MEDWIN PUBLISHERS
Committed to create value for Researchers

Psychology & Psychological Research International Journal
ISSN: 2576-0319

Boundary Issues in Psychoanalysis: Past, Present and Future

Laquercia T*

Center for Modern Psychoanalytic Studies (CMPS), USA

***Corresponding author:** Theodore Laquercia, Center for Modern Psychoanalytic Studies (CMPS), 15 West Street, Newyork, 10011, USA, Tel: 212-242-1107; Email: tlaquercia@aol.com

Case Report

Volume 4 Issue 6

Received Date: October 14, 2019

Published Date: November 14, 2019

DOI: 10.23880/pprij-16000230

Abstract

This paper is a modern psychoanalytic exploration of the boundary issues and potential frame-expansion involved in working psychoanalytically with patients who are known to each other, or where there is some other, frame-related, matter at hand. The topics are dealt with by considering some of the ways psychoanalysis has appeared to be in conflicted relation to frame-related subjects, as well as by looking at some of the author's own history with psychoanalysis and the frame. Case studies illustrate the author's way of working in this arena.

Keywords: Psychoanalysis; Future; Engaged; Transgressive

Introduction

Matters of the Frame

Psychoanalysis in pure form is a process that involves a psychoanalyst and an individual who has agreed to participate in the treatment with no relationship to others in his life including family or friends. The agreement to work together is free of the complication of outside relationships that might, in some way, influence how the process unfolds. In fact, in the years that I have been in practice, and during my training, I was exposed, initially, and have engaged eventually, in an extension of these parameters in working with patients. My own analyst, my supervisors, and other analysts I have known and still know, all engaged in treatment arrangements that had family members and others known to each other involved in treatment. As in the early history of psychoanalysis, my peers and those who were my teachers and supervisors treated their own relatives, treated the children of their patients, and treated husbands and wives simultaneously. This paper will be an attempt to describe a balanced view point, as opposed to the polarities that seem to have been established in the last century, between a stern materialist perspective wherein there is no overflow between cases, and an utterly transgressive vantage. I will begin by taking in some of the history of this polarity, however, and then expand the discussion to address contemporary conceptions of the frame, before returning to the idea of mixed treatment arrangements.

If we look at William J. McGrath's discussion of the reception of Freud's work we might understand the terms of the polarity mentioned above as being entrenched in a split attitude in favor of or against its being "scientific" (p. 17) [1]:

Whether or not Freud's work was actually scientific has been much debated. Although it has been argued with some justice that his followers and translators exaggerated the scientific quality of his thought and language, it seems evident that they did so in part because Freud himself strongly insisted he was a scientist. Those who have argued that he was not have sometimes done so out of a basic disagreement about what "scientific" means, a disagreement reinforced by the fact that the English word has a substantially narrower meaning than its German equivalent, *wissenschaftlich*. Beyond the problem of translation, however, is the more substantial issue involved in the nature of Freud's evidence. The

combination of using the subjective evidence of his own dreams with what some regard as an equally subjective mode of analysis has led various critics to conclude that Freud's work violates the objective standards demanded of scientific inquiry.

To add to this subjective legacy, and despite the current cultural perception that the analytic model is a solitary one, the early history of treatment in the dawn of the last century tells a different, not so solitary, story. There were complicated and often inbred combinations in early analytic practice: Freud analyzed his daughter Anna, and many others followed the leader: Karl Abraham treated his own daughter, as did Carl Jung, Ernst Kris treated both his children, and Melanie Klein, treated all of hers. Beyond children, the early analysts expanded their work to include nephews and nieces, with a case that ended in tragedy: A nephew, analyzed by his Aunt, Hermione Hug-Hellmuth, was tried for strangling her to death, and at the trial he testified that he was a "victim of Psychoanalysis." As unfortunate as this treatment was, many continued to work in this way. Beyond these treatment arrangements were those who saw analysts who treated each other at the same time, those who analyzed their lovers, wives or husbands, even those who analyzed their analysts.

McGrath makes the important point, though, that Freud's subjective orientation, so to speak, was much more sophisticated than his detractors allege, and, that some of the analytic free-for all might imply [1]. As a student at the University of Vienna, Freud wrote to his friend Eduard Silberstein letters which prove beyond any question that he approached psychological investigation from a highly sophisticated background in the philosophy of science, gained primarily through his work with Professor Franz Brentano . . . . [and Freud] followed his lead in developing a dualistic approach to understanding mental processes. This approach sought to combine physiological and anatomical evidence with that gleaned from the investigating scientist's perceptions of his own inner processes. (p. 17)

Anthony Bass's idea in "When the Frame Doesn't Fit the Picture" is consistent with these reports-from a very different angle [2]. Nonetheless, he suggests that Freud's clinical practice seems to have been more flexible than his technical papers would suggest (pp. 5-6). In other words, the inward-looking Freud may have authored rigidly technical-sounding precepts, but the reality of the frame-expansion may have been a different story-as we know from his analysis of his own child, for example, though, of course, Bass is speaking in a widely different context. He suggests a kind of (Freudian) heterogeneous technique for working with patients, one that includes a tightening and a loosening of the frame as and when required. Bass also notes: Freud recognized the necessity for establishing the frame early on in the treatment in his oft-cited metaphor of clinical psychoanalysis as a chess game, in which rules for the opening moves are more systematically formulated and easily mastered than approaches to the far more complex middle game, where play becomes increasingly subtle and the successful player relies increasingly on experience, intuition, and creative breakthroughs rather than preconceived rules to move the play forward (p.6).

Bass cites Hoffman and Symington in distinction with Langs [3], as presenting oppositional viewpoints about frame expansion as it diverges from what some consider to be "orthodox" doctrine, which is interesting, when we consider the history of frame expansion *per se*. Bass writes: Equally important . . . as Hoffman pointed out, is the option to toss out the book from time to time, to respond with spontaneity and creativity to unique features of any given patient [3], to feel one's way in the immediacy of experience, and to free up what may have become the constraints and rigidities of "policy." Such "acts of freedom", crucial to the analyst's repertoire, are highly personal, expressive of the analyst's personality as well as his understanding of the patient, and integral to the analyst's art. Indeed I believe these rogue interpretive moments lie at the heart of therapeutic action (p. 6).

