the whole experience, he will have to live with the patient as an everlasting reproach to his therapeutic misjudgement. (I am excluding instances where it is the understood aim of the therapy to support a patient through dying and to death.)

One or more of these dreaded scenes of the psychotherapist come to most psychotherapists who have been practising for long enough. They reflect our well-intentioned folly to think we can apply the analytic instrument to everyone who comes along seeking help. Later, we learn how to say no at the very start, before the transference has taken root; for transference is like a narrow one-way street; there is no reversing out of it.

Saying 'no' is based on both intuition and the formulation of psychopathology. The latter provides a degree of objectivity, for dynamic formulations can indeed predict, with some accuracy, the course of future events in therapy. (Incidentally, by the time the therapist is sufficiently experienced to make this judgement, he is also more likely to have outgrown his own need to cure. The problem diminishes in proportion to the modesty of the therapist's aim.)

Another kind of ending without end and which needs to be mentioned is the loss of the therapist through illness and sometimes death. What is the patient to do when his worst fears are realised? In the

midst of a regression, he may really feel he killed his analyst and who can say that he did not contribute?

Mindful of the way psychotherapists are encouraged to absorb the most toxic of projections in the interests of holding and containing, many years ago I endeavoured to obtain information from the British Psychoanalytical Society about the causes of death of psychoanalysts. It is perhaps not surprising that I did not succeed. The researches of Valerie Hunt, Professor of Physiology at University of California at Los Angeles (Hunt et al., 1977), have since demonstrated that the energy field of the therapist physically reacts to that of the patient and vice versa. This is what traditionally has been called the 'aura', and which now can be demonstrated visibly using computer-enhanced imaging. Even more extraordinary, Hunt has shown that the energy fields of two persons in proximity are interactive; the one will take on board energy from the other, a transaction that lends new meaning to the term 'projection'.

What then of the patient whose aggression is interpreted blow by blow while the therapist hides his cancer? Can this be good for either of them? The therapist may go on to die without his patient ever having the chance to support him and to show him concern and tenderness; both will have been deprived of the opportunity to have shared a healing experience in the face of a real and painful ending.

This defensive and denying stance on the part of the therapist can, of course, be the consequence of too much intensive analytic work. The therapist has to shield himself, he cannot be too porous and there have to be boundaries. But the price paid is an insidious rigidity, a kind of psychic Parkinsonism, which drains the therapist of natural warmth and affection. The subtle danger, in relation to the title of this paper, is that ending never takes place only because the human relationship never really got under way.

To go to the other extreme, of intimacy without bounds, we have the example of the patient and therapist who embark on a sexual relationship. Increasingly, this subject is being researched and some studies claim up to 15 per cent of therapists admit to one or more affairs with patients (Bouhoutsos 1984). We like to think it doesn't happen in the UK, that after all, these are American studies!

I don't need to go into the incestuous meaning of this, which is obvious. Neither, in my view, does the termination of therapy, with the usual safeguards of arranging another therapist and allowing a decent period of time to elapse, really make any difference. The relationship may bloom and lead even to marriage. But the fact is that it still began in the child's bedroom, and the couple have to live with the consequences of that knowledge.

While on this subject, am I right in thinking that this situation rarely, if ever, applies to group analysis? The openness of the group does not, I suspect, support the secretive nature of incestuous attraction, which in turn spawns the irresistible fantasy and the breaking of the social taboo.

Before leaving the subject of intimacy between patient and therapist, we find at the other end of the spectrum the highly esteemed

and professionally indispensable relationship between the analyst and his 'training patient', who hopes in the fullness of time to join the august institution to which his analyst belongs. Serious acting out is unlikely, since while a little protest may be deemed a good thing, too much will disqualify the candidate. But there is an overriding factor which operates from the start, that of mutual identification. There will be a stopping but how can there be any real ending, since on graduation the candidate will join with his parent/analyst in the body of the institute?

Is this patient therefore to be congratulated or does he merit our commiseration? The picture is a complex one, a conflation of creative and inhibiting factors. Surely he deserves congratulating to the extent that he has been raised to adulthood and now even has children/patients himself. He may deserve our sympathy in that he has denied himself, and been denied, an ending that could leave him gloriously free and unencumbered by the family business.

This far I have touched on paranoia, depression, death and incest. It is now time to consider the 'good' ending that follows a successful treatment and to see if under favourable conditions the concept of ending is any more convincing.

The hallmark of the good ending is broadly that it has been anticipated, worked through and reached by mutual accord and with a sense of mutual satisfaction. Since the good ending will have followed a good therapeutic experience, a creative inner dialogue in the patient will naturally continue. But at least as an episode in the life of patient and analyst, it would appear that some kind of ending really does seem to be taking place.

