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When is it time to stop? When good enough becomes bad enough

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Abstract: This article draws on Winnicott's concept of the good enough mother to discuss how to know whether a therapeutic situation is good enough to continue or bad enough to end. This dilemma is explored in terms of clinical syndromes, such as anorexia and pathological gambling, but focuses mainly on analyst-initiated endings, which are termed the 'Casablanca dilemma', based on an amplification of the ending of the film *Casablanca*. The author goes on to discuss such one-sided endings, drawing on interviews with 40 analysts and therapists about their clinical experience. A typology of bad enough endings is presented. The psychological differences between a good enough analysis as opposed to a bad enough one are explored through the ideas of Winnicott and Neumann.

Keywords: analysis, bad enough, *Casablanca*, ending, good enough, psychotherapy, termination, Winnicott

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When is an analysis good enough to continue? When is it bad enough to stop? We are all familiar with this agonizing clinical dilemma. In this paper, I wish to discuss how to know whether any given treatment is good enough or bad enough. First, I review Winnicott's concept of 'the good enough mother', then proceed to introduce the concept of 'bad enough'. The dilemma of whether a clinical situation is bad enough or good enough is discussed using the ending of the film, *Casablanca*, as an amplification. After reviewing literature on endings, I present results of interviews with 40 clinicians of their experiences concerning analyst-initiated endings.

The phrase 'the good enough mother' was first introduced by the British paediatrician and psychoanalyst, D.W. Winnicott, in his landmark article, *Transitional Objects and Transitional Phenomena – a Study of the First Not-Me Possession*. There he wrote:

> There is no possibility for an infant to proceed from the pleasure-principle to the reality principle or towards and beyond primary identification … unless there is a good enough mother. The good enough 'mother' (not necessarily the infant's own mother) is one who

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> makes active adaptation to the infant's needs, an active adaptation that gradually lessens, according to the growing ability … to tolerate the results of frustration.
>
> (Winnicott 1953, pp. 93-94)

Later, he further elaborated the concept in his remarkable book, *Playing and Reality (1971, second edition 2005; Saragnano & Seulin,* 2015*; Quatman* 2020*)*. Winnicott believed that the 'good enough mother' starts out with an almost total adaptation to her baby. She is entirely devoted to the baby and responds to his every need. She sacrifices sleep and her own personal needs to fulfil those of her baby (Winnicott 1960a). Over time, the mother allows the baby to gradually experience small amounts of frustration. At this point, she is no longer 'perfect' but rather, 'good enough'. Winnicott recognized the need for the infant to realize that:

> a mother is neither good nor bad nor the product of illusion, but is a separate and independent entity: the good-enough mother … adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure. Her failure to adapt to every need of the child helps them adapt to external realities.
>
> (Winnicott 1953, pp. 89-97)

For Winnicott, the idea of the good enough mother is connected not only to the mothering experience but also to the infant's cognitive development and concept of external reality. Initially, the baby experiences the mother as part of her or himself. The gradual shift away from the perfect mother's total empathic attunement to her baby stimulates the baby's mental activity and developing sense of an external world (Winnicott 1957; Abram 2013). A too perfect mother inhibits this discovery and exploration of an external reality and renders the child in a magical world of illusion or even hallucination, believing that every desire will be immediately fulfilled. Babies must begin with this 'necessary illusion', but it will be detrimental to their mental health and future happiness if they remain fixated there. He felt that an enormous contribution is made to the individual and to society by the 'ordinary good mother with her husband in support at the beginning … which she does by *simply being devoted to her infant*' (Winnicott 1973, p. 10. *italics in original*), with the 'sound instincts of normal parents … [in] stable and healthy families' (ibid. p. 173).

Winnicott argued that a good enough mother was far better than the perfect mother. The idea of a good enough mother was subsequently expanded to include the 'good enough parent', which would include fathers and later various non-traditional families, such as LGBT or polyamory parents (Bettelheim 1987; Gray 2015). The idea of the good enough parent was also designed to defend the ordinary mother and father against what Winnicott saw as the growing threat of intrusion into the family from professional

expertise, such as *The Informed Parent: A Science-Based Resource for Your Child's First Four Years* (Haelle & Willingham 2016). Mothers should trust their good enough instincts, not the experts (Lamb 2019). On the other hand, his approach was designed to offset the dangers of inherent idealization and envy built into Kleinian articulations of the 'good/bad object', by stressing instead the actual nurturing environment provided by the parents for the child (Winnicott 1960a). Significantly, the concept of the good enough mother created a liminal space in the mother's mind, and within the facilitating environment, between the oppressive demand to be the perfect mother and the egocentric pull toward a retaliatory or abandoning bad mother. In sum, with good enough mothering, a child has the ability to live in two worlds: the world of illusion, fantasy and magic; and a world that does not always conform to his or her wishes (Rodman 2003).

