ASPECTS OF ABRUPT TERMINATION: THOUGHTS ON LOSING MY MOST CHRONIC PATIENT

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You cannot face it steadily, but this thing is sure,
That time is no healer: the patient is no longer here.
When the train starts, and the passengers are settled
To fruit, periodicals and business letters
(And those who saw them off have left the platform)
Their faces relax from grief into relief,
To the sleepy rhythm of a hundred hours.

T. S. Eliot, *Four Quartets* The Dry Salvages, III (p. 134).

The chronically psychotic individual, whose primitive and brittle defenses are coupled with chronic anxiety, including prolonged spans of terror, calls into question our abilities and goals as analysts. We attempt to help the patient build a more secure defensive structure, while modifying the brutal attacks of the primitive superego. We hope that the patient will gain increasing self-awareness and that the process of self-exploration will become an autonomous and self-sustaining function. However, in reviewing our work with *any* patient, we often see that only a modification and not a transformation has occurred. The customary defenses remain a life-long part of the patient's reactive pattern, still available in times of severe stress. Freud (1937) said, "Of late years . . . , a relatively small number of severe cases of illness remained with me for continuous treatment, interrupted, however, by longer or shorter intervals. With them, the therapeutic aim was no longer the same. There was no question of shortening the treatment . . . ."

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The process of termination, with its attendant stresses, activates regressive forces. Our work may seem to crumble as we are caught up with our patient in a mutual and simultaneous regressive pull. In mourning the loss of our patient, we fear that our efforts may not be as fruitful as we had previously considered them to be. When the work is terminated *abruptly*, and when the patient has been chronically devastated by severe psychosis, the effect of termination may then seem to be total devastation of the long therapeutic effort. The regressive pull on the therapist is severe, bringing forth his or her own primitive defenses.

Fran and I had been meeting four times a week during the seven years of her hospitalization at Chestnut Lodge. Our work was terminated abruptly, with only two weeks' warning. (For those readers who are not acquainted with Chestnut Lodge, I refer you to Ping-Nie Pao (1979), and to John Cameron's description of the structure and philosophy of the Lodge (1966), and would add that Dr. Cameron served as interim therapist for Fran when I was away, and supervised the work for about one year.) I had known that her mother's financial situation was worsening, but did not know she had placed Fran's name on the waiting list of a supervised boarding house back home. When Fran was given the opportunity to live there, the hospital was notified. Fran's administrative psychiatrist informed each of us separately. Fran arrived for her next session, announcing gleefully, "I'll be so happy to be finally rid of you. I can't *begin* to tell you how happy I'll feel. You've been ruining my life ever since I was *born*. Now maybe I can get a job and get married like I was supposed to in the first place." I said she had taught me a great deal, and I was sorry we could not continue working together, then added, spitefully, "You can't say you never worked. You're working hard at destroying the relationship we've built together." She said she was worried I might follow her across the country as a magical hallucinated figure who would torment her at night, and take over leadership from Jesus, over the male aides and former boyfriends who kept pursuing and harassing her by magic. She clearly had experienced me as such an hallucination during some of our meetings, the most memorable occasion being one in which we were walking together from her unit to my office, when she looked awestruck and said "You're *glowing* so brightly I can hardly look at you. How do you *do* that?" I had felt transformed into a portrayal of the Messiah. Yet she feared I would torment her because I was so jealous of her, my having "no family *about* you, nowhere to go at night—you just live in that *desk* drawer over there. You don't have a job and never can get one." I was her unemployed self which would

stay safely in my desk drawer, perhaps with her chart, thereby freeing her employable self. I said, "My biggest regret is that I haven't been able to help you rely less on 'projection' when the going gets rough, seeing in others the problems you are grappling with, when those problems seem impossible to solve." I was struck by the clumsiness of my speech, and the alienating complexity of the sentence structure, and felt guilty that I was not more nurturing. This intense concern with nurturing her was rather specific to her, and was my strongest evidence that she has created her mother in me. She answered, "I'm sure you had this same job here in a former life. Just promise me that you won't work here in your next life, too. You don't know how to do it. You don't know how to be a friend, to go out shopping or to do dinner with someone. What good *are* you?" I said that if I had a choice about what to do in my next life, I probably would come back to work at Chestnut Lodge. I said I felt sure I'd remain interested in her, but just as I did not initiate outings, I probably wouldn't contact her, but would still remember and think of her. She at first was enthusiastic about accepting a trinket as a keepsake, but then said she wanted no part of me, since it would make it more likely that I would magically pursue her and torment her.

