A SABBATICAL LEAVE IN A PRIVATE PSYCHIATRIC PRACTICE

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Would it be feasible for three senior therapists in a private psychiatric practice to take a one-year sabbatical leave? What if patients were offered the opportunity to continue in treatment with therapists relatively new to the practice and less experienced? A brief chronology of the planning and preparation for such a programme will be presented here, demonstrating the variety of problems which arose and how they were handled. Obviously, such a major change in a therapeutic relationship raises important technical and administrative problems. For example, what happens to the therapeutic alliance and to the transference? This paper will consider theory, practice and emotional impact as both patients and therapists adjusted to the change, not without protest and not easily. It will be seen that the painful process of preparing for this sabbatical year was beneficial for patients and new

therapists alike. Perhaps the examination of this process will provide useful lessons to clinicians faced with similar, if not identical, circumstances: e.g. cases in which the therapist leaves an agency or teaching institution, dies, moves to another city, or otherwise interrupts treatment.

1. The Practice Originally: The practice consisted originally of a psychiatrist and director (Dr. Bar-Levav), three additional psychotherapists with a clinical casework background and approximately one hundred patients. All patients were in intensive, reconstructive psychotherapy and seen at least once weekly individually and twice a week in psycnotherapy group sessions lasting 90 minutes and consisting of eight to ten people. In addition, patients usually participated twice a year in 28 hour group therapy marathons. Each group met with two co-therapists who had worked together for several years, developing into an efficient and effective team. Each patient was also seen regularly in individual therapy by one of the group therapists.

2. A Few Comments on Crisis Mobilisation Therapy: An innovative psychotherapeutic system called Crisis Mobilisation Therapy, (C.M.T.) is used as the working-model in this practice. Because it aims the therapeutic effort at very early levels of ego-development, patients often use rather primitive defences that are common in infancy. Strong transference neuroses commonly develop and patients tend to see one of their therapists as all-giving and all-powerful, a "good mother". As part of this capsule summary of some C.M.T. assumptions and principles it needs also be said that the transference is routinely split between the therapists as object images were early in life. Thus the therapist seen as depriving the patient's gratification of infantile wishes is strongly experienced as "bad mother", eliciting strong preverbal hunger and rage. Archaic splitting of affects between "good" and "bad" transference objects is eventually followed by integration of such good and bad object representations *(1)*. The splitting of the transference is instrumental in eliciting affects with enough intensity to involve physiologic parameters similar to those experienced in pre-verbal stages of the separation-individuation process. When repressions are lifted in this setting, hurt, fear and rage of long ago are often brought to consciousness as affects without cognitive memory associations. Specialised techniques are used to profoundly arouse physiological parameters. The depression and fear of non-being that lie at the root of most functional mental illness can thus be addressed and permanently altered through patient working-through *(2)*.

3. The Development of B.L.E.A.: When the sabbatical leave was first conceived, no formal training programme existed as it does now. As originally planned, the sabbatical would have left most patients with several interrupted periods of therapy during the year but with no continuous contact. Several three-to-four week periods of therapy were planned for, as discussed more fully later. No new patients would have been accepted into the practice for one year before the beginning of such a sabbatical. It was anticipated that for patients in the middle phase of therapy the sabbatical separations would occasion the arousal of strong feelings associated with primitive fantasies of abandonment and starvation. The repeated reality experience of a therapist leaving would stimulate such affects again and again, reconstructing an emotional situation that infants experience when their fantasy of symbiotically sharing Mother's power and resources begins to shatter. While very painful, such separations would inadvertently provide excellent opportunities to separate present reality from archaic distortions. Much of this work would have to be done either before the three therapists left, after they returned, or in the course of relatively short periods during the sabbatical when they came back. The work of mourning for unfulfillable dreams would be in the foreground much of the time.

