BEYOND THERAPEUTIC NEUTRALITY--

A Second Look At Extra-Therapeutic Contacts Between Therapist and Patient

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The rationale for having no extra-therapeutic contacts in psychoanalysis and in dynamic psychotherapy in general is clear and has been assumed to be beyond need for further examination. Essentially, the psychotherapeutic setting has been constructed in such a way that it provides a well defined framework for the corrective emotional experiences that comprise the curative process. Sterility in the surgical arena is recognized as a prerequisite to prevent wound contamination, and likewise the avoidance of any extra--therapeutic contacts with patients is designed to avoid contaminations in the development of transference. It is generally assumed that contacts between therapist and patient outside of sessions would make it difficult, if not impossible, to distinguish between reactions that are transferential and those which are consequences of the real interactions between the two.

When, a few years ago, a report was circulating about a senior clinician who allowed his teen-age son to become a regular member in one of the therapist's on-going groups--it was immediately offered as proof of confusion, irresponsibility and counter-transferential acting-out. No ambiguity seemed then to exist that might perhaps explain such an unusual set of circumstances as being based on some acceptable and valid therapeutic rationale.

In the usual, traditional psychotherapy setting, the therapist not only would avoid extra-therapeutic contacts with his patient, but he would even attempt to keep most statistical and biographical details away from his patients' knowledge, thus affording them the greatest freedom to exercise their fantasies about him or her. The fewer the known hard facts about the therapist the more space and opportunities are available to patients for transferential

distortions to fit their dynamic needs. Such distortions are the grist for the therapeutic mill. It is generally assumed that any deviation from this scenario is likely to diminish the effectiveness and efficiency of the therapeutic process.

Freud himself was not as careful in these matters as his followers are. He reported not only taking long walks with some of his patients, but occasionally he even conducted therapy that way. He also reported having invited patients for meals with him at his house, and professional relationships of teacher-to-student obviously existed between him and many of the people who came to him for analysis. His writings were available to the public at large, and they were, in matter of fact, the reason why in latter years most of his patients sought him out. A ready-made positive transference usually pre-existed, and both the personality of the master and his theoretical formulations were such that the negative transference was hardly worked with, and sometimes it was not part of the process at all. The real admiration for the real Freud clearly served as an extra-therapeutic impediment to the development of the whole range of transference distortions.

Group psychotherapy, having developed as an offshoot of psychoanalysis and individual psychotherapy was generally based upon the same assumptions and techniques. The anonymity of the therapist cannot, however, be maintained as well in a group setting in which patients face the therapist in a circle, and when they observe him continuously. The power relationship in the group is altogether different and the setting permits, or even encourages, open challenges to the therapist that are not possible for those lying on a couch with the analyst sitting behind. Some observers of the group psychotherapy scene[1,2] have assumed, therefore, that the transference in a group is essentially different in character and weaker in intensity than that of the dyadic

setting. Many therapists conduct group therapy sessions as if the transference is altogether an interference in the interpersonal work for which the group is allegedly designed. Pines, for instance, writes that:

> "In a small group the power of transference has to be recognized in order to be overcome and has to be overcome before the members can enter more fully into the group situation and take part in and contribute to the network of communication and of relationships through which those change processes occur."[3]

This writer does not share these assumptions and holds, in fact, that transferences in a properly conducted therapy group should be, and commonly are, more intense and, therefore, also more useful than those in dyadic settings.

The following discussion about extra-therapeutic contacts with patients should be understood as relating to a therapeutic system that recognizes and accepts the central importance of transference in psychotherapy. Action-oriented therapeutic approaches or those in which "humanistic" concern and gratifications of infantile yearnings is substituted for the tedious process of intrapsychic working-through obviously do not concern themselves at all with the issues raised here.

A few introductory remarks about the clinical setting in which the following episodes have occured would be helpful in evaluating the clinical data. A team of six or more therapists work together, each having their own patients whom they see in 50 minute individual sessions once or twice weekly, but all patients are also involved with one or more of the other therapists in group sessions lasting 90 mintues, meeting regularly twice every week in addition. The therapist conducting the individual session is considered to be the main one, but since two or more therapists are involved with the patient at any one time the transference is often split among them. At least one therapist can usually maintain a firm therapeutic alliance and a strong real relationship with the patient, even while transferential distortions with another therapist

may be extreme. The group as such often also serves as an important instrument with which to evaluate reality, and the real support it provides on such occasions allows transference distortions to become very intense, since the danger of losing perspective altogether is perceived as being smaller. Solo practice of psychoanalysis or psychotherapy may well have built-in limitations on the possible intensity of psychotherapeutic involvement, and extra-therapeutic contacts might not be properly manageable in such a context. It follows that these parameters should probably not be used in such settings, since they are likely to cause more difficulties than good when used resistively.

This discussion of extra-therapeutic contacts will, however, probably prove useful also to those not directly involved in such unusual relationships, since the examination of the related issues requires further expansion and clarification of our understanding of the interplay between the real relationship and the transference, which is of central importance to psychotherapy in general.

CLINICAL MATERIAL

CASE #1

IB is a professional woman in her mid-40's who has been in intensive individual and group psychotherapy for four years. A psychotherapist herself she also is the wife of a close professional colleague and was referred because of moderately severe, life-long depressive symptoms which manifested themselves in a variety of somatic and other complaints. The patient is in the middle phase of therapy and the therapist is transferentially experienced as the immature and inadequate mother of childhood at whom the patient is now openly angry, especially in group sessions.

