

RIDING THE EDGE

Pamela Torracco

Changing Relationships: From Patient to Friend, from Friend to Patient



I am a psychotherapist in Southfield, Michigan with Dr. Reuven Bar-Levav and Associates. I enjoy the continuous challenge of using myself as the tool to help others. As I search to find creative ways to move through my patients' creative resistances, I become better acquainted with myself. Rather than burning out, I find my work more and more exciting. I also enjoy waking dormant pieces of my brain through foreign language study and dormant parts of my body through mountain hiking.

I answered the phone at home one evening and Sarah, a longtime acquaintance, was crying hard. She told me that Carole, a mutual friend, had made a suicide attempt earlier in the day and had just been taken to a local hospital. She had only vague information from a fellow worker of Carole's about pills, liquor, and gas. "I don't want to burden you but I called you right after I called her family because I know how important you are to Carole." Sarah spoke of Carole's recent talk of her despair and of her own firm encouragement to Carole to return to therapy.

I soon learned that Carole would be admitted to the hospital for overnight observation and then transferred to the psychiatric unit. I passed this information on to Sarah but did not call Carole myself, even though I worried about her welfare. Long before this episode, she had been my patient and although years had passed and we saw each other socially from time to time, I knew that she might reach for me again and not merely as a friend. I decided now to leave Carole the option of seeking me out in a professional capacity.

PREVIOUS HISTORY

Seventeen years before the incident just mentioned, Carole had started long-term therapy with a male colleague, NG, in the group practice in which I was a junior member. For about six years she saw him once a week individually, and twice a week in an on-going therapy group with a male co-therapist. During those years my involvement with Carole was minimal as I saw her only at some of the 28-hour marathon sessions that the patients in our large practice each attend once or twice per year.

Carole came to our practice at age 31 following a three-week psychiatric hospitalization, preceded by a year and a half of weekly sessions with a psychiatrist elsewhere. She was immature, frightened, and confused, often displaying a serious thought disorder. Once or twice a year she had regressive episodes in which she went to bed for a week or more, similar to her mother's typical behavior many years earlier. Carole's character had many hysterical features and when frightened and feeling powerless, she would attempt to manipulate others in a desperate effort to feel stronger. She denied most of her anger and much of her hurt, which left her feeling hopeless most of the time. She often presented herself as a suffering, whining waif who needed to be taken care of.

Since Carole had felt safer with her father than she had with her mother, we decided a male therapist was the better choice for her. Her poor object contact made it difficult to involve her in intensive psychotherapy, but in addition to her serious difficulties she also possessed a healthy tenacity and determination to get well. These NG was able to mobilize to establish a therapeutic alliance with her. Her transference involvement with him ranged from eroticized longings to expressions of rage and graphic wishes to annihilate him. She openly experienced all of these in both individual and group sessions and was more and more able to also thoughtfully observe the extremes of her reactions.

After several years, due to internal shifts in our practice, NG left Carole's group and I joined it as a co-therapist. Although angry and hurt, Carole did not experience much fear at NG's departure. Her much improved self-image and more competent ego boundaries served her well in the transition and she continued to make good use of both individual and group sessions. She was less prone to hysterical outbursts and experienced emotions more genuinely. When hurt, she sobbed deeply and her whole body convulsed with long-suppressed pain. When frightened, her eyes widened, her body tensed, and she would gasp or scream but remain in contact with other people in the room, rather than going into a deep withdrawal as she used to.

Now solidly in the middle phase of therapy, she was often angry and impatient and I was frequently the target of her criticism and fury. No longer terrified of her rage and of losing control, she felt safe enough with her therapists and group members to unleash the venom she had wished to direct at her mother whom she had experienced as insensitive and inept. A very important therapeutic split in the transference was taking place. This unique opportunity, available only when a patient works with a co-therapy team, is easily explainable by expanding on Klein's (1975) concept of "splitting." One therapist, regardless of gender, is experienced as a steady, ever-present caretaker, a "good mother," while another therapist is felt as the "bad mother" and is more often the target of preverbal rage since the patient experiences him or her as inadequate and insufficient. In this case, Carole's experience of both NG and his co-therapist was as steady "mothers" who had remained dependably at her side for years while I, a woman and relative newcomer, felt more like her undependable mother.

