IN "A PERILOUS CALLING"
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CHAPTER 11

Unexpected Encounters: The Wizard of Oz Exposed

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It was a hot, sweaty, Friday afternoon in July. I was glad to get out of my clothes and strip down to my bikini. I stepped into the cool, clear pond water—it felt so good. My boyfriend swam over to me, gave me a passionate kiss, and held me in the water. We played there for a long while. I unwound and for the first time in days felt really relaxed and peaceful. The world had become a cozy blur as it often is when my contact lenses are out.

I stepped out of the pond. As I squinted to look for my towel, my body tensed. I rushed to cover myself. I felt sick. I felt exposed. I was scared.

A family I had been treating for the past six weeks was sitting together watching me as I emerged from the water. "Hi" called out the mother who proceeded to introduce me to her friends. "By the way—we need to change our appointment next Tuesday." I tried to smile and mumble something coherent. I wanted to get out of there as fast as I could.

When we sit in our consultation rooms, we often try to present a carefully sculpted image to our patients. Our therapeutic persona is formed of many parts, some of them consciously designed to support therapeutic work, others coming from our own histories and emotional needs. At times, we are much like the Wizard of Oz, trying to make an impressive presentation while hoping that the curtain we hide behind won't be pulled aside to reveal more vulnerable parts of ourselves.

When we bump into patients outside the clinical hour, we have an opportunity to learn something about ourselves and the therapeutic process. Some encounters feel comfortable and mundane, whereas others can be very difficult. Why is this? What does this say about our personal issues? How can these experiences teach us something about our therapeutic stance and professional persona? What do they say about our attitude toward our work?

In this chapter, we will explore imagined and real extratherapeutic encounters as tools therapists can use to improve their craft. We were drawn to this topic after being disturbed by an encounter much like the one described earlier. It inspired a doctoral dissertation studying experienced psychologists' and psychiatrists' feelings about such encounters (Arons, 1985), which, in turn, led to the development of workshops for therapists using these experiences to better understand themselves and their work.

At some point in their development, most psychotherapeutic traditions have come to see the therapist as the central tool of psychotherapy. They have also observed that a therapist's wishes, fears, conflicts, and unresolved issues can easily interfere with treatment. This difficulty goes by different names in different theoretical systems. Psychoanalysts, who have studied the phenomena extensively, speak of many varieties of "countertransference" and "blind spots" that interfere with analysis. Family systems theorists describe therapists becoming "inducted" into the family system and losing their flexibility. Behavior therapists write of "observer bias" disrupting their objectivity. Client-centered therapists describe a "lack of congruence" in the therapist interfering with the patient's growth. Interpersonal theorists warn of "parataxic distortions" impairing the therapist.

Therapists' emotional responses, when conscious, are important sources of data, as they can help to reveal subtle processes in the patient and the treatment relationship. Problems arise, however, when our emotional responses are based on personal issues and unresolved conflicts of which we are unaware. To be effective tools, we need to recognize and understand the sources of our emotional reactions. Only with such awareness can we practice our craft effectively.

Various therapeutic schools use this insight in different ways to support therapeutic work. Personal awareness allows for using projective identification in psychoanalysis, joining the family system by family therapists, good interobserver reliability in behavior therapy, empathic listening for client-centered counseling, and interacting without distorting in interpersonal schools.

Since remaining aware of our own issues is key to using our emotional reactions productively rather than having them interfere with treatment, it is not surprising that therapeutic traditions have developed a variety of techniques to foster such awareness. It is common for therapists to use their own individual therapy or analysis, and supervision focused on the exploration of countertransference, incongruence, or parataxic distortion, to heighten conscious awareness of the personal issues that they bring to their work. From different angles, systems therapists use family

of origin work to avoid being "inducted" into family systems, and behavior therapists devise structured measurements to minimize observer biases.