For Winnicott, the good enough mother is opposed to the dangers of being a too perfect mother. But in another way, the good enough mother contrasts with the 'bad enough' mother, who does not provide basic needs, whether physical or emotional, who is neglectful or uses the infant as a narcissistic self-object. Such 'not good enough' mothering may lead to 'false self disorders' in the child, and even more profound disturbances (Winnicott 1957, 1960b). In this article, I focus on the concept of bad enough in any decision-making conflict, but most specifically within the therapeutic context. I will exclude from my inquiry the painful situation when an analyst is forced to stop because of severe illness or, through ethical violation, loses the right to practice (Dewald 1982; Deutsch 2014).

The influence of the concept of good enough

The concept of 'good enough' became a truly seminal idea. Its influence spread far beyond psychoanalysis to enrich many areas of human endeavour or inquiry. The Principle Of Good Enough (POGE) helped design the Internet and World Wide Web (Capps 2009). It provided new approaches to training physicians (Medscape 2020; Ratnapalan & Batty 2009). It strongly influenced contemporary, clinically-informed fiction, such as Bev Thomas' *A Good Enough Mother* (2019), and *Good Enough* (Yoo 2012). *Good Enough: a Novel* (Petro-Roy 2019a) painfully describes the absence of the 'good enough' in the experiences of a hospitalized young woman suffering from anorexia nervosa. We will return to this body image disorder later. Numerous self-help books draw on the good enough theme (Petro-Roy 2019b; Kingma 2011; Anthony & Swinson 2009). Just to note a pair of outstanding efforts that deal with two specialized populations: Van Gemert (2019), in *Perfectionism: A Practical Guide to Managing 'Never Good Enough'*, discusses the difficulties of helping gifted children find the good enough; and McBride (2009), *Will I Ever Be Good Enough?: Healing the Daughters of Narcissistic Mothers,*

analyses the deep wounds and self-esteem issues in the offspring of such self-absorbed parents. The good enough concept plays important and creative roles in marital counselling (Gottlieb 2010), social work (Yu et al. 2016), education (Kavedzija 2018), philosophy (Alpert 2019), science (Feist 2000), law (Schick 2012), and Christian theology (Stanley 2008) among other disciplines.

Significantly, Cozolino (2004), drawing on the parallel between mothers and therapists, developed the idea of the 'good enough therapist', who can surrender to his or her own imperfections while still guiding the therapeutic relationship to a positive outcome. He argued that 'good enough therapists make good mistakes'. Feeling good enough protects the therapist from guilty feelings associated with imperfection and failure (Abramovitch 1997). Implicit in Cozolino's account is the shadow of the good enough therapist, viz. the bad enough therapist, who neglects or exploits patients for narcisstic gratification. Perhaps the most common good enough – bad enough dilemma occurs in relationships. For example, a woman, married to a husband to whom she feels strongly attached, perhaps even loves, but who is authoritarian, makes decisions without consulting her and belittles her attempts at self-improvement. This wife is in a crisis of the bad enough dilemma. How bad does it have to be to demand changes? Insist on couple therapy? Or to just leave?

Winnicott assumed that being good enough felt natural, in what Erich Neumann called a healthy ego-Self axis (Neumann 1989 [1952]). In contrast, the bad enough dilemma is complicated, emotionally and cognitively. It requires not only serious initiative, but also calculating that the ensuing change will not be even worse. In other terms, when do you decide to persevere in the hope that things will improve, against having the courage to just 'cut your losses'?

Western cultural values strongly favour perseverance. This 'can do' cultural complex is reflected in widespread mottos, such as: 'If you don't succeed, try and try again', and 'Don't take "No!" for an answer'. In contrast, there are equally poignant examples of individuals who relentlessly persisted and refused to accept the situation as bad enough to stop. Anorexics, as we have seen, fail to understand their situation as bad enough. These individuals suffer from an extreme form of the good enough versus bad enough dilemma. They experience their emaciated bodies as never good enough and refuse to accept there is any body weight that is good enough for them. This absence of any good enough weight is the key diagnostic indicator in diagnosing anorexia nervosa. In such cases, the absence of understanding that their situation is bad enough may prove catastrophic, even fatal.

Likewise, focusing only on the good after an initial success may also cause lasting impairment. This is true of compulsive gamblers who often get hooked after a big early win, only for this to be followed by a subsequent series of horrific losses which are never experienced as bad enough to compel them to

stop. At what point is it bad enough for them to tell themselves that it is time to stop?