My own analyst had comforted me when, in the evaluation phase, after I had listed reasons why I thought he might feel I was not strong enough to be analyzed, he said "You seem to think I'm a quitter." One of my sessions followed that of a chronically deeply psychotic woman who had been and was still at that time an in-patient at Chestnut Lodge for over 20 years, and had been his patient for that entire time. I had not known this at the time, and had not yet applied for a job at the Lodge. I would arrive, and sit in the tiny waiting room, would leaf through a *New Yorker* magazine, and dread the patient's emergence from the consultation room. She would close the first of the double doors and stand transfixed, staring at me. I'd say something like "Hello," and would perhaps try to smile. After a long interval, she would walk across the waiting room and would finally leave. Some weeks later, after I'd made the heroic transition to the couch, I was again sitting in the waiting area, bracing myself against the patient's emergence. Instead of standing in the first doorway, she walked across the waiting room without first staring at me. Prematurely, I breathed a sigh of relief. But at the door to the hallway, she turned, paused, stared, and said quietly but with the intensity of an assault, "He's shrinking you to *death* in there. *Why?!*" and then left without awaiting a reply. I then experienced the feeling that the walls were actually shrinking in on me, like the giant trash compactor in the movie "Star

Wars,'' and began pacing, then almost rushed to get a drink of water from the hallway water cooler.

I include this vignette because when I first met Fran, she reminded me of this patient of my analyst. She was mine, and perhaps we would be at it for a quarter of a century or as long as we both would live, unless it turned out that I was a quitter. Fran was the third patient assigned to me upon my arrival at the Lodge. On arrival she had been disheveled and appeared much older than her 31 years. Her curly brown hair was matted and her clothes reeked of body odor. She was extremely soft spoken and talked slowly, muffling her words. ''The portions of food are too small. And they poison it.'' I said we would be meeting four times a week, saying that she would have two doctors here, an administrative doctor, whom she had already met, and a therapist, myself, who would be working with her toward increasing self-understanding. She answered ''All right,'' conveying ''if you say so. But it's futile.''

As was then the routine at the Lodge, she was taken off medication immediately. She had undergone seven prolonged hospitalizations during the previous 10 years. Her most recent psychiatrist had worked with her for five years and informed us that ''during our time together, she developed *no* transference feelings towards me. In our session following her father's death, she didn't even mention it, so finally I had to being the subject up. She seemed to have no reaction to it.'' He had treated her with a variety of medications, as had her previous therapist. On arrival at the Lodge, she had been receiving daily Navane 40 mg, Artane 6 mg, Tofranil 75 mg, Lithium 900mg, Phenergan 75 mg, Dalmane 60 mg, and Feosol and birth control pills. There was clear evidence of early tardive dyskinesia.

These medications had calmed her and helped her to maintain an extremely fragile organization. Without them, she became combative, as she had been toward her mother, who was then in her early sixties. Combativeness had been the feature precipitating her most recent hospitalization and then her transfer to the Lodge. She had attacked her mother violently when the latter forbade her going to the city where a man who had dated her 15 years previously was then living. Once off the medication, she let us know she was convinced that staff members were receiving telephone calls and letters from the man but were blocking her receipt of them. She then became convinced he was being tortured, operated upon, mutilated, and almost killed. She *had* to save him. She became so agitated that her administrator and I concurred that placing her in cold wet sheet pack routinely for her therapy sessions would externally secure her, calm her, and facilitate her working with me.

Her speech was so fragmented that I could grasp only occasional meaning. She raged at me for tormenting her. Gradually, she revealed her fear that she had been sent here to be cremated, and that this might be done while she was still alive. She refused to eat, and required tube feeding for three weeks. We established an early working alliance when she revealed her panic over the prospect of eating a potentially poisoned hamburger at a unit barbecue. Following that session, she did share in the food at that event, was not thereby poisoned, and was able to eat, although she was not able to tell the unit staff of her dread. She told me that the nights were even worse than the days, because the staff was there to keep the patients alive. They ''have to breathe for us. If they stop for a minute, we'll die. We turn into bottles on a shelf that could fall off and smash.'' When she confided this in me, I felt encouraged that she was beginning to trust me. Gradually, she conveyed to me that she was sure I came and went by magic, that I didn't need a car or a home since I was not limited to Earth.

