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THE THERAPEUTIC CONTRACT: A NEW LOOK

INTRODUCTION TO THIS ISSUE
THE "PERSON" OF THE CONTRACT

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The therapeutic relationship requires a reparative framework where appropriate boundaries help to channel the underlying affect of the patient in ways that are constructive to his or her maturational process. Therapy is a matter of repair more than insight. This requires that appropriate force of personality is brought to bear to help order the patient's disordered personality. The person of the therapist must enforce suitable limits and parameters to optimize a healthy outcome.

As a supervisor I have repeatedly come upon weaknesses in the capacity of the therapist to introduce and to properly sustain a contractual relationship with the patient. Every aspect of the therapist's personality seems to be involved in this difficulty. A therapist with a self-image of weakness may rigidly use a contract to reinforce him or herself, thus sending a signal to the patient that there is not really a solid human being there to be relied upon, but a rigid and formal "cast" around a person. A therapist who has the self-image of a child (which is a widespread ailment) might simply introduce the terms of the contract because their teachers told them to. This effectively sends the same signal to the patient, no one to count on if trouble gets deep. Therapists with a dominant fear of abandonment may wrongly use a contract to protect themselves from being left by their patient. Therapists with a dominant fear of engulfment may use a contract as something to stand between them and their patient.

With all this in mind you can see how many aspects of the therapist's personality impinge upon effectiveness in this critical area. Why critical? Simply because the patient needs a constructed framework, different from his everyday life, where his disturbing emotions can be invited into the relationship without oozing, in damaging ways, all over his or her life. The therapist's personal sensitivity and stability provides some sense of security to the patient which allows trust to build enough to let the more intense feelings come to the surface. But it is not truly safe (and patients can sense it) unless there is a defined limit for these emotions and their expression. The patients also need a real and reliable force behind those stated limits, since words alone carry no weight.

Therefore, the struggle with the contract is, in fact, a struggle with the therapist's self. There simply is no way around this fact, again. It is not what we say, but how we relate.

This issue of the Journal highlights struggles of therapists with this matter and with the self as the one who applies the therapeutic contract.

There are many ideas in this journal that can be taken usefully outside of the field of psychotherapy. There are implications for fathering, for organizational leadership, for political leadership, for classroom leadership, for mentoring, or simply for being an older brother or sister. Any of these relationships also requires a careful look at the self as the one who applies the rule.

Our editorial staff hopes that you find this matter, as it is elaborated in these pages, to be of great interest inside and outside of the clinic.

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Background Point of Theory

The attainment of well-defined ego boundaries is the ultimate goal of maturation, and it is not achievable through formal learning or by gaining insight. The self is only defined by repeated testing of one's size and strength in relation to other humans and things. This yields reliable and useful lessons only if those with whom the testing is done are predictable, consistent, and emotionally stable.

Damaged or incomplete boundaries of the self can be repaired provided that the same conditions exist; the work can be done only in long-term relationships that are deeply involving and truly reliable. They must be sturdy enough to withstand even repeated tests under the most intense stresses that can occur between people. Formal, superficial, or essentially intellectual relationships do not provide the setting needed for reaching this difficult goal. Most current attempts to repair boundaries in psychotherapy fail because the relationship is not real enough and the mutual involvement only tenuous and insubstantial. Character change is at least as difficult a process and almost as time-consuming as character formation was in the first place.

From R. Bar-Levav, M.D. (1988)
Thinking in the Shadow of Feelings, New York:
Simon and Schuster, p. 333.

THE THERAPEUTIC CONTRACT: PAST AND PRESENT

Leora Bar-Levav, M.D.

As stated in the title, this journal issue is concerned with the therapeutic contract, its content, its application and its "enforcement" in the treatment setting. While the use of some form of contract between therapist and patient is common to most clinicians, the particulars that make up the therapeutic contract across treatment modalities and the relative importance of the contract to the overall treatment process varies considerably. Many current texts that focus on psychotherapeutic practice make only a cursory reference to the therapeutic contract or omit addressing it altogether.

Historically, the term "contract" referred largely to the ground rules structuring the therapeutic setting. Only more recently is there recognition of the need for more binding, specific parameters for the therapeutic relationship, namely a therapeutic contract. The following provides a brief review, of ideas that led to modifications in how the ground rules for treatment have come to be viewed and employed since their inception in the early 1900's. As will be described, the changes were due in part to a refinement in understanding of the parallel "real" and transferential relationships that develop between patients and therapists. Second, the developments that led to the use of a therapeutic contract which is more binding than ground rules alone will be addressed. These resulted, in part, from basic shifts in the understanding of what elements of treatment are critical to the curative process itself.