Writers also need to know when a specific writing project is bad enough to stop. Here is how the author John Fox (2018) discovered the bad enough, writing on his website, 'Foxbox':

> When I was 31 years old, I'd been laboring over a novel for 5 years. It was a quagmire. I was hopelessly stuck in a plot that wouldn't move, in characters that couldn't elicit sympathy, and with ambitions that were far beyond my skill as a writer …. I had far, far too many characters. I couldn't find an ending. *But here's the thing: I wasn't a quitter. I thought that only losers quit* …. If you can become the type of person that doesn't give up, and you work very hard, you can get what you want. … Quitting, as it turns out, is one of the best skills you can have as a writer.
> First, let's talk about quitting projects. It was the best decision I ever made to quit that novel. One day I decided to throw it all away, and the next morning I started a new novel. I finished that new novel in two months. Boom.
>
> (Fox 2018)

In Fox's perspective, knowing when things are bad enough is the only way forward to good enough. Just as children need to be able to say 'No!' before they can say 'Yes!', so, too, bad enough is often the precursor of good enough.

When is analysis bad enough to stop?

Beginnings, from an archetypal perspective, embody hope. The future lies before the analyst and the patient (Thompson 1994). But as the process unfolds, difficulties are inevitably encountered. In extreme cases, the relationship may even be experienced as a 'mismeeting' or 'mismatch', for which Martin Buber, who had strong interests in psychiatry and psychotherapy (Buber 1965), invented the term, *vergegnung*, the negation of a true coming together (Abramovitch 2015). If such mismeeting/mismatch continues, at what point does the patient feel it is time to leave, even against the therapist's advice? That dilemma is at the heart of the bad enough situation in therapy and analysis. How bad do things have to be before it is time to do something drastic about it?

Patients and their therapists/analysts each experience the good enough-bad enough dilemma, but in an asymmetrical way. Patients coming for the first time to therapy or analysis may have difficulty knowing whether the match is good enough to stay or bad enough to leave. These therapeutic 'virgins', often in crisis situation, may have little to compare it to. Analysts, in contrast, have considerable experience in knowing whether a new patient is suitable for treatment or not. Their decision is tempered by clinical experience, self-awareness, supervision and their own experience as analysands. Some highly disturbed patients might be taken on as 'heroic measures', even when the

chances of therapeutic benefit are low. Many professionals feel that patients with a history of incest, sexual trauma or severe personality disorders ought to be treated by specialists. Only a small number of individuals are considered truly 'treatment resistant' (Varvin 2003). Research shows that patients often make their decision to pursue therapy/analysis based on the first session (Reith et al. 2011; 2018). In those first sessions, patients are consciously and preconsciously processing vast amounts of cognitive and emotional inputs in a very short time: am I ready for therapy at all? Do I trust this person enough to continue? Does the therapist's nonverbal communication make me feel safe? Will an empathetic failure permanently contaminate the holding environment, or rather, turn the therapy from something that was supposed to be perfect toward something that is good enough? When I feel uneasy in this initial encounter, is it a transference reaction or a poor match that will never be good enough?

Winnicott wrote that:

> *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.*
>
> (Winnicott 1971, p. 38, italics in original)

Winnicott further elaborates that psychoanalysis is 'a highly specialized form of playing in the service of communication with oneself and with others' (ibid., p. 41). Playing, he writes, is a natural and exciting thing, just as is being a good enough mother. His remarkable description of psychotherapy as playing provides a clear criterion for when to stop. If the therapist feels she or he is not able to bring the patient into a state of being able to play, then the therapy should end. Likewise, if the patient feels that the therapist is not the right or even the good enough playmate, then therapy should cease. Winnicott claimed, 'play is immensely exciting' (ibid., p. 47) and indeed that 'play is itself a therapy' (p. 50), even if 'playing is always liable to become frightening'. Perhaps we may formulate another Winnicottian criteria for ending therapy: when psychotherapy stops being an exciting sort of play, it may be time to stop. At the same time, it is important to distinguish a normal plateau phase in analysis, when analyst and patient may be asking themselves, 'Are we making any progress?', from a deeper and more fundamental flaw in the analytical process or container that makes the analysis itself untenable.

Endings

Freud expressed the changing ambivalence toward the timing of ending in his famous quote:

> In the early years of my psycho-analytic practice I used to have the greatest difficulty in prevailing on my patients to continue their analysis. This difficulty has long since been shifted, and I now have to take the greatest pains to induce them to give it up.
>
> (Freud 1958 [1913], p. 130)

Sandor Ferenczi suggested a very different model: 'The proper ending of an analysis is when neither the physician nor the patient puts an end to it, but when it dies of exhaustion. … A truly cured patient frees himself from analysis slowly but surely …' (Ferenczi (1955 [1927] p. 85). Following Ferenczi, analysts almost always prefer a scheduled, mutually agreed upon ending, to review the whole course of treatment and experience more deeply in the process of ending itself. Such scheduled endings help make the therapeutic experience itself feel good enough: to accept that even though the experience was not perfect, and not all goals were fully achieved, good work was done.

