Descending the Therapeutic Slopes—Slippery, Slipperier, Slipperiest: Commentary on Papers by Barbara Pizer and by Glen O. Gabbard

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Over the past 10 years, I have spent a good deal of my professional life writing and speaking about the long-term effects of childhood sexual abuse; what constitutes psychological trauma; and which part of the experience so pervades and controls future psychological functioning and so undermines the development of positive, nurturing interpersonal relationships. In the course of this work, I have become convinced that the most devastating aspect of childhood abuse, particularly parental abuse, is not the physical overstimulation or the fantasied elaborations of these actual events (though these are of great significance). I have come to believe that the most singularly devastating aspect of childhood abuse is the violent penetration and coopting of mind that occurs when one is emotionally and physically dependent on another who violates and exploits—when, due to the simultaneously dependent and exploitive aspects, one person in a dyad is granted the authority to control and define the other's reality, even when that definition of reality exists in stark contrast to the person's actual lived experience. This severing of consciousness—the irreconcilable rift between what must be consciously held in order to survive in an abusive parent—child relationship and what must be secretly hidden away in order to preserve one's own dearly bought sense of reality so crucial to healthy psychic functioning—has, I believe, the most seriously deleterious effects on long-term functioning.

So why do I begin my paper on supervisory consultation with a reference to childhood trauma and abuse? I am suggesting that the analyst—patient relationship has a potential for psychic penetration, control, and exploitation not entirely dissimilar to what occurs in cases of actual parental abuse. Patient and analyst exist in a rather insular world. It becomes incumbent upon the two of them to construct and define the reality that will pass between them and only between them. They must give shape and meaning to their experience together. Yet we know that patient and analyst often have irreconcilably different experiences of their shared therapeutic encounter. To further complicate matters, we have also come to understand that the degree of power that each exerts over the other is clearly unequal. The patient is far more likely to be dependent on the analyst's goodwill than vice versa. In many cases, the patient can become completely preoccupied with cultivating the analyst's good opinion of her. So, the potential for the analyst's vision of their shared reality to prevail in the ostensibly coconstructed articulation of therapeutic meaning is quite formidable. Again, the ultimate boundary violation becomes the coercive superimposing of one individual's reality into the mental integrity of another, less powerful individual.

However, we also know that most people will struggle when their reality comes to be defined solely by the experience of another. It is in this arena, I believe, that most unconscious enactments occur—an arena in which both participants struggle to contain and preserve a vision of experience that has not found its way into the consciously articulated and ostensibly agreed-on rendition of events. Thus, the unconscious but coercive projective-introjective attempt to invade and shape the experience of the other ensues in bidirectional patterns that can become mystifying to patient and analyst alike.

A supervisory consultation occurring amid such bidirectional projective-introjective processes has the potential to open up a kind of transitional holding space for the analyst—a space in which she can feel free to explore with a trusted colleague her own participation in the kinds of treatment stalemates or clinical choice points that must ordinarily be negotiated alone. It becomes a place, as in Barbara Pizer's model, for the analyst to explore her own personal history and defensive proclivities and meaning-making inclinations as they interface with those of any particular
patient. It is an opportunity to reopen certain clinical choices and interpretive stances and reflect with another on the therapeutic impact of these decisions.

In his commentary I look more closely at how Glen Gabbard and Barbara Pizer each view the supervisory consultation experience. I then offer my own version of how such an experience may be viewed. In his paper Gabbard discusses examples of serious boundary violations, and, therefore, his vision of the consultative process involves a therapist who for one countertransference reason or another begins to slide inexorably into a gradually escalating pattern of therapeutic overinvolvement and frank boundary violation. In the model he presents, the consultant stands as auxiliary superego—paternal oedipal third, guardian of the incest taboo, a decidedly phallic paternal representive of law, order, and generational authority who stands ready to protect the patient/child from the incestuously/generationally inappropriate needs of a countertransferentially embedded, indeed overwhelmed analyst. Gabbard suggests that the therapist's resistance to seeking supervisory consultation often stems from a preference for exclusive, dyadic, quasi-incestuous relatedness. I think of this resistance as a therapeutic preference for a kind of intoxicating, mutual, preoedipal idealization that steers a clearly avoidant course away from the more ambivalent, aggressively infused triangular relatedness of later years. Gabbard suggests, and gives clinical examples to elucidate, that it is only when the consultant in the symbolic role of oedipal other interrupts this dyadic exclusivity that the patient becomes able to deal with this aggressive material.