The patient attends one individual and two group sessions each week. In one Wednesday group session, IB's characterologic self-pity and hurt are

soon replaced by loud expressions of rage at the therapist who is claimed to have disappointed her on several scores. She is bitter, sarcastic and loudly protests her alleged mistreatment. Her "dart-shooting" eyes express deadly hatred at the therapist, the abhored disappointing object. Powerful expressions of anger and hurt, with only minimal experiences of fear, last for approximately 10 minutes.

An unusual invitation for dinner occasioned by special circumstances was extended to the therapist sometime prior to the session by the patient's husband. The date happened to have been for the Saturday following the Wednesday of the session. This was an altogether uncommon experience and only the first time since the patient's therapy began that such a visit was ever contemplated or accepted, after careful consideration of the circumstances. The genuine expressions of rage at the therapist during the Wednesday session did not affect the original plans and the dinner date was kept as scheduled, although with some understandable hesitation. The patient was gracious and friendly as a hostess, prepared an elegant and tasteful meal, and the entire evening passed very pleasantly and without strain.

The next regular group session was scheduled, as usual, for the following Sunday morning, and everyone, including IB, was present. IB resumed promptly her expressions of distain and fury, after a brief mention of the social circumstances. Her friendliness of the previous day did not interfere with the loathing and rage which she powerfully directed at the therapist who allegedly had failed her so grossly. The observing-ego did not impinge upon important expressions of long repressed material until much later.

CASE #2

LS is a man of 30, a contractor who had been in therapy for 3½ years when some construction work was necessary in the therapist's house. The patient had expressed an interest in bidding on the job, which he did. Although not the

lowest, his bid was accepted since the quality of the patient's work and his reliability were known and believed to be the best available.

LS came to therapy with complaints of extreme social isolation in a state of markedly constricted affect and psychomotor retardation. He was at that time merely engaged in occasional house painting, which represented the peak of his professional achievement. Since then he established his own business, obtained a contractor's license, bought a house and gradually turned into a successful businessman. His interpersonal relationships have, however, not changed as dramatically, and he still found it very difficult and frightening to take risks with intimate relationships. Transferentially the therapist was experienced as an idealized father, consistent over time and essentially fair.

The extra-therapeutic contacts with LS occurred over a period of several months. They included supervision of the details of the construction job and obviously entailed also the settling of the financial accounts between them. The patient was helped to bring his reactions to all such extra-therapeutic contacts openly into his sessions, both individually and in the group. On occasions he complained loudly about aspects which he did not like in his other relationship with the therapist. Jealousy at the patient and criticism of the therapist for engaging in such outside contacts were also expressed by other group members on several occasions. The idealized image of the therapist was being tested repeatedly. LS believed at one point that a payment was not rendered on time, and he felt safe enough to thunder his rage and disappointment without holding back, before it was clarified that his office had already acknowledged receipt of the funds. The project was completed to the satisfaction of both sides, and the patient is continuing in therapy.

CASE #3

AW is a 21-year-old college student who has been in therapy for several years. The daughter of a previous patient, she was referred at age 17 because of academic failure, having almost flunked out of high school, and withdrawal

into an almost total silent existence in her family, with occasional explosive outbursts. Her typical mode of being in the group reflected the silence and withdrawal that were reported by the parents. She would sit almost motionless session after session, hardly uttering a word, and with almost no change in her bodily or facial expressions. The underlying panic was soon exposed, but her massive muscular armor was very slow to diminish. She would sometimes hesitatingly begin to speak in a very low voice, but would suddenly interrupt herself as fear became overwhelming. Her wide-open eyes would tear on such occasions and her voice would choke.

AW was the oldest in a sibship of four, and she absorbed the brunt of mother's hysterical outbursts and father's stoic silence and occasional thunderous protests. Father was physically very large, and his angry yet essentially harmless outbursts were experienced by the little girl as real threats to her very survival.

Her therapist demanded as a condition of continued therapy that AW shoulder a small part of the financial burden for therapy, in an effort to help her assume increasingly greater responsibility for her life. Although a full-time university student four years after beginning therapy, she was struggling to earn some money to pay for therapy, working as a part-time waitress and occasionally holding several other odd jobs. It always required major efforts on her part to find jobs and to maintain them in spite of changing schedules at school.

A person was needed in the practice to help serve food and to perform similar duties at weekend marathon sessions, and the job was offered to the patient. She requested a week to consider her options, wishing to discuss her reactions and feelings in her individual and group sessions. Carefully weighing the financial pros and cons and how she believed the job might affect her therapy and her relationships with the therapists, and after consulting her parents, she finally decided to accept the offer.

Her duties included shopping for fruit and for other supplies, preparation of coffee and, in general, responsibility for keeping the physical environment tidy and trouble-free. She proved to be eager, very reliable, outgoing and efficient. A previously unseen facet of her personality emerged, one not only unknown to her therapists but previously also hidden from herself. As she came into close and repeated extra-therapeutic contacts with her therapist and with his associates her withdrawal in therapy also diminished.