Six months later, she told me with startling clarity about an aide who had actually kissed her while she was in pack, and had contributed to her panic. Previously she had alluded to this, but not in a way that I could understand, and thus, when she did tell me clearly, I was left feeling guilty and inadequate, having missed a myriad of clues. I asked her permission to talk with her administrator; she agreed. Other unprofessional behavior on the part of the aide had come to light. He was fired, but remained entrenched in Fran's hallucinated world. He had given her gentle attention as well, and she thought they might marry. As a real and then hallucinated figure, he competed for her with her hallucinated boyfriend.

I felt optimistic as she began describing past events. However, it was not ''me,'' Dr. Silver, whom she was informing, but it was me as Lucy, her girlfriend when she was 10 to 12 years old, and who had moved away. ''Don't you remember the gully where the clay was that we'd play with? Or the rope swing? And the time when you were stuck out there and afraid to let go of the rope, and I waded out and pulled the rope back in? And don't you remember Ginny, who got polio, and her mother killed her because she had nothing to live for, when she was in the iron lung?'' I asked how she knew that, and she answered with a chilling calmness, ''My mother told me about it.'' She could not have conveyed more clearly her desire to be a rescuer of her friend, nor her fear-wish that her own mother or I as a possible

maternal figure would put her out of her misery. But, more centrally, she conveyed her awareness of a mother as capable of murdering a defective offspring.

She then told me about her first psychiatric hospitalization when she was eight years old. A cousin had insulted her, saying her legs were fat. She then had gone to school keeping her raincoat wrapped around her legs to hide them. Then, her father, who had become increasingly irritable, worrying that he might lose his job if the company went bankrupt, reprimanded her for some bit of poor table manners, saying, "I can't stand eating with you. You're a disgrace. I'm leaving." He then did leave on a business trip. Fran stopped eating, and her weight went from 75 to 51 pounds. Her mother and pediatrician became frantic. The latter threatened her with an nasogastric tube, then transferred her to a teaching hospital far from home. Fran recalled climbing over the crib sides, sneaking out to a balcony where she fed her meals to the birds, terrified that if the nurses caught her at this, she would be put to death. I think this was the first time she had revealed that she recalled this hospitalization, and speculate that this event itself was a remembrance through reenactment of profound disruption of the pleasure of taking nourishment, occurring in infancy. The official hospital records had been destroyed, but perhaps they were recreated in the reliving of the events, during her unmedicated regression.

Her mother's recollection of Fran's infancy does not confirm my hypothesis of disruption of maternal–infant symbiosis. She describes a normal pregnancy and delivery, satisfactory breast feeding for six months, and uneventful weaning, the patient not being colicky as had been her only sibling, her sister who was older by 5 years. She reported normal developmental milestones, uneventful toilet training at 1½ to 2 years of age, and an easy transition to kindergarten at 4½ years. On Fran's return home from the teaching hospital, as her mother described it, she and Fran took walks to an ice cream parlor, where they would share milk shakes and ice cream sodas. "The doctors told me not to expect much from her, and I kow-towed."

Some weeks later, Fran told me about her attempt to attend nursing school. She dropped out during a course in nutrition, finding those lectures deeply upsetting: "I had to leave, or there would have been *nothing* safe to eat." Harry Stack Sullivan (1953) said, "Very intense anxiety precipitated by a sudden, intense, negative emotional reaction on the part of the significant environment has more than a little in common with a blow on the head. It tends to erase any possibility of elaborating the exact circumstances of its occurrence, and about the most the person can remember in retrospect is a somewhat fenestrated account of the event in the immediate neighborhood." We were recalling these distorted events, with the accompanying blunting of affect and the defense of displacement which made tolerable this recalling.

A few months later, I was found to have a life-threatening illness, underwent debilitating treatments, and was away from work for two months. Fran sent me a moving letter in which she wondered if her favorite nurse had delivered the vanilla milk shake which Fran had magically commanded her to bring to me, along with rhododendrons and nasturtiums from Hawaii (Silver, 1982). This was like a miracle for me, as I was at that time, while surrounded by flowers, chronically nauseated, and felt I would die if I did not eat. It had not occurred to me nor to those caring for me to suggest a vanilla milk shake, but it was probably the *only* sustenance I could have managed. It was only upon writing this paper that I finally realized that she "knew" I needed the milk shake because this was the substance which had quelled her psychotic nausea when she was eight years old.

On my return, Fran was wildly combative. She said "I don't think there's enough apple pie to last a year. Your legs are so *thin*!" For her, it wasn't Mom's apple pie, but Mom is apple pie. There was shared confusion among the staff as to whether Fran had been clearly informed about my illness. In retrospect, it was obvious that she had been told by the administrator and head nurse together, and that Fran had then sent me the moving get well letter. But then everyone, myself included, joined in an effort to obliterate reality. The nurse whom Fran had referred to in that letter, as the one she imagined would bring me rhododendrons and nasturtiums from Hawaii, was injured by Fran in the process of getting her into pack. There was a consensus two months later that Fran had to be placed on medication.

