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THE THERAPEUTIC RELATIONSHIP AND DEVIATIONS IN TECHNIQUE

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EDITOR'S NOTE

This paper offers, in addition to a condensed review of the literature on the ground rules or framework, an extensive set of postulates regarding (1) the therapist's management of the ground rules and boundaries of the therapeutic relationship, and (2) the unconscious meanings and functions of deviations.

It is suggested that the humanistic maintenance of the therapeutic hold, setting, and framework is an essential component of a sound therapeutic experience, and that most if not all deviations contain important countertransference-based inputs. This is a position that has evoked extensive controversy despite what I consider successful efforts at extensive clinical documentation. Clearly I feel it is a position to be carefully considered and evaluated.

The framework and boundaries of the patient-analyst and patient-therapist relationships are a relatively neglected but important area. It is my main thesis that the manner in which the analyst or therapist establishes and maintains the ground rules and boundaries of the therapeutic setting and interaction is among the most important means through which he conveys to the patient the essence of his identity and the dynamic state of his own intrapsychic structures, conflicts, and balances. The therapist's management of the therapeutic relationship therefore influences the ongoing identificatory and incorporative processes in the patient vis-à-vis the therapist, and contributes to the nature of the analytic "field" or "screen"—the person with whom the patient interacts and onto whom he projects his intrapsychic fantasies. It therefore influences the transference dimension as well. As a result, modifications or deviations in the established ground rules and boundaries of the therapeutic setting and relationship have a wide range of deeply significant consequences, of which only a certain portion is modifiable through subsequent analytic-interpretive work in the cognitive-verbal sphere. Actual changes in the therapist's stance are essential to correct the detrimental consequences of such deviations and, further, it may prove virtually impossible to alter certain effects on the patient through any means.

Specifically defined, the ground rules and boundaries of the therapeutic relationship include the following: set fee, hours, and length of sessions; the fundamental rule of free association with communication occurring while the patient is in his chair or on the couch; the absence of physical contact and other extratherapeutic gratifications; the therapist's relative anonymity, physicianly concern, and use of neutral interventions geared primarily toward interpretations; and the exclusive one-to-one relationship with total confidentiality. While the psychoanalytic and psychotherapeutic situations may differ in the placement of the patient and the analyst or therapist, and in frequency of sessions, they nonetheless are both created with a definable set of ground rules that offer as good as possible a therapeutic situation and relationship. I shall focus in this paper on the management of these ground rules and boundaries; I shall be less concerned here with the consequences arising from the different framework of the two

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therapeutic modalities. For both settings, it is these ground rules and boundaries that delimit the therapeutic "hold" (Winnicott 1958) and the boundaries of the therapeutic interaction; they are experiences that, per se, offer important opportunities for identification, structure building, and the projection of intrapsychic fantasies by the patient. Further, they influence the manner in which the patient perceives and assimilates the therapist's verbal interventions.

With this as our basic definition, let us now consider the relevant literature. With the single exception of Bleger (1967), explorations of the ground rules and boundaries of the analytic relationship derive initially from the technical issue of whether ego defects or dysfunctions in the patient call for modification of the usual limits of psychoanalytic technique, i.e., for *parameters* of technique, a term suggested by Eissler (1953). From there, such exploration extends into considerations of the therapist's flexibility (A. Freud 1954a;b) and, more recently, into the degree of deprivation necessary and optimal in the psychoanalytic situation (e.g., Stone 1961) and into those deviations in technique supposedly designed to foster the therapeutic alliance (e.g., Zetzel 1966-69 and Greenson and Wexler 1969). While, as we shall see, a wide range of deviations and parameters in technique have been advocated by various writers, the specific consequences of these deviations for the therapeutic relationship and the intrapsychic conflicts and structures of the patient are virtually neglected. Most writers limit themselves to general impressions of the productivity of such maneuvers—a factor I shall discuss later in this paper.

The papers on parameters and deviations in technique raise a host of issues, only some of which are pertinent here. The most unavoidable of these important secondary problems is that of delineation of classical psychoanalytic technique (Eissler 1953, Greenson 1958). Here I shall simply offer a brief definition of the classical psychoanalytic situation as one in which a relationship between a patient and analyst is established in order to assist the patient in resolving his neurotic difficulties through constructive unconscious identifications and the greatest possible development of insight and adaptive, inner-structural change; the latter is reflected in symptom alleviation and in constructive characterological alterations. The treatment milieu is designed to foster the fullest possible expression of the patient's intrapsychic conflicts, fantasies, and memories, especially as revealed in the relationship between the patient and the analyst. Thus, it is a setting in which all efforts are made to minimize the contribution of the analyst's unresolved intrapsychic conflicts and fantasies to the unfolding interaction between himself and the patient, and, further, to offer the patient an opportunity for inevitable identifications with the analyst based on the latter's constructive manner of functioning and relating. Without digressing, I would suggest that the psychotherapeutic situation is of comparable design, though less intensely so (for details, see Langs 1973b, 1974; since the literature on deviations is founded on the psychoanalytic situation, I will base my own discussion here on that modality).