Interestingly, therapists have written little about using real or imagined extratherapeutic encounters as potential tools to heighten our understanding of our reactions to patients. When such encounters are mentioned in the professional literature, the emphasis is on how they affect patients and threaten treatment alliances, not on what they stir in the therapist (e.g., Flaherty, 1979; Searles, 1979). The closest analogies to our subject that we found in the literature involve traumatic events and visible transitions in the therapist's life, such as pregnancy (Rubin, 1980), losing a loved one (Givelber & Simon, 1981), illness (Chernin, 1976; Dewald, 1982; Halpert, 1981), or injuries (Cottle, 1980). In these circumstances, therapists describe their discomfort at being exposed to their patients.

We have found that studying therapists' reactions to real and imagined chance encounters with patients reveals a treasure trove of information about their therapeutic stance, professional persona, and attitudes toward therapeutic work. It also helps to illuminate personal wishes, conflicts, and concerns related to particular patients.

To help therapists increase their awareness of these issues, we have designed several exercises centered around real and imagined extratherapeutic encounters. In the original study (Arons, 1985), a structured interview was conducted with 10 experienced clinicians, 5 men and 5 women, affiliated with Harvard Medical School. The interview presented guided fantasies of extratherapeutic encounters with patients, questions about actual chance meetings that therapists have had with their patients, and therapists' descriptions of themselves inside and outside the clinical setting. Since this study, other therapists have tried the exercises in workshops and supervision, and the format has gradually been refined.

We invite therapist readers to try the exercises themselves before reading about others' reactions to them. The exercises appear at the end of this chapter.

THE WIZARDS EXPOSED

The great and powerful Oz stood behind his cloth curtain while his subjects were full of awe and respect for the image he projected. As therapists, we use different sorts of curtains. In the safety of our offices where we control the time, the decor, the seating arrangement, the fee,

our dress, and our manner, we often seem so sane, so calm, so wise. When we meet our patient outside the clinical hour, the curtain begins to slide open. Many therapists are surprised to see how uncomfortable extratherapeutic encounters can be.

The Wizard of Oz seemed pretty uncomfortable himself when Toto showed him to be human. As it turned out, he still had plenty to offer as he helped the Scarecrow, Tin Woodman, and Cowardly Lion to recognize their brain, heart, and courage, but he was clearly mortal. The Wizard knew he was involved in deception before Toto came along. As therapists, we're not always so self-aware.

Two therapists, stirred by the exercises, remarked:

> I get most upset when a patient sees a part of me that I don't like about myself. I wonder what there is in me that needs to perpetuate the myth of the perfect ideal therapist.
>
> It aroused a lot of feeling in me. I'm surprised I never think of it.

Two other therapists were struck by what they suspect may be well-established defenses:

> I suppose my responses suggest that I'm more blasé than I feel. I act like an old pro and some of it may be denial.
>
> I'm thinking that 20 years of experience makes a difference. . . . Am I pretending or am I beyond this?

The limited existing clinical literature on extratherapeutic encounters focuses on their effect on the patient's transference and treatment alliance. We found, however, in both guided fantasies as well as memories of actual encounters, that most therapists report being more concerned with how they themselves feel and appear than with the effect of the encounter on the patient or on the therapeutic process.

Often therapists are surprised to realize how vulnerable they feel. For example, one female therapist explained:

> Right now at this moment there are certain social situations that would make me feel uncomfortable. Seeing a patient when I'm feeling most alone . . . would be difficult. I'd feel I was exposing the patient to that most vulnerable side of myself. . . . Something makes me uncomfortable with anyone seeing. I'd feel . . . like I might not be able to assume my professional stance in the same way. . . .

Therapists generally report the most discomfort where they feel most exposed. Many therapists describe fear that their personal foibles will be revealed, causing feelings of vulnerability, inadequacy, shame, and humiliation.