The work with Fran changed in character. Fran seemed calmer and more organized, but simultaneously more distant. Her intense conflict over whether or not to incorporate me was obliterated by her ingesting a prescribed pill. Antipsychotic medications, which were to include Haldol, then thorazine, Trilafon, Stelazine, and Moban calmed her and helped her become better organized. The dosages were always far below her level of medication on admission. She became more productive and began demanding a paying job, resumed typing, and worked as a cashier at the hospital snack bar. Outpatiency seemed a conceivable goal. I had been taperecording the sessions for about four years, and she suggested she type one so that we could read and study it together. Inadvertently, I gave her a tape that had both a recent and a very much earlier session on it. After typing the recent one, she

attempted the other, but said she couldn't do it. It made no sense. She abandoned the typing project. She then said she hoped I would never play those tapes for anyone since they were embarrassing, not to *her* but to *me*. She was thus illustrating both her wisdom and her reliance on projection.

She wrote an essay in which she developed the idea that the government should find jobs for everyone and should insure that no one be fired. She was perhaps continuing to keep her father alive, with his profound anxiety over losing his job, and, while it is perhaps obvious to the reader, but was not in either her or my awareness at the time, she may have been trying to create a governmental safety net for me should I be fired from the Lodge staff. Next, she attempted a volunteer job at a blood donor center, but was unable to do this, fearing that if she made a mistake, someone would die.

We began holding sessions in my office rather than on the unit. She nagged at me to go to the dining room for tea or to restaurants in town for luncheon outings. As a compromise, I began sharing tea with her. Initially, she was extremely apprehensive. The ritual grew to include instant soups of various kinds. At first, any choice overwhelmed her, but over the months, she mastered this. It became an instant mental status examination, borne out by the session itself: no interest in tea or soup forecast paranoia of almost panic intensity. The desire to have ordinary tea indicated that she could barely tolerate me, and was experiencing me as having abandoned her. Mandarin orange tea was linked with her trusting me while massively distrusting the unit staff, while sessions beginning with her requesting instant cream of chicken soup were invariably warm, collaborative, and informative, usually including linkages of past and present.

Throughout this phase, she remained stubbornly grandiose, telling me that everyone on the unit depended on her to live. That is, if she did not remain sitting for hours at a time in the day room, the staff and patients would cease to be able to talk with each other or even to move. Yet she was panicky because she experienced them as disappearing by magic. She would be doing needlepoint, sitting across from another patient. She would become absorbed in her work, and look up to find the other patient was no longer sitting there. Rather than assume she had not noticed the other's departure, she saw this as evidence that they could come and go by magic. Similarly, any misplaced item had been stolen or mischievously moved by one of her hallucinated male aides. She was convinced that I had access to life on Mars or somewhere, that I could move people there, give them new personalities, and return them to Earth to live as movie or television stars. I could put words in their mouths so they could appear intelligent; or maybe they were speaking about their previous lives. Why was I refusing to do this for her?

During this phase, I felt I was coming to share in an experience of a life of futility. We kept feeling hopeful about one venture after another, and our hopes would be dashed. She would then blame me or "them," while never entertaining the notion that she might have performed some task inadequately but might master it through diligence. I felt I was trying to force-feed a neurotic world view, as if this would help her outgrow her psychotic organization. I felt incapable of working as her analytic therapist, and felt I needed a magical transformation.

As I reviewed this phase, it became clear that she had developed a delusional system to allay her massive anxiety over my possible death. (This perhaps was a reenactment of her attempt to deal with her father's absence when she was 8 years old.) I had similarly regressed into a driven work mode as a distraction from my own massive anxiety. I then consistently stopped "joining" her in enthusiasm over the various job possibilities, and returned to listening and analyzing. I was rewarded by her telling me about her experience of her father, and her chronic frustration in relating to him. For example, one night, a decade previously, she had heard his loud breathing as he slept, and was convinced he had been transformed into a monstrous rapist. This event occurred soon after she had undergone an abortion. She had returned home, and as had been the pattern, she was unable to find employment, and her father had been nagging her. That night, she had stood on her bed for hours, fearing that if he came into her room, she would have to kill him in self-defense. It seemed that this was the first time she had told anyone about these events which had led to one of her many hospitalizations. She revealed that she had never believed that five years later he actually had died, but felt sure that he was transformed into other people and often returned to live with his wife. As she talked about him, she said that for the first time, she realized that he was dead. For the next few years, she no longer needed the reincarnation delusion, since she was no longer relying so heavily on denial. I felt transformed from a totally incompetent and destructive therapist, who had fostered the development of a delusional system, to a magnificently powerful one, able to bring the grim reality of a parent's death "home" to her.