And: For Langs, modifications of the frame, departure from classical technique (e.g., making noninterpretive interventions or indulging in extraneous or social remarks, or any form of self-disclosure), are likely to generate what he called a "misalliance" with the patient and always reflect disturbances in the analyst (countertransference difficulties) that the patient takes note of consciously or unconsciously and responds to by trying to cure, virtually always to the detriment of the process and the patient's own best interests. In such a model, self-disclosure, noninterpretive forms of participation, or varying kinds of participation in transference-counter-transference enactments are regarded as destructive because they compromise traditional framing principles of anonymity, neutrality, and non-gratification—all key shibboleths of Freudian analysis (pp. 6-7).

As opposed to Lang's position, this paper argues that a certain vein of frame- expansion may promote a relationship defined by a working together between analyst and patient, rather than a "misalliance," and the

Copyright© Laquercia T.

expected counter-transference difficulties. By way of example, we may consider I. Z. Hoffman's discussion of the case of Ken, which he presented to the Annual Meeting of the Rapaport-Klein Study Group [3].

Hoffman presents the case of a patient he calls Ken, a man who suffered from fear of heights, and who, in an apparently frame-breaking maneuver, Hoffman walked to the elevator of his own 21st-floor office space, when asked. Hoffman writes:

There is no way for the analyst to know, with certainty, what course to pursue with respect to the balance between spontaneous, personal responsiveness and adherence to psychoanalytic rituals at any given moment, nor can the balance that is struck be one that the analyst can completely control. The basis for the patient's trust is often best established through evidence of the analyst's struggle with the issue and through his or her openness to reflect critically on whatever paths he or she has taken, prompted more or less by the patient's reactions and direct and indirect communications (Para 12).

Hoffman's deviation from the frame was brief—the act of walking the patient to the elevator-but it clearly engendered a great deal of thought. This relatively small deviation was sufficient for Hoffman to look critically at the rigidity at the enterprise he was engaged in, with its two participants locked into position. If we look at Gabbard's response to Bass's paper [2,4], "When the Frame Doesn't Fit the Picture," we get a more long-term notion of frame-expansion, however.

Gabbard responds to Bass's paper by suggesting that, in his own experience, the frame functions better when it is flexible [3]. Gabbard describes an experience wherein one of his supervisors would consistently say to him, "Have you noticed how much better the patient does when you maintain a classical frame and simply interpret the transference" (p. 923.)? Gabbard continues, "Although I didn't come right out and say it, I thought to myself, No, I actually hadn't noticed that. In fact, I noticed that she deteriorated when I attempted to do what he suggested, so I continued to be flexible with the frame because I felt that was the only way to engage her" (p. 923.). Similarly Hoffman [3], in walking Ken to the elevator, was, in essence, engaging his patient with "spontaneous, personal responsivity" when his "frame-breaking" act was not an interpretation of the transference.

***

Looking further at the way that matters of the frame were viewed as history unfolded, we see changes occurring. The earliest phase of the psychoanalytic movement gave way to standards and ethics that altered much of the in-bred analytic process, especially as institute training began to emerge in the 1930s in Europe and the United States. In this country, prior to the 1940s, psychoanalytic training was exclusively medical. However, the medicalization of analysis may have in part been a reaction formation against an otherwise incestuous tendency—a reaction formation that, in its turn, went over the top. Theresa Aiello notes [5]:

Frederick Wyatt has suggested that the severing of psychoanalysis from the humanist and classical tradition of Western Europe was especially harmful to psychoanalysis in America. He believed that "medicalization" of American analysis was restrictive in several respects: in terms of dissemination of psychoanalytic training; in practice, because it would be available only to clients who could afford a psychiatrist's private fee; and ultimately in the expression of psychoanalytic theory. Jacoby, Lindner and Hale have all criticized the theme of conformity in the name of adaptation that to some degree has characterized the "medicalization" of psychoanalysis. Wyatt proposes that when psychoanalysis lost its cultural matrix and humanist derivatives in literature, culture, and history, it lost its very essence for understanding the human condition (pp. 9-10).

Even today, the ethical standards established that prohibited dual relationships have remained, and a culture regarding the inappropriateness of such analytic relationships remains in place, with the general population dismayed or even shocked that an analyst would cross a perceived boundary by seeing others related to their patient. Despite this covenant against dual relationships, one wonders if, in practice, there are many who go beyond the boundary set by standards founded by the establishment, and whether this "going beyond" might not be a function of a self-reflexive practice of psychoanalysis, rather than its opposite. Indeed, my own practice is certainly different on this score.

This self-reflection is highly important. Interestingly, Celenza reports that in cases of sexual transgression/misconduct on the part of a therapist [6], it appeared that the motivation for sexual transgression(s) most often involved unconscious, denied, or compartmentalized conflicts about which the therapist had little insight. These issues were usually related to personal conflicts in the character of the therapist, rendering the therapist vulnerable to enactments when

Copyright© Laquercia T.

intolerable helplessness, loss of self-esteem, or rage was evoked. (pp. 379-380.)

It is certainly understandable that a climate of fear would exist in relation to misconduct of this nature, particularly in the setting of a hypothetical therapeutic community that fails to self-reflect, which is not what I am advocating. Of course, Celenza and Gabbard do make the point that there are [7], in the analytic world, one time sexual transgressors who, otherwise, do good analytic work: "It is common for a transgressor's other analysands to report acceptable analytic work being done concurrently with his ongoing sexual relationship with that one patient. In other words, the misconduct, though an extreme ethical violation, can occur in an otherwise ethically sound and competent practitioner" (p. 622). This, then, is a matter for serious reflection on the part of the analytic community in a general sense.