Several months later the patient believed that, based upon her performance, she was entitled to a raise. She struggled in several group sessions with the anxiety surrounding the issue and with her wish to confront her therapist-employer, wondering how much of her wish for the raise was realistic and to what extent it was motivated by a desire to be treated preferentially and lovingly by him. She became psychologically sophisticated as her therapy proceeded, and was able, therefore, to wonder by herself about the possibility that her wish to be paid more might represent a test of her general value to the therapist. Even the size of the contemplated raise was considered from this point of view as well as from the perspectives of the market place. Her total relationship with the therapist, and indirectly with others, was thus thoroughly examined before the issue was settled.

As both the business and therapeutic relationships continued to co-exist the patient's ability to participate verbally in her sessions slowly improved. Her life-long silent withdrawal which previously had been ego-syntonic was increasingly experienced as alien, and it began to slowly crumble. The intense, almost psychotic alternating transferences by which the therapist was experienced as either a powerful, threatening father who might devastate her or as an unsteady, explosive mother who might engulf her--were now more readily accessable for working-through, aided by the perspective gained by the real relationship with the therapist as employer.

CASE #4

JA is a 55-year-old professor of Medicine who got to know the therapist many years before, while JA was a department chairman and the therapist a medical student. They have had only a few brief contacts since, and JA's phone call asking for an appointment was, therefore, completely unexpected and unusual. He explained during the initial interview his reasons for needing therapy and for choosing the therapist, whom he grew to respect both as a person and as a professional. The previous non-therapeutic contacts were reviewed, and other less-than-fully-conscious motives for the choice were carefully explored. Did JA feel safer with an ex-student, perhaps believing that their previous hierarchical positions might protect him from having to experience too much pain? JA was deeply distrustful of father-like authority figures, believing that they, too, would prove to be inconsistent and weak, as he remembered his real father to be. The therapist, he claimed, was one of a very small number of exceptions on this score, and he believed that the choice was, therefore, a good one.

The patient was taken on for a trial period of several months to allow sufficient time to carefully determine whether or not a viable therapeutic relationship could be established. As long as the therapist served transferentially as an idealized father figure, helping JA work through difficulties with masculine identification, the task was being carried out without too many disturbances. When the patient's narcissistic expectations were seriously challenged, however, the entire project eventually ground to a complete halt. The pre-therapy relationship was civilly substituted by the therapeutic one, without crisis or struggle but also without a real psychologic impact upon the personality. As a result, the real relationship was always proper and dignified but not intense enough. When transferentially the therapist began to be experienced as an inconstant and ungiving mother that did not cater to the patient's infantile demands for exquisite gratification--therapy was ended. The

real relationship was too weak to hold JA. Even slightly bruised narcissism was experienced by him as a major assault upon his self-righteous expectations, and he left prematurely.

CASE #5

LK is a 30-year-old attractive woman with whom the therapist has had a short but intimate personal relationship several years before she asked to be seen as a patient. There have essentially been no contacts with her in the intervening years, but when she sought professional help from the therapist it was believed that because of the past involvement it would be best to refer her to someone else. The patient began a course of psychotherapy with a senior and competent analyst, seeing him three times weekly for approximately eight months when she quit. The patient's hysterical character structure and her excessive narcissistic demands apparently were too much of an obstacle in this setting, and the attempts to frustrate some of her unrealistic expectations eventually led to her parting. Soon thereafter the patient again approached the writer with a wish to enter therapy with him, and she was again referred elsewhere for the same reasons.

The second course of therapy was a bit longer, but it ended similarly, apparently for similar reasons. Nearly suicidal, chronically and acutely depressed, her marriage having recently broken, LK was in acute distress. "Just because you and I have known each other intimately many years ago, do I have to die? I followed your recommendations, not once but twice, and it did not work. I know I'm a difficult patient. I cannot help it. I'm very scared. They meant well but could not cope with me. I believe you could. It is not right that our past relationship be held against me forever."

The patient was eventually accepted into the practice, but with the understanding that she be seen individually by an associate under the writer's supervision. His only direct contact with her would be as one of two co-therapists in the group. The specifics of a therapeutic contract which strictly

excluded acting-out and extra-therapeutic contacts were carefully worked out with the patient, who understood and cognitively accepted them and their rationale. The struggle began.

Several months after the beginning of therapy the "honeymoon" was ending as her narcissistic yearnings remained ungratified, and she increasingly recognized her self-destructive tendencies. From time to time, as she experienced panic and great pain, the patient ignored her initial agreements and attempted, instead, to make extra-therapeutic telephone contact with the writer, based on their past relationship. Such attempts to find solace outside the therapeutic setting were frustrated and openly explored both in individual and in group sessions. It was clear to the patient no less than it was to her therapists that the contamination of the past relationship seriously interfered with the therapeutic efforts, but she was, nonetheless, seemingly unable to close this loophole from time to time. After about six months, when it became obvious that the psychotherapeutic attempts were heading towards failure, the patient was informed that her therapy would be stopped after a few more sessions were held.

This announcement precipitated a major panic reaction which was expressed in psychotic-like behavior in the office. LK began screaming hysterically, sobbing uncontrollably, threatening to kill herself and to do harm to her therapists. With the help of reality-oriented assurance she was soon able to gain control of herself. She was advised to remain in the waiting room to further calm herself, which she agreed to do. Several minutes later the patient left, and the therapists locked the office door behind them as they were also leaving for a short lunch break. An alarmed building guard was soon looking for the therapists, informing them that a disturbed-looking young woman was reported pounding forcefully and furiously with her handbag on the thick glass door of the office, finally breaking it in a very loud explosion. The glass shattered into many shrapnel-like pieces, some forcefully

imbedding themselves in the adjacent plaster wall. Like bullets they would have severely injured, if not killed, anyone who might have been there. The guard did not have to restrain the patient who collasped, sobbing in despair, soon thereafter.