A trial at outpatiency ended in failure. The isolation of a rented room led to her resorting again to grandiose delusions. The more in need of help she became, the more she felt herself to be responsible

for the well-being of others. She could not solve the complexities of the Middle East crisis, nor balance the federal budget, and so she came back to the hospital. After another two years, she succeeded in becoming an outpatient, sharing a house with two other Lodge patients, and then, accompanied by her social worker, successfully managed a home visit. All previous attempts at planning a home visit had led to regression in which she would insist on looking for her lost boyfriend. This time, however, she shared Christmas with her mother and her older sister's marital family, and came back with detailed reports about them, including saying clearly that she was sad that she had not been able to raise a family, adding gratifyingly, "It seems to be a very difficult thing to do, keeping everyone straight on the right track. I don't know how my sister does it."

She asked to reread the essay she had written four years earlier:

> People need credit in the world for job that they might have in the working world and also in the entertainment world in which society is engaged.
>
> To get more credit for the job that you may have, one has to be dedicated to what he does and not feel so obligated to the machine he works. To get a job he should be able to get one by being told that he has one at the employment agency. At the employment agency, they should be able to match the applicants to the jobs there, and then when you arrive at the employment agency, they should be able to tell you what job you got. Thus your employer should know before you come what kind of requirements your seeking. Your type of work can be handled like civil service jobs and you being placed in the job can be referred to as a dream machine. People can get what their after by decreasing the amount of competition which decreases your level of anxiety. Another words a person's works would be handled by a government employment agency. Meetings can work into job placement.
>
> Each coherent actor in the entertainment world should be instead responsible for the audience's reaction to the show. The actors role should be worked over and finally worked out. The government producer of the show should be able to criticize the talent of the show instead of blaming the audience for parts that would give a negative feeling. The gold rule should be a part of common sense for actors v.s. audience. Thus, working out the dreams that the audience might have will increase better working conditions.

Upon rereading the original handwritten essay, she commented, "All the logic has been left out!" I had felt pleased, experiencing this as her realizing that she herself had problems with logical reasoning, and that her difficulty had been greater in the past than at present.

The next day, she fired me. I was perplexed. She refused to discuss it, saying "It's ridiculous." She had given up on me. The next day, we met on the grounds. She said "I can't trust someone who would

change my essay around like that, who would purposely take the logic out." I told her I wouldn't be able to trust a person who would do such a thing either, and that I didn't tamper with her essay. She said "All right, Ann," and returned to meeting with me. This proved to be a rehearsal of our stopping our work together. In retrospect, it seems possible that her mother had indicated to her that the money was running out. Fran had dealt with this news much as she had done with the news of my illness, obliterating conscious awareness of it, and then making herself responsible for the event. Two months later, we were informed she would have to leave.

DISCUSSION OF CASE PRESENTATION

This patient came to the Lodge having suffered a lifetime of disappointment. Outdone academically, socially, and financially by her older sister and her contemporaries, she experienced herself as a burden on both her parents. The intensity of her despair was reflected in her life-threatening starvation strike at age 7, whose rationale she was unable to convey to her mother. She considered herself to be so paralyzed as to need euthanasia, as intimated in her distortion of the death of a playmate when she was 10 years old. As the tasks of each developmental level were not mastered, the burdens of failure and lost opportunity bore down on her, to the point that reality-based hopefulness was impossible. Turning first to conventional religion, through attendance at Bible classes, and then to a personally created religion which was reified by her chronic hallucinatory experiences, she became convinced that reincarnation was possible, and that one could be reincarnated without having to die. She became convinced that everyone who was not overwhelmed by psychotic anxiety had access to this continual transformation, and that God or Jesus told them things to say in conversations. Thus, she felt chronically deprived, and had attempted to master this situation by creating an explanation which was at once comforting and yet perpetuated her situation.

My role at first was to be there with her, to be noticed by her as a person. This entailed many sessions in which she was autistically absorbed, staring blankly, picking her nose, or seemingly studying a *TV Guide* which was a few months old and which she held upside down. This behavior characterized her heavily medicated state of somnambulism, in which she had existed for about a decade.

