I want to say a few more words about the gender of the therapist, elaborating on my comments in the previous chapter. I am aware I have sometimes used the sexist term "mother" for parent, and have reported a female perspective on transference and countertransference issues. Besides the obvious reason for this, I would also like to point out that much of the recent analytically-oriented couples therapy literature has been written by women (e.g. Solomon and Siegel, 1997; Sharpe, 2000), although a significant amount of the earlier work has been done by male therapists (e.g. Dicks, 1967; Ruszczynski, 1993). Even the *New Yorker* cartoons picture female therapists for this type of work (and usually male therapists for individual therapy).

Countertransferences in male couples therapists will be different from those of female therapists; certainly, a couple must react differently to a male therapist and males must react differently to the oedipal triadic setting of couples therapy. However, the differences may not be as great as they would seem at first blush. In addition, gay or straight therapists treating gay or lesbian couples might encounter somewhat differing transferences and countertransferences. Hopefully these limitations of this book will continue to be rectified by other writers.

Chapter 7

Dénouement: working through and termination

The analytic literature on the processes of working through and termination describes the complex emotional responses that the latter, particularly, evokes in therapist and patient alike. As the reader might now expect, these processes are even more complex when they are happening with two patients at the same time.

Working through, which "permits the subject to pass from rejection [of an interpretation] or merely intellectual acceptance to a conviction based on lived experience" (Laplanche and Pontalis, 1973, p. 488), does not happen quickly, as we know from individual treatment. Despite what the movies tell us, patients rarely have an "aha" experience – exclaiming "Oh thank you, Doctor, now all is clear!" – and even more rarely do they proceed to change their behaviour if they do. Resistance to change is the most likely sequela to insight, as people are attached to their past familiar ways of relating, and even to their symptoms. In couples therapy, when a dysfunctional pattern has been identified, several interesting possibilities arise. One partner may want a change and try to move the interaction in that direction; the other, however, may see any change as threatening the relationship and therefore hang on more tightly. If the interpretation or observation originates with one of the partners, rather than with the therapist, it may be accepted more easily, because of the lack of authority-loading, or less easily, because of resentment of the other. What makes the working through more difficult with couples is that the behaviour is usually

part of a long-established, collusive, way of relating; what makes it easier is that it is there in the room for all to see and experience. Also, sometimes patients in individual treatment fear the response of their partner should they begin to act differently; here, that response can be checked out, modified, and checked out again, to ensure that both partners are as much on side as possible.

Working through implies repetition, that is, new responses and behaviours have to be experienced and re-experienced many, many times, and in different ways. Sometimes one partner needs more time, or more repetitions, than the other. This is always interesting to observe; at these times, the other partner may be of help in the process. This repetitive exposure to conflicts, and the understanding and working through of them, by each individual at their own pace, is part of what accounts for the amount of time I think needs to be given to couples. When Mirella and Nick started the session after we had discussed Nick's father's diagnosis of cancer (Chapter 4) by saying "We're still fighting," it was not as surprising to me as it was to them. I knew it wasn't over yet, even though it did have a different feel to it now, but it was almost as if they expected things to change quickly and were disappointed in themselves.

Remember Chantal and Brad? Their therapy progressed, somewhat unevenly, as they worked through understanding Chantal's needs that had led to her affair, and Brad's feelings of anger, frustration, and impotence. Part of the working through process in couples, as with individuals, is the internalization of the relationship with the therapist based on new experience, as well as the development of insight through interpretation. As our work together progressed, Chantal and Brad began to feel closer to each other and closer to me. In one session, Brad commented, "We're all wearing brown today" – even though I was wearing black!