It seemed self-evident that such an obvious violation of the non-acting out requirement of the therapeutic contract would bring about an immediate cessation of therapy, plus other possible measures. But, careful consideration of the situation resulted in an altogether different course of affairs. The patient was given another chance to continue in therapy, since the powerful impact of this dramatic episode which could have resulted in death or serious injury altered the patient's behavior to a degree that allowed the work to continue. She finally really understood and really agreed to the limits of acceptable behavior if therapy were not to be stopped.

The violent episode and its aftermath served as a turning point in LK's life. Smooth transitions are perhaps not possible when a radical change in character of important relationships becomes necessary. No further extra-therapeutic contacts were attempted during the next four years of therapy, even during periods of extreme turbulence. Although not finished, much of the patient's narcissistic expectations were worked-through by the time she left to live in a different state. Her depression did not lift entirely, but the hysterical character traits have essentially yielded to the demands of reality. She became increasingly more realistic in her role as mother, and to her own and everyone else's surprise, she clearly became the more mature and the more responsible of the two parents.

INTRODUCTORY THEORETICAL DISCUSSION

The above clinical vignettes have been garnered over a period of 15 years in a very large private practice with as many as seven therapists working full time. Extra-therapeutic contacts were few in number, and they represented

exceptions rather than the rule. They are presented here not in order to help routinize or legitimize all such contacts, but because the unusual nature of the extra-ordinary helps us understand the ordinary more clearly. The difficult dilemmas posed by the illustrated case material provide contrasting perspectives with which to focus upon the parallel dual relationships of psychotherapy in general, the real one and that of the transference. As a rule, when extra-therapeutic contacts occur under strictly controlled conditions and all the transactions and the reactions to them are fully brought into therapy and fully worked with, the extra dimension of extra-therapeutic contacts enhances, rather than retards, the curative process. On the other hand, when for whatever reasons, pre-therapy or extra-therapy contacts are not sufficiently neutralized, they eventually are used in the service of resistance to change, and they doom the entire effort to failure.

For psychotherapy to be effective it must always involve the patient forcefully in two opposite spheres: his or her affective expressions must, on the one hand, reflect the entire gamut of all previous life experiences from the moment of birth (perhaps even from before) as they manifest themselves in the transference distortions of the therapist and/or other patients. The more intense the emotional involvement of the patient in the process, the greater the transferential distortions that are available for scrutiny and for eventual change. On the other hand, such powerful transferential distortions are only tolerable within a framework of a real relationship that is equally intense and involving, one which is based on true _mutual_ respect and _mutual_ honesty, a relationship which is consistent over time, and in which the patient really has the freedom to experience and to express the negative as well as the positive transference fully and without interferences, directly _at_ the therapist.

In psychoanalysis and in most traditional psychotherapy the pull in either of the two directions is usually not powerful enough to allow for the desired changes to occur. The almost total anonymity that some therapists adhere to strictly in the name of maintaining therapeutic neutrality and guarding the transference against contamination may often merely be a disguised device to maximize the comfort of the less-than-fully secure analyst or therapist. The mutuality of the real relationship requires that the therapist be willing to disclose himself as a humane and sensitive real person, even if biographical and statistical details about him are purposefully kept vague. Trusting a therapist who remains essentially an unknown in his human qualities cannot but be an expression of poor judgment borne out of despair and fear. A relationship based on such blind trust stands on shaky ground, and it is likely to break down as soon as the patient's fears decrease sufficiently. Such a weak relationship is not a real one, and in such cases both the patient and the therapist sense that transference distortions better be constantly and carefully monitored, lest they become too strong for the holding capacity of the real relationship.

That which is obviously irrational or "crazy" is very difficult for patients to express openly, even in a confidential dyadic setting, because the observing ego knows it as making no sense. Embarrassment and humiliation are commonly associated with such expressions, and patients must, therefore, be "educated" and helped not to act according to their natural tendency to inhibit such expressions, which are often suppressed for long, except when the distortions are relatively mild. The stance of therapeutic neutrality was designed to minimize such embarrassment and humiliation on the part of patients, but it normally achieves this goal only with limited success because terror-filled fears of rejection and abandonment lie at the bottom of such embarrassment and humiliation.

For therapy to achieve its goals it is necessary, therefore, to go beyond the stance of therapeutic neutrality. The real relationship must be shored up sufficiently so that it becomes powerful enough to contend with the patient's greatest moments of panic. Paradoxically, even as the patient is gripped by the certainty of abandonment by the therapist, he must also be equally certain that no such abandonment would occur in reality. Even with a real relationship of such intensity in place, patients still find it exceedingly difficult to venture into areas associated with embarrassment and humiliation, and exquisite sensitivity and timing on the part of the therapist is required to help them through such seemingly life-endangering rapids. Without such an intense real relationship, therapy remains essentially a cognitive process without sufficient force to effect life-long characterologic, and therefore characteristic, responses.