In creating a climate in which these goals can be achieved, the analyst directly and indirectly indicates to the patient the nature of their respective roles and responsibilities; he delineates a set of explicit ground rules and implicit boundaries in the relationship. In this context, the analyst develops and maintains an atmosphere of warm and growth-promoting concern (Loewald 1960, Greenson 1967), while his primary goal is to understand the patient's communications and to intervene in a relatively neutral manner, ultimately through interpretations that lead to the patient's achievement of insight into his unconscious fantasies, memories, and conflicts. Other types of interventions, such as directives, manipulations, and counterreactions to the patient's associations, fall beyond the scope of such standard technique.

Within this classical framework, *variations* in technique are inevitable (Greenson 1958); they reflect each analyst's personality, style of work, and his appropriate, limited, flexible responses to momentary clinical situations. Beyond these variations, which fall clearly within the classical psychoanalytic framework, lie minor and major *deviations* in technique. Greenson (1958), for example, refers to minor deviations as modifications in technique—necessary and temporary interruptions of the basic procedures and aims of psychoanalysis—and speaks of major deviations as measures that entail "permanent changes in the psychoanalytic method with a consequent renunciation of its results" (p. 200). *Minor deviations* in technique may therefore be defined as consciously intended or inadvertent extensions of the basic psychoanalytic stance that are within such limits for any given patient and analyst that the essential therapeutic relationship and analytic work are not significantly modified, providing that they are recognized, corrected, and the patient's reactions to them analyzed. The ultimate determination of this group of relatively benign deviations, which fall into the gray area between standard technique and extensions which modify it significantly, depends on

a careful assessment of the patient's—and analyst's—total reaction to the deviation in question. As I shall show later, patients in analysis and therapy are exquisitely sensitive to these deviations and universally react to them. The issue is whether, by exploring the consequences, such a deviation can be clearly distinguished from a technical error evoked by faulty knowledge and especially by the analyst's countertransference needs, and whether it—in any case—can be worked through so that there is no lasting impairment in the analytic relationship and situation. If this is impossible, then the intervention is best designated a major deviation which has altered to some degree the analysis and its outcome. If the measure was used because of the patient's unmodifiable psychopathology, the intervention may be termed a *parameter* of technique.

Major deviations and parameters clearly transcend the boundaries of the standard psychoanalytic situation. They will usually result in a permanent modification of the patient-analyst relationship and the outcome of the psychoanalytic work. Even when indicated, these deviations always provide considerable inappropriate gratification for the patient and they may affect constructive structural change. It is here that the distinction between necessary parameters and unneeded deviations—technical errors—becomes critical. Since major deviations also generally provide the analyst with momentary gratifications which extend beyond those usually available to him in the analytic situation, the deviation itself may have countertransference-based motives which must be separated from the realistic, patient-oriented indications for the measure.

Turning now to the literature, I shall bypass here a study of Freud's deviations in technique since I have made a separate exploration of them (Langs, in press). The findings, it may be noted, are in keeping with data to be presented here: these deviations have major consequences; the distinction between deviations and technical errors or countertransference-evoked measures is often difficult; the deviations may permanently modify the patient-analyst relationship and compromise the analytic outcome; and they generally evoke strong, regressive responses in the analysand in addition to any positive consequences.

The definitive paper on the subject of parameters was that of Eissler (1953), who, following leads developed by Freud (1937), proposed that our theoretical understanding of the structure of the ego leads us to develop varieties of (deviant) psychoanalytic technique to enhance the ego's achievement of mastery. While he defined standard psychoanalytic technique as one in which interpretations alone are made, he acknowledged the idealization of this model and attempted to modify it in a later paper (Eissler 1958). In his original presentation, he coined the term *parameter* for a technique which he defined as a deviation that is both quantitatively and qualitatively different from the basic model of psychoanalysis, which requires interpretation as an exclusive tool. He stated that such parameters are introduced only when: (1) the basic model of analysis does not suffice in the analytic situation; (2) the alteration never transgresses the unavoidable minimum; (3) its use can finally lead to its self-elimination; and (4) its effects on the patient's transference can be undone by interpretation.