To continue the story of psychoanalysis in America: Theodor Reiek's emigration to New York was a seminal turning point, one that Freud looked at askance. Reik, a nonmedical, "lay analyst," was asked by the New York Psychoanalytic Society not to train nonmedical individuals in psychoanalysis. He naturally refused because in his own history Freud had discouraged him from seeking medical training [8]. Indeed, Freud wrote in a letter of 1938: "What ill wind has blown you, just you, to America? . . . You must have known that [there] psychoanalysis is nothing more than one of the hand maidens of psychiatry" (p. 5) And in another letter he noted that he was "surprised to learn that Dr. Th. Reik has gone to America where the fact that he is not a medical man is likely to interfere with his activity as an analyst (p. 6).

In fact, however, T. Reik replicated Freud's own early model of informally training his patients in his waiting room-much like the Wednesday night meetings held in the first decade of the twentieth century. In ten years that group became the core of the first institute to accept individuals from any academic background, not exclusive to medicine or to any other profession. A new era had begun in this country.

My Immersion in Modern Psychoanalysis

My own analyst and many of my early teachers and supervisors were trained in that institute. For example, Hyman Spotnitz was to a significant portion of the students and faculty there a salient influence. His ideas, especially on the basic premise of inclusion, and his openness to a form of treatment that would be patient-oriented, rather than "rule bound," eventuated in a rift that saw his adherents breaking away to create the first institute devoted to the principles of Modern Psychoanalysis. In that *new* community analysts, motivated by a climate that encouraged inclusion and an openness to innovation, accepted the potential for applications that went beyond the traditional. Yet, it took several decades before one of the founding analysts of this new institute wrote about extending the treatment to include people related to each other, and even treatment of her own relatives, and the children, and grandchildren of her patients:

You may be wondering why anyone would want to treat relatives. Why did I not send them elsewhere? Certainly there is no dearth of mental health professionals. Initially there seemed to be no other choices, and I have a philosophy of life that the only healthy and happy family I may ever have will be my own. So why should helping strangers be any more important to me than helping relatives? An early life history instilled in me a powerful drive to be therapeutic. This, coupled with intense curiosity, and fueled by having received a gift on my thirteenth birthday of Freud's Interpretation of Dreams by an emotionally significant relative, committed me to this work [9].

My own Modern Psychoanalytic story starts in the 1970s as a member of the first classes of this newly founded institute. Initially, I applied and was accepted at the Institute founded by the Reik followers, but I transferred to the then called Manhattan Center for Advanced Psychoanalytic Studies (MCAPS), eventually the Center for Modern Psychoanalytic Studies (CMPS). The beginning student population started this program having had attended lectures at the Academy of Sciences at which Spotnitz and others presented their views and new ideas about psychoanalysis and training. Classes began in the fall of 1971 with a vibrant mix of individuals drawn from many different professional and personal backgrounds. Husbands and wives attended classes together, MD's sat with students who had not yet received their first degrees. An air of openness and inclusion filled the air. I had been in analysis for a short time, and the woman I would later marry sought to begin hers. Indeed, my (now) wife of over 40 years was told by a leader in the field, whom she consulted to consider starting a treatment, that if she loved the man she was engaged to and wanted to marry she should be in treatment with his analyst. She followed his advice and we are still married over forty years later.

What distinguished this new institute requires we digress for a moment into theory. The first conceptualization that the early analysts worked from,

Copyright© Laquercia T.

the first topography of the mind, i.e. the unconscious, preconscious, and conscious made a convenient model to assert that what had to be accomplished in the analysis only was to retrieve hidden memories, where trauma figured into the symptoms a person was suffering from. The hysteria that was so widespread at that time yielded to this process that confirmed the earliest theoretical understanding of psychoanalysis: make the unconscious conscious, and create a potential for catharsis and abreaction, and symptoms would be relieved or disappear entirely. Charcot's impressive demonstrations using hypnosis were a key factor in the earliest thinking of Freud and others. According to Eric Kandel [10], "Charcot found that, under hypnosis, a hysterical patient could be relieved of symptoms and a normal patient could acquire symptoms indistinguishable from those of hysteria" (p. 51). As theoretical understanding expanded, a newer structural model of the mind emerged (Id, Ego, Superego), allowing for an ever widening set of possibilities. Indeed, Kandel describes how Freud's thinking can be divided into neurobiological and nonneuobiological models of mind (p. 43). He also notes that, "Upon Freud's death, the British poet W.H. Auden commented that Freudian thinking no longer represented the ideas of a single individual , but a 'whole climate of opinion'" (p. 43). So, although making the unconscious conscious still had its place, ways of thinking about the workings of the mind were broadened to take in defenses related to id impulses, ego configurations, and superego constraints. Whole new theoretical assumptions abounded, focusing on the Ego, Objects, Self, Relational and Interpersonal modes of thinking, and of course, defenses. In a century of ideas, treatment and training, schools of thought, and the theoretical underpinnings of these systems has resulted in ever-expanding numbers of papers and books espousing one approach or another, all claiming an overarching identification with psychoanalysis as a whole. In as much as theory informs techniques, such a process results in the relative improvement of patients. As diverse as these approaches may be, with their focus related to such variations in theory and technique, the question emerges, what is the common element in all that can be identified as curative? The tension in differing points of view is generally positive for the field as it provides a continuous challenge to the extent that theory is able to withstand critical examination and therefore remains vibrant and alive. Yet, we ask, why do people get better?.

In Modern Psychoanalysis, the *foundational* premise that resulted from the publication of Spotnitz's *Modern Psychoanalysis of the Schizophrenic Patient* in 1969 was that a schizophrenic patient could be treated analytically and could be cured. In my practice of over forty years, I have not cured a schizophrenic patient and I don't believe that I have had a florid schizophrenic appear for treatment but I have had individuals fixed at psychotic levels of pathology with symptoms that rendered them diagnosable in the *realm* of psychosis. And there are patients in my practice treated by utilizing the techniques borne of the principles of Modern Psychoanalysis-men and women whose life paths were altered by their analyses in view of the defenses that would have remained in place had they not been analyzed, and who would have resulted in having breakdowns of considerable pathology leaving them bereft of significant personal relationships and lives marked by failure and collapse. These are patients whose needs required my being in the resistance with them as a function of those very needs driven by the unconscious process at a psychotic level.