Not all affects are equally embarrassing and, therefore, not all are equally shunned in psychotherapy. Hurt and pain (including self-pity), mild anger and a little bit of loving, in doses acceptable by rationalization to the observing ego, are commonly part of any long-term psychotherapy and psychoanalysis. Most patients experience emotional insights that cause them at times to cry and to sob, and most leave some sessions in a great deal of turmoil or in a state of deep self-reflection. But, when rage represents unsatisfied pre-verbal hunger, and when love is an expression of pre-verbal yearnings and, therefore, assumes immense and seemingly absurd proportions, their open expression often appears to the patient to be so "crazy" that the affects are suppressed or denied altogether. Such rage or loving yearnings are more commonly expressed merely as thoughts or as affects towards objects or persons outside of the therapy setting. Talking _about_ affects is obviously altogether different than actually feeling and expressing them with all their primitive power directly in relation to, and _at_ the therapist. Indirect and once-removed

expressions of feelings have relatively little emotional impact upon the person, and they are, therefore, of lesser benefit in the process. When the real relationship, however, is not strong enough[4] or even when its strength simply cannot be confirmed by testing, patients generally deny and do not openly express such extreme manifestations of "craziness". They generally want to appear as healthy as possible even to their therapists, since fear of decompensation commonly follows the experiencing of very strong emotions that appear to have the power to overwhelm the defenses. Grossly irrational views of the self are almost always perceived as extremely threatening, as if conscious recognition of their existence has in itself the power to destabilize the personality. Hence, the tremendous pressure to keep the accompanying affects repressed. When therapist fail to actively help patients overcome this hurdle of continued repression because they, too, equate expressions of primitive affect with a more severe degree of illness--an unconscious pact of denial is struck between the two.

A therapist who fails to recognize the universality of powerful and primitive emotional experiences would knowingly or unknowingly convey clues to his patients that the uninhibited expression of primitive affect may indicate the presence of a serious illness, not treatable by out-patient psychotherapy. This may well be perceived by patients as a thinly veiled message that the therapist's limits of tolerance have been reached and that the continuation of therapy is in danger. Whether true or not, such perception is often experienced by patients as a threat of abandonment, which may represent the earliest and, therefore, the worst fear. Such fears are very difficult to work with even when they merely represent transference distortions, and they are likely to halt the therapeutic process altogether when they actually reflect the reality of the therapist. Even under the best of circumstances patients commonly deny grossly "unreasonable" affects. The fears associated with their full exposure must,

therefore, first be brought into realistic focus before they become available for working-through. This is achieved with the aid, and against the background, of the real relationship. Extra-therapeutic contacts can, in some circumstances, be helpful in resolving especially tenacious and sticky transference distortions, provided that a strict therapeutic framework is maintained.

DISCUSSION OF CASE #1

Some of the general principles of the previous discussion are well illustrated in Case #1. IB's ability to experience the therapist in such totally different ways within very close time proximity should not be misunderstood to mean that a schizophrenic-like personality split existed, nor that her affect was isolated from real life situations outside the therapeutic setting. On the contrary, the patient demonstrated during a long course of therapy that she was able to clearly separate the requirements of a real relationship from the unique privileges of distorting affectively within the transference. Although regularly daring to regress to almost psychotic states of feeling during sessions, and on one occasion even to experience a few minutes of actual psychotic confusion, she was always able to fully reconstitute before the end of each session, and her ability to function as an adult in her roles as mother, wife, and therapist was never in question. Both her family and her employers have independently confirmed an increasing capacity to function appropriately and to fulfill very demanding and responsible tasks well and without difficulties. Her therapists noticed, sometimes almost in disbelief, her parallel ability to easily regress at the beginning of sessions and to easily return to adult functuning at their end. This ability to shift back and forth from the demands of one setting to those of the other is obviously an essential requirement for any work in psychotherapy or psychoanalysis. When patients have difficulties in this area it generally is a clear indication of diffuse and ill-defined ego boundaries. IB's ability to shift so easily back

and forth could clearly <u>not</u> be explained this way. Her symbiotic-like attachment to an engulfing mother brought her into therapy in the first place, and she was still actively struggling with the problem of self definition. Another explanation had to be found.

When the real relationship and the transference distortions are of greatest intensity, shifts in affect from one framework to the other are by definition markedly greater in magnitude than otherwise. Contrary to expectations, the case of IB strongly suggests that such shifts are in fact more easily accomplished when the amplitude of the change from the transferential-feeling state to the adult-observing one is the greatest, since the boundary between them is then the clearest.

All feelings of any individual must be understood as true reflections of the totality of the specific life experiences of each person and, therefore, as exactly correct and as always accurately portraying the residue of all of one's perceptions of the world. The thinking-observing process, on the other hand, is the psychic instrument that is available for the definition of "objective" reality as it really is, not as perceived through the filter of individual experience. Since feelings reflect <u>our</u> individual experiences and <u>our</u> particular idiosyncratic way of "knowing" the inner and outer world, it is always disturbing and often very frightening to have to accept the fact that it is not necessarily an accurate reflection of reality. When we no longer can escape this realization nor continue to deny it, we not only sustain the loss of an important delusion, but moreover, we are left to cope with existence without a reliable instrument to help us assess our surroundings. This always increases fear even more and explains the universal tendency of Man to cling tenaciously to his feelings and to refuse, for as long as possible, to be "confused" by real facts. Our common use of language reflects this attitude. Were these fears not of such great proportions, no one would ever act except

rationally and in the pursuit of one's best interests, and neurotic conflicts would easily and quickly yield their hold on the person as soon as their wasteful nature is recognized. Although plainly absurd, many orthodox Freudians still base their entire clinical philosophy on the assumption that cure is achieved by making the unconscious conscious, as if increased understanding, insight and rationality could prevail by themselves.