Since the early planning phase, however, changes occurred in the practice that allowed patients the option of continuing in on-going therapy with relatively

junior therapists during the sabbatical. Dr. Bar-Levav had been interested in developing a training programme for psychotherapists for a number of years, and in the autumn of 1975 invited three prospective colleagues to attend weekly seminars at his office. These three newcomers and another part-time psychotherapist already associated with the practice eventually became the first Fellows of the Bar-Levav Educational Association (B.L.E.A.), and eventually began to function as full-time psychotherapists. During the sabbatical, patients would then be able to use the opportunities presented by the sabbatical separation on a regular and uninterrupted basis with the B.L.E.A. Fellows, working-through much of their hurt, anger and disappointment. The anxiety associated with the impending changes could also be useful as a training opportunity for the Fellows. The weekly seminars were a forum in which many anxiety-laden issues were critically examined and re-examined until clinically sound conclusions were reached. The seminars became an integral part of the training programme, for here was a place to work with the hidden agendas and the attitudes of the new therapists that interfered with their effectiveness as well as with their co-operation with each other. With the welfare of the patient always in the centre of the discussions, the details surrounding the sabbatical were planned in these seminars, while theoretical and clinical formulations were repeatedly sharpened.

4. First Steps in Implementing the Plan: To allow ample time to work with the emotional and reality issues that would develop, the veteran therapists began discussing their plans with patients approximately 18 months before the sabbatical would begin. Also discussed were plans for a week of therapy in a small Italian resort later in the year with the three departing therapists.

Six months later, the junior therapists had begun working in the practice, taking on new patients for individual treatment and regularly attending as co-therapists some of the groups that they would be fully responsible for later on. The visibility of these new therapists in the groups stirred up many feelings surrounding this "intrusion", doubts were openly expressed about their competence and patients became increasingly more aware of the major changes that were occurring in the practice. Some complained loudly with anger or fear that the new therapists knew less about what was going on than they themselves did. Others maintained a steady denial of the reality that was developing in front of them. For example, a full 90 minute group session passed without a single group member commenting in any way about the presence of another therapist there for the first time. If therapy eventually were to continue in the absence of the senior therapists, each patient would first have to be helped to separate his feelings about the new therapists from a realistic evaluation of their competence. Rational decisions about continuing in treatment with the new therapists would be impossible otherwise. Increased involvement of the junior therapists in the groups allowed this reality-testing to take place.

While the patients struggled with their feelings about the sabbatical, the new therapists did so also. During weekly group and individual supervision meetings, the new therapists wrestled with a fearful unwillingness to actually accept the responsibility for their patients, a responsibility described to be no less awesome than that of a surgeon who must cut into living tissue. The junior therapists sometimes unconsciously caused themselves to appear stupid or temporarily disorientated in an effort to elicit parental guidance from the veteran therapists. Recognising this unconscious gambit for what it was, the veterans steadfastly refused to gratify those infantile wishes expecting, instead, that their new colleagues demonstrate the competence they had mastered. Persistently troublesome in the early phases of this programme was the tendency of the new therapists to imitate mannerisms and procedures of the veterans, probably hoping to postpone facing the heavy burden and responsibility. Afraid of being inadequate or rejected, they sometimes resorted to quasi-therapeutic

manoeuvres, such as inappropriate confrontations or premature interpretations, the real function of which was to insulate themselves from their own feelings. Such abuses were not tolerated by the veteran therapists, who struggled with their own anger and frustration at their capable but frightened fellows, as well as with a fearful reluctance to entrust patients to such wavering newcomers.

The new therapists, like the patients, experienced fear and anger for being "abandoned" by the veterans, feelings which sometimes put them at odds with one another and with their "deserting" senior colleagues. The four B.L.E.A. Fellows decided, therefore, to begin meeting regularly by themselves to explore their own feelings about the sabbatical change, the senior therapists and each other. The first six scheduled meetings were cancelled for a variety of reasons, only vaguely recognised at the time as expressions of reluctance to get involved in this painful process of self-reflection. Once started the meetings continued regularly, however, and the four Junior therapists began to function more efficiently, helping each other face their fears and accept their responsibilities. As the Fellows began to depend less on the veterans and more on themselves, supervision sessions came to be less a matter of reporting blunders and expecting infantilising advice, and more a matter of improving the capacity to recognise one's own errors. Thus, the juniors grew more self-sufficient in their capacity both to identify technical problems and to correct them.