From the earliest days of psychoanalytic practice, frameworks for the treatment setting and therapeutic relationship were recognized as necessary to enable therapeutic work to proceed. The ground rules, defined by Freud (1912b, 1913, 1914, 1915), including the setting of fixed fees, time and frequency of sessions, the maintenance of the analyst's anonymity, the analysts's restriction to interpretive comments as well as the use of the analytic couch and specific positioning of the analyst were all designed to optimize conditions for analytic work - particularly the unfolding of the transference.

Marked modifications of these rules have developed over the last 80 years. Some argue that this is due to the dilution of a standard which is difficult to maintain by virtue of the strain it places on the analyst/therapist to renounce the pathological gratifications that deviations in a sound framework afford. (Langs, 1976) Such practitioners, represented in the literature by clinicians such as Menninger, Langs or Greenacre, hold that any deviations made in the ground rules ultimately lead to a therapeutic rela-

tionship experienced by the patient as unstable, and introduce elements in the treatment that immutably interfere with the resolution of transference, sometimes referred to as "contamination".

A majority of other authors dating back to Ferenczi (1921) have, in contrast, made a point of the need to modify these ground rules. Sterba (1941) and Menaker (1942) advised the analyst to expose his personality and allow for limited gratifications which, as Alexander described (1954), provide a "corrective emotional experience". Berman (1949) and Zetzel (1956) similarly made allowances for realistic anxieties related to treatment and the need to make modifications in teaching to help convey the analyst's genuine interest in the patient. These and other works likely reflected a growing recognition of the real-relationship (Greenson) between patient and therapist.

Both S. Freud and A. Freud (1954), among others had made references to the real, direct and healthy portion of the relationship between therapist and patient which exists independent of the transference. But it was not until the late 1960's with the writings of Greenson (1967), Roland (1967) and Stone (1967) that the real-relationship was more fully examined. This relationship makes room for realistic emotional and human responses of the therapist and patient.

A movement followed this period in the late 1950's and 1960's that attempted to "humanize" the therapeutic relationship. While many rejected loosening of the parameters previously required for the treatment setting, the notion that the real human qualities of the therapist need to be experienced by patients had taken hold. Thus, the classical guidelines for the treatment setting introduced (but not uniformly adhered to) by S. Freud 50 years earlier became lastingly altered. For that reason, today, the overwhelming majority of clinicians, even of orthodox psychoanalytic training find reason to make exceptions to the original ground rules.

Still greater deviations from the original guidelines for treatment were introduced in the 1950's and 1960's as attempts were made to apply the analytic model to more profoundly disturbed patients. In working with schizophrenia, character disorders, anorexia and perversions, qualitative modifications of technique, termed "parameters" by Eissler (1953), became necessary. These changes included variations in the type of interpretations and degree of the therapist's activity in treatment (Bouvet), the occasional abandonment of therapeutic neutrality (Reich and Nacht), the use of directives (Rappaport), and even the setting of therapeutic limits (Hoedemaker).

Central to the basis for these modifications was the appreciation that the ego function of more severely disturbed patients was relatively weak. Their capacity, therefore, to tolerate anxiety, to inhibit impulsive action

and to stand back and observe themselves and their experience was limited. The intensity of the primitive transferences often led such patients to lose their hold on reality and their capacity to reality-test their experience.

In his work with patients in the "borderline-narcissistic spectrum" Kernberg (1979) wrote, "At times the psychotherapist has to spell out certain conditions which the patient must meet in order for outpatient psychotherapy to proceed...The setting up of such conditions for treatment represents, of course, an abandonment of the position of neutrality on the part of the psychotherapist and the setting up of parameters of technique". (p. 189).

Kernberg goes on to describe instances in which he believes parameters of technique need to be employed and in the process mentions features of a therapeutic contract he employs with patients. At the heart of this contract is a commitment made by the patient to "carry out full responsibility for himself" and his actions. By example, Kernberg describes how, in treating a patient who has historically cut himself, a therapist must discuss his expectation at the outset of treatment that the patient talk about his wish to cut himself while assuming responsibility to not act on that wish. Furthermore, the patient is expected to request hospitalization if he believes he is truly unable to control his impulses. Kernberg concludes that this parameter of technique "will eventually require resolution through interpretation" (p. 193) suggesting that its impact on the transferences is a necessary but unwanted by-product of the need to set specific limits on the therapeutic relationship.