Having been exposed to this, (Modern Analytic) method of treatment and conceptualization, and believing that it was a departure from the more orthodox approaches, I accepted the premise that it could be helpful, not harmful, to work with members of the same family using modern psychoanalytic principles, including working with multiple members of the same family or social group, and that the complexity of these relationships would be opportunities to deepen the treatment of either party. In the early years of my training and practice I was fortunate to have persons who accepted the notion that their outside important relationships would benefit if their partners would come into treatment while they were in treatment. I will present several examples of my early work here.

There are currently in my practice several extended treatment models. Husbands and wife; father, son, and stepmother; sister and brother; father and son; mother and daughter; sister and sister; mother, son, and stepfather. In each of these treatment combinations the individuals present in treatment in the usual fashion and, despite the presence of the related person, deals with particular individual issues in what appears to be the general pattern of transference and resistances. I will address some particular approaches to unique resistance patterns that I believe relate to working in this Modern Analytic way, later in this paper.

In preparation for the case studies to follow, I am presenting a list, below, of various boundary extensions that have existed or that currently exist in my practice.

Copyright© Laquercia T.

• Father, Mother, and son;
• Individual analysis with a woman who brought her husband into treatment, and eventually their son began treatment
• Mother and Son
• Woman in analysis and her boyfriend
• Patient who sends the boyfriend of a patient of hers
• Female patient who occasionally brings her husband into a session for a couples session
• Two sisters
• A supervisee introduces his father for treatment, he introduces his son into sessions, and he then brings his grandson into treatment
• Husband and Wife (2 couples)
• Wife, husband, and son
• Wife and husband (2 couples)
• Husband and Wife come for couple sessions. The wife decides that she doesn't want to work on the marriage. The husband remains and decides to enter analysis with me
• Supervisee and her son
• Mother and daughter
• Mother and twin daughters (other twin with one of my patients)

Figure 1: List of Boundary Extensions in the Author's Practice.

These combinations add up to 33 persons in my practice roster of 80 individuals who see me while the other(s) also are in treatment.

It would seem to me that what needs to be explained about such a process—to be described further along in this paper-is that the experience is perceived by those involved, not as breach of psychoanalytic principles, but rather an opportunity to broaden the potential for analytic exposure. It could be seen as an appropriate analytic process that has efficacy among the many approaches that exist in the field itself.

Although the examples I present as case studies share the common element of blurred boundaries, making them qualitatively different experientially from the, perhaps more orthodox one on one relation of exclusivity, there are differences from one another with respect to how they emerged as cases. In some instances one person began treatment and introduced someone connected or related to him into treatment. The recommendation that the new person enter treatment was not related to a need on the part of the referring person's own issues. Several other examples have an entirely different impetus for the boundaries to be extended. The patient herself is driven to enact a sense of need for outside contact and there is an urgency, if not an imperative for the contact to be extended or the treatment would be imperiled. Therefore, I describe the cases in two categories: *1.) The boundary is extended as a function arising from the treatment, and 2.) the boundary is extended as an enactment occurs in treatment.*

Case Studies

Case 1

Example 1: The boundary is extended as an enactment that occurs in the course of treatment: It is likely that the most dramatic example of a boundary extension that I can give relates to my own analysis, and an experience that I had with my analyst while in group therapy. At some point in time, after I had been in treatment for many years, both individually and in group analysis, a new person arrived in my group who was not in individual analysis with my analyst. She was a young woman in her thirties who said that she was advised by her analyst, a woman she had been seeing for some time, to join a group run by my analyst in order to break an impasse in her treatment. She had been interested in finding a man to have a relationship with that would lead to marriage and children. She and her analyst agreed that her treatment had not resulted in that accomplishment, and she agreed to take the advice of her analyst, and joined the group I was in. Initially, she had participated as any new member would and related her issues and dealt with the process of the group in an appropriate manner. In one session however, she indicated that she felt she needed more than just the group to attain her goals. She felt that she had always worked with women and wondered if she needed to work with a male analyst in order to accomplish this goal. The leader of the group accepted that idea and suggested that she might choose someone in the group, as there were several members who were certified analysts and she had gotten to know

Copyright© Laquercia T.

them in the time she was in the group. When asked who among the men in the group she would want to work with, she said she thought I would be someone she would feel comfortable working with. I was somewhat surprised at even the idea that this could be done, but the analyst communicated openness to it as a possibility. I wondered how we could do this: first, being several men of the same group, with personal interactions that revealed so much, and then, second, going on to establish an analytic relationship outside of the group where I would be her analyst and she, my patient. It astounded me but she seemed willing to consider it and the group talked about it and processed what we both felt about this possibility. It was discussed deeply and she said she was willing to try, and I did also. She called within days and made an appointment to come to see me. We made the typical arrangements and treatment began. Surprisingly, her sessions were not at all unusual. She spoke of her history, her family, mother and father, and married sister; and I began to experience the slow establishment of her transference. What was very intriguing to me was the fact that in the setting of my office we engaged in what was an ordinary treatment duality and later on in the same day, sat in group together as co-group members. I did not feel inhibited in dealing with the issues in the group and she reported that she felt the same. It appeared that she looked forward to her sessions with me and discussed her disappointments with men. As time went on it became clear that while in session with me she moved into what appeared to be the usual transference condition, and I felt corresponding counter-transference feelings. I could feel the attempts at attachment to me and an unspoken positive desire that generated in me a mutual positive sense about her.

When I first began working with her it was clear that she was inhibited by a sense of being unattractive. I understood her reason for that perception but with time, and a growing admiration of her desire to find a man in her life, and the willingness to be in this very unusual relationship with me, I began to deeply admire her intelligence and liked to hear her voice. I began to see her as pretty. From one profile side I found her beautiful, and when she spoke in session I could hear the yearning and desire for a life with a man, and sex, and family. She had been very apprehensive about dating, and self-conscious about her looks, but gradually she made an effort to go on dates. Her description of her experiences was not unlike any other female patient I had that went through what she was going through and eventually she did find a man whom she fell in love with, and the feeling was returned. They married and she reported that they had a good relationship that she was sure would lead to a baby. When it became clear that what she came into treatment with me for had been accomplished, she and the group decided to discontinue both treatments, and she remained only in her own original analysis. I later found out that she gave birth to a son, and that she and her husband were raising their child.