Because therapists—since the time of Freud—have been reputed to deal directly and openly with sexual feelings and fantasies, it is especially interesting that many therapists seem to dread most that their sexual feelings will be seen. For example, one male therapist struggled with concerns about his sexuality and professional persona as he described his worst case fantasy of an extratherapeutic encounter:

> In a sexual situation—lying on the banks of the Charles [River], and a patient comes along in the midst. I just wouldn't feel great. I have guilt feelings about sex and rage. If the patient saw me in some sexual situation, I'd know I'd have to go into it and I wouldn't fit it. I think my patients have an image of me somehow having everything in order and this just wouldn't fit.

Another male therapist responded to the guided fantasy of encountering a patient while waiting to see an art film many consider to be pornographic (see Exercises on pp. 134–137). He reported that, externally, the patient "wouldn't see much but might judge me to be cool, distant, and unfriendly. . . ." Meanwhile, internally, his thoughts would be quite different:

> I'd feel anxious and embarrassed. I'd be in turmoil wondering should I explain. I'd feel that somehow this event would open up the therapy to personal events and fantasies in my life that I wouldn't be willing to share. My fantasy about how the patient would interpret this situation is that they'd think I'm unhappy, lonely, and that I have perverse fantasies. He might think that I'm neurotic and I'd feel exposed in a way I wouldn't want.

Therapists also report discomfort about their bodies in exploring fantasies of extratherapeutic encounters. One female therapist imagined:

> I'm in a changing room trying on a string bikini. A client walks up to me from behind and says, "Oh, I love that one." I'd feel so exposed, imagining that she'd think I wasn't attractive.

Other therapists reported similar uncomfortable fantasies dancing in a sexy way, swimming at nude beaches, kissing erotically in public, and watching sexy women or men walk by.

Along with their reputation for directness and openness in sexual matters, therapists are known for helping patients to become comfortable with angry feelings, particularly toward loved ones. Many a parody centers on the therapist "helping" a patient to hate their parents. It is thus ironic that therapists are often afraid of being seen getting angry. They fear that their difficulty handling anger will be exposed, and their patients will judge them harshly. Responding to a guided fantasy about encountering a patient while having a painful public argument with a loved one (see Exercises), a female therapist reported that outwardly, she would just "say hi quickly" and walk on. However:

> Inside I'd be embarrassed, especially if the patient overheard. I'd be particularly upset if a patient saw me angry or nasty with my children, more upset if it were with my husband . . . and I'd die if it was with my mother, which puts me back to being a child. I'd seem infantile and out of control and I'd worry that my patient would think "Oh, she can't even manage her own life; how can she help me?"

Along with concerns about sexuality and aggression, the exercises bring up discomfort with being seen in a myriad of other activities, including displaying public playfulness, being unkempt or dirty, drinking alcohol, engaging in religious or political activities, getting therapy themselves, shopping at "cheap" stores, shopping at "fancy" stores, and enjoying a variety of "unsophisticated" entertainment.

During the exercises, therapists are often surprised to see how much they worry that the image they try to maintain in their professional role will be tarnished by an extratherapeutic encounter. They discover concerns about no longer being viewed as a "paragon of functioning." For example, a male therapist remarked that he would dread being seen:

> When in the course of normal life if I'm acting in a way I don't want others to know—If I got drunker than I should. Really I hope people whose esteem I want to hold don't see me like that.

Some therapists are confused about why they are so uneasy about shattering the myth of the perfect therapist. A female therapist reflected:

> I don't really understand. I get most upset when a patient sees in me a part I don't like about myself. But rationally it doesn't make sense. I certainly say to my patients that their feelings are OK. I don't judge, so why am I afraid to have them see me?

In our experience leading therapists through these exercises, we repeatedly find that therapists are far more accepting of their patients' humanity than they are of their own. They can be quite harsh in their self-criticism and are often ashamed of the same human foibles that they try to help patients to accept in themselves.