Pizer, in discussing the analyst's ongoing need for consultation experiences, presents us with a somewhat different understanding of the consultative process—one approaching a more quasi-therapeutic agenda, a space in which the analyst has an opportunity to explore her own countertransference rigidity, entrenched affect states, dissociated fantasies and cognitive disorganization. Pizer carefully distinguishes between the therapist's capacity to use affects as signals to mark knowable and usable countertransference processes and the embeddedness in dissociated affect states that mark problematic fixedness in transference—countertransference enactment. For Pizer, the consultative process begins with an awareness of dialogue about one's own typical and atypical patterns of defensive activity. The consultation itself begins with rigorous self-reflective discipline in preparing a case for presentation and opens into a dialogue in which superman or superwoman is freed of the terror and untoward burden of carrying the world of another human being on her own shoulders. Within the classical lexicon, one might think of Pizer's model as a more ego-based formulation—in contrast to Gabbard's superego emphasis.

Despite having different agendas, Gabbard and Pizer present examples of egregious boundary violations—explicit sexual contact between a patient and a therapist; a therapist's taking the hand of a patient who is in the throes of an intensely eroticized transference; a therapist's sleeping in his office with a patient he believed to be suicidal in order to fend off the negative transference reaction that might follow his attempt to hospitalize her; a male therapist's using aggressively sexualized language with a young female patient struggling with a prior experience of sexual abuse; a clinician's using clearly unauthorized confidential material in a public forum.

The problem here is not that any of us would dispute the inappropriateness of these therapeutic decisions but rather that their extreme nature allows us to create too safe a distance between "the kind of therapist who might do that kind of thing" and ourselves. Such examples could surely lead us to the conclusion that, although some therapists "like these" might be in need of ongoing consultation and supervision, we ourselves would never fall prey to such behaviors.

The emphasis on such extreme boundary violations has, I believe, another effect on the way we begin to understand and image psychoanalytic enactments and the role of supervisory consultation. In the vision or metaphor used by Gabbard, the road to the now famous "slippery slope" appears as a rather gradual but ultimately knowable and recognizable pathway—an escalating gradient with several clearly marked "points of no return." Now, although I believe this to be true in certain cases of frank boundary violation (how many of us would contemplate sleeping in our offices in order to contend with a patient's suicidality?) and although I agree with Pizer that the goal of therapeutic self-analysis and consultation is certainly a familiarity with one's own neurotic needs and defensive postures, I believe that there is an entire arena of countertransference embroilment and consultative usefulness that is in fact much more common and not sufficiently described in these papers. I hope to use my role as commentator to fill in that perceived gap.

My own experience of a consultative imperative has over the years had less the quality of treading a dangerous but well-illuminated pathway or of engaging in a process of increasingly dangerous but personally gratifying behavior. My experience has been more one of feeling that I have suddenly awakened not at the precipice of a slippery slope but rather at the tip of an inverted cone, with almost no room to maneuver and surrounded by treacherous slopes at any given turn.

Let me share some clinical material of my own—material that speaks to the experience of finding oneself at a clinical choice point surrounded by slippery slopes and needing to determine which of the paths before me was the least treacherous alternative. This is a clinical vignette in which I felt myself to be in rather urgent and unexpected need of a supervisory consultation.
Sam was a 40-year-old man who had survived particularly horrific paternal abuse. This abuse involved violent physical and sexual transgressions occurring regularly over the course of many years and ending finally when the patient's father died in a car accident when Sam was 12 years old. When Sam began his analysis, he had memories of what we might call the tip of the iceberg. He knew that he had been physically and sexually abused but had few explicit memories and little affective awareness of the devastating impact of this history. His abuse was more a concept he used to explain a multitude of psychological symptoms. It had never become an emotional reality for him.