Once we withdrew medication, she was in obvious intense distress of almost panic proportions. She spoke rapidly in a primary process

mode, and was almost totally unintelligible. But as the months passed, she became more coherent, clearly noticed me, came to find the sessions to be important to her, and began adjusting her daily routine around them. She then confided in me, telling me of the unprofessional behavior of the aide, and then reviewed aspects of her past with me. I felt that together we were proving that no matter how grim the clinical picture, and no matter how hopeless the prognosis, that we were achieving something monumental. The patient's previous therapist had found "no evidence of transference" and yet, I was clearly her childhood best friend, and at other times I was her big sister, and also her parents. I had connections with Jesus and Fromm-Reichmann (1950, 1959), although Fran did not seem to "know" of her. I felt profoundly connected with my patient, in this phase of ambivalent symbiosis, as described by Searles (1965).

> This relatedness, with its lack of felt ego-boundaries between the two participants, at times involves the kind of deep contentment, the kind of felt communion that needs no words, which characterizes a loving relatedness between mother and infant. But at other times it involves the therapist's feeling unable to experience himself as differentiated from the pathology-ridden personality of the patient. He feels helplessly caught in the patient's deep ambivalence. He feels at one with the patient's hatred and despair and thwarted love, and at times he cannot differentiate between his own subjectively harmful effect upon the patient, and the illness with which the patient was afflicted when he, the therapist, first undertook to help him. Thus, at these anxiety-ridden moments in the symbiotic phase, the therapist feels his own personality to be invaded by the patient's pathology, and feels his identity severely threatened, whereas in the more contented moments, part of the contentment resides in both participants enjoying a freedom from any concern with identity. (p. 339)

The next phase was characterized by a mutual effort to save each other and to be saved ourselves. My own life-threatening illness, may have promoted this phase, since we each struggled to grasp and yet deny the grim implications, each in our own way (Silver, 1982). She attempted a religious conversion of me, as she portrayed the vividness of the hallucinated drama which substituted for wakeful imaginative play or for dreams. "I" became a character in these scenes of harassment, and sometimes led the crowd of bullies who kept her nights from being simply lonely. Simultaneously, I sometimes found myself preaching a neurotic view, which then intensified my own guilt-laden feeling of inadequacy regarding my own professional capability.

We entered a phase of delusional hopefulness, buoyed up by a shared perception of collaboration. While I did not go on outings with her, we did share tea or soup. Here, I am sure many would criticize my technique, pointing out that I was *re-enacting* a pattern she had

shared with her mother, rather than simply and clearly being her analyst. I was, in this way, unprofessional, much as was the male aide was who had kissed her, and rekindled the patient's feared wish of sexual union with her father. She was sure I had been with her all her life, and that I was the cause of all her pleasures and defeats. The hours were an adventure which more often than not we each seemed to anticipate with pleasure. It was as if we were succeeding.

Disillusionment, blaming, re-establishment of collaboration, followed by repetition of this cycle characterized the penultimate phase. Here I had, against my best intentions, become her mother, and had lived out an enactment of their shared frustration. That is, Fran had formed an intense attachment to me as a maternal object, and I had reacted countertransferentially much as had her mother. Often, I was aware of feeling that I had to "get her to succeed" so that I could be rid of her. Simultaneously, she wanted to succeed so that she could be rid of me.

Once I became clearly aware of this pattern, I was able to diminish the intensity of my participation in the enactments, and we entered an exciting phase of construction of her biography, with patterns of causality arrived at on occasion. It was at that point, when I felt we could have gone on building forever, that she left.

At the time of this writing, she has been living in the boarding house for 18 months, without causing disturbances, without wandering off, or going in search of her old boyfriend, or getting into raging disputes with her mother or authority figures at the boarding house. In addition, she has kept an image of me in mind, as evidenced by her sending me a ceramic cup on which she painted a pattern of interlocking triangles. There was no note included with the gift. While she had wanted no part of me, as represented by her refusal to accept a trinket from my office, fearing I would thereby track her down and haunt her, she was able to send me an apt symbol of our work, a cup. She has stayed in touch with one of the patients who shared the outpatiency house with her, and invited this woman to visit for two weeks to celebrate Fran's 39th birthday. She has returned to her former therapist.