Strangely, the standard psychoanalytic term for ending in English is 'termination'. This word carries harsh, symbolic associations to an abrupt stoppage, as in a termination of medical treatment for a dying patient, or a termination of pregnancy. The emotional associations to termination contrasts sharply with the ending most analysts seek. Indeed, Schacter and Kachele (2013), in their review article, claim that there is no clear paradigm for termination in psychoanalysis and only half the patients who begin analysis end in a mutually agreed way.

Schlesinger (2014) discusses the history of the term, 'termination'. Joan Riviere, while still a patient of Freud, was asked by him to translate his *Die Endliche und die Unendliche Analyse* (1937) into English. The expected translation should have been 'finite' and 'infinite', or perhaps, 'endable' and 'not endable'. But for some unexplained reason Riviere chose 'Terminable and Interminable' and in this way ending analysis became 'Termination', which still remains the standard term (Schacter & Kachele 2013; Schlesinger 2014). In contrast, 'sium', the equivalent Hebrew word, meaning to complete or conclude, has a gentler, more natural sense of coming to a close. A 'sium' style, good ending helps make the therapeutic experience become good enough. Some patients do indeed terminate treatment abruptly. They may do so in an impulsive, unplanned fashion, leaving the therapist helpless and hurt. It is in this situation when mental health professionals are most vulnerable: abandoned by a person in distress without knowing why. In this situation, the therapist will almost always experience the ending as bad and incomplete. Auger's excellent article 'Images of endings' (1986), published in this journal, gives a moving account of just such a premature termination by a patient, based on their misreading of a dream. Many patients feel wounded in their abrupt departure but some patients may feel the opposite. Terminating suddenly, even impulsively, may be the patient's true act of autonomy.

Significantly, recent in-depth research in Brazil discovered that many patients who did abruptly 'drop out' of treatment subsequently reported it as successful (Jung et al. 2013). Borderline patients, with their profound attachment issues, often find a measured ending too painful. Instead, they leave with a 'goodbye kick' (Sansone et al. 1991). After the separation, they may look back on the therapist with fondness.

Therapists do not end therapy lightly. But there are special conditions when the analyst or therapist feels treatment is untenable and must be ended. Boris Matthews in his chapter 'Termination in Analysis' in Murray Stein's *Jungian Analysis* writes: 'The analyst may feel burned out, fed up, or otherwise exhausted, and find it impossible to go further with this particular analysand' (Matthews 1995, p. 279). I call such analyst-initiated termination, the '*Casablanca* dilemma', based on the ending of the great film *Casablanca* starring Ingrid Bergman as Ilsa and Humphrey Bogart as Rick Blaine. Toward the end of the film, Ilsa, the character played by Ingrid Bergman, is torn between her husband, Victor, and her lover, Rick. The three meet at the airport, where she believes that she is about to leave with Rick but learns Rick has decided she must depart with her husband instead. Here is the key extract from that scene (Myers 2016):

Ilsa:	No, Richard, no! What has happened to you? Last night we said …
Rick:	Last night we said a great many things. You said I was to do the thinking for both of us. Well, I've done a lot of it since then, and it all adds up to one thing: you're getting on that plane with Victor where you belong.
Ilsa:	But, Richard, no, I… I…
Rick:	– you've got to listen to me! Do you have any idea what you'd have to look forward to if you stayed here? Nine chances out of ten, we'd both wind up in a concentration camp. Isn't that true, Louie?
Capt. Louis Renault:	I'm afraid Major Strasser would insist.
Ilsa:	You're saying this only to make me go.
Rick:	I'm saying it because it's true. Inside of us, we both know you belong with Victor. You're part of his work, the thing that keeps him going. If that plane leaves the ground and you're not with him, you'll regret it. Maybe not today. Maybe not tomorrow, but soon, and for the rest of your life.
Ilsa:	But what about us?
Rick:	We'll always have Paris. We didn't have it, we lost it until you came to Casablanca. We got it back last night.
Ilsa:	And I said I would never leave you.
Rick:	And you never will. But I've got a job to do, too. Where I'm going, you can't follow. What I've got to do, you can't be any part of. Ilsa, I'm no good at being noble, but it doesn't take much to see that the problems of three little people don't amount to a hill of beans in this crazy

world. Someday you'll understand that. (*Ilsa lowers her head and begins to cry.*) Now, now …(*Rick gently places his hand under her chin and raises it so their eyes meet.)*

