Nolan Saltzman

Helping a Physician Heal Herself

The Research Section welcomes articles that aim at (a) discovering the secrets of psychotherapy (b) through careful clinical study (c) of actual psychotherapy sessions. In this article, a distinguished therapist probes into new ways of eliciting and using intense emotional expression. I have selected this article as a valuable contribution toward fulfilling those goals.

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Carrie, 43, is a physician who has virtually given up her practice due to panic, depression, and intermittent illness. I have been struck by the extent to which many clients operated well and felt relatively good for years or "my whole life" until a point of breakdown. What I am learning from these outwardly successful clients is that falling apart in the safe setting of my therapy room is scary and painful, but ultimately allows reintegration. I suggest or encourage an attitude that allows clients like Carrie to continue or resume working: "These are just my feelings of falling to pieces; I can finish my work today and fall apart in my next session."

This paper shows a client urged to lose control of her cries in the context of emotional support and tender holding. The out-of-control cries can be uttered only at a moment of giving up defenses; then validation of the "naked self" thus exposed helps her begin to learn to feel good about herself at the core.

Here are excerpts of a tape from Carrie's eighth session, wherein cognitive and experiential methods are intensified by eliciting and validating her intense emotional expression. The therapist improvises by combining elements from (a) the immediate circumstances, as the voices in the corridor; (b) the dynamic history of the client, from earlier consultations and as she elaborates it in the present session; and (c) the imagery of violent slaughter offered by the client.

Carrie and her therapist are seated close in easy chairs facing each other at a conversational angle.

recognized my fear of becoming intimately involved. The cockiness that I had once seen as expressing freedom from that fear, I came to realize instead, expressed that very fear! It allowed a kind of contact with others, but also kept them safely distant.

Reflecting on my work with Lois, it is clear that the more a therapist and patient are really involved with each other as two human beings, the more likely are the unresolved difficulties of *both* patient and therapist to come to light. Concurrently, the more healthy my patients become as a result of my good work, the more able they will be to recognize my real shortcomings and confront me with them. In Lois' case, I had used power to force the reality principle upon her, and it was out of this therapeutic use of power that she found her own true power as an adult woman.

And so it was that I was stunned when Lois complained, "You have always been too quick to shut me out." She knew what I was like better than I myself wanted to know. Obviously, our relationship was a two-way street.

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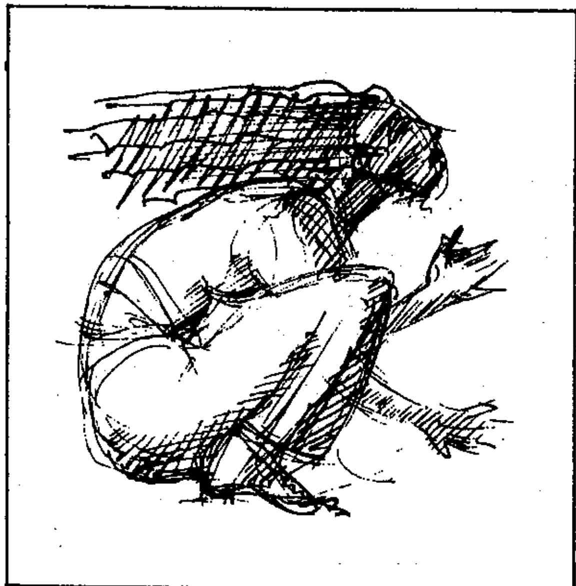

but the bottom line is that you have repeatedly violated our contract, putting me in a position where I was worrying about things that are not part of my job to worry about. I'm no longer willing."

Now somewhat angry, but in control and thoughtful, Lois protested. "Well, maybe I learned something from this experience! It has taught me a lesson that I won't forget!" She was convincing.

As the hour continued, I questioned anew my emotional withdrawal, realizing she had been far more frightened by the incident than had I. Why had I not seen this obvious fact before? By sessions's end I was willing to reconsider and agreed to meet again in two weeks. In time she convinced me that her walk in the night had so emphasized the necessity of self-control that she was unlikely to do it again. But even so, I told her, I doubted my ability to again open my heart to her. Seemingly the underdog here, Lois nonetheless was free to question my character. "You have always been too quick to shut me out. I think that is one of the problems in our relationship."

I was stunned for a moment. In working with myself over the years, I had become aware of that tendency in all my relationships, both personal and professional: with my colleagues, with my family, and with patients like Lois. Suddenly, the tables were turned. The question was no longer whether Lois would hold up her end of the relationship. The question was whether *I* could!