In actuality, feelings often masquerade as thoughts so that the painful and frightening revision of our relationship to reality might be avoided or at least postponed. Close scrutiny as well as constant vigilance must, therefore, be exercised so that feelings be recognized as completely distinct entities, often completely unrelated to current thoughts, although Man in his efforts to appear rational always tends to wed the two. When in psychotherapy the separation is strictly maintained and when, in addition, feelings of any kind and of any intensity are clearly understood as never being in themselves a sufficient basis for action--then the intensity of experienced and expressed affect within therapy increases dramatically.[5]

Patients accomplish shifts from the feeling-experiencing mode in which the transference resides to the thinking-observing mode of the real relationship most easily when the two are clearly distinct and separate from each other. When that boundary is not sufficiently clear patients understandably tend to resist shifting from one mode to the other for fear of getting lost in the process, since they sense the danger of slipping in and out either mode inadvertently and without control.

IB's ability to act as a gracious hostess was based on a strong and clearly defined real relationship between her and her therapist in the adult mode of current reality. Her ability to resume her transferential distortions will full force soon thereafter indicated at least an unconscious recognition that all her feelings were valid, even if they did not coincide with the real relationship. The sharp differences between the two provided IB with more proof

that her strong feelings were at least in part transitory emotional residues from the past and not necessarily representative of her present relationship.

THEORETICAL SUMMARY

In general, the greater the contrast between that which is experienced in the real relationship and that which is experienced in the transference, the greater the impact upon the personality and the greater the beneficial effects upon the character structure. It follows, therefore, that the impact of the real relationship upon the transference distortions is greatest when the time interval between powerful emotional experiences and the process of observation is the shortest. Ideally, the time lapse between the two should be brief enough not to permit the ego to use old and tried pathological defenses to lower the anxiety and the panic that are evoked by emotional crises. Dormant and previously under-used ego functions are then forced into use, thus expanding the range of the ego's adaptive responses.

DISCUSSION OF CASE #2

The extra-therapeutic contacts of LS, extending over some time, fed the transferential distortions on the one hand, since the special relationship with the therapist was interpreted transferentially as indicating that he indeed may be the chosen and beloved child of the idealized mother. Concurrently, on the other hand, the real relationship with the therapist as an employer forced the patient to see the former as a real person whom he must satisfy before he is paid. The delusion of exclusivity with an idealized mother who exists essentially to meet the patient's demands and wishes was repeatedly smashed against the reality of their business relationship, in which the patient was strictly held to the terms of the contract. As a result of these extra-therapeutic contacts both the transference distortions and the real relationship were thus intensified.

The boundary between the two relationships was never allowed to become blurred. For instance, whenever the patient would call in matters relating to the business relationship, he would intuitively and on his own introduce himself by also identifying his role: "This is LS, the contractor." It was probably as much to avoid his own confusion as it was for the therapist's sake that such a clear introduction was made during every contact. The therapist had similarly recognized the need to strictly avoid any discussion of business matters in the same room in which the sessions were held, nor immediately before or after a session.

Personal and biographical data about the therapist would normally be kept out of the therapeutic relationship, but this, obviously, was no longer completely possible. The house in which the patient was occasionally seen before was not previously confirmed as being the therapist's residence, but this became obvious now. Some useful lack of clarity had to be sacrificed. LS was now able to garner from direct observations of the house and its contents as well as from their business relationship much information that was previously only speculative. The limitations thus placed on the patient's freedom to fantasize were clearly believed to be more than offset by the gains in intensity of the transference distortions and of the real relationship.

DISCUSSION OF CASE #3

When psychotherapy is intense enough and when interim relief of symptoms is not misunderstood to mean that a cure has been achieved, increasingly more primitive and less rational layers of the personality are revealed, in a gradual process which follows predictable and duplicable steps and phases. When the natural course of the psychotherapeutic process is not fully understood it can be as discouraging to therapists as a difficult mountain-climbing project would be for those approaching it without topographical maps of the terrain. Tremendous effort, patience and courage are often required to overcome the

difficulties of reaching the next visible peak, only to discover when it is finally reached that the top of the mountain is still far away. For the life-long depression of any individual to lift, a person must fully overcome the previously developed tendencies to fold-in and to give-up that have become part of the character structure in the earliest days or weeks of life. Such character traits begin to be firmly established in the neonate's physiology as it becomes inescapably clear that even the most powerful and persistent demands for restoration of the relatively anxiety-free pre-birth state will never make it happen. Every survivor then compromises by learning to co-exist with ever-present, though not necessarily constant, anxiety, sacrificing in the process some of its hope, viability and spontaneity. The physiologic patterns that begin to be established very early probably include shallowness of breath, slowing of motion (or the corresponding opposite reaction of jumpiness) and some generalized weakening of the force with which the organism pushes to have its wants and needs satisfied. This is also psychologically expressed in the form of diminution in the optimistic expectations from the environment. These are all pathognomonic findings of adult depression, as expected. Such physiologic compromises must be basically reversed before depression can finally lift.