The clinical material I wish to relate came from a particularly horrifying session during the phase of work in which Sam came unavoidably face to face with the severity and relentlessness of the psychic devastation incurred at his father's hands. This particular session had been emotionally grueling and depleting for both of us. I myself had been moved to tears as I listened to the truly insane cruelty that had been perpetrated on this young boy, and I sat somewhat awed by the courage and tenacity with which my patient struggled to integrate these truly horrific experiences into his consciously available self-experience. I wondered if I could muster the same courage under similar circumstances and was left highly doubtful that I could. Sam sobbed quietly through most of the session as he recounted in excruciating detail the sadistic twists and turns of his father's cruelty. I remember wishing that I could somehow find a way to extract the 8-year-old boy who had survived these atrocities from my 40-year-old patient, so that I might physically hold and comfort him. But since this was clearly not possible I stayed in my seat and struggled to find words that might partially accomplish this same goal—words that might hold, soothe, and communicate a most urgently required therapeutic presence.

When the session ended, I remember the sense of physical exhaustion I felt. I remember being grateful that it was my last session of the day. Sam seemed okay at first. We spoke of how terribly painful the session had been for him, for both of us, but also how necessary. We agreed that going through it together, as two adults, was far different from what one little 8-year-old boy could do, so completely by himself. We were both okay, we agreed. But something shifted radically and suddenly. Sam got up to leave and made it to the door of my office. He stopped abruptly before the still closed door..."something's wrong," he said..."terribly wrong." "The room is spinning...I can't leave...I can't go out there alone..." This last "I can't" coming more as a gasping, gulping cry than a spoken statement. He began to shake violently, something he had done before, but then he fell to the floor in a heap...screaming out in convulsive, body-wrenching sobs...the intensity of which I had rarely if ever witnessed.

I remember feeling frozen to my seat...resuming my struggle for words. But this time my words clearly fell on deaf ears. Sam was not hearing me, was not taking anything in. It seemed he had become the 8-year-old boy I had wanted to hold some minutes before—an 8-year-old boy completely alone and overwhelmed by his experience of parental betrayal and emotional abandonment. I remember thinking ..." Be careful. You know that what you want to do is probably not a good idea. Sam could be terrified and not soothed by any kind of physical contact." And so I sat, feeling more and more paralyzed, my words more and more awkward and inadequate. I contemplated going over and sitting next to Sam at what would seem a safely appropriate distance. Perhaps this would help him feel my presence. Perhaps from that position and distance he could begin to hear words again. But this felt somewhat dangerous, one step perhaps too close to the edge. But what if I sat. It felt like a million miles between the place where Sam cried out and the place where I felt glued to my seat. Was the slippery slope of emotional abandonment not just as treacherous as the slope of therapeutic overinvolvement?

Eventually, I got up and, doing the best I could to judge an appropriate, noninvasive distance, sat down on the floor next to Sam. For the first time since falling, he looked up and met my gaze. "Let me know if this makes you uncomfortable, "I said. "If it does, I'll go back to my chair. I just didn't want you to feel so alone with all of this one more time." "No, please stay with me," Sam said. But these were his last words...for in the split second that followed, he let out another convulsive sob, jumped the distance I had carefully measured between us, and, grabbing my arm, fell crying onto my shoulder.

I remember clearly the sense of sliding down some steep, slippery incline, of feeling Gabbard's slippery slope beneath me. It seemed I had three options, three slopes I could descend. The first was to gently push Sam away and suggest that this was probably not an appropriate way to proceed; second to sit there frozen and transfixed as I felt in that moment, thereby disowning my own participation in what had evolved and attempting to maximize my patient's own dawning recognition of its inappropriatness...or third to put my free arm around Sam's shoulder and allow him to use my physical presence to help contain and integrate his overwhelming grief. Slippery...slipperier...slipperiest...which here was the most treacherous alternative. I do recall a mere split second which was available for self-reflection. Although I am not in the habit of physically holding patients, in that moment and given those alternatives it seemed like the most therapeutic option, and so I put my arm around Sam's shoulder and let him cry.
Although I have not written about this particular clinical moment before, I have presented it many times in different clinical settings. I have presented it to peers in supervisory groups as well as to students in study groups I run. It has become, for me, the quintessential example of the unpredictability of clinical events, of the inherent risks in clinical decision making, of our inability to know in advance how any one clinical decision will affect the shape and course of future events. The reactions I receive when I share this vignette always run the usual gamut between those who feel horrified that I would have allowed myself to even be in such a compromised position, to those who revert to the other extreme of...yes it is unusual but what on earth else could you have done in such a difficult position? Because I am convinced that the distribution of reactions by readers of this journal will probably mirror those I have received elsewhere, I focus the rest of my commentary not on the rightness or wrongness of my choice but on the value of the supervisory consultation that I initiated and on its impact on the evolving clinical process.