Lois was right, at least in part. Since we could not usefully continue unless these difficulties were exposed and resolved, I decided to speak openly. "As I know myself Lois, I think you're at least partially right. I do have a tendency to sometimes react that way, not just to patients. But how much of our problem is because of my shortcomings and how much is because of your illness, is difficult to measure. Obviously, if my weakness is great enough, I cannot do the job with you properly."

Reviewing this session later, many things came together. During my early years, my supervisor said many times, "You're not involved with the patient. You are busy with your own ideas." I did not see it then, but now realize I was very busy indeed, trying hard to *do* therapy, to *make* the patient see it my way. Sometimes I confronted the patient with caustic remarks like, "Do you know you are boring?" My conscious intent was to make contact with them by provoking *some* interaction.

With time and continued self-scrutiny, I came to realize that some of my provocative remarks were over-done. I cringe when recalling this, for I pride myself on holding high standards. It was only as I saw more clearly these shortcomings that I looked more closely: A patient may indeed have been boring in his presentation, but why? Maybe he was preoccupied with his own ideas, his own internal world, but maybe *I* also was preoccupied! My bluster had often been a clumsy attempt to break out of this and make contact. Yet, having contact at any cost is costly. I had difficulties with certain patients repeatedly. In peer supervision over the years, I slowly

thoughtfully about the situation, and expressed their concern about what the therapists would do.

In a firm, calm voice I spoke to Lois. "I'm glad to see that you are safe and sound, and that you came back here. But obviously this is a serious breach of our contract." I paused. "You have acted pretty crazy before, Lois, but this incident goes beyond my limits. When I realized how inappropriate it was for me to drive around looking for you, I felt angry, and I think anger is realistic. I think that this action has irreparably damaged our relationship. Sadly, I don't think that I can open my heart to you anymore. And I surely am no longer willing to expose myself to such legal risks. In short, my well-being is more important to me than whether or not you get well."

While I was no longer Lois' individual therapist, she did remain in her group, at least for now. In the following weeks, she struggled mightily, freely expressing her hurt, anger, and humiliation. She was self-observant as well, going beyond feelings to consider the damage she had done. I had become important to her, not only as her idealized father, but as a *real person* consistently with her in her efforts to overcome fear. Her fear of losing an idealized father was less than sadness at abusing her relationship with Paul Shultz, who had his own life and well-being to care for. Unlike previous episodes, she was aware that she had imposed on me a measure of risk that was not my job to accept. She spoke of how difficult, if not impossible, it must be for me to invest further in her. Nonetheless, she implored my co-therapist to speak on her behalf requesting a meeting. I did not warm to the idea. And yet, I had spent several years of my life alongside Lois in her struggle. Over a period of several weeks, I examined and re-examined this issue in my peer supervision group. I used the case in a seminar presentation. Finally, it became clear that if there were any chance that I might be able to work with her, the only ethical thing to do was meet. Once.

In that session, I felt no anger but was emotionally withdrawn, finding it difficult to allow myself to care about her. I told her so. Her response was unlike anything she had said before. "I'm sorry I put you through that. I can understand why you don't want to trust me. But I panicked and didn't know what I was doing."

"Whatever the reasons, I don't think I can open my heart to you. If you really cannot control yourself, after all this time, then I don't want to risk working with you." I felt a sense of loss in my belly. "I'm really sad about this Lois, because I like you. You and I have done a lot of work together. But I'm only a human being and I have limitations like anyone else." I felt as if I were giving up on a relative.

Her response surprised me. "Are you sure you're not acting on *your* feelings?"

Even in her seemingly powerless position, she had the courage to ask this! I collected myself. "I don't think so Lois. I've had a lot of feelings about this,

"Lois, sit down! Lois, stop!" my co-therapist yelled. Wide-eyed and panic-stricken, she bolted for the door. Since these sessions were held in a private residence, the door led not to the hallway of an office building, but to the street.

I followed her out to the driveway, repeatedly encouraging her to stop. Knowing I should not physically restrain her, I finally gave up. She headed down the sidewalk.

Nothing like this had even happened before! We had to quickly assess the limits of our responsibility, both ethically and legally. Conferring, we decided that one of us had to follow Lois to either help her come back, or at least watch after her lest she get into trouble on the street; night had fallen by now and she had no car with her. It shouldn't be me, since that might play into her unrealistic wishes, so instead we sent one of the other therapists. The rest of us returned to the structured exercise. As I sat, I found myself again worrying about Lois' physical well-being. I went further with it this time, however, and imagining the possibility of a messy, very nasty lawsuit, I became angry! I had been willing to shoulder some risks for her therapy. But this?