5. Specific Plans for the Sabbatical Year: As the sabbatical year drew closer, it became increasingly necessary to reach conclusions and make recommendations about the realistic needs of each patient. Some patients would soon be ready to terminate. Others, those who recently began therapy with one of the new therapists, would continue as before. But what about the rest? Patients in the middle phases of therapy would be offered a chance to work with one of the new therapists, but having invested several years in treatment with one of the departing therapists they might naturally wish to continue without changing. To ensure the possibility of continuing, if irregular, contact of patients with their original therapists, a plan for a modified sabbatical leave was decided upon. After six-week periods of absence, the senior therapists would return to the office for three-week periods during which: a) two weekend marathon group sessions would be held, attended by all seven therapists and a selected group of patients; b) the senior therapists would attend on-going groups and participate as co-therapists in the on-going work; c) the veteran therapists would hold individual sessions with those patients not seeing other therapists.

One three-week period was to take place in Italy, and 60 patients would be offered an opportunity to participate in a one-week programme of group, individual and marathon sessions. It was reasoned that the physical separation of patients from their homes, jobs and families would further evoke early experiences associated with archaic separations, and that such primitive feelings would then be worked with intensively and extensively. A unique and unusual therapeutic experiment was expected to result, perhaps with implications about the optimal unit, dosage and form of therapy in other circumstances also.

To further develop specific plans and to review the disposition of every patient, all seven therapists, plus Dr. H., a consulting member of the staff who is a Professor of Psychology in a nearby university, attended two all-day meetings, which proved to be a valuable learning experience. The placement of incoming patients into particular groups in terms of age, gender, level of pathology and group composition was discussed first, the rationale for determining the frequency of group sessions next. C.M.T. groups are usually experienced as non-gratifying (bad mother), while individual sessions are more commonly experienced as nurturant (good mother). Aside from the usual therapeutic frustration of infantile wishes, patients would undergo during the sabbatical the added real

deprivation of the veteran therapists' presence. It was decided, therefore, to decrease the frequency of group sessions from twice to once weekly to keep the total frustrations within tolerable limits, and whenever possible, to increase the frequency of individual sessions to twice weekly, particularly with relatively new patients. Therapists were assigned to specific groups in addition to those they already worked with so that all groups would have two regular therapists at each session throughout the sabbatical. The difficulties each of the remaining therapists might have in working with any of the others were reviewed at some length and attempts made to decrease the scope of such interferences. Means were decided upon to continue this process during the entire sabbatical year.

The treatment plan for each patient was considered in detail next, each departing therapist stating what he considered the best plan for his patients, and why. Each suggestion and evaluation was examined critically by the entire staff and revised. Through such lengthy discussions, several recommended treatment plans emerged:

A. Some patients would work towards terminating therapy at the beginning of the sabbatical, with the recommendation that they attend one of the therapy weeks in Italy to continue working with issues arising from and related to the termination itself.

B. Patients nearing the end of treatment would be offered a "trial separation" from all therapeutic contact during the year, except for the marathon, group and individual sessions offered during the week in Italy.

After the year's separation, these patients and their individual therapists would evaluate the need for continuing in therapy.

C. Some patients in the later phases of therapy, but clearly not yet ready for termination, would be offered the opportunity of continuing with regular weekly group sessions and periodic marathons, but would not be referred to a new therapist for individual therapy. These patients would meet with their usual veteran therapists during their return visits.