After eight years in therapy (two of which had included me), Carole began to think seriously about leaving. Months of examining this idea in both individual and group sessions seemed to indicate that her wish to leave was not a way of resisting further frightening involvement. Instead, it appeared that having moved closer than ever to real individuation she now needed to continue her work with herself completely on her own without the assistance of formal therapy. She had already started her own small business, which was doing well. A date for her last session was mutually agreed upon and she left, knowing that she might return one day to deal with trouble-spots she was likely to encounter.

Carole approached me socially a year or two after her departure and we began to meet for lunch or dinner from time to time. I do not generally become friends with my patients after they leave therapy. My life is full and includes non-therapy interests and friends who have never sat in my patient chair. But the long hours of struggling together in the battles against inner demons and the long years together of slow but steady change require a real as well as a therapeutic relationship that ought not be denied and ought not *necessarily* end for all time with the last session. After the needed separation of the post-termination phase of therapy, it is possible for the two people who were once therapist and patient to establish a different relationship.

I am accustomed to "being myself" in sessions in the sense of not attempting to hide my personality although I do limit disclosure of factual information so as not to interfere with patients' needs to fantasize about me. So Carole knew me well in some ways but not at all in others. Her curiosity about my history and personal life were understandably exciting for her to pursue and somewhat awkward for me at first. The shift in our relationship necessitated changes for both of us. Whereas I had previously been paid for my time and, in exchange, had agreed to use myself for her benefit, I was now free to reveal more of myself and to take for myself as well as give. Even though Carole had to limit some of her former freedom to bring all her thoughts and feelings into her relationship with me, she could now involve herself with me as a peer. As our relationship developed, we found room for two rational adults to enjoy each others' company and although we did not become close friends, we occasionally spent time together over a period of seven or eight years.

FOLLOW-UP TO THE SUICIDAL BEHAVIOR

I knew that after her release from the hospital Carole might ask me to take her on as a patient. Could I see her myself or would it be better to refer her to someone else?

I first had to deal with my own pain and self-doubt about her current crisis. Had I done all I could as her therapist in previous years? Had I failed her as a friend? I felt compassion for the person who was a part of my life. It seemed to me that I could best help her now as a therapist if I could properly switch roles

again. There was some heaviness in that realization, but since I liked and respected her, I wanted to do all I could to help.

Having grown up as a "good girl," a recurrent theme noted by several supervisors has been my tendency to try too hard to be too helpful. I now called upon several close colleagues to help me examine myself. Their incisive questions, though sometimes painful, forced me to look further into my motives.

I wondered whether I was angry at Carole for acting out her despair rather than calling on me or someone else sooner, or hurt that she had not talked to me, her friend, about her inner turmoil. Perhaps I experienced her action as an hysterical attempt to manipulate me. To see her as a patient I would have to be willing to give her up as a friend since our patient-therapist relationship would have to come before anything else, and I would have to be able to maintain this position during the times she would try to use our friendship to escape the painful confrontations with herself that therapy necessitates. Would I be able to hold and support her properly, without overidentifying, losing perspective and becoming too "mothering," or might I try so hard to avoid overmothering that I would push her too hard and be harsh and insensitive? My willingness to be a steady target for her negative transferences as well as positive also had to be evaluated along with my willingness to have aspects of my personal life exposed to scrutiny since my patients have the right to talk (in both individual and group sessions) about anything they know or believe about me. If I tried too hard to "fix" my friend, I would doom her therapy. I wondered whether I should charge my full fee. Most importantly, was this struggle of mine really helpful or just ruminative discharge masking anxiety?

After much soul-searching, it seemed to me that if Carole consulted me, I could treat her properly and respectfully. I would schedule two or three evaluation sessions, just as I do with a new patient, to observe and assess her illness, her health, and her ability to modify her involvement with me. Her therapy history and our history of previously established relationships meant that these sessions would differ somewhat from those with a new patient. But the purpose would be the same: to evaluate and define her emotional health and illness, partly through gathering information but mostly by observing her in the process of the verbal and nonverbal interchanges with me.

