

THE THERAPEUTIC ALLIANCE AS A LIFE-GIVING FORCE.

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Suicide basically serves only one of two possible purposes:

1. The self-destruction of the individual who, for a variety of reasons, has lost hope so totally that death seems a desirable solution.
2. The summoning of help for an individual who believes himself to be unable to call for help in less extreme ways, or who is unwilling to do so for a variety of reasons.

Tremendous hostility, sometimes only thinly veiled, is usually present at the root of the manipulative efforts by a potentially suicidal person. By putting his very life on the line, such a person attempts to force significant others around him to come to his side, without delay or hesitation and in clear preference to all other interests and concerns. Under the guise of hopelessness and helplessness, a tremendous amount of power is used to mold the environment according to one's wishes. As is widely recognized, the suicidal gesture or attempt is often the most brazen form of power-play.

True hopelessness is a characteristic of some suicidal attempts, especially when terminal patients sense their imminent demise and wish to end their own suffering and the suffering of those around them. These are rare exceptions. More commonly, hopelessness is the result of distortions of reality that cause a person to experience himself as being totally alone in the world, a belief which often has a most tenacious and persistent hold. The seemingly unyielding tenacity that hopelessness appears to have is a function of its underlying cause: a last ditch attempt to summon an idealized and unreachable mothering figure, who would unconditionally and unceasingly care for the patient. Since it is a last ditch attempt, no holds are barred, and the

very life of the individual is at stake.

Patients in psychotherapy present a unique set of circumstances if and when they become potentially suicidal. The therapist as a distorted transference figure is often the one against whom the patient's hostility is directed. Such cases are not uncommon, and techniques that would prevent such potentially dangerous situations from developing might well help save otherwise lost lives.

Crisis Mobilization Therapy, C. M. T. , is a recently developed system of combined individual and group psychotherapy that has been found to be effective in combating such reality distortions. In C. M. T. , affective crises are repeatedly mobilized with sufficient intensity to alter physiologic pathways that were established in response to early psychologic trauma, using a variety of provocative tactics to mobilize such feeling crises. Patients invariably experience such therapeutic interventions as personal attacks, although they are in reality aimed not at the person, but at his pathology. The goal is to turn character defenses from an ego syntonic position to an ego alien one, thus enabling the process of separating the patient from his pathology to begin.] C. M. T. , like surgery, is a painful and a frightening process. Medications are, nevertheless, used very sparingly and very rarely. In spite of this, relatively few suicidal episodes ever occur, even though many of these patients have histories of such attempts, and are encouraged to speak openly of current suicidal wishes. The very intense involvement in therapy by patients in C. M. T. and the unequivocal insistence on separation of actions from feelings, explain the rarity of suicidal episodes.] Patients are usually seen twice a week in a psychotherapy group and once a week in an individual session. It is immediately made clear to every new patient that the therapist cannot and will not assume responsibility for his or her life, and that such responsibility will always rest completely with the patient. The therapist as a real, interested human being aims at making affective contact with the patient

during the initial interview and in each subsequent session. A strong therapeutic alliance between the healthy part of the patient and the therapist is forged, based on a mutual commitment to therapy on the part of both. Although the patient pays for the therapist's time, both of them make a voluntary choice about working together in therapy, with the implied expectation that the therapist will remain with the patient for the duration of therapy, provided the patient also commits himself to treat his own life with respect and to guard it with vigilance. Bowlby (1973) pointed out that fear of separation and anxious attachment and over-dependency result when a mother leaves a child, or a child is removed unwillingly from the mother. An entirely different situation develops when a mother remains in a known place while the child explores and wanders away. Not only is such a child, who initiates the movement himself, lacking in separation anxiety, but he also is often adventurous. Patients in Crisis Mobilization Therapy are assured of the same conditions, provided they adhere to the essentials of the therapeutic contract and do not act on their feelings without first checking the validity of such action by the use of their cognitive process. Suicide is not excluded as one viable and possible option, provided the patient consciously assesses the basis of such a course of action, and realistically comprehends all of its implications.

Patients, like most individuals outside of therapy, do not generally appreciate the fact that the intensity of one's feelings can never be a justified cause in itself for any action. The principle of Separation of Affect from Action (not to be confused with isolation of affect) is stressed to patients in C. M. T., beginning with the initial interview and repeatedly thereafter. It serves as the base from which affective storms of great intensity can be mobilized with safety. Deep hurt, intense fear, murderous rage and strong hate and love can all be experienced without real danger to the patient. Any and all such feelings are also experienced in relation to the therapists, without endangering the therapeutic relationship and without involving patients in real-life

situations that may be inappropriate to their present-day circumstances.

Although the expression of infantile yearnings on the part of patients is encouraged, their fulfillment is always frustrated, regardless of the intensity of the desire for gratification. Adult needs, on the other hand, are satisfied when possible. This combination of responses enables patients to experience the therapist not only as a frustrating transference figure, but also as a gratifying real person. The rage that patients in C. M. T. experience as their infantile wishes are repeatedly frustrated is eventually expressed openly in the safe therapeutic milieu. Unlike the situation in classical psychoanalysis, rage rather than sub-clinical depression is the result of such deprivation, since it occurs in a setting that has a clear potential for bringing comfort in an adult framework.

The active part played by the therapist, the intensity of the involvement in therapy, and the explicit recognition of the legitimacy of gratification of adult needs, cause patients to experience the therapeutic relationship in C. M. T. as a real "home", one which they cherish and which they would not give up easily, mindlessly or impulsively. The determination not to have their therapy terminated, thus maintaining the contact with the good "mother-group" or the good "mother-therapist", is usually strong enough to prevent patients from actually carrying out suicidal attempts or gestures, regardless of their wish to test the therapist's sincerity and interest in them.

REFERENCES

Bar-Levav, R. (1975), "Do You Love Me, Yafah Booltiyaniski?", Voices Vol. 11, No. 3.

_____ "Advances in the Psychotherapy Technique - Crisis Mobilization Therapy,"
Am. J. Psych., in print.

_____ "The Treatment of Pre-Oedipal Hunger and Rage in a Group", Inter. J.
Grp. Psychoth., in print.

Bowlby, J. (1973), "Separation", Basic Books, New York.