However, Eissler (1953) himself acknowledged possible dangers in the use of parameters. He described three: (1) that the therapeutic process might be falsified so that obedience is substituted for structural change and for the resolution of the corresponding conflicts; (2) that resistances might be temporarily eliminated without having been properly analyzed; and (3) that the concept of parameters might be used to cover an inability to use interpretations properly. In addition, he commented that parameters might have a lasting effect on the patient's transference—one that could not be undone by interpretation. In a later panel discussion (1958) Eissler also raised the point that an analyst might utilize a parameter when an interpretation was feasible and it was not necessary for him to be directive. He introduced the concept of "pseudo-parameters" so that he could include relatively neutral interventions other than interpretations within the framework of classical technique, and indicated that at times these might have interfering qualities, such as, for instance, a gift to the patient.

In the same panel, Loewenstein (1958) pointed out the dangers of modifying psychoanalytic technique in noting these possible consequences: that it may curtail the spontaneous productions of the patient and therefore lead the analyst to misunderstand his unconscious; that interpretation may be minimized and manipulation maximized; and that it may hamper analyzability and jeopardize the transference neurosis. His own discussion centered upon variations in analytic technique rather than clear-cut deviations, although he included several of these as well. He also noted that deviations in technique may occur in many forms, on many levels, and entail a variety of meanings.

Bouvet's (1958) presentation at this panel was based on his particular concepts of object relationships and of the distance between patient and

analyst. While recognizing that deviations may be rationalized and actually stem from countertransference problems, he advocated modifications that help to modulate the distance between patient and analyst, thereby fostering the analytic work, and he noted that they must subsequently be eliminated and analyzed.

Reich (1958), in her contribution to this panel, described a special variation of technique in which she utilized strong confrontations regarding an analysand's mother in a manner which was unusual for her, and which she felt conveyed value judgments which went beyond her usual neutrality. This proved necessary with a sadomasochistic, guilt-ridden, acting-out patient who had idealized her mother and had developed an analytic impasse of acting out and acting in, which alternated with unbearable guilt. The devaluation of the patient's mother proved vital to the resolution of this stalemate.

Nacht (1958), in discussing the panel presentation, pointed out that parting from the analyst's neutrality can provide unconscious neurotic satisfactions for the patient; these may become an end in themselves and, as a result, make the transference neurosis unresolvable. On the other hand, rigid neutrality can create the same type of situation by creating a sadomasochistic couple. He suggested that with certain types of patients, after a full countertransference exploration, an abandonment of neutrality is necessary in order to establish the analyst's "presence" and at times in order to provide some type of reality to his relationship with the patient in the form of a reparative gift. He emphasized that he did not mean by this concrete gratification, but primarily a gratifying attitude. Rosenfeld (1958) stated his preference for interpretations rather than parameters.

Frank (1956) stated that every analysis includes moments of advice and injunctions, and he spoke out against ritualism in analytic technique. He described two patients, who appeared to be schizophrenic or severely disturbed, and with whom he used grossly modified analytic techniques. (I shall not examine the use of deviations with such patients here.)

Allen (1956) pointed out that the analyst's wish to "break" or change the basic rules of analysis always creates considerable conflict within him; she emphasized that such decisions should always be based on the needs of the patient's personality. In considering such changes, the analyst inevitably struggles against the introjects of his own analyst, teachers, and parents—his superego figures—and he must therefore fully analyze within himself both any inappropriate need to comply rigidly with these figures or to rebel against them. She then presented patients with whom she felt that the classical model was creating either stasis or undue emergencies; she found it useful for the progress of the analytic work to modify the use of the couch and to have the patient sit facing her at times.

Lorand (1963) pointed out that complete neutrality is a myth; advice and manipulation are part of every analytic situation. He noted that these can be excessive, reflecting countertransference problems, but presented one patient with whom such advice, in the form of a confrontation with alternatives in reality, appeared to be beneficial. He also offered two vignettes from his supervisory experiences in which deviations in technique were clearly a reflection of countertransference problems and constituted technical errors. Balint (1968) wrote of the difficulties in treating certain types of severe character disorder on borderline patients, and described in a general way the use of certain variations and deviations in analytic technique which, he felt, fostered analytic work with these patients.

Hoedemaker (1960) discussed variations in technique used primarily with delinquent and schizophrenic patients. His emphasis on setting limits as part of the standard analytic technique led him to describe situations in which he ejected patients from analysis and from his office. Stating that such limit-setting fosters healthy identifications, he yet leaves a number of unanswered questions in his discussion of the issue of deviations in technique. Similarly, Rodgers (1965) advocated the parameter of concurrent psychotherapy of the spouse of an analysand by the same analyst in order to overcome a stalemate supported by the spouse, and Calogeras (1967) sanctioned silence and nonadherence to the fundamental rule of free association with a patient who was apparently unable to adhere to this ground rule. They describe pragmatic success with these measures, but the presentations do not permit a thorough study of the reasons the parameter worked as it did—a comment that is pertinent to almost all of the presentations reviewed here.