An hour passed, and Lois had not returned. Had she been unable to accept help from my colleague since he lacked involvement with her? After consulting with my colleagues, I climbed into my car, off to search for Lois. Once on the street, I knew something was very wrong. "What am I doing driving around, in search of my crazy patient?" I muttered. "I am practicing long-term, outpatient psychotherapy, not rescue work." My limit had been exceeded. Abandoning my search, I headed back to the house, convinced that I was through with Lois. I reviewed the dynamics of what was happening, aware of possible countertransference; Lois was not my hysterical mother. Indeed, it was years of working with my reactions to Lois' maneuvers that had helped me see clearly the difference between remnants of this countertransference and the reality of the present. While I felt anger at her for doing this, I also felt sadness that it had come to this. I found my thought processes clear and internally consistent as I considered reasons for terminating my relationship with her. Nonetheless, strong feelings often cloud thinking, so I discussed this with my colleagues to protect my patient from any possible mistreatment.

They found no distorted thinking. We all agreed that it was ethically and clinically proper for me to speak openly to Lois about my thoughts and emotional reactions, and tell her that I was no longer willing to work with her. This would best be done in the open forum of the marathon. But would she return to the house? I half-hoped that she would not, reluctant to do what needed doing. I liked Lois, and knew that she was doing herself severe psychological damage.

Lois slipped into the room and sat quietly in a corner. The session continued. Then, several patients brought up their reactions to Lois, spoke

"I think I was probably anxious, not angry. I'm sorry for getting in your way. Go ahead." And she was able to. The fact that she could have real impact on me was a powerful corrective emotional experience. Troubled by this occasional inappropriateness of mine, I nonetheless handled it effectively. Generally it is unwise for a therapist to reveal his inner life to patients, but the overt expressions of my unresolved conflicts that Lois identified had to be acknowledged openly. Obviously, a therapist's embarrassment is unimportant compared to a patient's difficulty to separate feelings from reality. It was crucial that my real shortcomings not be confused with her projections from the past. In a given instance, I may actually have behaved in a manner somewhat similar to her mother, but in reality I was not her mother and she was no longer a powerless little girl.

While painful, being excluded from therapy had obviously helped Lois. Sometimes still claiming that I really wanted to get rid of her, she was occasionally grateful, once reflecting that most psychiatrists would have treated her with anti-psychotic medication. Slowly sessions became more rewarding for both of us as we explored territory new and frightening to Lois.

The frail woman with deep eye sockets and wild eyes had gained several pounds, and no longer looked girlish, but womanly. Over her six years of therapy, she had finally achieved a bachelor's degree and was working in a business setting. Her typical black slacks and sweater had given way to a business suit, her hair done attractively. She smiled more frequently and was sometimes quite witty. Much more settled, she had greater freedom to ponder life decisions facing her: What could be done about her marginal marriage? Where was she headed professionally?

Convinced that Lois had changed fundamentally in controlling her actions, we had found a place for her in another group. She progressed steadily there, considerably less withdrawn, spontaneously involved with others, and altogether more willing to expose herself in spite of her fear. Panic episodes became more brief and isolated, with no physical flight from the room. Usually, within minutes she was able to reflect upon what she had experienced, and talk about it.

She had been very anxious about attending the upcoming marathon with 23 other patients. Having attended several such sessions (conducted regularly as part of treatment) she was afraid of spending 28 hours together with no place to hide. Frightened to face what seemed inevitable, she struggled hard to overcome her fear. Ultimately she did, of course, and began the marathon by using the session well, not at all withdrawn as in the past. Quietly involved almost all the time, she spontaneously spoke with other group members occasionally. It was truly a pleasure to see how she was. Then it happened. We had just begun a structured group experience that involves selecting and rejecting partners.

requires parallel individual and group sessions, she would now also lose her place in the group.

She was pretty sure I would hold to my ultimatum, and remorsefully telephoned my co-therapist. He agreed to meet with her. In spite of her poor self-image and sense of powerlessness, she seemed to know that we expected the reality principle to apply to us as well as her. If indeed she needed therapy as much as we said she did, then how could we humanly refuse to treat her? She argued that we should not give up on her, since our work with her was superior to anything she had found elsewhere. Furthermore, she argued convincingly that her relationship with me was too important and helpful to her to allow it to end this way.