Rick: Here's looking at you, kid …

The ending of *Casablanca* is perhaps the most famous parting scene in cinematic history. I want to reframe this romantic scene where Rick is analyst and Ilsa is his patient. The scene plays out the situation when the patient eagerly wishes to continue in therapy but the analyst knows that continuing to work together is not in their patient's best interest or is even detrimental both to the therapist and the 'analytical couple'. In my symbolic interpretation, Rick is the analyst who is ending the relationship with Ilsa, his patient, for her sake as much as for his own. The reasons for a *Casablanca* dilemma are varied. The analyst may feel that therapy or analysis has exhausted itself and will never succeed. The analyst may have an ethical dilemma, some sudden, secret revelation of a dual relationship that may require ending treatment, for example, that the analyst discovers another patient is this patient's alienated sibling or former fiancé; or that the analyst's partner is being sued by a member of the patient's family. But perhaps the most likely reason, and closest to the film *Casablanca* itself, is the onset of a mutual erotic, loving transference-countertransference, that the analyst fears he or she will act out. In such cases, the therapist must do the thinking for both of them. As Bogart in effect says, 'If we do what we both want to do with all our heart: you'll regret it. Maybe not today. Maybe not tomorrow, but soon and for the rest of your life'. Bergman, responding as if in the role of the patient, says: 'But what about us?'

Patients often wonder what are the therapist's true feelings toward them. Do they really care or even love (or hate) them? Winnicott himself wrote extensively of the importance of the analyst hating disturbed patients, and at some point having the patient understand this. Although he was most concerned with psychotic patients, he wrote: 'If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love …. It seems he can only believe in being loved only after reaching being hated' (Winnicott 1949, p. 72).

Bogart, as the good enough analyst, replies: 'We'll always have Paris'. To 'always have Paris', means to be able to permanently hold onto the intimate experience between analyst and patient within the temenos, the therapeutic container. Rick the analyst, is pointing to all the good enough, even loving work that was done together in analysis. Regardless of the current and painful separation, our 'Paris' can never be taken away.

He goes on to say: 'We didn't have it, we lost it until you came to Casablanca. We got it back last night'. Ilsa responds: 'And I said I would never leave you'.

This exchange reflects the openness to feelings in and with the transference, as well as regaining the capacity to love, which are the hallmarks of a successful ending.

Rick's final phrase to Ilsa: 'Here's looking at you, kid', embodies a profound sense of seeing and being seen, which is the essence of all good therapeutic work. In fact Rick's iconic, last line of the film is said not to Ilsa but to Louis, the transformed Vichy policeman ready to join the Resistance, 'I think this is the beginning of a beautiful friendship'. Although it is very rare for analyst and patient to become 'friends', a good enough ending does transform the relationship in which the previous hierarchy is dissolved. At the end of a deep and successful analysis, this new kind of relationship may be expressed in a special silence: when everything that needs to be said has already been said. Such an analysis-ending silence may have the fullness of a 'tranquil, quiet experience of harmony', which is just the opposite of silence as absence. 'Now analyst and patient may sit in a silence of togetherness, a "silence for two"' (Abramovitch 2020, p. 70).

Analysis and therapy are the only intimate human relationships which are designed to end (Abramovitch & Wiener 2017). Therefore, final sessions often involve extraordinary gestures. They may be as simple as an exchange of gifts or even a farewell hug. Naomi Lloyd (2014), in her remarkable account of her Jungian analysis, *The Knife and the Butterfly*, recounts how she engineered her final session by bringing sound equipment so that she and her analyst could listen to her favourite music together in silence. Only then, after the music, was the analysis good enough. Some patients need special comforting at this last goodbye, like Rick saying to Ilsa, 'Now, now'. But here, too, there is yet another bad enough dilemma. How bad does the patient's last session have to be in order to cancel the ending and continue working? If the analyst feels that the ending is undoing the work that has been done together so that the patient may be suicidal, or dissociative, or in a serious crisis that is not a just temporary reaction to the pain of separation, then termination must be suspended and further treatment offered.

Jung himself reported how his misperception of the therapeutic task led him to propose a premature ending. In *The Practice of Psychotherapy* Jung describes his clinical anxieties:

> The whole case worried me so much that I told the patient that there was no sense in her coming to see me for treatment. I didn't understand two-thirds of her dreams, to say nothing of her symptoms … I had no notion of how I could help her. She looked at me in astonishment and said: 'But it is going splendidly! It doesn't matter that I don't understand my dreams. I always have the craziest symptoms but something is happening all the time'.
>
> (Jung 1954, p. 334)

A contemporary analyst would likely try to understand Jung's feelings of helplessness as part of the countertransference. But it is heartwarming to see that their therapeutic relationship triumphed over his sense of uselessness and despair. This case highlights once more how a good enough ending requires the active collaboration of both patient and analyst, which is almost always absent in endings which are bad enough.