A part of their working through involved the "externalization" of the conflict around suburban living. Brad agreed to move into the city, giving up his attachment to their home, as he thought that Chantal would be happier. Discussion in the

therapy revolved around compromises: i.e. could they get a house closer to the university, but with enough land so that Brad could still enjoy gardening? At this point in the therapy, a real estate agent was added to our triad – this person was talked about a great deal, as they discussed how to make their desires known to her. She tried to provide them with a solution to their city/country problem, although not exactly in a therapeutic manner. All of this time, Brad was enduring what he came to refer to as "banishment" when living in the apartment that Chantal was so reluctant to relinquish. He was anxious that Chantal might need to "break out again" even though they were in a new home, and there was some discussion about whether she needed to keep the apartment longer. Looking for the house provided them with opportunities for working through Brad's feelings about the apartment, and his lack of trust in Chantal. This led to a re-working of the affair, with material emerging again about how the former lover had been able to listen to Chantal, and to encourage her to express her feelings, something that Brad was unable to do to her satisfaction. Brad, now aware of this, tried to listen more; this was especially observable in our sessions.

Two years into treatment, "*Things are starting to feel better between them. B. really has changed, and I told him so. He is now able to listen to C.'s outpourings, which hopefully she will deliver in a manner that is considerate of him. They both said they can talk to each other more. There was some discussion of cutting back, which C. was more ready to do than B. She has gone through a lot emotionally in here – really been honest.*"

Anne and Michael, the lawyers struggling with hepatitis C, began, as our work progressed, to talk about what they had hoped for when they married each other. As Michael expressed his frustration in a calmer, more reasonable, and more palatable manner, Anne noticed how she had contributed to the rage by her response of shutting down and crying, and not "getting in the ring" with him. They were now able to talk to each other in a manner that was more satisfying to both of them. I noticed, however, that once our discussions about illness and possible death were less frequent, the instant

intimacy that had been generated for all three of us by this subject began to recede. As time went on, we reconnected in a more gradual way, over issues that were less emotionally charged.

They discussed the firm and how they interacted there, with Michael pointing out that Anne tended to be "officious and controlling" in meetings. She stated that this was in response to his lack of attention to detail, and his impatience with juniors who were also scared of him. All along we had understood Anne's "officiousness" as being an identification with a father who was successful in business, although cold and distant, and a disidentification with her mother, who had little education and who was treated as a "slave" by her father. Anne acknowledged that she had many of her mother's characteristics of being nurturing and reasonable; in times of stress, however, she reverted back to her identification with her father.

Michael's father, on the other hand, was unable to survive physically and mentally after losing a job when Michael was 10 years of age. He gained an enormous amount of weight, never worked again, and became diabetic and severely depressed. His mother, described as active and energetic, took over the support and maintenance of the family of four children. She, however, evidently had times of quiet desperation, when she would bang her fists against her forehead in silent, but intense, rage. We understood that the childhood experience of witnessing such inexpressible anger and frustration made a significant impression on Michael. He may have made a conscious decision to express his anger aloud so that people would hear him. In addition, his attempts to be "strong," and not like his father, were fuelling his fearsome image. Still, he did not want to cause pain to Anne or their son, or anyone at their firm. When he heard that his behaviour was affecting the juniors, he worked at being more aware in the office as well as at home.

Parallel to this, as we began to notice that Anne and Michael were "parents" everywhere but in therapy – at the firm, at home, and with their ageing parents – they both

decided they needed a place to take better care of themselves and each other. They looked for and bought a beautiful home in the country, something both of them thought they would never be able to afford, as neither of their original families had managed this. This country home became not only a retreat for them and their son and other family and friends on weekends and holidays, but a place to which each of them could go separately when they needed to. This gave them some relief from the intensity of living and working together, and thereby had a general calming effect.

During this seemingly smooth working through, Michael's anger erupted at me in one session. He told me he wanted to quit therapy as he was finding the whole process too "negative." He felt that he had changed a lot, but that every time Anne got the chance to complain about him, she brought him back in the sessions to where he had been, and then we spent our time on these complaints. Anne then acknowledged that she was annoyed that I had not taken her side more, when I could see how angry Michael became. Here, finally, was some negative transference from each of them – both disappointed that I had not fixed this relationship and their individual conflicts faster and better. I was glad to hear these feelings expressed – and considered this a real step toward ending, i.e. that they were beginning to allow themselves to see me as more real, and certainly more limited, than they had imagined. I also realized that I had felt overwhelmed by the complexity of the issues: the marriage, the business, and the illness. As we talked about their frustration with the therapy, which, of course, they had talked about at home with each other, I resisted the urge to point out how different things were now from when they first came.