DISCUSSION OF TERMINATIONS

I would like to focus my remarks on the experience of termination, the patient's response to it, my counterresponse, and then to relate the termination response to her initial reaction to me. This was a forced severance after seven years of work, and one in which there was no

opportunity to consider the possibility of regularly scheduled follow-up appointments, as the patient was moving across the continent. Neither of us consciously had chosen to end our work in this way, and so we were both confronted with an experience of impotence, as we succumbed to external and our own unconscious forces. Searles (1984 a,b) noted, on reading an early draft of this paper, that Fran and I, as is generally the case in seemingly externally caused terminations, probably contributed unconsciously to the termination as we struggled to get free of each other, and to kill our relationship. This echoed, he noted, what probably seemed as complete a parting from her mother on her hospitalization at age eight and again when she was admitted to the Lodge. Yet paradoxically, this was just as we seemed to be less of a burden to each other. This sort of termination has, to my knowledge, received scant attention in the psychoanalytic literature (Firestein, 1978; Lichtenberg, 1982).

Winnicott (1971) stated, "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible, then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play" (p. 38). We had often played well together. But she was forced to leave, and was gathering up her things, kicking down the building-block structures we'd made together. The ambient feeling was, as Fairbairn (1952) articulated it, a sense of futility. "It is only when a massive repression of affect occurs that the individual becomes unduly detached and experiences a pronounced sense of futility" (p. 131).

I felt compelled, during those final weeks and the ones that followed, to write a paper about our time together. Perhaps I experienced a need to grieve for both of us, despairing of her ability to do her share of this work. Perhaps I needed to reassure myself that I did "in fact" have a job. As I became preoccupied with the plans to write, I did seem to withdraw from my family and seemed to be living in my desk drawer. I imagined distributing the paper to the members of Dr. Robert A. Cohen's study group on chronicity in which I participate. Some of my colleagues might comment that this still unwritten paper was merely self-serving. I would respond that it probably was an effort at "self" preservation, and then would add that our own struggle to preserve our selves as we work with chronically psychotic people is perhaps our only therapeutic tool. I imagined startling them with my wisdom as I had startled myself with my inadequacy when I raged quietly and impotently at my departing patient.

The process of termination, like that of dying, is one which has received far less attention than has the process of beginning analytic work, or the process of being born. Humans tend to turn away from the process of turning away. I suspect this demonstrates that we are more basically animal than we would choose to admit. That is, we are like other herd or social creatures, whose safety is endangered by the sick and weak. Perhaps this drive motivates mothers to enforce sternly the principle of not staring at the maimed or diseased, as they say to their children, projecting their own uneasiness, "They feel bad if you stare at them." I believe that both mother and child then turn away from awareness of the impulse to destroy or abandon the weak members of the group or herd. Predators nip at the heels of the group which must turn away from the sick, whose presence endangers the healthy. This basic instinctual self-preservatory response of abandonment, with its accompanying feeling of guilt in "us," the healthier, with our memberships in our professional community, seems to me to demonstrate itself in the relative paucity of literature attempting to understand the process of letting go.

In the case presented here, there was no opportunity to reach a consensus, and little opportunity to work toward achieving one. We were forced to part. When she had been forced to part from her mother, on admission to the Lodge seven years earlier, Fran had the dread notion that she had been sent to the hospital to be cremated, perhaps alive. As I read the quotation from *Four Quartets,* "When the train starts . . .," I imagined my patient being forced into a cattle car, the victim of a World War II extermination. This would seem to me to reflect a perverse love for her, as if to say "If I can't have her, nobody can."

My patient's initial response to the news that she was to be moved to a boarding house was one of massive devaluation of me, not merely to the level of my being worthless to her, but to seeing me as suddenly extremely dangerous. She then could identify her mother as rescuer, and she could experience herself as actively choosing to leave me as fast as possible, as if she had suddenly realized that I was destructive. My initial experience of her reaction was that our work was being erased from a blackboard or a computer memory bank, as if it were gone forever. Perhaps I needed to write a paper to have tangible proof that we had actually done work together.

This patient's illness throughout her life, centered around difficulties of orality. She had been unable to establish a functional oral personality in which "the central dynamic is understood to be the establishment of a receptive orientation toward the work and others, in which

magical properties are attributed to something outside the self—food, love, sex, ideas; life becomes organized around the longing to receive and ingest the magical substance'' (Greenberg and Mitchell). She starved herself severely at age eight, withdrew from nursing school in a panic that all foods would soon become poison, and experienced a similar panic on arrival at the Lodge. Her previous psychiatrists, who had medicated her at the outset of their work with her, had thereby shifted the focus of concern over the safety or danger of ingesting from themselves to the more obvious and readily agreed-upon subject of the medication. One could readily discuss the relative merits and dangers of the substances in the pills or capsules, thus keeping out of awareness that the patient was continuing to view the therapist quite concretely as a poisonous substance not to be incorporated. She took the pills in order to appease a dangerous enemy whom she did not want to arouse.