How do we know, on the other hand, whether the patient is actually saying goodbye or *au revoir*? There is the story of the young man who underwent a lengthy and arduous Kleinian analysis in South America. After a good many years and much agonising, he decided that he was ready to finish his analysis and actually made arrangements to immigrate to Europe. The date for ending was set. About to leave the consulting room for the very last time, he turned to shake hands with his analyst. To his amazement, no hand was proffered in return. 'But why not?' he expostulated. 'Because you never know when you may need to see me again' came the sombre reply.

When I first heard this story, I merely took it as another rather unkind joke at the expense of the Kleinians. But joking aside, there is a more serious point. Why should a good analysis ever end? And why not leave the door open? Life takes many twists and turns, most of them unforeseen. Psychotherapy that goes well is not a surgical operation, despite the many parallels that can be drawn. There is no end-point, any more than a relationship between a child and its parent ever comes to an end during the lifetime of either.

I can assert this confidently because where there has been no true human encounter and no love, in the platonic sense, between patient and therapist, not all the analytic technique in the world will have made that patient better. At best, the therapy will not have worked and at worst the patient will have felt deeply affronted.

If, on the other hand, there has been a real meeting of minds and the struggle hard won, there will be mutual respect and gratitude, for both patient and analyst will have learned much, not only about each other but each about themselves. Those crude distortions inflicted by the transference will have resolved and the therapist can at last stop thinking about his countertransference. Or can he?

I hesitate, for I am reminded that this relationship was not initiated in friendship. There never was a natural, mutual seeking out of the other; the patient was referred for treatment; that is how it all began. Even discounting the transference for a moment, one person principally gave (in return for money) and the other person received. It was always a transaction, and not an equal one.

What are we left with? There is a paradox of sorts here, a friendship, which is not a friendship, nor can it be until the therapist is free to confide in his patient as readily as did the patient in him. This is rare. How do John Cleese and Robin Skynner do it? Is there still a faint but perceptible awkwardness about their double act? Perhaps I am imagining it. But come to think of it, wasn't John Cleese in a group anyway? Maybe that doesn't really count.

The problem is that the analyst has been more than the agent of cure; he has been taken in, ingested via the transference, as the cure itself. This is quite different from, say, the relationship of the Buddhist novice to the Master. At the end of the day it is the teachings that count, and the aim is for the monk to get enlightened just like his Master, even if he has to take a beating periodically to help him get there. The 'truth' is always known to be a third party, which is quite impartial.

Jungian analysis does, I imagine, come closer to this model. For the analyst is there to assist in his patient an alchemical transformation not unlike enlightenment, the *coincidentia oppositorum* (Jung 1939). As I understand it, this process is fundamentally different from psychoanalysis, despite the interest in early child development now taken by analytical psychologists and some degree of realignment, in the U K at least, between the two schools.

At the heart of the Jungian approach is spiritual transformation through individuation, whether it is taken to be an intra-psychic process or a transcendental one. This kind of vocabulary has no place in psychoanalysis. Freud was profoundly sceptical of such ideas, being determined to ground his theory in the empirical sciences. Jung, however, sought to integrate his mystical experiences in a wider vision of reality.

In this search, analyst and patient join as fellow seekers after a higher-dimensional truth and this allows (or can allow) for the emergence of a democracy of intent and experience. Transference distortions must indeed be confronted, for they will seriously jeopardise the venture, but the process is fundamentally an educational one. Psychoanalysts have not understood this and see the Jungian aversion to working primarily with the transference as a cop-out.

Is there a danger to the therapist in working with such personal transparency? First, it affords no refuge from the curiosity of the patient, which in contrast, friendship allows because of its mutually self-

regulating nature. Friends don't *have* to meet one, two or more times a week. The therapist is on trial as a human being, a matter of intense concern to his patient who may enter this relationship with an experience of having already been traumatised at the hands of the human race. Can the therapist bear the exposure of his personal failings and weaknesses, which sooner or later must come to light? Should he pay his patient for these therapeutic revelations? Trigant Burrow, former President of the American Psychoanalytic Association and the founding father of group analysis, was challenged to role-reverse by one of his analytic patients, and did so. This interesting experience has not been repeated in the analytic fraternity, although Jacob Moreno made role-reversal the hallmark of psychodrama (Moreno 1959).

Then there is the problem of falling between two stools, when partial disclosures by the therapist can come to be experienced as painfully tantalising. It appears that friendship is on offer. But when the therapist feels invaded, he starts to back off. This is likely to humiliate and anger his patient, especially if the patient's behaviour now gets interpreted in the transference. Perhaps the more honest tack would be to come out with it and tell the patient to mind his own business! Worse still, the therapist may be driven to stop the therapy. But it will certainly not end there, as I reported earlier.

Where might group analysis fit in to all of this? Two group-specific factors are particularly relevant. First, unless the group conductor is highly narcissistic and needs to centre the group on himself, once the dependent transferences have been brought out into the open and tackled, he is not so powerfully the object of interest. Other interesting relationships are being formed in the group on an egalitarian footing and the conductor is happy to sit back a good part of the time. Undue intrusion by a group member will be picked up and checked by other group members so that a self-modulating function comes into play. The public nature of the encounter brings a balance, which is complemented by the realisation, in time, that the group is wiser than the individual, and that this goes for the conductor too.