This couple needed to discuss their negative feelings to the fullest extent possible; also, it turned out that even though they were coming at it from different angles, they both agreed that the therapy had been a much more difficult and time-consuming process than they had ever imagined.

Leading up to termination, there were many sessions spent on the business and how to make working together less

"It may surprise you to know that, contrary to your experience, you're actually very happily married."

conflicted. In some ways, the firm magnified their personality differences: Anne as the perfect one, Michael as the angry one. Not surprisingly, as with children in a family, these stereotyped perceptions had been communicated to, and accepted by, the rest of the staff. There began an interesting process of changing these perceptions, made easier because Anne and Michael were by then both unambivalently involved in the process and had made it part of their job to notice when someone was reacting to either of them in these extreme ways. Also, they decided in the sessions how to divide up meetings and client files, so that they became more separate at work.

During the working through phase, as interpretations and understanding take hold, all kinds of action plans may be thought up and even instituted, but time and repetition are still needed to ensure there is at least some consolidation. One interesting sidepoint that I have noticed is that often in this phase partners are freed up to allow the expression of their opposite-sex characteristics. Brad's cooking lessons

were mentioned earlier. As well, when Michael was asked by Anne what he wanted for his December birthday, he revealed that he wanted to bake for a day, with his son – cookies and cakes for Christmas. Anne was surprised, and delighted, to hear this. Perhaps this is part of not having to hold on so tightly to extreme ends of a continuum, as the relationship can now bear increasing flexibility without breaking.

Termination can be a complex time for both the couple and the therapist. Here, again, I usually re-read the notes taken in the first few sessions of the treatment. This is helpful in predicting the responses to separation and ending, in noticing change that has occurred as a result of treatment, in avoiding as much as possible the repetition of earlier traumas, and in organizing the therapist's comments. The therapist's familiarity with the history helps the couple to integrate their

"First we had couples therapy, then we had sex."

earlier life with the problems they have had, the work they have done, and with looking ahead to their future lives together.

Termination in couples therapy is an important phase, just as it is in work with individuals. The impetus for it can come from both partners, or from one of them. As in individual treatment, the idea of ending has to be able to be talked about without the fear of being precipitously terminated. In this modality, often it is one partner who has the courage to enquire about how the ending will happen. I then describe how they will begin to notice that they are resolving issues themselves they could not resolve earlier, that there is less fighting, that their sex life has improved, and that they actually look forward to being with their partner. They may also start to feel that the therapy is becoming a "nuisance" and inconvenient, and that there is not much to talk about except to report successes: another criterion I sometimes offer in helping them to decide is to consider whether they would initiate therapy right now, if they were not already here. In most situations, when both partners are ready to end, we set a date together, usually a few months in advance, and work toward that date.

In psychoanalysis and psychoanalytic psychotherapy, criteria for ending include the resolution of the transference, a more equitable relationship with the therapist, the resolution of early conflicts, particularly with parents and siblings, and as Freud said, an increased capacity to love and to work.

In couples therapy, there is some of this and more. The therapist does become more realistically viewed, but that is usually not so difficult as, first, the therapist is more active in this type of work and, second, the focus is on the two individuals. The criterion that is most important with couples is, to state it broadly, "symptom" improvement: that is, the easing of, or resolution of, the presenting problems; a more comprehensive understanding by both partners as to why and how conflicts arose in the relationship; a more realistic perception of *each other*, with, as much as possible, the resolution

of maladaptive partner-to-partner transferences; a greater tolerance for flaws and times of weakness in the other; a better way of communicating to each other; a way of providing a holding environment for the other; ways of meeting a partner's selfobject needs, when appropriate; and a way of empathizing with one's partner so that each individual can, at least at times, feel deeply understood by the other.