The treatment process described above, unique as it was successful (in part, because of the acceptance that it was in the service of something that was constructive, both within the individual analysis and in the group that we shared, and with the joint positive regard for the objectives that were part of her quest) was helpful to me and to her. We as a team felt supported and did not feel that what was being done was unacceptable or wrong. Acceptance of that sort was useful to be free to engage in the treatment process without self-abnegation and doubt.

Case 2: Boundary Extension as a function arising from the expressed need of the patient

In the 1970s, early on in my practice, two young men of about the same age began treatment within weeks of each other. Shortly after starting treatment they were open to inviting their partners into the process. Both men were positively disposed to the therapy and seemingly, very dedicated to their treatment. One of these men came into treatment via the treatment service at my institute. He was married. The other came into my private practice and was engaged to be married. Treatment proceeded unremarkably for all four individuals, and the fact that their partners were mutually involved in treatment did not seem to deter them, for there was no objection on anyone's part to the partners' beginning treatment with me.

Around the same time that these two couples began to work with me, another treatment service patient, a woman, asked her boyfriend to begin treatment with me also. I had six people engaged in treatment with either a spouse or a future spouse at the same time. I found that the marked similarity of their issues gave me opportunity to study them both individually with respect to the treatment process itself, and to consider the issues that young couples faced in beginning relationships.

Eventually another female treatment service patient began seeing me and, in time, she too asked that her new boyfriend get involved, and though he was in analysis at the time, he agreed to, occasionally, have couple sessions. With eight people around the same age in couples relationships, married or engaged, and the treatment progressing over several years, I considered beginning a couples therapy group. I invited them to participate and

Copyright© Laquercia T.

they agreed to begin. During this time they continued their individual work while attending weekly group couples therapy.

Eight people, all close in age, bonded in a process that was an extension of their personal analyses and examined the particular issues of each as individuals and persons in marriage, and intimate personal relations. This closeness seemed unique to me at that time, having not had an experience such as this myself, though I was open to conducting the analytic process while learning and being supervised in my own training.

Curiously, all the women's names began with S, and they seemed genuinely interested in relating to each other and talking about themselves and the issues that their relationships brought to them. In time the focus moved toward creating families, hoping that they would be constructive and well-functioning; and they were pleased that their men were likewise involved. The individual treatment and the group process lasted many years and over time each woman announced a pregnancy to the group with a feeling of happiness, and was greeted with approbation. At some point it seemed that one or another couple was pregnant, and children were brought into these families and the group.

As the group matured, the families grew. Two of the couples had three children during the life of the group and the other two couples had two children each. With each pregnancy the sense of accomplishment and life forces were infused in the process, with shared experience, deep attention to each other, and analysis of the forces that bind together relationships and family. I had the gratifying experience, over those many years, to work analytically with eight people who brought ten children into the world and to learn a great deal about relationships, and birth, and child rearing. My supervision in this experience expanded my ability to remain both the individual analyst to each of those I was treating, and to lead the group process, an extension of the treatment of each, to the benefit of them all, and myself.

At this time, so many years later, with all the treatments completed and the group's work concluded, as far as I know all these marriages are still intact. The children are grown and are the beneficiaries of parents who were engaged in their developmental processes borne out of their personal analyses and mutual group process. My practice over the years has continued to be open to the expanded treatment potential for those connected with a patient I might be seeing.

Given this early experience in working with persons related to each other and seeing the benefit that occurred as each used the individual sessions to gain personal growth and maturation and to witness the seeming benefit of hearing from both sides of any issue brought into session or group process, I became convinced that productive work could be accomplished if I could remain committed to the basic premise of analytic intervention based on resolving resistances to communication of any sort while the person was in his or her individual session. The challenge that analysts have to be nonjudgmental as the patient presents whatever comes to mind is amplified when there is "another" that is known to the analyst. The ability to convey to the patient that whatever is said in the individual session remains there, and that confidentiality is paramount, establishes the potential for trust in the process. In addition to the early experience with these eight patients I have had other opportunities to see and discuss this kind of expanded treatment that extended the usual boundaries of psychoanalytic treatment and further reinforced my belief that it is indeed possible to work this way and to utilize the extension to the benefit of the individuals involved. In the life of *this* group the couples brought into the world nine babies, and the shared process of personal issues and child rearing became an important component of their therapy.

Example 3: Boundary extension as a function of the need of the patient: This example of boundary extension that was a part of the treatment process from the very beginning is a representation of an analytic treatment that could not have existed if not for the extra-analytic dimension. It began when I was in the very first years of my training and not yet a graduate, and lasted over 20 years. I was working in an agency that provided psychotherapy for people in the community in which it was located. I was assigned a woman who was in her late 40s or early 50s. She was an Italian woman, dressed in black, with a sallow complexion; she looked much older than her years. At first she appeared somewhat disheveled and unattractive; and it appeared that she had not tended to her hygienic needs. I remember the odor as I write. I had two simultaneous feelings when she came into the room: one, is that she reminded me of the old Italian relatives that I recalled from my childhood, and the memories of pictures that my family had of the women in black from the families on "the other side." That is how my father and mother spoke of Italy. The second was an apprehension bordering on terror. She provided me with the slip of paper that indicated that she had paid for the session and I invited her to sit down.

Copyright© Laquercia T.

For the next 40 minutes she spoke without interruption in a rapid-fire manner. All I could remember was that she was apprehended while trying to run away from her husband and her family and was found somewhere in a local park by the police. I don't remember how and when the session was over because I found myself in a different part of the clinic-some 20 minutes had passed and I was totally unaware of how and when the session with this woman had ended. Somehow, it apparently *had* ended, and I entered into a psychic space with no memory or thought.