Greenacre (1959, 1971) generally recommended adherence to basic analytic technique, emphasizing that deviations tend to undermine the patient's autonomy and to create narcissistic alliances (misalliances; see Langs 1975b). Anna Freud (1954a,b) attempted to define the dangers of both inflexibility and excessive flexibility in regard to the technical rules of analysis, and suggested that deviations in these rules are usually "necessary whenever the

aspects of a case leads us to expect manifestations of transference or resistance which exceed in force or in malignancy the amounts with which we are able to cope" (1954a, p. 50).

Lastly, Stone (1954, 1961, 1967) has spoken out against rigid adherence to technical rules, including those related to anonymity and the absence of transference gratifications. In a series of complex presentations that are too detailed for full discussion here, he advocates the use of parameters and deviations in technique as long as they bring about the ultimate analytic outcome. Under these conditions they can, he states, usually be deprived of their negative effects on the transference.

While Stone (1961) was reacting primarily to inappropriate rigidities in the clinical stance of many psychoanalysts, the present paper has arisen out of repeated observations that therapists and analysts currently tend all too readily to discard or modify the ground rules and boundaries in their relationship with their parents. The concept of parameters is often used to justify countertransference-based interventions and technical errors. In the literature, these issues are discussed without the specific study of clinical data (a striking feature of the literature). Often there is a failure to recognize the far-reaching and universal effects of all variations in technique—correct or erroneous—on their patients (Langs 1973b).

In general, there have been many additional reasons offered to justify temporary deviations in technique. The purported or expected effects are too often taken at face value, while the latent and implicit content and meanings of the deviation and its consequences are ignored. Deviations have been advocated to enhance the therapeutic alliance, to express the "real" relationship between patient and therapist, to lessen the deprivation inherent in analysis and therapy, to promote the therapeutic relationship, to avoid unnecessary frustration of the patient, to avoid a trauma that the patient will not be able to tolerate, to make the therapist seem more human, and to demonstrate his flexibility. The far-reaching effects of deviations per se are relatively neglected, as is the basic psychoanalytic methodology of probing the meanings of the analyst's interventions and the patient's responses to them rather than confining one's considerations to preconceived theories or to naive, surface-oriented assessments of manifest meanings and reactions (see Kanzer 1975).

As noted, Bleger's contribution (1967) is along different lines. Taking as his starting point Winnicott's definition (1958) of the analytic setting as the summation of all of the details of management, Bleger considers the total psychoanalytic relationship and defines the frame of this relationship as non-process, made up of constants within whose bounds the process of analysis takes place. He then focuses on the silently maintained protective elements in the frame and the necessity of their ultimate analysis, relating that frame to the concept of institutions that are viewed as contributing to the individual's identity. It is invariable and nonpalpable, and Bleger therefore postulates that it is related to the most primitive and undifferentiated psychic organization out of which the ego is built, and that it has a strong basis in the bodily ego and in the early symbiosis between mother and child. The frame therefore contains the symbiotic elements of the patient-analyst relationship and acts as a support and mainstay, interfering only when it changes or breaks.

Modifications in the frame may occur at the patient's behest and compliance by the analyst repeats the neurotic interaction of the patient's childhood. However, when the frame is respected, the repetition does not occur, and this brings out and makes available for analysis the most permanent elements in the patient's personality, viewed by Bleger as his psychotic core.

Bleger also suggests that the patient brings his own frame—in the institution of his primitive, symbiotic relatedness—to the analytic situation. On the one hand, the patient may attempt to have the analyst modify the frame in order to create a sense of magical union with him and to evoke a magical cure; on the other, any break or variation in the frame, necessary or unnecessary, induced by the analyst, is disruptive and creates a catastrophic situation for the patient, bringing the "non-ego" to a crisis, contradicting the fusion, challenging the ego, and compelling ego changes and defenses. Moreover, the frame may become a kind of addiction if it is not systematically analyzed, leading to a false ego development without internal stability. While the analyst must initially accept the frame that the patient brings to the analysis and the primitive symbiosis that it contains, Bleger suggests that he should not bend his own frame, since it is through that vehicle that he is able to analyze the disturbance within the patient and to transform the frame itself into useful processes for the patient. Any patient-analyst relationship outside this strict frame enables the psychotic transference to be concealed; instead, there develops a facade which he terms *the psychoanalytic character.* Since the frame is viewed as the most primitive fusion with the mother's body, Bleger feels that the psychoanalyst's frame helps reestablish the original

Clinical Example

A paper by Gudeman (1974) describes a clinical vignette pertinent to this presentation. In brief, the material relates to a married woman, the mother of two children, who came to analysis because of frigidity and a poor marriage. In her analysis, there was an initial flood of instinctualized material and a description of her kleptomania after her grandfather died, her masturbatory practices, and the recall of a seduction by an older man in her early adolescence; though no sexual intimacy had occurred, the patient had felt guilty, since she had contributed to what had happened.