As the tool of the therapy, we therapists have to use ourselves flexibly, creatively, and thoughtfully to palpate the patient's character. We can utilize our senses in the same way an internist uses his or her fingers, eyes, and ears to palpate and evaluate the body. We "apply" our voice, eyes, posture and general manner consciously to elicit responses that tell us about the patient's character structure and physiologic reaction patterns. After all, how else can we measure the strength, flexibility, and degree of completeness of the ego boundaries; the capability of the observing ego; the ability to separate thinking and feeling; the ability to directly experience basic emotions such as hurt, anger, fear, and sadness; the major defense mechanisms utilized and the degree of fear

tolerated before defensive operations are initiated; the tendency toward specific transference reactions; and the ability to test reality accurately?

* * *

When she called my office from the hospital a week after her admission, Carole was polite but serious and direct, not unduly familiar or distant. She clearly requested an appointment and we met a few days later.

She was about 30 pounds overweight, as she had been from time to time in the years I had known her. She wore no make-up and looked tired, strained, and slightly dazed. She began to half-cry and half-whine as soon as she sat down, moaning about not wanting to be here and being embarrassed. I told her I was sorry about her pain but glad she was alive. I hoped I could help her. Although she spoke in a half-hearted manner about being discharged in the next day or two, being dissatisfied with her psychiatrist and not being sure whether she wanted to live or die, she was not fully present; this was not the same person who had telephoned me. I addressed her distance—the veil I sensed between us. She sensed it too but there was no change. I asked if she was on medication; yes, but the type and amount did not explain the daze.

In an effort to emphasize the gravity of her situation, I asked to see the hospital bracelet she had obviously been trying to hide. Still no change. I pushed for details of her activities on the day of her self-destructive behavior. She had taken a few of her asthma pills at 9:00 a.m., then a few more when the first dose “didn’t work,” then a few drinks, which caused her to vomit. Finally she turned on the gas but woke up again, angry that she was still alive. “I turned off the gas because it smelled so bad and decided to just go to bed. That’s where my co-worker found me when he came to pick me up for work in the evening.” The details were all there, punctuated with an occasional wry smile or sardonic laugh, but her affect was still basically flat and I still had the sense that I could not really find Carole.

I continued to try to get through but without real success. She was holding back, frightened and embarrassed, not feeling safe enough yet. It was my job to help her push beyond her own apparent limitations. But I also knew I felt frustrated. How hard should I try? I feared I would push too hard because I wanted to get through to make myself feel powerful. Was I correctly challenging her hopelessness or using her to work with my own?

I took a chance, banking on her health and on our long real relationship. As a person who was, in reality, an important figure in her life I had more leverage than as a transference figure only (Bar-Levav, 1988). I sat on the edge of my chair, leaned toward her, fixed my eyes on her and raised my voice. “Carole, do you really want to be here, in *this* session, with *me*?” “I don’t know,” was the mournful, choked response. “Do you want to live or die?” Same response with the throat even more tightly constricted.

In a firm voice I asked her to look at me. The eyes that met mine were already somewhat more clear. “I take my work and the people who come to me

very seriously. I don't play when I sit in this chair. You called me *from a hospital* for this appointment. I assume that your being here in my office means that you want to save your life. You could easily have been dead—you had all day, you could have arranged it, and you didn't.

"But if I'm wrong about you, if you are not sure you want to save your life, then let's not fool ourselves. You're free to leave now and I will charge you only for the eighteen minutes you've been here. I like you and I'm willing to do all I can to help you. But I know I can't work without you. Either we fight this battle together or not at all. You must tell me now whether you plan to save yourself or not."

A slight pause was followed by a deep breath and a clear, intense gaze. "I'm staying," was the firm reply. The healthier Carole had finally entered the room. "You scare me sometimes, but I really like your straight talk. I've always liked that about you." She leaned forward, rested her head in her hands, and began to sob deeply. There were tears in my eyes, too, as I watched her body heave and listened to her sounds of pain.

When she raised her head a few minutes later, she spoke of the terrible loneliness she had experienced since her mother's death a year earlier. She had been withdrawing more and more, sleeping a great deal and often not going to work.