"My wife understands me."

Yet another very tall order. However, these are guidelines to which the couples therapist can refer mentally as the therapy evolves and as this phase unfolds. The ideal termination – when everyone feels content that the therapeutic work is "finished," and that the ending is nothing more than a smooth outgrowth of the therapy – is probably about as rare with couples as it is in individual treatment.

As sometimes happens during the termination phase of individual therapy, couples may experience a revival of their

earlier symptoms – for example, problems with sexual expression, old arguments that haven't been fought for a while, or unresolved partner-to-partner transferences. These flare-ups have to be taken at face value, and further working through may be required. Also, interpretations regarding how each individual sees termination – for example, anxiety or feelings of guilt about achieving independence as an adult couple – can be very productive. Couples, like individuals, will reminisce during the ending phase about their thinking when they first came, their expectations of the therapy, and goals that have been met and not met.

As has been mentioned earlier, it often happens that as a couple move into the termination phase, they may spend more time on extra-couple issues, by mutual agreement. Even though subjects such as one partner's work, difficulties with children, or care of parents can be woven into the middle phase of therapy, they seem more prominent in this phase. It is as if before taking their leave, they want to make use of this safe environment to clear up whatever else they can in their lives. This is often a very productive use of time, as both people are present, and the therapy often moves along fairly quickly. Sometimes one partner's problem has been affecting both people and neither have ever had the chance to talk about it or to hear about it in a focussed way.

For example, near the end of our work together, Anne raised the issue that she was frightened to drive (that was news to me), and related it to being hit by a car at age 5. She remembered the clothes she was wearing at the time, but had no affective memory of the incident. She said that as an adult, she always takes taxis, but would like to be able to drive. We spent some time on this, and discovered that Michael was not only not bothered by her phobia but, in fact, found it quite handy as he got the car all the time. This led to a productive interchange about his contribution to the perpetuation of her fear, which she had not known about – and to further exploration of the dynamic of dependence–independence in their relationship. I can't claim that we cured the phobia, but we did give it a different slant. Anne said she was at least able

to consider driving lessons, although she did not feel ready to make the move.

Because there are two individuals, there can sometimes be a discrepancy in desires and motivations for ending. It may happen that one partner wants to, or even is ready to, terminate earlier than the other. In this case, it is always helpful to examine the individual motives for termination. In the case of Diane and Tom (Diane had acted as a surrogate mother for her sister), although Tom was trying to cooperate throughout the treatment, one got the sense that he would rather be on the squash court. About six months into it, when the first crises had been resolved, Diane suggested termination, saying she felt much better about Tom, that he was now easier to live with, and that she thought they could move ahead on their own. My first thought was that Tom had instructed her to say this; it was denied by both. Then I suggested that she was worried about delving more deeply into their problems for fear the relationship might suffer a fatal blow. Both paused on this one; Diane said she didn't think so, but that she just felt ready to end. Tom was certainly ready to stop. So, with some misgivings, I agreed, of course instructing them to call should any difficulties arise. Four sessions later, we shook hands and said goodbye. In the above situation, I persuaded them to stay another month, as I hoped for a better understanding for all of us of what was transpiring. This was not to happen at that time.

Six weeks later I got a call from Diane requesting, nay, begging, to come for individual therapy. She felt she had finally found someone with whom she could talk, and wanted to set up weekly sessions with me – the motive behind the rush to end. This is difficult, and a lot of therapists would not agree with me on this point. I said I was really sorry, because I liked her and felt I could work with her, but I wanted to remain a resource for them as a couple. If we began individual sessions, they would lose this should they need it again. I gave her the name of a colleague I thought she would like, but she did not contact this colleague, as far as I knew.

As I write, I still feel unsure about this – it probably reflected too rigid a boundary on my part.