While in the opening months of the treatment, following the description of the death of her grandfather, the patient came early to a session carrying a bouquet of flowers. While the analyst saw that she was living out the wish for a wedding, he accepted the flowers with some discomfort and said nothing immediately. He knew that the acceptance of the gift could enhance the erotic components of the "transference," but he felt that rejection of it would mobilize separation, anxiety and anger beyond the patient's ability to understand and analyze. He also viewed the gift as a possible harbinger of fragile ego boundaries and a reflection of significant regressive potential. His goal in accepting the gift was to foster the therapeutic alliance and to prevent undue regression.

In the session, after giving her gift, the patient spoke of wanting to be loved by her analyst and wanting him to be her father. She wanted to know his first name and the analyst responded that it would be of most use to talk about these feelings and not always useful to give him a present, although she might want to do so. The patient was angry when the analyst did not give her a pat on the head.

Later on, when her husband was away, the patient brought her children to the waiting room. At another time, she gave her analyst tobacco as a present, having had a gynecological examination on the previous day. Other material demonstrated that the patient had set up a triangular situation in which the analyst was the loving, good person who could provide her gratification, while the husband was seen as withholding and hostile.

After nine months of treatment, the patient took a one-week vacation (we are not informed as to whether she was held responsible for these sessions). Then, a month after the analyst's summer vacation, the patient brought in a request from her husband that the analyst write a letter justifying a vasectomy for him because of his wife's emotional illness. In associating to this request, the patient said that she preferred that it be done, since it would eliminate the problem of her being a woman or having her own tubes tied. The analyst eventually indicated that there was no psychiatric basis for such a letter and that he would not write it. The patient responded by saying that she could then have another child and cut it into little pieces. She felt pleased and disappointed, as if the analyst had taken something away from her. She probably thought that she could get him to write the letter and felt that her husband would be cross with her but would survive.

Soon after, the patient dreamt that she was in a bathroom where there were toilets for deaf and blind people. She felt exposed and there was a younger man being seduced by an older woman. She came to the analyst's office and the analyst told her, "That's it," and the patient sat up and they ended up talking. An intervention that the dream indicated that the analyst was not hearing or seeing something led to associations about her not getting away with the vasectomy request, but little else.

There followed fears that the analyst would abandon her and then a phone call from her husband because the patient was disturbed. In the next session, she appeared psychotic and, in a disorganized way, she spoke of taking a knife to herself, of her father beating her, of her grandfather teaching her to masturbate, of lies, of being seduced by the analyst, of masturbating, of blaming the analyst, and of secrets. The analyst became more active and in subsequent sessions, the patient brought in a long biographical sketch, and she spoke of dead babies and being raped by her father and everyone. When the patient did not respond well one particular session, the analyst called her by telephone and had her return that day, seeing her in the sitting position. He decribed to the patient his sense of confusion and medicated her, and over the following several days the patient became calmer.

In confining my discussion of this vignette to the question of deviations in technique, we can see that central to this patient's psychotic episode was a series of deviations in technique, rationalized by the analyst on the basis of promoting the therapeutic alliance and the wish to avoid so-called undue regression, that apparently remained relatively unanalyzed with the patient. They evoked in her intense wishes for erotic gratification from the analyst, desires to modify a number of other boundaries in the relationship, and the offer of further gifts to him. The sequence culminated in the request that the analyst justify the vasectomy for the husband, and when the analyst now modified his stance and attempted to establish that particular boundary, a psychotic episode followed.

In dealing with the dream that was reported at this time, the analyst chose to allude to the possible representations of his deafness and blindness, but apparently missed the other communications (both perceptions and fantasies), thereby confirming the very unconscious perception that he was attempting to clarify. As we have already seen, the dream contains elements characteristic in communications from patients when they are adapting to deviations in technique. It was undoubtedly prompted by the change in the therapist's stance, which the patient perceived as a reflection of his own unconscious guilt and anxieties regarding the extent to which he had permitted the patient to seduce him. In a manner that is typical of reactions to technical errors of this kind (Langs 1975a), the patient dreamt of deaf and blind people, alluding to the analyst who had missed the implications of his erroneous interventions—here the deviations in technique. The patient feels exposed, in part because of an incorporative identification with the analyst who exposed himself, and the manifest dream (we have few associations) reflects her unconscious perception of her having seduced the analyst, who then suddenly tells her the analysis is at an end. A subsequent association alludes to seduction and to her great confusion over the boundaries between herself and the analyst.