My own reaction to that evening's session incorporated both extremes of the reactions I just mentioned. As I sat there with Sam crying on my arm, I felt the rightness of what was occurring; but, as the evening progressed after the session, my anxiety and discomfort mounted. The next morning, I called a former supervisor—someone whose creative work I respected, someone I knew respected me...but also someone I knew would not be afraid to be critical if he felt that my work with Sam was in trouble.

We met for several sessions. I described in great detail the treatment process, the patient, and the history of my own countertransference responses—something of a countertransference narrative of this treatment. My consultant concluded that, although he would not have chosen the path I did—he would most likely have remained in his chair and kept talking—he saw nothing catastrophic or transgressive about my reactions. We both agreed that such a moment could not become part of a pattern of physical contact but that the circumstances, the intensity of the patient's grief, the strength of the therapeutic relationship, the fact that Sam was not a patient who typically eroticized interactions, and my own recognition of these events as highly unusual all contributed to the conviction that the events of the evening would ultimately be incorporated into an appropriate place within the therapeutic narrative.

My consultant did become interested, though, in what he viewed as somewhat excessive guilt and discomfort on my part—even as the consultation progressed. Having made the clinical decision and having appropriately sought a supervisory situation, he still sensed decided unease on my part. As we explored what I felt was his accurate perception, we came interestingly close to one aspect of Gabbard's paper. We began to focus on the pleasure I took from being so important to my patient, the value for me in feeling my own power to heal him, the seductiveness of the mutually idealizing space that we had evolved.

Although we came close to these questions, we reached, I believe, conclusions that, when held in a kind of dialectical relationship to Gabbard's, give us something of the breadth of possibilities inherent in consultative processes; a breadth of possibilities with which I am sure both Gabbard and Pizer would concur. Indeed, we both became convinced that neurotic issues were at work in my continued discomfort with this phase of clinical work. Here our discussion of my reactions came closest to Pizer's model of the consultation as an opportunity for the analyst to explore her own unconscious participation in a particular treatment context. But we also both felt that the exclusivity and dyadic intensity of this treatment, particularly during this phase of the analytic work, was not only appropriate but necessary to the deepening therapeutic process. What emerged was a growing recognition for both of us that supervisory contact could be used not only to inhibit inappropriate acting out of the analyst's personal dynamics but to facilitate the expression of a degree of intimacy and emotional engagement that could also be avoided because it touched on certain guilt-inducing neurotic gratifications of the analyst. In short, just because something is found to be neurotically gratifying for the analyst does not automatically mean that it is the wrong therapeutic decision. In the same way that the analyst must sustain certain emotional frustrations, she must also on occasion sustain certain intense emotional gratifications—gratifications that have the potential to elicit a certain degree of anxiety or guilt—for the sake of her therapeutic effectiveness.