Second, the group is, in reality, an *artefact*. Once a member leaves, he cannot go back in, for with his departure and replacement, the group has forever changed. Alternatively, the group may have disbanded, and so any further group experience will have to be gained elsewhere. Last and not least, should the patient form a friendship with his former group analyst, it is no longer in the group and shaped by the group. Because the context has profoundly changed and no longer bears a therapeutic significance, a new kind of relationship is available, free to develop in the one-to-one setting, which can become friendship if mutually desired.

Does this entitle us to say that in group work both stopping and ending are possible? I believe so, because since the same group no longer exists in external reality, it can only be retained as an *imago*, an internal source of reference and richness of experience.

In conclusion, I suggest that the differences between stopping and ending may be set out as follows: for psychoanalysis, stopping yes, ending never. For analytical psychology, stopping yes, ending

sometimes yes but not without difficulty. For group analysis, stopping yes, ending yes and the door open to the possibility of friendship.

By way of a postscript, while I have been concerned in this paper with conditions that apply to the clinical frame of reference, I would like to widen the stage, since I see the whole of each and every life as a therapeutic challenge. In this sense, the only stopping, and ending, comes with death. Yet this too is now being questioned by formerly sceptical scientists on the basis of research into near-death and past-life experiences. On the theoretical front, quantum physics and field theory also suggest that while the body may wither, the psychophysical mind is turning out to be indestructible after all. Endings and beginnings interweave throughout the matrix of space and time (Powell, 1991).

Scientific and religious communities increasingly share the same perception of reality, that nothing which has once made an appearance in this universe of ours can be destroyed. It simply reforms in another dimensional plane, what David Bohm has called the 'implicate order' (Bohm 1980). To quote from *The Rubaiyat of Omar Khayyam*,

*The Moving Finger writes; and, having writ
Moves on: nor all thy Piety nor Wit
Shall lure it back to cancel half a Line,
Nor all thy Tears wash out a word of it.*

(Trans. Edward Fitzgerald, 1859)

We also now have scientific evidence that what was once joined can never be put asunder. Two photons that once shared the same quantum field remain intimately connected even when sent off to opposite ends of the universe (Dossey 1982). In other words, the way we ordinarily conceive of space and time is nothing more than the product of our special sense organs. This is required for our experience of an incarnate reality, but we do well to remember that what we call physical reality is, in turn, merely one facet of a greater whole.

Overarching the whole debate about whether the therapeutic relationship ends or stops is this awareness that all relationships, once formed, are forever. How they subsequently manifest is another matter. We should not be surprised if some strange reversals lie in store for us. According to the Law of Karma (rediscovered in Isaac Newton's Third Law of Motion), every action has its equal and opposite reaction. Had Trigant Burrow chosen to wait, he may indeed have got his chance to reverse roles with his patient not in this life but the next. This could be a sobering prospect for therapists who might otherwise be relieved to think that there are some patients they will never meet again!

Note

1. 'He' is a term applied for convenience to both patient and therapist and is not intended to denote gender.

References

- Bohm D. (1980) *Wholeness and the Implicate Order*. London: Routledge.
- Bouhoutsos J. (1984) 'Sexual Intimacy Between Psychotherapists and Clients: Policy Implications for the Future', in L. Walker (ed.) *Women and Mental Health Policy*. Beverley Hills, CA: Sage.
- Dossey I (1982) *Space, Time and Medicine*. Boulder, CO and London: Shambhala.
- Freud, S. (1912) 'Recommendations to Physicians Practising Psychoanalysis' *Standard Edition*, Vol. 12. London: Hogarth Press, 1958.
- Hunt V., Massey W., Weinberg R., Bruyere R. and Hahn P. (1977). 'A Study of Structural Integration from Neuromuscular, Energy Field and Emotional Approaches'. *Project report, Boulder, CO: Rolf Institute of Structural Integration*.
- Jung C. (1939) Foreword to Suzuki's *Introduction to Zen Buddhism*, in *Psychology and Religion: West and East*. Collected Works, Vol. 11. London: Routledge and Kegan Paul, 1958.
- Masson J. (1988) *Against Therapy*. London: Harper Collins.
- Moreno J. (1959) *Psychodrama*. Vol. 2. Reprinted New York: Beacon House, 1975.
- Powell A. (1991) 'Matrix, Mind and Matter: From the Internal to the Eternal', *Group Analysis* 24(3): 299-322
- Roazen P. (1975) *Freud and his Followers*. Reprinted Harmondsworth: Penguin, 1979.

First published in *Group Analysis* (1994) SAGE, London,
Thousand Oaks, CA and New Delhi, Vol. 27:1 25-36

© Andrew Powell 1994