To investigate the clinical aspects of bad enough endings, I interviewed 40 colleagues, mostly members of the Israel Association of Jungian Psychology in honor of Erich Neumann (IIJP) or the International Association of Analytical Psychology (IAAP), in person, by phone, online and via email, using a snowball sample, concerning occasions when they had unilaterally terminated therapy, even though the patient wished to continue. The reasons for ending fell into a number of distinct categories. One dilemma involved situations *external to the analytic process,* such as when the patient broke the therapeutic contract in a way that made the analyst feel it was impossible to continue. One case concerned a troubled young man who used to smoke marijuana on weekends. But as his distress increased, he began smoking during weekdays, then during daytime and finally coming to sessions stoned. At this point, the therapist felt that therapy had become a sham. He terminated the analysis and sent the patient to rehab. Another case concerned couple therapy in which the husband was emotionally abusive toward his wife. Gradually, it emerged that in between sessions the husband was also physically abusive to his wife. The husband wished to continue the couple work but the therapist felt the pre-conditions had been violated. Couple counselling was terminated and the authorities brought in.

Another reason for ending had to with the modality of the therapy. Some analysts felt that talking therapy was not appropriate as it only distanced the patient from inner feeling. The decision was made to transfer to an expressive therapy and ending work was done to accomplish this goal. Another issue was the personal characteristics of a specific patient; something in their appearance, way of speaking or mannerism that interfered with the therapist's ability to form a connection. Provocative dress or issues of personal hygiene have also undermined therapeutic alliances. And another important issue is when the patient's life problems touch on the counter-transference or life issue of the therapist (Eissler 1977; Morrison 1990): e.g. a patient during the course of treatment becomes widowed, divorced or seriously ill, just when the analyst has lost a spouse, or has undergone a painful divorce, or is suffering from a major illness. Under such circumstances the analyst should accept that the situation is bad enough to end the analysis, with or without revealing the reason. Like Humphrey Bogart, the analyst must do the thinking for both of them.

In my interviews, the most difficult cases involved issues or dynamics that were *within the analytic relationship*. The typical cases were very long-term treatments with very difficult patients. In some cases, after a period of minor

positive gains, the treatment levelled off at a plateau, with no progress or improvement, but which left the analyst feeling exhausted or exploited. Analysts debated again and again with themselves concerning whether it was bad enough to stop. A few consulted colleagues or peer supervision groups. These encounters were often helpful – and supervision in these circumstances is the wise way to go. However, a few of the interviewees continued to experience the agonies of indecision, even when peers were unanimous concerning the need to end. Guilt and fear of creating yet another abandonment situation played a role in delaying an ending. I believe this was true especially for some Israeli analysts who had vicariously experienced the emotional reality of the traumatic separations during the holocaust, whether they were second generation survivors or not. I believe a similar countertransference is also likely for any analyst who had undergone early loss. These clinicians were deeply concerned how a one-sided ending could be retraumatizing for their patient, who had already experienced brutal abandonments in the past. In a symbolic sense, the image of an abrupt ending put the analyst in the archetypal role of the abandoning witch mother, or even an abuser-like perpetrator. One analyst wrote sensitively about such a countertransference conundrum:

> Somehow, I felt I had committed myself as much as possible to S, my patient and I had reached my limits. During the course of our work … the analysis of my countertransference made it quite apparent that my relationship with my mother was put into vibration during this analytical journey with S. My mother was, like S, deeply depressed, suicidal, yet very courageous facing her commitments and responsibilities, very loving towards me, having projected her narcissistic ideal upon me. As a child, already she had 'chosen' me in order to listen to her painful existence for endless hours, even late at night. There was a moment when I felt I could no longer accompany S: it was when I realized that my counter-transference ceased to be 'neutral', due to a recurrence of S's masochistic dimension: unconsciously she seemed proud of her suffering. … [after a dream] When I felt, and realized, that she was almost constantly on my mind, I knew that, due to my countertransference, it would not be beneficial for her if we continued to work together, nor would it allow me to live freely as a woman, apart from being an analyst. Furthermore, I thought it would be very beneficial for her to work with a male analyst …. S accepted my proposition with regret, but gracefully, thanking me for my patience and kindness throughout the work …. She added that she will regret losing me a lot and will never forget the way I looked at her, like nobody else in her life.
>
> (von Benedek 2020, personal communication)

Here we have an ending truly worthy of *Casablanca*. The analyst, von Benedek, was deeply aware of her own countertransference issues, while still able to understand what will be good for the patient, that is, here, to work with a man. In this way she was able to do the thinking for both of them and bring about a satisfying conclusion to their work.

Her experience suggests that we may only know whether it was a good time to stop after the decision has been enacted. If the analyst continues to remain uneasy, with thoughts of the patient intruding into their inner life, subsequent to the separation, then the ending is likely mistimed and incomplete. Carl Rodgers (1972) describes such an impulsive abandonment of a very difficult patient, probably with a severe borderline personality structure, whose dynamics were not well understood at the time. He felt he must help her, even though the relationship was very destructive for him. Ultimately, on the edge of a complete breakdown, he sensed that he must escape. He left with his wife within the hour and stayed away for three months, abandoning not only this patient but all his others. When he returned he was still overwhelmed with guilt, worthlessness and inadequacy. Only when a student of his invited him to enter treatment with him, did Rodgers begin to get some perspective on what had happened. In contrast, von Benedek and S both felt relieved, hopeful and 'seen'. Clearly a good 'sium' had taken place.