In the next session she appeared on time, somewhat better dressed and presented me with an index card with a poem. I read it quickly, put it aside, and listened to what she spoke of that day. After the session I read the poem more carefully and found myself fascinated by the symbolism and the intensity of the feeling it imparted. As her sessions took root her intense transference seemed to have no bounds. I began to have phone calls between sessions; she began to have trouble leaving the sessions at the end of the hour; she would send mail to me almost every day. The elemental communication was that her needs were boundless and I was expected to be everything to her. I felt bombarded and at the same time challenged to hold onto her; to keep her coming and keep talking. She did and her narrative was filled with the suffering of her life circumstances. She had two grown sons and lived with a husband who she described as a "Nazi" who raped her every night. Not a night would go by without his seeking and demanding sex and if she refused he forced her. This she said led to her going "crazy" and running away. Yet, as the transference evolved and our relationship deepened through what might be called the boundary extensions of mail, poetry, and phone calls, I saw "the woman in black" coalesce in her psychic integration, and she emerged into the space of the present time and place.

Example 4: Boundary Extension as a Function Of Need of the Patient

While enrolled in a master's degree program a young woman took a class in the institute where I was teaching. The course topic was "Transference and Counter-transference." Sometime during term the she approached me and asked if I would see her for supervision of her work in her field placement at the college where she was studying. I asked her to wait till the semester was over and ask me then. She did and we started the supervision process. An attractive and well-dressed woman, she presented with a very subdued and somewhat depressed demeanor. In short order it became apparent that the feelings she had in the process were intense, and I experienced the internal agitation that one has in the presence of deep pathology.

What appeared at first to be an ordinary request for supervision turned into what was more akin to an analytic process with a person suffering at the aforementioned deep level of pathology. The initial complication in relating to her in the need that she brought to me was the fact that she was in analysis with one of my own patients. She had begun treatment several years earlier when she was assigned to him in the psychotherapy clinic where he was working. The feelings in this beginning phase mirrored what she had experience with him; and he managed, despite the rigors of the intensity, to help her stay with him—when he left that agency he brought her into treatment in his office. Eventually she attended the institute. I continued to work with her, alternating with the supervisory issues she brought and the regressions that occurred, while she continued having her sessions with her analyst. At some point her analyst began to react to her with efforts to control her need to be with him. Her desire and need seemed to go beyond his capacity to stay connected, and in his attempt to thwart her unwanted approaches, he threatened to terminate the sessions. She then began to ask if I would work with her as her analyst. I was between what seemed to be her need for what he wouldn't offer, and my patient who was quite relieved to let her go. Beyond this very unusual set of conditions, her analyst had been in control analysis on this case, and was using this case for his final case presentation to be certified as an analyst. He conferred with his control analyst and his research supervisors, and all agreed with the transfer to me as expressed by the patient's need.

Likewise, there was a time in my professional life that I had sought out supervision from the most senior member of my community. It turned out that many of my former teachers and supervisors were being supervised in group supervision and despite that, I was invited to join. I found that not only were my teachers and supervisors in the group, but so was my analyst and her husband. Again, I was exposed to an example of boundary extension that was acceptable to the persons I was taught by, who were, at the time, the leaders in my field, and who could experience an understanding of my work and theirs without seeming detriment to my relationships with them in other contexts.

***

The above illustrate considerable extension of boundary when viewed from the perspective of strict orthodoxy. The literature shows scant evidence of such accounts and when it does it is couched in carefully

Copyright© Laquercia T.

constructed terms so as to explain that the so-called boundary extensions are not the norm. This carefulness suggests a significant inhibition against being open to the potential that analytic relationships can be extended for the benefit of the analysand and be in keeping with analytic work.

In a recent article in the Psychoanalytic Quarterly, Fred Pine writes about experiences he has had in supervising individuals who had been his patients [11]. He sees this as a boundary issue, and reveals that in his practice over the years he has extended himself in ways that he had not done when he first began working: "My work in psychoanalysis has evolved over the years . . . telephone sessions. . . self disclosure within the process [and] accepting of gifts . . ." (161). He begins his article with a memory of Phyllis Greenacre, indicating that she took notes in her sessions, something that he himself has not done generally, and he describes his surprise when analysts in the audience of his lecture "confessed" that they did so too. One can only surmise that the sensitivity to the way one works and the potential critical assessment of so called boundary violations or even the simplest experience of taking notes would create a secret nether world of activity that analysts might live in.

In my years of practice I have been in continual contact professionally and personally with others who accepted as a fact of life that boundary extensions were part of the game and could not be eliminated. Rather, the stricture that they should be avoided at all costs seemed to be not present at all and, in fact, was found useful in analyzing enactments that could shed light on the analytic drama being played out in the process of such enactments. That being the case, all that needed to be done was related to the basic rule of analysis: say everything! If one could say everything in the supervisory process, in the analytic engagement, so-called boundary issues could be used to understand the analyst, the analysand, and the analysis. With a willingness to engage in treatment of related individuals a climate of acceptance allows for individuals to ask to be seen or for those being seen to ask that someone related to them come to see me. As I indicated in the beginning of this paper several of my early analysands asked that I see their spouses and I did so. But there are other ways, too, that boundary extensions can come about.
***

Case 5: Boundary Extension as a Function of Family Need

This began with a woman who came to me for supervision while completing her training at her institute. In addition to presenting cases she spoke of not completing her doctoral dissertation and her unhappiness about that. The doctorate was in a field other than analysis but it still bothered her deeply. Invariably, despite her case presentations at the institute, she would allude to this sense of incompleteness. Her thesis was of interest to me, and I enjoyed hearing her talk about how much research she had done and the things she read. Her talking led to a tentative idea that maybe one of her research advisors at the university was still in her department and would sponsor her. Though filled with trepidation she called and found that he was indeed there, and was very encouraging. She returned to the university, was readmitted to complete the doctoral thesis, finished it, defended it, and graduated. Afterwards, her supervision continued and occasionally she would talk about her relationship with her family members and the deep concern she had for her oldest son, a 10th grade student in one of the better high schools in the city. She was terribly frightened that his behavior would never allow him to graduate and possibly be fatal to him as she thought he was involved in substance abuse and activities that were dangerous. She asked if I would be willing to see him. I said "yes," and he called.