We may speculate that the dream is an effort to communicate the patient's unconscious interpretations of the basis of the analyst's behavior in his bodily anxieties and erotic countertransference. Most striking in this situation is the analyst's abrupt shift in his management of the boundaries of the analytic relationship, and this is reflected in the manifest dream in the shift from exposure and seduction to the words "that's it" and the patient's sitting up in the session. The analyst's confusion—which he later directly acknowledged to the patient—is reflected in the patient's psychotic confusion. Here, both incorporative identification and the patient's own pathology played a role.

It seems clear that rather than enhancing this patient's therapeutic alliance, reality testing, and self-boundaries, and rather than assisting this patient to avoid disruptive regression, the deviations in technique significantly contributed to the patient's potential for disturbance in each of these areas. Once again, we see that this patient's regressive reaction, her sense of fusion with the analyst, and her guilt over seducing him and being seduced by him, were all intensified by the analyst's failure to provide appropriate boundaries and to indicate his own ability to maintain appropriate limits to their relationship. While this reaction certainly reflects the patient's own psychopathology, it seems likely that it would have emerged in a more gradual and manageable fashion, and in the context of a viable therapeutic alliance, if the analyst had not permitted the patient to seduce him into modifying the boundaries of their relationship and had, instead, adhered to the ground rules and extensively analyzed the patient's wishes to modify them.

Discussion and Conclusions

In concluding, I will briefly highlight the main implications of these observations and suggest some important areas of further study.

1. The manner in which the therapist or analyst establishes and maintains the ground rules and boundaries of the therapeutic relationship is an important manifestation of his identity, the state of his controls, and his capacity for renunciation, for managing his own intrapsychic conflicts, for handling the stirrings within himself evoked by the patient, and for avoiding pathogenic interactions. Modifications of these boundaries and ground rules often stem from unresolved countertransference problems and reflect difficulties that are unconsciously detected by the patient. Even when deviations are invoked in emergency situations, or when a ground rule is altered for some other real reason, they generally provide the therapist—and the patient—with inappropriate gratifications and repetitions of pathogenic object relationships of which the therapist must be aware since this too will be unconsciously perceived by the patient.

2. The therapist's maintenance of the ground rules and boundaries of the therapeutic relationship is an area of activity that is constantly monitored by the patient and is utilized as a basis for unconscious, incorporative identification. Constructively handled, it provides a basis for positive and adaptive inner change that supplements the patient's endeavors to achieve conflict resolution and symptom relief through cognitive insight based on the therapist's interpretations. In addition, the proper maintenance of these boundaries is essential to give the patient the best opportunity to project his intrapsychic fantasies and to attempt to enact his past pathogenic object relationships in his interaction with the analyst in a manner that can be recognized and analyzed. Modifications in these boundaries lead to significant contaminations of the patient's intrapsychic projections, and to a situation in which the pathological introjects, unconscious fantasies,

and past object relationships are repeated and justified in the therapeutic relationship, rather than frustrated and not confirmed in reality so that they can be analyzed primarily in terms of the patient's unconscious conflicts, fantasies, and memories.

3. The idea that deviations in technique are necessary to foster the therapeutic alliance appears to be based on a naive treatment of the subject, one that fails to recognize the extensive unconscious meanings and implications of these deviations. Such an attitude overlooks the manner in which firm, analytically justified maintenance of the ground rules offers to the patient a structured framework and secure image of the therapist through which a strong and viable therapeutic relationship can be established. In this context, it is to be noted that, empirically, deviations in technique of all kinds often stem from uncontrolled anxieties in the therapist and from doubts regarding his capacity to analyze the patient; further, the patient unconsciously recognizes such sources of deviations and reacts strongly to these unconscious meanings.

4. Clinically, the ramifications of unneeded deviations in technique are unconsciously perceived by the patient, who attempts to alert the therapist to the unconscious meanings of the deviation, to offer—interpret—to the therapist his ideas as to the neurotic difficulties that have prompted the therapist to undertake these deviations, and to assist the therapist in restoring the proper boundaries of the therapeutic relationship. On the other hand, the hope of sharing inappropriate defenses and of finding momentary gratifications and symptom relief through the misalliance engendered by the acceptance of the therapist's deviations in technique will lead the patient to accept these deviations and seek out others. However, as the guilt and anxiety mount, in response to the unconscious awareness of the mutual corruption in the lack of boundaries and in reaction to its hidden, forbidden meanings, the patient will react by ultimately terminating the treatment or interrupting it temporarily, withdrawing from the therapist in some other way, and acting out in keeping with the model offered by the therapist. Other, contrasting efforts are made to reestablish the necessary boundaries in the hope of some ultimate benefit from the treatment.