About five months before Anne and Michael ended, Michael broached the subject of termination, asking how they would know when to leave. My response was that I saw them as having one foot on solid ground and that they were almost ready to put the other foot over. I asked them to talk more about ending. Anne felt they needed more time, and wanted reassurance that they would be the ones to decide. Once the topic has been raised, I encourage couples to make it one of the themes of the ongoing therapy.

Countertransference feelings and fantasies are often painfully evoked during a couple's termination phase. How much of a selfobject has this couple been for the therapist? How much of a holding environment has been provided in *both* directions? What did the couple represent for the therapist, and what does saying goodbye to them mean? Oedipal issues, present throughout most of the work, now rise up in a significant way. Did the therapist get the chance to fix his or her parents? Or to be parented by them? Does the therapist feel reluctant to end because he or she is disappointed in how far the treatment went? Or is the therapist relieved to see these warring people leave and to restore quiet and calm in the office? Unresolved separation issues in the therapist also come to the surface, as they do in the termination of any analytically oriented work. Is the therapist able to let the couple go? The therapist's needs are, consciously or unconsciously, a part of the couple's decision to terminate. We can hold the couple back, lingering over the positive, warm feelings we have established together as a threesome; or we can hurry them along, evacuating the negative or envious emotions they stir up.

When Chantal and Brad began to talk about ending, I thought, "*I will really miss them.*" The beginning of their ending phase was heralded by my asking the question – which seemed to me to be in the air, but not being addressed: does Chantal still need space, and what is the function of the downtown apartment now? I also articulated for them that

Brad did not want to move into the city, and that he was making a very difficult choice by doing so, hoping for a better relationship. Chantal, for her part, was still worried about being "smothered" when they found a house and moved in together. We talked about this for several sessions; our brilliant compromise was starting to sound like a problem for both of them. This needed more discussion. After some time, they agreed to try the compromise and asked to cut back their frequency to once a month.

Three months later: "*Termination – almost. Both reporting things are going well. C. still hanging onto the apartment which B. hates. Taking the reins again, since they are so reluctant to, I asked directly how vulnerable C. feels to another affair. She was very reassuring about this. B. got uncomfortable, but I said I just wanted to check things out – knowing that he must, too. They had set a date together to end, but told me B. had 'chickened out.*'"

As we tried to understand the meaning of the ending for each of them, I also tried to understand the meaning of it for me. That I would miss them has already been said. But I also was worried about letting them go before all the loose ends had been tied up (e.g. the apartment, the new house, Brad feeling even more trusting of Chantal). By forcing myself to listen to them, however, I was able to hear that they wanted to solve some of these issues on their own. Again, this may be a difference with couples therapy: they have each other with whom to continue the work and are keen to try out what they have learned; they don't feel as alone as an individual does at termination. We set a date.

They were both excited to come to their last session. Although Brad was still somewhat wary about ending, he said he really wanted to try it. "Could you phone us in a couple of months to see how we're doing?" he asked me. I said they were welcome to call me at any time. "We'll probably have other issues, maybe not about each other, but about our parents," he said. It was clear to me that he had not only formed a strong attachment to me, but also had "gotten it" – in terms of what therapy is about. Probably

because the ending was hard for all three of us, we decided to have a check-in appointment three months later. Chantal was the one who set it up. This is not typical for me, but on the other hand, I don't refuse it if both partners want to meet once more (and naturally I have the desire to see how they are doing). An expression I sometimes use at termination time, with individuals and with couples, is that if they ever feel the need to do "post-graduate work," they can always come back. This gives them the sense of accomplishment that comes from having graduated, and also leaves the door ajar in a non-pejorative way in case further contact is needed.