My co-therapist agreed to intervene on her behalf, suggesting I compromise in some way. Eventually, I would see her once a month for three months, with the understanding that future therapy depended upon her demonstrating her capacity to live up to the contract. Having lost her place in the group, she recognized it had been more important than she had acknowledged in the past. In those three sessions, she expressed her anger and disappointment with some delusional accusations, but indicated she knew this was an outmoded way of expressing herself. An internal shift had begun. She seemed relieved that we had finally drawn the line, but couldn't quite say so.

At the end of the three months, I agreed to see her once a week. Slowly, she began to replace "I can't tolerate the group," with, "I don't want to be there." She also could begin to reflect upon "I don't want to . . .," recognizing the quality of a temper tantrum. It was becoming clear that not only fear crippled Lois, but a lack of self-discipline born of an absence of firm fathering.

The internal shift accompanied continuing complaints about my "uncaring" attitude, and claims that I surely must not like her if I didn't find her a place in the group. I didn't like her being "nasty," she said, and she was acceptable to me only if "nice." I had learned to be cautious about how I handled this. If it were not for my weekly peer supervision meetings, I might not have known there was some truth to this. Hearing her complaints as being accurate, at least in part, I noticed that when she was most anxious and accusing in her paranoid way, I also tended to become anxious and tried even harder to get through. She would then become more anxious, and complain more. If I caught myself and softened my demeanor, she would settle herself down and speak more thoughtfully. I helped her see this pattern for herself, and acknowledged my responsibility to either correct myself, or declare myself unfit to treat her.

As I was more able to acknowledge when I had been too "busy," Lois was more able to be thoughtfully critical of me, indirectly "helping" me to see what I was doing.

"You sound angry at me, Mr. Shultz."

apt this analogy was! Lois could actually die during therapy. I pictured her in a coffin and shuddered. I wanted to phone her, but to do so would play into her manipulativeness. What to do, then? If a patient repeatedly violates the contract in gross and potentially dangerous ways, what is the appropriate response from the therapist? While the therapist certainly has the right to terminate treatment under such circumstances, must he do so? A therapist might act out unconscious wishes by allowing the patient to remain in treatment. Conversely, he might act out his archaic fears by terminating treatment. Clearly, ongoing supervision for experienced as well as novice clinicians is crucial in resolving such issues.

Lois came to her next session, very troubled by what she had done and almost certain I would terminate her therapy. I was relieved to find that she had not actually attempted suicide, but had been in fact frightened about defiantly taking several Valium. She said she knew her therapy was on the line, and earnestly assured me she would adhere to the contract. Our relationship had survived another crisis, and continued on, sometimes limping, sometimes crawling, but never really going very well. Yet, as time passed, I became aware of a pattern. When my co-therapist worked with Lois I saw a totally different side of her. She did not fight with him so quickly as with me, was far less evasive, and sometimes much more thoughtful. I tried to fathom the reason for this, usually explaining it in terms of her particular transference to me. I did not really understand my colleague's assertion that I often was not "with" Lois. The acting-out persisted.

The day finally came when stronger measures were needed. Whatever real inadequacies there were in our relationship, I would have to impose some sanction, not as a punishment but to emphasize that I could not ethically accept the relationship this way. How could I accept money for this? "I will interrupt my work with you if you walk out of the group again," I told her. "I know it makes sense," she said.

Months passed as she struggled with her feelings, often withdrawing in the group, sometimes speaking up, and becoming somewhat more reflective in her individual sessions. Weeks would pass in which she expressed little else but gross distortions and projections, appearing to lack an observing ego. Nonetheless, she sometimes spoke very thoughtfully, making accurate transference interpretations, and occasionally even accurate counter-transference interpretations. She once speculated that my mother may have been like her, and that my feelings interfered in her therapy! I took this to heart, beginning to wonder if my mother was still more alive within me than I thought.

In spite of everyone's best efforts, however, it finally happened: She stormed out of a group. Still only vaguely aware of the similarity to my efforts to "get through" to my mother, I was saddened by what faced me. Having stuck with Lois through thick and thin, she had now forced my hand: I now had to interrupt her therapy. Since our model of therapy

sometimes giving interpretations, but generally experiencing myself as powerless in my efforts to help.

I so much wanted her trust that I did not recognize clearly enough the depth of her fear. Fortunately for Lois, I work in an outpatient practice that truly follows a team approach. While she saw me once weekly in individual sessions, she also attended twice-weekly psychotherapy groups in which I had one and sometimes two co-therapists.