As patients go through intensive psychotherapy and more primitive aspects of the personality are revealed, increasingly earlier states of development and compromise formation are reflected through re-experience. Temporary regressive episodes within sessions occur regularly and are routinely expected, but <u>this</u> time they are resolved with the help of an adult ego which is brought to bear upon the panic which was unfathomable when first experienced, long ago. Every patient who feels safe enough in therapy and who stays long enough would eventually go through many such temporary, psychotic-like moments unless they are somehow disallowed by the therapist or analyst, since none of us is exempt from having had psychotic-like experiences, including normal autism, before

cognition and the concept of self were developed. As Klein and Tribich suggest in their review of five of Freud's major case studies, his work with these patients was sharply limited by Freud's own lack of freedom and ability to see beyond his blindness.[6] The work with Dora or with the Wolf-Man was merely concentrated upon the most superficial layers of their neurotic personalities and behavior. Analysis, which was only mildly therapeutic, was ended long before termination should have occurred and long before real cures were achieved. The underlying depression continued to plague them both.

Many of AW's difficulties represented very early fixations, and in sessions she repeatedly experienced psychotic-like states when her adult ego seemed temporarily to be unreachable. She was generally able, however, to reconstitute quickly, and at the very least by the end of each session. She was always able to drive home, and to maintain herself in school and meet all other requirements of reality adequately, even if not always well. As if by design, she was appropriately the sickest when she was in her doctor's office. Here her withdrawal was often extreme, her terror-filled eyes wide open, as she was gasping for air and speaking little. Her generalized distrust and fear did not allow the real relationships with members of her group and with the therapists to flourish, and it appeared to have been too weak to contend with her archaic panic which was transferentially re-experienced in sessions.

The extra-therapeutic contacts with her therapists added weight and increased the dimensions of that real relationship. As a result, she found it increasingly more difficult to ignore, or to keep it from impinging upon her delusions and her gross transference distortions.

THEORETICAL SUMMARY

Extra-therapeutic contacts are by no means the only, nor perhaps even the best, way to resolve gross transference distortions, but since intensive psychotherapy is expensive, painful and long, any avenue helpful in the process

ought to be seriously considered. Psychotic and psychotic-like transferences are exceedingly tenacious, and they often endanger the welfare of the patient as well as the continuation of therapy. Parameters that are useful in resolving such extreme distortions are, therefore, of great value. Extra-therapeutic contacts may benefit out-patients in intensive psychotherapy in much the same way as regressed hospitalized patients benefit by engaging in reality-oriented tasks on the hospital grounds. Such extra-therapeutic contacts must, however, be titrated carefully and always be designed for the patient's benefit so that the essential framework of therapy would not be compromised.

DISCUSSION OF CASES # 4 AND #5

Both these cases are different from the previous ones in the sense that all non-therapeutic contacts occurred before therapy began, and that essentially no extra-therapeutic encounters existed while therapy was in progress. They are also different from each other in the sense that case #4 represents a failure to resolve the difficulties while Case #5 is a report of at least a partial success, since the sticky issues were dealth with more fully.

The concept of time is psychologically not as clearly fixed on a chronological continuum as it is in reality. Both JA and LK understood and accepted the need to completely separate their previous social relationship from the therapeutic one. They have also recognized the special difficulties that were likely to be encountered because of these previous contacts. Cognitive recognition, although genuine, was, however, not a sufficiently strong force to overcome the push towards obtaining extra-therapeutic solace when panic was re-experienced during therapy from time to time.

The issue was really never sufficiently resolved with JA. He was deeply involved in the therapeutic process for 2½ years, during which time the acute depression which was precipitated by his divorce had lifted. The life-long

characterologic aspects of his chronic depression have, however, only begun to give way when he stopped therapy in disappointment and hurt, using the understandable excuse that his therapist was leaving for several weeks at a time during a long-prepared-for, modified, sabbatical year. Rigid rationalizations which proved to be impenetrable were tightly held on to by this very bright man, to ward off the fear of abandonment that he was beginning to experience. The absences of the therapist intensified this fear which was emerging anyway, as ever more primitive layers of the personality were being worked with. Temporary regressive episodes in the service of ego repair were never achieved, the core depression had not lifted, and although JA is markedly improved, many constrictions placed upon him by a rigid character structure continues to exert their toll.

In the case of LK, on the other hand, the dramatic clarity with which the change in relationship was impressed upon the patient apparently was of sufficient intensity to override the previous, non-therapeutic contacts, and therapy could proceed. Although she, too, did not finish the job by the time she left the state for seemingly valid reasons, some of the earliest and most primitive aspects of her personality were worked with, at least partially. The patient is functioning on a significantly more mature level, although much remains to be done.

Both cases also posed special challenges to the therapist since the task required that he assume an entirely different position vis-a-vis these patients and relinquish old expectations and attitudes. This was achieved by a continuous process of self-scrutiny, aided on a regular basis by close peer supervision. The presence of a co-therapist in group sessions also helped neutralize possible contaminations on his part. In spite of such efforts, the complex task of working so intensely with patients became more difficult and the results were less than completely successful.

THEORETICAL SUMMARY

Surgeons operate on close members of their own family only in the absence of all other alternatives, knowing that they are assuming additional burdens by doing so. When the circumstances require it and if both patient and therapist are able and prepared to adhere strictly to the terms of a new and different relationship, withstanding all pressures to bend it, as was the case with LK, at least partial success may be expected. The fact that neither of these two patients completed the course of therapy confirms, however, that the existence of non-therapeutic contacts prior to the beginning of therapy burdens the task with an extra weight that is best avoided whenever possible.