D. Most patients in the beginning and middle phases of treatment would be referred to one of the new therapists with whom contact was already established in the group. Many variables were considered carefully. For example, a young female patient with sexual identity problems had been seeing Miss T., one of the senior therapists. As all B.L.E.A. Fellows were male, the question arose whether she should be referred to a male therapist close to her in age, to one twenty years her senior, or remain with Miss T. and see her intermittently. To maintain this patient's therapeutic involvement and in consideration of her transference distortions at the time, she was referred to the older male therapist.

E. In a few cases, it was thought best not to change therapists even though the patients were in the beginning and middle phases of therapy. Some, for example, had found it extremely difficult to become involved meaningfully in the therapeutic process, and now, having at last developed a firm therapeutic relationship, might suffer a needless setback in changing to a new therapist. These patients would continue in group therapy and in periodic marathons, and would see their original individual therapists during their return visits also.

F. A few patients presented particularly unusual circumstances. For example, one of the patients, a clinican of many years experience, had had previous collegial or supervisory relationships with all four B.L.E.A. Fellows. This man obviously could not be referred to any of the new therapists, nor could he continue attending the group sessions during the sabbatical. He would see his usual therapist when possible, go to Italy, and resume therapy with the senior therapists when the sabbatical was over.

This lengthy discussion of treatment plans proved to be very profitable to the B.L.E.A. Fellows as it was essential for the welfare of the patients. The B.L.E.A. Fellows were able to sharpen their diagnostic and prognostic skills by taking an active part in these lengthy discussions.

The considerations were then focused on how to implement these changes. The new therapists would attend newly-assigned groups as soon as possible, to help strengthen the developing therapeutic relationship with group members, especially with those they would see individually during the sabbatical. During upcoming individual sessions, the veteran therapists would introduce the various issues surrounding the sabbatical and their recommendations. Patients would be helped to assume an active role in planning for their therapy during the sabbatical. Their freedom to make conscious, rational decisions would be repeatedly stressed. Therapeutic efforts would have the two-fold aim of assisting them in realistically evaluating the various possible treatment plans, and in working-through feelings and distortions associated with these changes. These issues were repeatedly brought up both in individual and group sessions, thus examining them in different settings and from different view-points. In no case would a final decision be made until both feelings and realistic considerations had been discussed thoroughly over the course of several weeks. The reality situation would be used as an opportunity to exercise underdeveloped ego functions. Material reflecting transference distortions would be analysed and worked-through.

Although Dr. Bar-Levav would remain the responsible physician during the sabbatical, seeing each patient regularly during his return periods in marathon, group or individual sessions, a psychiatrist would be retained to meet regularly with the B.L.E.A. Fellows and to be on call in the unlikely event that medication or hospitalisation might be needed. Such measures are only rarely required, even though very high levels of affect are customarily worked with in C.M.T.

6. Patient Reactions to the Sabbatical Plans: In the days following the meetings, the specific treatment plans were discussed with each patient. The reactions of many patients were discussed as the weeks went by in seminars, and the treatment implications explored. An example is the case of M.E., who treated the recommendation of her therapist as if it were a mandate she had no choice but to accept. Because such fatalistic passivity characterised much of her life, the situation offered another important therapeutic opportunity, to explore and work with her life-long tendencies to deprecate her needs and her interests. As M.E. struggled with these issues in her individual sessions, she began to express openly fears and doubts regarding the trustworthiness of the therapist that was suggested to her. She finally began to realise that she did, indeed, have choices - she could refuse her therapist's recommendation, ask for a different therapist, or suggest a different plan altogether. She did, however, steadfastly avoid the issue in group sessions, which were attended by the proposed new therapist. Almost two months had elapsed before she was able to tell him, face to face, that she doubted his capacity to do the job. She could at last also begin to separate archaic fears and yearnings associated with her mother from a realistic evaluation of the new therapist's competence.