In this situation, my consultant functioned not as the prohibitive oedipal father assiduously guarding the incest barrier with anxious vigilance but more as the erotically contented father who enjoys the playful, intimate, even sensual attachment of mother and son and who by his quiet presence and tacit approval sanctions the joyful unfolding of this experience, separating it out from more secretive, guilt-ridden enactments. Let me add my belief that the accidental correspondence of the participants to a positive oedipal constellation is irrelevant to the functions being suggested and would occur in any gendered combinations of dyadic and triadic configurations. It is the presence of the other that makes the playful, intimate, quasi-erotic bonding of mother and son, mother and daughter, father and daughter, father and son, a generationally sanctioned form of intimate emotional experimentation.
But how does the consultant become the significant other within a psychoanalytic process in which, unlike the familial oedipal constellation, he or she has no actual physical presence. I believe that the analyst who has sought consultation carries the oedipal other as an identificatory object within her own internal world—that in reaching for help she reconstitutes appropriate generational boundaries, quietly strengthening her identification with her own psychoanalytic tradition of thought, theory, and self-reflection. There is in this reaching out, an implicitly self-correcting process of what might have become a slight overidentification with a particular patient's struggle and a willingness to move too far away from a flexible but definable psychoanalytic frame that loosely circumscribes the safe-enough territory in which we all conduct our analytic work. The consultant stands internally for the analyst, shaping the textures and nuances of what she communicates to her patient. Let me illustrate this process by returning to my clinical story.

Several weeks after the clinical events I have described, Sam opened a session with a request. “There is something I need to talk to you about, “he said,” but it is bound to be very traumatic for me. It would be so helpful if you could come over here and sit next to me.” I felt the little hairs at the back of my neck stand up and a burgeoning sense of nauseous guilt in my gut. It was clearly time to pay the piper. Gone was the traumatized 8-year-old; in his place was a skillful seducter intent on challenging me with an escalating transgressive process. There was evil afoot in the patient's identification with his own seductive abuser. “I don't think that would be a good idea,” I said to Sam.” I suppose you're thinking of what happened a few weeks ago, but this feels different. Here you are anticipating that you may feel very frightened, and, because you can anticipate, maybe we can come up with some things that will make you feel safer, without being confusing or even overstimulating in the way that physical contact can be.” In what felt like a rapid series of kaleidoscopic transference—countertransference shifts, this comment—this reaffirmation of more traditional limits—seemed to instantly subdue Sam's identification with his abuser, but before me once again sat the frightened 8-year-old boy. Timidly, he posed what I believe to be one of the most crucial questions pertinent to the imposition of cognitive meaning onto this piece of clinical work—a question that also goes to the heart of the consultant's presence within the analyst's response: “Do you think what we did that night was wrong?” Sam asked. Clearly feeling the strength of my consultant's presence, of his carefully considered sanctioning of what had transpired, I tried to answer Sam's question in a way that communicated both the specialness of what had transpired between us—as well as its safe containment and anchoring within a larger frame of limits, authority, and accountability.

“Well, from your questions it sounds as if you may have some doubts,” I said. “Why don't you tell me what your concerns are.” Sam replied, “No…I want to know what you think”…I don't know what to think, I'm very confused.” Knowing that for abused children parental eroticization of what should be predominantly intimate seriously clouds their ability to understand any intense emotional connection, I agreed to describe what I would otherwise have preferred to hear from the patient first. “No, I don't think it was wrong at all,” I said. “It was an extraordinary session…so much of what happened coming back to you…so intensely overwhelming…I couldn't let you feel alone with it again, the way you did as a child…and you reached out for me…for another person…in a way you so rarely let yourself do…letting yourself use me to help contain all of that grief.” “But,” I continued, with the voice of my consultant adding assuredness to my own, “it was a moment…a good moment…but a moment nonetheless…and we have so many intensely emotional and sexual things we need to talk about, you and I…issues that that kind of physical contact can make unnecessarily confusing. For the most part, in our day-to-day work, I think it's better if we both try to rely on words where we can.”

Sam nodded, smiled a somewhat wistful smile, and seemed to breathe more easily. His moment of intimacy had not been eroticized after all. It had been okay to reach out and safe to feel that close to another person. But he also felt reassured that this moment of physical contact would not burgeon into an escalating progression of transgressive enactments. In a well-lit corner of my mind, my consultant sat, smiling contentedly…a wink to me and a short pat on the back. I breathed more easily also. It seemed for the moment as if we had all come down this one very treacherous slope intact. But I knew there would be moments of crisis and doubt, then aren't we functioning as hypocrites if we communicate to our patients that they can rely on us and need not stand alone?

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