The psychologic non-sequential chronology of the concept of time also applies to non-therapeutic relationships between therapist and patient after termination. Although transference distortions are expected to have been essentially resolved by then and the real relationship should serve as the only basis for what happens between them, remnants of old yearnings and disappointments cannot but come up from time to time, especially when the going gets tough in the first year or two after termination. Patients would tend at such times to ignore the sequence of time and the important change that had occurred in the relationship, and they would on occasion experience strong transferential distortions in relation to their ex-therapists. The patient is likely to possess by then adequate tools to self-correct such distortions, if therapy was conducted properly and termination was not premature, provided that the ex-therapist remains vigilant and does not lend himself to the patient in a role that is no longer applicable.

UNDESIRABLE EXTRA-THERAPEUTIC CONTACTS

Extra-therapeutic contacts with patients are generally discouraged because they impose an extra burden upon the process and present difficulties, especially to less-than-fully-experienced therapists. Most patients probably can

complete the required work of therapy successfully without the use of this additional parameter. Although useful when carefully controlled, having extra-therapeutic contacts with patients opens an avenue through which abuse of patients by less than fully-ethical or less than fully-experienced therapists becomes possible. Not only can patients be used and abused by such contacts, but also the harm they may sustain may doom all future therapeutic efforts to almost certain failure.

Even under ideal conditions, when the therapist is fully ethical, competent and experienced not always are extra-therapeutic contacts helpful in the ways described. In some cases they serve essentially the cause of resistance, and they should then, obviously, be strictly avoided. The following vignette is a case in point:

CLINICAL VIGNETTE

RS is a prominent physician in his 50's who came to therapy because of serious and persistent social and professional difficulties of long duration and a history of physical illnesses since childhood that the patient himself recognizes as having been psychologically induced. Asthma and a variety of other respiratory illnesses were especially prominent in this picture. Being very intelligent, RS has helped himself throughout life by manipulating all his relationships, and he is both proud of this capacity and deeply ashamed of it. He also adopted rigid philosophic systems that offered definitive and clear solutions to the problems of existence, which he applied simplistically to himself and to others. He always assumed heavy responsibilities and worked hard, wishing to "do well".

A crisis of mid-life was precipitated by an increasing recognition that all these approaches failed to bring him peace of mind. His excessive anxiety was expressed by periods of social isolation and emotional withdrawal alternating with long episodes of hyperactivity. He knew that something had to be done to alter his self-destructive patterns.

The patient's enormous panic surfaced as expected when he began to trust himself sufficiently with the therapist and with his group to allow previously hidden fears to surface, and as the hollow value of his old adjustments could no longer be denied. RS then attempted to lower his anxiety by repeatedly seeking extra-therapeutic contacts with his therapist, using a rather ingenious and innocent-appearing pre-conscious plan: he would refer patients from his practice to the therapist, sending along proper referral notes which often included a few astute psychological comments about the patient and how he might best be treated. He expected, and rightly so, some acknowledgment for each referral, and it soon became obvious that he was deeply disappointed, hurt and angry when the replies were proper and matter-of-fact but short and strictly business-like. His attempts to engage his therapist as a colleague, thus creating a parallel extra-therapeutic relationship side-by-side with the therapeutic one, were successfully frustrated. Although the comments RS volunteered in his referral notes were often insightful, no acknowledgment of their validity was ever made.

RS had a large medical practice and his well-considered referrals were welcome at a time of economic stress, when many psychiatrists in the area reported difficulties in finding patients suitable for psychotherapy. The disappointment of RS at failing to create a special relationship with the therapist was openly expressed eventually, the patient typically also trying to manipulate the situation by implying that he might not refer patients again unless he got more satisfactory replies. Much rage was triggered before the unconscious yearnings could be explored and worked with directly. Only after all of RS's attempts to establish a special extra-therapeutic relationship were thwarted did his therapy continue appropriately.

CONCLUSION

Extra-therapeutic and non-therapeutic contacts between therapist and patient are explored in depth because they probably happen more commonly than expected and their potential for harm and for good needs to be better understood. In addition, the exploration of the effects of such contacts helps shed light on the dimension and quality of the real relationship in psychotherapy and how it relates to the intensity of the transference. This, obviously, is of central importance to the outcome and results of all our efforts.

The old and customary prohibitions against extra-therapeutic contacts between patient and therapist have generally been followed rigidly by those who work daily with transference distortions, but such dogmatic attitudes may well represent no more than theoretical assumptions from a time when psychotherapy was younger and less clearly understood. As the need for a more intense real relationship is increasingly being recognized and its essential characteristics elucidated--transference distortions also become correspondingly more intense. When the boundary between the two stands out with sterling clarity, important parameters such as well-conceived and well-controlled extra-therapeutic contacts may be used beneficially on a limited basis. Clinical material is presented to richly illustrate the discussion.

The importance of a crisis that forces difficult changes is well illustrated in the contrast between cases #4 and #5. An emotional crisis is thus viewed as an opportunity or as an inescapable cross-roads where choices cannot be avoided. This is the sense in which "Crisis" is used in Crisis Mobilization Therapy (CMT), which identifies the psychotherapeutic system from which the clinical material for this discussion was obtained.