A more recent theoretical orientation, in contrast, does not recognize the introduction of this type of "conditional" status to the therapeutic relationship as an interference but rather as a necessary and desirable framework for treatment. Indeed, it holds such a non-acting out agreement central to the therapeutic work, as part of a larger, explicit contract that the therapist and patient conduct their relationship in a realistic way. Here the therapist is not "neutral". At times he must insist that the patient correct destructive actions before the relationship can continue. At other times he pointedly makes no room for transference distortions to be freely expressed when a minimum of the patient's observing ego is not evident.

Unlike the classical analytic model, this new model called Crisis Mobilization Therapy does not hold that such activity interferes with the unfolding of the transference neurosis. On the contrary, it suggests that such activity of the therapist fosters the development of a relationship based on reality—a "real-relationship". When realistic limits are held firmly in place, the therapist has the freedom to safely expose his personality and express genuine interest in the patient (see above). It is the strength of the real-relationship that taps developmentally early material

in the patient and allows the primitive transference to unfold. As Bar-Levav (1988) noted, "Constructing a safe setting begins by making real contact with the patient...The therapist must touch and welcome the patient's 'soul'. The hidden and denied fears and hurt must be recognized, verbalized and sensitively addressed. The patient's confusion and silence must be listened to, and heard. An immediate sense of relief follows when this is properly done, and contact is thus established. This is a solid base for the beginning of a solid real-relationship." (p. 232) He continues to note, however, that such exquisite understanding gives rise to magical expectations based in life-long yearnings to be perfectly heard and people tend to idealize those who relieve their fear.

The greater the sense of safety, the more primitive material and defenses tend to surface. As Kernberg (1976) noted, not only in severely disturbed patients but also in neurotic and "normal" individuals, "past object relations with a primitive self- and object-representation linked by a primitive affect can be observed at points of deep regression". (p. 66)

The therapeutic involvement stimulates these regressions which have a physical template in physiologic pathways. (Bar-Levav, pp. 88-93) These pathways, laid down in the first weeks and months of life are the residues of preverbal experiences and provide the psychic fuel that drives transference. When the contact between patient and therapist is as described, such regressions become typical. But such regressions can be therapeutically useful only when a sound therapeutic contract is in place from the outset of treatment. A contract which includes at its core that therapist and patient alike agree to conduct themselves according to the reality principle binds these parties to living by what makes sense objectively rather than by the dictates of feelings influenced by distortions of the past. It provides a standard against which not only transference but also countertransference must be assessed. The contract secures the therapeutic purpose by immediately calling upon the adult part of the patient to reality test the situation and momentarily curb impulsive behavior even as strong feelings flare.

It is at such moments when patients' primitive feelings are juxtaposed against the reality of current living that opportunities for real characterologic change are made possible. Such crises productively stress patients' ego boundaries. The patient's capacity to distinguish between past and present, to separate thinking and feeling, and emotional reactions from immediate action is more limited at such times. Typical characterologic defenses and adjustments to the experience of powerful surges of fear, hurt, and anger threaten to be acted out as they always had been during the course of a patient's life. It is the contract that serves as added weight to the temporarily strained ego and helps to anchor the patient to reality and his adult living. By helping the patient delay gratification, impulse regulation is improved. So, too, is the patient's reality testing improved

as the actual source of strong feelings is examined. Here the adage "where id was, there shall ego be" is particularly apt. Ego boundaries repeatedly challenged in this way become more competent and flexible as archaic feelings lose their strength. Establishing that the relationship between patient and therapist always be based on reality provides the backdrop against which such a curative process can occur.

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Background Point of Theory

No real intimacy or closeness is possible without a sense of clear boundaries. Close contacts without tension are best maintained between individuals or states that are stable and secure within their boundaries and more or less equally matched in terms of power. Disturbances in the balance of power typically precipitate turmoil and unrest. When the psychologic or geographic borders are not clearly demarcated, the person or state is in constant uncertainty and flux, and closeness is commonly experienced as a dangerous encroachment.

From R. Bar-Levav, M.D. (1988)
Thinking in the Shadow of Feelings, New York:
Simon and Schuster, p. 331.