Another therapeutic opportunity arose when the veteran co-therapist of the group was absent on one occasion, leaving the group in the hands of the new therapist for one session. S.F. refused to attend or pay for the session, saying, "My contract is with Dr. Bar-Levav, not with Mr. H. As far as I'm concerned, Mr. H. is not a therapist, and he is surely not *my* therapist!" The confrontation was thoroughly discussed in the seminar, in which S.F's. valid argument regarding the contract was obviously recognised, even though it was also used in the service of resistance. She was not charged for the session, was encouraged to experience fully her anger and the underlying fear, and was helped to do so directly *at* Mr. H., who was present at the sessions together with the senior therapist. The archaic roots were clearly visible and usefully explored, examined and partly neutralised. She was then asked to consider a new contract which would include Mr. H. as a therapist. After much struggling in four to six group sessions, she reluctantly accepted the frightening reality facing her, and finally decided that it was realistically in her best interests to remain a patient in this practice with new therapists. This episode was an important milestone in her therapy.

7. Finalising the Plans: About two months before the sabbatical was to begin, another lengthy meeting was held to review and finalise plans for the year ahead. By then, most of the patients had accepted the change ahead, including the shift to new therapists. If patient or therapist had concluded that a shift to a new therapist would not be appropriate, other alternatives were considered, but every patient would have someone in the office at least on call. Regular meeting times were offered to patients for the sabbatical year, to the extent possible on the same day and at the same time that the patient had met with his old therapist. In some cases, the new therapists would attend two or three of the patient's individual sessions with his old therapist to facilitate the actual transitions. Patients would be told of such plans and would have to agree to them before they took place, but the exact dates of visits would not be revealed beforehand to minimise censorship or preparation of material. Sufficient time would be allowed in between such visits, so that patients might work with the feelings aroused by them.

A plan for supervision during the sabbatical was also decided upon. Dr. H., the psychologist, would meet with all four B.L.E.A. Fellows every other week for group supervision, followed by individual supervision with each Fellow. A schedule was also determined for supervision with Dr. Bar-Levav and the other senior therapists on their return visits. The B.L.E.A. Fellows also decided to continue meeting with each other at an additional time for informal group supervision. Furthermore, the usual Wednesday seminar would continue after their senior colleagues left, and both theoretical and practical issues would continue to be regularly discussed.

Other issues continued to arise and to be discussed in seminars. For example, patients wondered whether the senior therapists would regularly attend the group during their return visits, an issue that was not explicitly considered until then, perhaps out of the staff's own anxiety about the upcoming separation. The junior therapists, now finally experiencing themselves less as dependent trainees and more as fully responsible for the welfare of their patients, recommended that the returning therapists not attend every group session, but merely rotate among the groups in a way that would least interfere with the real and transferential involvements of patients with their new therapists while still available both to patients and Fellows. This was basically acceptable to all. Other patients transferring themselves to new therapists wanted to know whether they would resume work with their original therapists after the sabbatical was over, even though they were previously assured that all options remained open and that their best interests would determine the future course of therapy. It became clear that such persistent interest and

fantasies about the future served as a resistance against the rage at being abandoned, and the fear of getting involved in the present. In addressing these issues it became obvious to therapists and patients alike that the sabbatical marked a permanent change from the way things had been, a fact that many consistently attempted to deny. The practice would be changed for ever even after the sabbatical was over, since all relationships and transferences would have undergone major changes. As such issues were clarified, new storms of affect were unleashed and the pain, fear and anger among both patients and therapists was on occasions rather extreme.

8. Conclusion: This paper has considered the vicissitudes occurring in an ongoing psychiatric practice when the senior therapists were about to take a modified one-year sabbatical leave. The variety of practical and technical problems which arose and how they were dealt with was discussed, as well as the emotional impact on both patients and therapists. While the process of preparing for the sabbatical year was difficult and painful, it was, nevertheless therapeutically useful to the patients and an excellent training opportunity for the new therapists. Hopefully, the discussion of this process has provided ideas useful in approaching situations similar, if not identical, to the sabbatical.

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