With considerable unconscious perceptiveness, patients recognize that deviations in technique tend to promote undue surrender and loss of autonomy; reflect inappropriate and destructive mothering; have exhibitionistic and seductive implications; reflect a lack of barriers, including those that range from separateness of self and object to the incest barrier; are unconscious attempts at seduction; are inherently destructive toward the patient; reflect some degree of loss of control in the therapist; and often serve to conceal underlying sexual and aggressive conflicts in the therapist—to name but a few of the kinds of communications latently inherent in these measures. The appearance of such themes in the material from patients should prompt the therapist to examine his management of the ground rules and boundaries of the therapeutic relationship for any gross or subtle modification in his stance.

5. Technically, a deviation in technique, however minor, that has been evoked by a patient or offered by the therapist, calls for the following measures:

(a) Identification of the deviation and modification of the therapeutic stance so that the deviation is not continued unnecessarily, and it is made clear to the patient, implicitly or explicitly, that the boundaries will be restored and maintained. Without the modification of the deviant situation in reality, all other therapeutic endeavors will be of no avail.

(b) A full exploration and analysis of the patient's reaction to the deviation and to the reestablishment of the boundaries. During such an analysis, it is generally not advisable for the therapist to directly acknowledge that his deviation was in error, but his attitude should *implicitly* reflect his awareness that the deviation was inappropriate and that the patient's perceptions of this aspect of the deviation are not fantasy but have significant kernels of realistic perceptiveness in them. The advice that the therapist acknowledge his errors to the patient has generally been based on a wish to appear human and fallible to the patient when it seems appropriate. This stance overlooks the deviation in boundaries that such an explicit acknowledgment entails, and the consequences thereof. This is a complex issue that deserves fuller study; my present observations suggest that implicit acceptance of appropriate responsibility is the most helpful therapeutic attitude for the patient.

The therapist must carefully and sensitively separate the patient's valid perceptions of the implications of the deviation and the therapist's unconscious need for it from the extension of these perceptions into the patient's fantasies. In addition, he should try to understand how the deviation in technique was perceived by the patient as a loss of control, an acting out, and a failure to maintain inner and outer boundaries on the part of the therapist. Failure to analyze the implications of these nonverbal aspects will prompt a negative incorporative identification and acting out on the part of the patient, who will often attempt to misuse the therapist's countertransference

problems as an inappropriate sanction for his own acting out. In addition, the specific working through of these aspects of the deviation in technique fosters the reestablishment of the patient's own inner and outer boundaries and controls.

(c) The therapist should be prepared for derivatives related to deviations in technique to appear in the patient's associations and his adaptive responses for some time following such an incident; he should also be prepared for their reemergence throughout the subsequent treatment and especially at the time of termination. Continued analytic work with the repercussions of such deviations will reveal their genetic and current dynamic unconscious meanings for the patient. It will enable an assessment of the extent to which the deviation did in reality repeat the pathogenic behavior of, and interaction with, early significant figures, and the extent to which the patient used the stimulus of the deviation as a source of more distorted transference fantasies. Clearly, reactions to deviations in technique cannot be viewed simply as transference responses, but must be understood in terms of the mixture of reality and fantasy involved.

6. The marked productivity of patients following deviations in technique can now be understood to reflect the traumatic impact that such deviations have on them and the intense adaptive efforts that they make in response. Such efforts include attempts to cure the therapist of his own intrapsychic conflicts as reflected in the unneeded deviation (Searles 1975, Langs 1975), attempts to rectify the actual therapeutic situation, and efforts to readapt to the intrapsychic conflicts and memories stirred up by the deviation in technique.

7. The present findings suggest that deviations in technique should be restricted to emergency situations and to the use of parameters that are truly necessitated by ego dysfunctions in the patient. They point to a need to reevaluate the indications for deviations in technique and parameters, and should promote extensive self-scrutiny by the therapist when he is considering or has made a modification in technique. In addition, these observations suggest that even in those emergency situations where deviations prove necessary for the patient, their unconscious ramifications are extensive and require considerable subsequent analysis and modification.