Discovering that the patient had been actively or passively deceitful in a major manner which undermined trust could also be a trigger for termination in these agonizing and interminable relationships. For example, in one case, much of the analysis dealt with the difficult feelings of being the father of a disabled child. Years later, the analyst discovered by chance that no such child existed. Feeling that the analyst had been exploited and that the breach of trust was irreparable, termination and referral followed. In another similar case, the analyst provided strong emotional support for a risky medical procedure in what seemed like a strong therapeutic alliance. A few years later, however, the patient underwent a similar operation without even telling the analyst. The analyst felt betrayed and unable to continue the analysis.

In my sample, no one reported any negative consequences of an analyst-initiated ending. But there are reports of serious post-termination harassment of therapists by former patients. Murdin (2015, p. 83), describes a case of a therapist whose dismissed patient left threatening messages on her answering machine, made phones calls 'at all hours day and night' and completely filled up her answerphone with messages, 'many of which consisted merely of silence that was filled with malice'. Ultimately, the therapist felt defeated. She answered the phone and offered further sessions but in order 'to learn to be less afraid of the patient's anger and more confident in her own strength'. In sharp contrast, another colleague I interviewed related how an abrupt termination had a decisive and positive impact. She related two examples of how an inappropriate attitude by patients stymied therapeutic work, such as unrelenting aggression, or a whimsical lack of serious commitment. Saying she was unable to work under such circumstances, she indeed terminated the sessions. Remarkably, a short time later, each patient returned with a newly altered attitude so that the work of healing was taken up again. In contrast, other analysts who were interviewed reported on the enormous therapeutic challenge of treating

patients who had great difficulties to reattach to the new therapist in the wake of an abrupt or brutal termination. This post-termination separation trauma is worthy of further study.

Conclusions

Let me try to summarize some preliminary conclusions about the dilemma of recognizing the bad enough situation. First, it is easier to recognize a good enough situation than a bad enough one. The experience of being good enough feels full, in and of itself. It is both satisfying in itself, as well as protected from perfectionistic or obsessive anxieties. In Neumann's terms, it is situated in an expanded state of being, within a dynamic ego-Self axis. The experience of bad enough is more complex and conflicted. There is usually a contradictory pull between head and heart, between duty and feeling, between not being sure 'where the line is drawn' (Shehadeh 2017). Being good enough typically means continuing what you are doing in a relaxed, wholesome manner. Being bad enough usually implies the need for painful and uncertain change. The danger of the bad enough situation is it becoming even worse. Whereas feeling good enough is experienced in the present, bad enough must consider both past, present and future in a complex algebra of emotions and expectations. In the therapeutic situation, Winnicott's emphasis on playing may serve as an important guideline for knowing when to stop. As Fox argued, being able to say definitively that this is bad enough may be the first decisive step toward a new beginning that is more than good enough. My colleagues' accounts convinced me that it is important for the analytic community to understand that some treatments may run their course and need to end. In other cases, the analyst's emotional exhaustion may contribute legitimately to feeling, 'Enough!' Knowing when it is time to stop is an important skill that analysts need to learn and be able to teach. Understanding what is bad enough in analysis may be essential knowledge for all psychotherapists and analysts. At the same time, it is important during times of normal therapeutic turmoil to understand when it is right to continue, because the temenos and therapeutic dynamics are essentially good enough to contain the process. Distinguishing right and wrong in the presence of the forces of the shadow may be difficult, but discerning bad enough from good enough may be an even greater challenge.

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Translations of Abstract

Cet article s'appuie sur le concept de Winnicott de la mère suffisamment bonne afin de discuter de comment savoir si une situation thérapeutique est suffisamment bonne pour poursuivre ou suffisamment mauvaise pour arrêter. Ce dilemme est étudié du point de vue de syndromes cliniques tels l'anorexie ou l'addiction aux jeux d'argent. L'article se concentre principalement sur les terminaisons initiées par l'analyste, pour lesquelles on parle du « dilemme de Casablanca » en amplification de la fin du film *Casablanca*. L'auteur explore de telles terminaisons - décidées unilatéralement - s'appuyant sur des entretiens avec 40 analystes et thérapeutes au sujet de leur expérience clinique. L'article présente une typologie des terminaisons suffisamment mauvaises. Il examine les différences entre une analyse suffisamment bonne et une analyse suffisamment mauvaise, à travers les idées de Winnicott et de Neumann.