What appeared was an adolescent young man, dressed in black leather, chains dangling from his shoulders and around his waist with a hair style of the time: purple and spiked up four inches above his scalp. He was filled with fury and rage and I listened to his tirades against any and all. He would describe his activities and pleasures. Many were certainly dangerous and he relished telling the tales as though the telling was tantamount to action. I listened as he talked, sitting across from me, never ever suggesting the couch. His obvious intellectual prowess and his way with words entertained me and himself. His vivid portrayal of "raves" where people were thrown across a throng of "raving," drug induced kids, almost created in me a feeling that I was there, hearing the music and the cheers, sharing the visceral experience and thrill of the danger.

In the sessions (that he responsibly kept) it was apparent that I provided a safe place for him to say everything and express whatever he was feeling. During this period, his mother had her sessions also, and would sometimes tell me that she still didn't know if he would ever graduate and survive his adolescence. At some point in his 11th year of school, it appeared that he changed his hairstyle and the talk became less filled with the rage he first presented with. In one session he remarked that he knew his mother was doing analysis and her patients used the couch. My couch was directly across from where he sat, and he asked if he could try using it. I said,

Copyright© Laquercia T.

certainly, if that is what he wanted to do. The treatment deepened. Instead of talking about the activities of his life, with his friends and the usual issues of wanting a girlfriend, having sex, and other general adolescent issues, he began to tell me about himself and his life in other ways. He, without instruction, began to tell me about his past, his dreams, and most importantly the feelings he had about his mother and father. Several elements converged to open him up for the change that would occur. One was an essay he wrote for an English class in which he described his mother and the love he felt for her and she for him. Another was his ability to express his anguish over the hatred he had for his father, because his father had a disability that didn't allow him to do the things other fathers did with their sons. The transferential underpinnings were apparent when he revealed this, and he said, "unlike you, a normal dad, a guy who could play catch with his son, my father couldn't do anything like that . . ." He wept so deeply in this session that the room felt like it would fill with his tears. He expressed with such power, then, how much he loved his father and hated him, at once. He was so filled with remorse for the hatred, and calmed down when I said it was good that he knew what he was feeling, and that hating is as good as loving. He said he hated me for saying that, and I felt the love that was embedded in that expression to me. Sessions went on through the senior year with him looking and talking like a typical high school senior, and his first forays into romance began.

The week after his graduation his mother came to her session and with great excitement said, "You would never believe what happened at his graduation. His best friend, the valedictorian of the class, headed for Harvard, spent his whole valedictory address talking about her son. He said that if it wasn't for him the class before this audience of graduates would be much smaller, victims of drug abuse and violence. He called him the class analyst." This young man continued in treatment with me through college, using the telephone, and having in person sessions when he was home. After graduation from college he terminated his sessions and went on to graduate studies in the same field as his father.

Conclusion: The Patient's Narrative is Corrective Regardless of its Ultimate Truth

The above cases are but a few that demonstrate improvement, if not cure. Yet, the field is filled with examples of improvement, coming from all of the theoretical approaches. How is this so? In my search for confluence what I see is a basic foundational premise in all analyses. I also recognize that in the field the basic commonality with those doing the treatment is that clinicians are patients first and foremost. In their preparation for the work they are required to be analyzed themselves. As the decades passed this requirement has become more and more codified in the institutes that certify analysts [12].

Moreover, at the heart of the process is an individual who appears for treatment, at first symptom-bound, suffering, having whatever difficulties their conditions bring to them, and they enter the office and process the particular practitioner has to offer. They lie on the couch and the drama of their treatment begins, resistances arise, defenses are presented, and the analyst works to be a non-judgmental listener to a narrative that is a by-product of a life created by forces unknown to the patient. The narrative is questionable and full of falsehoods, but necessary to the survival of the individual. Whatever techniques the analyst provides to move the process along makes less of a difference than the fact that the person returns session after session and the work continues. It is my opinion that the life drive forces predominate when the patient returns. No matter how difficult the previous session was, or how the person is metabolizing this difficult journey, he/she keeps coming back and talking. Talking, and presumed explanation of the narrative keep doing something that is "corrective" [13].

In Modern Psychoanalytic work an array of topics are generated from the remote past memories of the patient, the contemporary past of life circumstances, remembered dreams, repetitive and current life experiences related to sexual and aggressive drives, and feelings about the process itself, as well as about the analyst in particular. When all of these elements are present in any particular session it seems like a well-orchestrated presentation by the patient desiring to "say everything." However, it is more common to have sessions that have the narrative focused on one or two of these elements. Analysis of the resistance to saying everything as described above is the responsibility of the analyst and resistance to it falls to the patient. It appears that it is in the resolution of these resistances over time that keeps the person in the process and returning session after session. The analyst and the patient, over time, perhaps a long time, begin to understand the patient more and more, knowing in a way that was unknown before. My particular work, including boundary extension, is part of a culture born in the middle of the last century. I know there are those who would take umbrage with this process, yet having lived it as I have over these four decades, both professionally and

Copyright© Laquercia T.

personally, I believe that it is an effective and beneficial way for many individuals to gain from psychoanalytic therapy.

The conclusions of this paper hopefully are strengthened by examining several cases that were presented and intended to demonstrate that the boundary "violation" itself was an inherent element that was at the heart of the potential progress of the case. As the author of this paper I offer an amplification of what has been written in the hope that I replicate in the writing of this paper an equivalent boundary extension and in so doing add more for the reader to experience.

What Follows are Selected Cases that Expand the Conclusion Section. Enjoy!!

Case 1: In Case 1 the work of the personal analysis was extended beyond the woman's ongoing analysis and became a part of her treatment with me. A conceptual explanation of the evolving progress is replaced by evidence of change that occurred over time in her relationship with me as her "new analyst" The evolution of her transference and my corresponding

Counter-transference can be seen as both "ordinary" and unique. That uniqueness appears to be extremely important in the choices she made to behave in ways in the world to gain the things she so intensely desired. Ie. a normal loving relationship shared with a man that led to marriage. Although a very unusual start of the analytic process, her treatment with me led to life changes for her that provides a window to see that such an unique extension of treatment is, indeed possible. From the very beginning of her treatment with me, we both experienced the usual transference and counter-transference feelings and provided a basis for the issues that had created difficulty in improving her life condition and led to accomplishing her life goals. What is demonstrated in this case is that the outside boundary experience itself was more powerful than the analysis of resistance that would be more usual. In other words, I could live outside of what would be more traditional for her benefit she could engage in progress herself.