In our last few months of work together, Anne and Michael began cutting back their frequency in what seemed like a "reasonable" way, in that their work was extremely busy and time seemed short for them. What was happening, in fact, was that they were no longer sacrificing everything at the office for their therapy sessions; in other words, therapy was less important, less desperate. They also took more holidays together for longer periods of time. As they moved toward thoughts of ending, both began spontaneously to talk about when they first came, what problems were on their minds, and how they had felt about each other. Anne also took the opportunity to say she still wasn't sure the issue of handling the hepatitis C was completely dealt with. This made Michael angry at first; then, he was able to really see how much he disliked talking about it. They decided on a method for broaching the subject: Anne would say: "I feel the need to say something about it now, is this a good time?" Both agreed to this. I noticed that they talked more and more to each other in the sessions, and hardly needed or wanted much from me.

The idea of ending seemed to be in the minds of both partners when they noticed that they did well during their periods of absence from the therapy – either their holidays or mine. When this happened, and it was actually articulated, Anne brought in worries about their son's school where there were classroom size problems, stating they needed to make a decision now as to whether he should switch schools. They

talked about this in a seemingly productive way, and in the next session she talked about needing to persuade her parents to sell their home as it was too big for them. Again Michael readily joined in – maybe relieved that the complaints had nothing to do with him. By this time I was thinking: either Anne is not ready to end, or she feels she'll never have Michael's attention again in this way, and needs to discuss these issues with him – or both. I mentioned these observations to them.

Anne agreed on both counts. We had the chance to discuss her fears about ending – that Michael would revert to his angry self, that she would feel terribly alone, and that they wouldn't be able to talk outside the sessions the way they could when we were together. I also mentioned that her anxiety about Michael possibly becoming ill again might be getting displaced onto the subject of his anger – which had, for the most part, come under control. We talked again about Michael's medical situation and prognosis. Michael then said reassuringly to Anne: "You've seen how I don't get as angry anymore. And we can talk about so many things, even my illness – I'll try to keep this up as much as I can, because I want it, too. It's been so much better for me over the last while. I really feel happy to be married to you." We all beamed.

The process of termination was now rolling: they made an official cutback in frequency, first to every second week, then to once per month. During this time, Anne discovered a lump in her left breast. I was tempted to try an interpretation, linking the lump to her anxiety about our termination, hoping she'd say: "You're right!" and then the lump would disappear – but even my grandiosity could not be stretched that far. The termination process was now derailed; I tried to maintain the holding environment in which they had conquered so many fears. We waited together for the results of various tests. When the results of the biopsy came back resoundingly negative, we breathed a collective sigh of relief. Michael had been very supportive during this period, which had helped Anne to feel she could depend on him again, a feeling she had not had for many years.

In our last session, they brought in photographs of their families – their parents, their son, and their brother and sisters. I was interested to "meet" these people we had talked so much about, and to hear further discussion of them. Was I now a part of that family? Probably – in the strange way we therapists tend to be – present in our patients' psychic families, if not in their "real" ones.

A common response of therapists to ending, according to Firestein (1978), is anxiety about the results of the work – whether it has been sufficiently thoroughgoing. With Anne and Michael, I had the added countertransference burden of trying to evaluate the experience related to the illness and dying that I had so recently endured with my own analyst. I was aware of a desire to continue to help them, when they no longer needed my help (at least not at that time). As Shane and Shane (1984) have indicated, the quality and resolution of the separation and mourning process by the therapist at termination time depend on their previous experience with separation from parents, *and* in their own therapy; their ability to master their own therapeutic ambition; and their finely-tuned self-analysing functions. Self-analysis in this situation (which I did in the form of journaling) was extremely useful.

It seems to me that what is mourned and relinquished for the couple in ending this work is not so much the therapist, as the holding environment that was created by all three participants – which allowed them to talk, confidentially, to another person and to each other about private and difficult matters. This threesome will never be the same again. The hope, of course, is that the feeling and experience have been internalized sufficiently and can be carried on without the therapist; but the room, the time, the space will necessarily be different. If the therapist has allowed for the door to always be open for couples who may want to return, they will usually find that they do not come back, and that if they do, the issues are new and very different. This allows for a great deal of optimism about the couple's ability to help each other to internalize and remember what they have worked so hard to learn about each other.

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.
(T.S. Eliot, "Little Gidding")