Mots clés: suffisamment bon, suffisamment mauvais, Winnicott, analyse, psychothérapie, fin, terminaison, *Casablanca*

Dieser Artikel stützt sich auf Winnicotts Konzept der *good enough mother* und erörtert wie man wissen kann, ob eine therapeutische Situation gut genug ist um fortzufahren oder schlecht genug um beendet zu werden. Dieses Dilemma wird im Hinblick auf klinische Syndrome wie Anorexie und pathologisches Glücksspiel untersucht, konzentriert sich jedoch hauptsächlich auf von Analytikern initiierte Beendigungen, die als 'Casablanca-Dilemma' bezeichnet werden und auf einer Amplifikation des Endes des Films *Casablanca* beruhen. Der Autor diskutiert solche einseitigen Beendigungen anhand von Interviews mit 40 Analytikern und Therapeuten bezüglich ihrer klinischen Erfahrungen. Eine Typologie von ausreichend schlechten Beendigungen wird vorgestellt. Die psychologischen Unterschiede zwischen einer ausreichend guten und einer ausreichend schlechten Analyse werden mit Hilfe der Ideen von Winnicott und Neumann erforscht.

Schlüsselwörter: gut genug, schlecht genug, Winnicott, Analyse, Psychotherapie, Beendigung, Terminierung, *Casablanca*

Questo articolo parte dal concetto di Winnicott della madre sufficientemente buona per discutere come capire se una situazione terapeutica sia sufficientemente buona per continuare o cattiva per finire. Questo dilemma è esplorato nei termini delle sindromi cliniche, come l'anoressia ed il gioco patologico, e si focalizza principalmente sulle conclusioni dell'analisi avviate dall'analista, che sono definite il "Dilemma di Casablanca", in riferimento all'amplificazione della conclusione del film *Casablanca*. L'Autore prosegue discutendo queste conclusioni unilaterali, presentando le interviste fatte a 40 analisti e terapeuti sulla loro esperienza clinica. Viene anche presentato un modello di cattiva conclusione. Le differenze psicologiche tra una analisi sufficientemente buona come contrapposta ad una sufficientemente cattiva vengono esplorate alla luce delle idee di Winnicott e Neumann.

Parole chiave: abbastanza buono, abbastanza cattivo, Winnicott, analisi, psicoterapia, chiusura, conclusione, *Casablanca*

Статья написана на основе понятия Винникота о достаточно хорошей матери и выносит на обсуждение вопрос: как понять, что терапевтическая ситуация является достаточно хорошей, чтобы продолжить, или достаточно плохой, чтобы закончить. Эта дилемма исследуется в терминах клинических синдромов, таких как анорексия и патологический гемблинг. Однако основной фокус статьи – это «дилемма Касабланки»: завершение терапии по инициативе аналитика. Название появилось в результате амплификации финала фильма «Касабланка». Автор исследует одностороннее завершение, основываясь на данных интервью с 40 аналитиками и терапевтами. Предложена типология плохого окончания. Психологические различия между достаточно хорошим анализом и достаточно плохим рассмотрены через призму идей Винникота и Нойманна.

Ключевые слова: достаточно хороший, достаточно плохой, Винникот, анализ, психотерапия, завершение, окончание, Касабланка

Este artículo se basa en el concepto de la madre suficientemente buena, de Winnicott, para analizar cómo reconocer cuándo una situación terapéutica es suficientemente buena para continuar o suficientemente mala para concluir. Se explora este dilema en síndromes clínicos, como anorexia y juego patológico, pero se focaliza principalmente en el analista – iniciador de finales, llamado 'el dilema Casablanca', en base a la amplificación del final de la película Casablanca. El autor continúa analizando semejantes finales unilaterales, a partir de entrevistas a cuarenta analistas y terapeutas acerca de su experiencia clínica. Se presenta una tipología de finales suficientemente malos. Se exploran las diferencias psicológicas entre un suficiente buen análisis en oposición a uno suficientemente malo, a través de las ideas de Winnicott y Neumann.

Palabras clave: suficientemente bueno, suficientemente malo, Winnicott, análisis, psicoterapia, final, terminación, *Casablanca*

何时停止?当刚刚够好变成刚刚够坏的时候

这篇文章引出了温尼克特刚刚够好的母亲的概念， 来讨论如何知道治疗的情境是不是刚刚够好，可以持续，还是刚刚不够好，可以结束了。文章通过临床症状来探讨这种困境，这些症状包括神经性厌食，病理性赌博，但是主要集中讨论的是分析师发起的结束， 这被称为"卡萨布兰卡困境"， 命名来源于电影卡萨布兰卡的结局部分的放大。作者继续讨论这种来自单方面的结束， 这些讨论基于对40位分析师和治疗师关于其临床经验的访谈。文章呈现了一种刚刚不够好的结束的类型。文章通过温尼克特和诺伊曼的观点讨论了刚刚够好和刚刚够坏的分析师之间的心理差别。

关键词: 刚刚够好, 刚刚够坏, 温尼克特, 分析, 心理治疗, 结束, 终止, 卡萨布兰卡