Case 3

Example 3: Boundary extension as a function of the patient.

This example of boundary extension that was a part of the treatment process from the very beginning is a representation of an analytic treatment that could not have existed if not for the extra-analytic dimension. It began when I was in the very first years of my training and not yet a graduate, and lasted over 20 years. I was working in an agency that provided psychotherapy for people in the community in which it was located. I was assigned a woman who was in her late 40s or early 50s. She was an Italian woman, dressed in black, with a sallow complexion; she looked much older than her years. At first she appeared somewhat disheveled and unattractive; and it appeared that she had not tended to her hygienic needs. I remember the odor as I write. I had two simultaneous feelings when she came into the room: one, is that she reminded me of the old Italian relatives that I recalled from my childhood, and the memories of pictures that my family had of the women in black from the families on "the other side." That is how my father and mother spoke of Italy. The second was an apprehension bordering on terror. She provided me with the slip of paper that indicated that she had paid for the session and I invited her to sit down.

For the next 40 minutes she spoke without interruption in a rapid-fire manner. All I could remember was that she was apprehended while trying to run away from her husband and her family and was found somewhere in a local park by the police. I don't remember how and when the session was over because I found myself in a different part of the clinic—some 20 minutes had passed and I was totally unaware of how and when the session with this woman had ended. Somehow, it apparently had ended, and I entered into a psychic space with no memory or thought.

In the next session she appeared on time, somewhat better dressed and presented me with an index card with a poem. I read it quickly, put it aside, and listened to what she spoke of that day. After the session I read the poem more carefully and found myself fascinated by the symbolism and the intensity of the feeling it imparted. As her sessions took root her intense transference seemed to have no bounds. I began to have phone calls between sessions; she began to have trouble leaving the sessions at the end of the hour; she would send mail to me almost every day. The elemental communication was that her needs were boundless and I was expected to be everything to her. I felt bombarded and at the same time challenged to hold onto her; to keep her coming and keep talking. She did and her narrative was filled with the suffering of her life circumstances. She had two grown sons and lived with a husband who she described as a "Nazi" who raped her every night. Not a night would go by without his seeking and demanding sex and if she refused he forced her. This she said led to her going "crazy" and running away. Yet, as the transference evolved and our relationship deepened through what might be called the

Copyright© Laquercia T.

boundary extensions of mail, poetry, and phone calls, I saw "the woman in black" coalesce in her psychic integration, and she emerged into the space of the present time and In this case it is not so important to cite and describe interventions that were made in the process of the sessions but just recognize that the patients intention and behavior of returning session after session to engage in the treatment that made the important difference. Coming week after week conveys the conscious and unconscious desire for change. The life forces that keep one alive with whatever defenses one has to improve and get better. The analyst needs to manage to stay out of the way so that would transpire. it becomes the sine qua noon for continued improvement.

In this case it very evident that my reaction to the initial presentation and the evolution of the treatment included induction and counter-transference that led to behaviors that are atypical of the "usual" treatment process, yet when viewed from the progress made, raises important questions that challenge an orthodox, fixed perspective of how treatment should be conducted. It would appear that the really significant thing that happened was that the patient kept her appointments and came back session after session. The importance of her own desire to "get better" was what made her keep her schedule, not because I wanted her to but what interior landscape drove he to continue so she could use her sessions to become better at being her. What I can understand about what promoted change was her own life forces that were operating to lead to constructive positive changes. Accepting all of the "acting out" without criticism was all that was needed for her to improve. Hours of supervision focused on the intense feelings we shared helped me to be open to the boundary extensions that appeared to benefit her. If I could put up with the behavior she presented without complaint or remonstration she could continue to improve. And she did! We both did.

Ps

From the very beginning my feelings in her treatment were very intense from my own history of the Italian American culture and being the child of a first generation of Italian American immigrants. There were feelings from the very beginning that established confusion between me and her. I often wondered if i was were actually hearing her or listening to voices in my memory or accessing embedded unconscious memories of my own primitive past. Having this awareness of our merged experience and the ebb and flow of shifting boundary kept me focused on my dedication to show up for session after session like her.

References

1. John Forrester, Mcgrath WJ (1987) Freud's discovery of psychoanalysis: The politics of hysteria. Ithaca: Cornell University Press 20(2): 225-227.

2. Hoffman IZ (2008) Ritual and spontaneity in the psychoanalytic process.

3. Gabbard G (2007) Flexibility of the frame revisited: Commentary on Tony Bass's "When the frame doesn't fit the picture." Psychoanalytic Dialogues 17(6): 923-929.

4. Bass A (2007) When the frame doesn't fit the picture. Psychoanalytic Dialogues 17: 1-27.

5. Aiello T (2009) Psychoanalysts in exile. Psychoanalytic Perspectives 6(2): 8-34.

6. Celenza A (1998) Precursors to therapist sexual misconduct: Preliminary findings. Psychoanalytic Psychology 15(3): 378-395.

7. Celenza A, Gabbard GO (2003) Analysts who commit sexual boundary violations: A lost cause? Journal of the American Psychoanalytic Association 51(2): 617-636.

8. Freud S (1952) "Three letters to America" in Psychoanalysis: Journal of Psychoanalytic Psycholog 1: 5-6.

9. Liegner EJ (1984) Countertransference in the treatment of friends and relatives. Modern Psychoanalysis 9: 157-169.

10. Kandel ER (2012) The age of insight: The quest to understand the unconscious in art, mind, and brain. New York: Random House.

11. Pine F (2011) A Note on Supervision. Psychoanalytic Quarterly 80(1): 161-169.

12. Laquercia T (1985) The training analysis in psychoanalytic training: A historical and contemporary examination and evaluation. (Unpublished doctoral dissertation). California Graduate Institute, California.

13. Holmes L (2007) Wrestling with destiny: The promise of psych oanalysis. Modern Psychoanalysis 32: 43-51.

Copyright© Laquercia T.