She spoke about her therapy, about how much she had changed and what was still left to do. There was no tone of hopelessness in her now—she clearly believed she had the ability to change more, given proper assistance. She asked me straightforwardly to take her on as a patient, asked about fees, and began to formulate a plan to earn more in order to be able to pay me.

I was tempted to accept her then and there, touched as I was by this woman I had known for so long in so many ways. Instead, I told her I needed more time to decide, that this was too important a decision and I did not want to make a mistake. Even as I spoke, I wondered whether my words represented proper self-scrutiny or pathological self-doubt. We who do this work seem both condemned and blessed to scrutinize ourselves without end.

I later added that I work only with people who live in a life-affirming manner and do not make important decisions based solely on their feelings. If she becomes my patient, all of her feelings in any intensity are welcome in her therapy but they must always be separated from her actions and must always be observed by her as well. I would handle any suicidal attempt or gesture of any sort by immediately resigning as her therapist and that would be the end of any relationship between us. She was not surprised and thoughtfully accepted.

Carole maintained this healthier level of contact with me and resolve with herself during the next two sessions. I have been seeing her regularly now for over two years. The two therapists in the group in which she was offered a place each met with her to obtain her recommitment to the non-acting-out contract. Only then did each agree to accept her as a patient. They, like me, wanted to assure themselves of her commitment to life and to reality before becoming involved. One insisted that she lose a few pounds before her first group session

as a token of her resolve and good faith and of her ability to discipline herself. She readily did so. Her conflict between complying with others and doing things for herself continues to be an active issue in her work.

Carole is benefitting from having an individual therapist who is not only a woman, but one she also knows intimately and trusts beyond the transference. Having resolved most of her rage at her mother and consequent rejection of herself as a woman, she can now explore more basic issues related to her female identification. She has lost more weight and enjoys her body rather than fearing it as she used to. And the presence of two male therapists helps her sort out remaining confusions about her father.

Perhaps she and I will be friends again one day. But for now her therapy clearly takes precedence. I enjoy my involvement with two courageous women—Carole and myself. She continues to valiantly battle for her life and sanity. I persevere as a clear-headed and competent professional in a potentially confusion-fraught situation.

3000 Town Center, Suite 1250
Southfield, MI 48075

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COMMENTARIES

The author takes credit for courage: No argument there—writing an article so openly and honestly about such a thorny issue in psychotherapy (dual relationships). Whether there's true clinical courage here, however, or just plain hubris, is another matter. The author neatly rationalizes changing relationships with Carole, the patient. Or more precisely, adding another relationship to the therapeutic one they already have. Something to do with needing a burnout antidote, which “. . . includes non-therapy interests and friends . . . [and] a real as well as a therapeutic relationship that ought not to be denied and ought not *necessarily* end automatically with the last session.”

The American Psychological Association's Statement of Ethical Principles says it clearly: Once a patient—always a patient. The wimpy American Psychiatric Association states more weakly: no socializing with a patient for one year after therapy terminates. The professional organizations are finally waking up and smelling the coffee. Why? What's the big deal, anyway?

One of the real problems with dual relationships in therapy is this: Once the possibility exists within therapy that another relationship could develop down the road, that therapy is henceforward starstruck with myriad unconscious fantasies, hopes, and unmet needs of both therapist and patient. In other words, contaminated. And flawed.

Having a therapist-friend, or friend-therapist—or whatever we have here—reminds me of John Warkentin's old Boatcar—a hybrid car that one could drive into Lake Lanier for boating, and then motor back to shore for the drive back to the city. A piss-poor

excuse for a car, it was an even worse boat. Moral: Avoid hybrid objects, people, and experiences. And therapists.

There are enough wonderful people out there to choose for friends that no one should have to use patients for friends, for God's sake. Pure, unalloyed, ethical therapeutic experiences, on the other hand, are much more uncommon, and a thing of beauty. Psychotherapy is difficult enough, without bending or breaking the frame to meet our own needs. Don't make friends out of patients, or patients out of friends.

If you do feel the urge to socialize with one of your patients, take a nice, stiff drink first - and then call them.

In about 30 years.

DAVID KIRKPATRICK
111 N. 3rd Street
Ashland, OR 97520