In her unmedicated state, I became the substitute for the medication, and she had the opportunity to decide whether to ingest me or not. She did so cautiously, as if nibbling at a potentially poisonous mushroom. But she did take me in. I became a being inside her mental system, in part an internalized object, as described by Klein (1975), Kernberg (1976), Searles (1979), Schafer (1968, 1976), Volkan (1976), Joseph (1982), Ogden (1982), and others, but on a more primitive level, I was not an internalized but an ingested object, as if I came in through the opening of the mouth, and with the sudden threat of cessation of our work, the still primitive ''me'' which still existed as an undigested, potentially menacing substance, was then ejected via her mouth, by the defensive action akin to a psychologic emesis, the spewing forth of descriptions of me as dangerous, worthless, and disgusting.

Even though I certainly ''knew better,'' I could not restrain myself from retaliatory, condemning remarks, as if to blame her for the destruction of our relationship. Just as vomitus causes an instinctive reaction of nausea in those who see or smell the substance (and here, too, I think this is probably a primitive reflex of self-preservation: if one individual in a herd has ingested a toxic substance, the sooner the stomachs of the others are also emptied, the greater the chances of survival of the others), I vomited up my primitive introject of her, as I condemned her for continuing to ''use projection when the going gets rough.''

Ogden (1979) eloquently defined projective identification as ''a set of fantasies and object relations that can be schematically conceptualized as occurring in three phases: first, the fantasy of ridding oneself of an unwanted part of oneself and of putting that part into another person in a controlling way; then the induction of feelings in the recipient that are congruent with the projective fantasy by means of an interpersonal interaction; and finally, the processing of the projection by the recipient, followed by the re-internalization by the projector of the 'metabolized projection'.'' Fran had struggled throughout her life to cure her parents' senses of joblessness or near-joblessness (Searles, 1984a), and seemed to grapple with this *by* remaining jobless. Thus, her own job was to be her unemployed parents so that they might thereby feel themselves to be part of the working world. The part of her that was striving for recovery projected this joblessness into me, in the hope that I could digest it emotionally and cognitively. When I realized she was leaving me, I felt a strong compulsion to write about our work together, that is, I felt I had a job to do, to metabolize the projection, and *then* to write an essay about the process. As I completed this phase, I realized that my compulsion revealed a *shared* delusion of magic, and I had felt that somehow my written words would transform her, if not in this life, then in her next one. I then came to see that this paper and her essay, quoted earlier, seemed to form a complementary set, each seeming to seek the existence of a larger governing body that would provide a secure and eternal structure, minimizing anxiety. Each, thereby, is quasi-religious.

Searles (1984a) focused his comments on the importance of the mutual remembering of important people, events, and the nonhuman environment in the pasts of both the patient and therapist. He emphasized that if this does not occur in a mutual way, the work is incomplete. Relevant here is a comment of his concerning the treatment of borderline patients: ''Effective therapy with these patients involves the therapist's own deeper working through of his own losses'' (Searles, 1984b). Each time this patient said, when she was convinced I was her childhood best friend, ''Don't you remember when . . .,'' I cast her description in the setting of backyards or vacant lots of my home town, and found myself to be 10 years old again, and my parents then became the age I am now, only to find an instant later, that they were both gone. Fran's and my loss of each other, Searles emphasized, activated in each of us our previous experiences of sudden loss of significant people. Searles commented that there seemed to be a recurrent hope in me and in her, for grandiose omnipotence, and to have *both* the full loving symbiosis *and* personal unshared omnipotence, which was recurringly nonfulfillable. He noted that an unrecognized element was the patient's rage at me at allowing her to individuate.

Included in this was my rage for having individuated as well. Each of us then unconsciously contributed to Fran's mother's decision to terminate our relationship, he noted.

It has often been noted that our patients' families seem to rescue them from us just as the patients seem to be changing in some definitive way, when they seem to be "recovering." (Boszormenyi-Nagy and Spark, 1973; Ryckoff, Day and Wynne, 1959; Searles, 1965) Fran's situation exemplified this. As soon as she began attending family reunions and managing her first home visit in seven years, she was forced to leave the Lodge. I felt frustrated, ragingly angry, but then, having spewed forth my own invective, and then having written about our time together, I, too, relaxed, as Eliot described, "Their faces relax from grief into relief, . . . To the sleepy rhythm of a hundred hours."

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