The group was frightening and painful for Lois, who yearned for an exclusive relationship with me. She was often withdrawn and in individual sessions angrily accused me of playing favorites in the group. My interpretations of the transference seemed to fall on deaf ears. In frustration, a remnant of trying to "get through" to my mother, I sometimes failed to recognize how well Lois understood our working agreement: She knew I was sticking with her, regardless of what she said, or how she said it. My co-therapists reminded me that Lois—nonreflective as she seemed—was using her individual sessions well to say what was in her heart. However, she rarely spoke openly of her hurt and anger in the group; there, these feelings surfaced in explosive episodes, sometimes erupting in physical flight from the room.

Having agreed to a very clear contract before beginning therapy, it was difficult for Lois to live up to it. Terrified of being vulnerable, the option she knew best was to act impulsively; our job was to help her find it safe to expose herself in the group setting. Meanwhile, we could not accept this impulsive behavior. Besides discharging material that would be usefully expressed verbally, it could prove to be dangerous.

As months became years, she repeatedly violated the contract by fleeing the group. Many were the confrontations, and many were her frightened regrets and assurances that she would not violate the contract again. Each time I was faced with my own anxiety and a wish to terminate her therapy. Each time I asked, "How much anxiety fits the present, and how much comes from my past?"

I recall passing her in the hallway after a group one evening. "I think I took too many Valium." She had not spoken in the group, had refused all efforts to help her, and now wanted to engage me after the session. This was clearly a suicidal gesture, but how serious was the actual danger? My response had been brief: "Then you'd better get to an emergency room right away." And I continued on my way. Nonetheless, I found myself again struggling with my sense of powerlessness. I felt angry at her, momentarily forgetting she was really hurting herself, not me. What she did was an integral part of her illness and, while clearly not acceptable, could not be magically changed by agreement to a contract. I discussed the situation with my colleagues.

A clear question arose: "What risks would I be willing to take in treating this difficult illness?" A surgeon risks losing his patient on the table. How

yelled. She hesitated, her hand on the doorknob. "Sit down!" Still she hesitated. I lowered my voice. "Come sit down in your chair. Talk about what's happening to you, but don't act crazy." She took her hand off the doorknob, hesitated, then slowly returned to her seat where she sat cross-legged, clutching her purse with both arms.

My heart pounded. Startled, I had fortunately known how to keep her in the room. "I'm not a little girl!" she protested. I realized that my comment, taken literally, was demeaning. Agreeing, I apologized for the poor choice of words and explained my intention. Beyond that, however, I made it clear we could not work together unless she controlled her actions. She was relieved, and agreed to a contract forbidding impulsive actions, something I required of all my patients. Of course, she was free to express anything and everything vocally. Still leery of me, she nonetheless made another appointment.

After the session, I was pleased with how I had handled her rush for the door. Too pleased. My own sense of power had blinded me to Lois's powerlessness. As a youngster, Lois frequently ran from her mother's outbursts to hide in her "special place" in the woods. This pattern had repeated itself in her adult life, and was to repeat itself many times in therapy.

The story of Lois' therapy and the real relationship that developed between Lois and me includes my own struggle to overcome remnants of issues similar to hers. Like Lois, I had had a mother whose outbursts had terrified me. My own treatment had helped me overcome much of that fear, as I faced hysterical women in my psychotherapy group. From an essentially shy, timid young man, I had slowly grown confident in myself, and was essentially no longer frightened of hysterical women. However, to help with the remaining fear I developed a brashness that later found its way into my work as a psychotherapist. At the time Lois began treatment with me, I tended to harshly confront patients.

Obviously, a therapist ideally has no unresolved conflicts. To the degree this is not true, the patient is at risk. Since none of us can be perfect, we owe it to our patients to constantly work with ourselves to uncover and resolve our difficulties, even if we have no personal wish to do so. Despite many years of personal psychotherapy, further work in ongoing peer supervision helped me face more of my unresolved fears as I struggled to help Lois overcome hers.

During the first year, Lois accused me of many things, including having sex with patients. She questioned my credentials and demanded to see my diplomas. These were difficult sessions for me; knowing it was pointless to try to document my credibility, I seemed unable to help her reflect thoughtfully on her fears. During any given session there might be periods of loose associations interspersed with intellectualized reports of actual events. I squirmed through many sessions, sometimes trying to reason with her,