Tentatively it would appear that many of the therapeutic crises that prompt therapists to deviate in their technique are evoked by the interaction between the patient's psychopathology and that of the therapist. These data suggest that the therapist's initial stance at such times should center on an effort to understand the specific precipitants of the crisis and on self-analytic work toward modifying his own contribution, as well as the basic use of correct interpretations to the patient. This not only provides the patient cognitive insight, but affords him an actual experience in which the therapist does not repeat the past pathogenic interaction, but instead detaches himself from it and is capable of interpreting it (Racker 1968). The danger of mutual acting out and misalliance through deviations should, if at all possible, be considered before they are invoked. The therapist should engage in considerable self-scrutiny and in a reassessment of his interaction with the patient and of his understanding of the material; he should preferably restrict the use of deviations to those situations where he is unable to detect any countertransference difficulties and there is an emergency need, such as a suicidal or homicidal patient. In doing so, the deviation should be kept to the absolute minimum and modified in reality as quickly as possible, with a full analysis of all the dimensions of the experience (Eissler 1953).

8. Technically, the therapeutic stance used when the deviation is entirely necessary and justified is different from those situations in which the deviation proves to have been unneeded and in large measure a product of the therapist's countertransference. In the former situation, the inappropriate gratifications afforded to both patient and therapist can be analyzed as inevitable side effects of an essential technical measure, while in the latter situation the neurotic gratifications and the repetition of past neurotic object relationships is the central contributing factor and must be recognized as such.

9. The counterpart of these findings regarding deviations in technique is the postulate that the present ground rules and boundaries of the therapeutic relationship in adult psychoanalysis and psychotherapy offer an optimal therapeutic hold and setting for the patient. The finding that patients are exquisitely sensitive to the seemingly most trivial alterations in the boundaries and ground rules—e.g., a necessary change of hour—also attests the importance of this dimension of the therapeutic relationship.

10. The present findings should, however, not be construed as a brief for therapeutic rigidity or misconstrued as a basis upon which to advocate a lack of humanity and concern in the psychotherapist or analyst. To the contrary, it is intended to help the therapist become aware of the major ramifications of any deviation in technique so that these factors can be considered along with other dimensions when such a measure is contemplated. These observations prepare the therapist who has expressed human

concern or other controlled, noninterpretive reactions to the patient for those consequences that he might not otherwise have anticipated. They can serve to remind us that the most meaningful expression of the therapist's or analyst's humanity in the treatment setting lies in his usual attitude of concern and in his capacity to offer the patient a correct interpretation, especially at a moment when he has not participated in a neurotic interaction with the patient. Without deviating, the therapist who wishes to be appropriately supportive can respond to emergency situations with implicit concern, an increased rate of intervening, and by affording the patient a model of someone who is reasonably involved, interpretively helpful, and also has the capacity to maintain necessary limits. Many who have written on the subject of deviations in technique have failed to appreciate the powerful supportive dimensions inherent in nondeviant analytic technique and seem to underestimate the power of a correct interpretation that emanates from an analyst who is not involved in a misalliance or embroiled in a countertransference conflict.

11. These findings also remind us of the powerful inner forces that move the therapist or analyst toward deviations in technique and misalliances, ranging from deep personal needs to deny one's own limitations and mortality to the search for specific countertransference-based neurotic interactions, gratifications, and defenses (Langs 1975b).

12. Finally, this study also emphasizes the importance of the distinction between reality and fantasy in the therapeutic relationship (Langs 1973a). It is insufficient to explore and analyze the content of the patient's reactions to deviations in technique in terms of his intrapsychic fantasies, without recognition of their basis and stimulus in reality and the actual, nonverbal meanings and effects of these deviations on the patient. Here, the distinctions between interpretation and management, free association and interaction, fantasy and actuality, and verbal interaction and nonverbal communication became pertinent. Who and what the therapist is becomes as important as what he says. The culmination of analytic work in insight gained from the analyst's interpretations does not thereby lose status, but is supplemented by another important dimension of technique: the management of the analytic relationship.

NOTES

1. The area under study in this presentation is largely comparable for psychotherapy and psychoanalysis, and I shall therefore use the term *therapist* generically to allude to both the psychotherapist and the psychoanalyst, and reserve the latter two terms when referring specifically to a psychotherapeutic or psychoanalytic situation. I have not included material from my own psychotherapeutic and psychoanalytic practice because of a decision to not use these sources in my writings. Among the many reasons for this decision is the empirical discovery that such use of one's clinical experience, past and present, significantly modifies the framework and boundaries of the therapeutic situation. It is, in effect, a deviation in technique that has all the consequences, more or less, of the deviations described in the body of this paper. Since some degree of deviation is already inherent in the supervisory situation and in material published by others, I shall use vignettes drawn from these sources to develop the theses offered here.

2. Upon completion of this paper, I came across Milner's (1952) intriguing comments, made in the context of a study of symbolism and child analysis, regarding the frame that demarks the reality that prevails within the psychoanalytic situation from that which exists outside of it. She views the frame as essential to the creation of the transference illusions—a suggestion that clearly relates to the ground rules and boundaries discussed in this paper.

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