Therapists are, of course, also concerned about the effect on their work of an unplanned encounter. Some report worrying that they will no longer be experienced as useful by their patients if they are seen as they really are. A male therapist mused over what he hoped would not be exposed in an encounter:

> A million things. It's consistent with personality things. I don't think I want my patients to discover them. Little psychoses—antitherapeutics—it might frighten off the patient—some fragile patients might never come back. What's most valuable might be lost.

This idea that patients might leave treatment after seeing their therapist as he or she really is surfaces repeatedly. Like the Wizard of Oz, we therapists often believe that we need an impressive persona to keep our patients believing that we can help them.

For most therapists, the fear that patients would leave treatment if they saw their therapist's foibles extends beyond concerns for their patients' well-being. It could be bad for business. One female therapist commented:

> My clients aren't particularly open-minded. I fear their rejection. Many wouldn't like me if they really knew me, and that wouldn't be very good for my practice.

Therapists' concerns about their patients' closed-mindedness become acute in realms where the therapists may be comfortable but fear that their patients are not. For example, many gay and lesbian therapists are particularly concerned about their patients' attitudes regarding sexual orientation. While some are explicit with their patients about this, others are not and worry about being discovered. They report fears of being rejected by their patients if they are seen at activities such as gay clubs or homosexual rights marches.

Some therapists report similar concerns about having their social or political views exposed. One politically active therapist commented:

> I've spent a lot of time obsessing about whether to put bumper stickers on my car. While I want to support the movements I believe in, I'm sure

that many of my patients would see me as the "enemy" if they knew my beliefs.

It is not surprising, given the feelings that arise during these exercises, that therapists typically do not wish to encounter patients outside the clinical hour. The feelings of shame, vulnerability, and inadequacy that often arise are obviously unpleasant, and most therapists would rather avoid them. Concerns about "losing" patients are similarly compelling. However, there are other, less obvious reasons that they dislike extratherapeutic encounters.

Therapists report that they resent the intrusion into their private life. This can take many forms. Therapists may dislike feeling exposed and having their family and friends "on display" for their patients. They also often remark on the lack of control they experience in an extratherapeutic encounter compared with a scheduled session. Whereas many therapists feel comfortable revealing aspects of themselves or their family when they choose to do so as part of treatment, they feel intruded on when involuntarily exposed. One female therapist commented, "I do draw on my personal experiences in the treatment setting," but there's a "difference between choosing to reveal something and being exposed." Another therapist described an evening in which she knew that both she and her patient would be at the same concert. The therapist was anxious to spot her patient in the crowd before the patient found her, so as to maintain a feeling of control.

Another source of discomfort in extratherapeutic encounters involves resentment of having to work when "off duty." Therapists feel a responsibility to be therapeutic in their responses to patients outside the clinical hour. Perhaps more than other professionals, therapists feel a need to act professionally when encountering their clients outside work. As one therapist put it, "they have the power on the outside—we can't be ourselves, we're committed to not have a regular social relationship." This same therapist highlighted another common concern when he added, "I wouldn't want my patients to see how much I prefer not working."

Psychotherapeutic work requires the therapist to exercise careful, thoughtful control of his or her behavior. This is particularly challenging outside formal sessions, when other people may be participating in the encounter, the therapist hasn't had time to formulate a therapeutic strategy, and there is no time to process the feelings that arise. There are limitless opportunities during extratherapeutic encounters to do the wrong thing, to hurt the feelings of your patient, to seem insensitive, to be too

friendly or too distant. Therapists thus report feeling resentment along with inadequacy, resenting having to work after hours and feeling unable to do an adequate job under adverse conditions.

Perhaps because we feel uneasy in extratherapeutic encounters and resist exposing our vulnerability, therapists have done little to help each other figure out how to handle these moments effectively. We Wizards would probably have less difficulty with extratherapeutic encounters if we discussed them more freely.

In view of therapists' reactions to fantasies of extratherapeutic encounters, it is not surprising that when they do the descriptive exercises (see Exercises), they see themselves as rather different people inside and outside the clinical hour. Interestingly, most therapists view this difference in their presentation as a sign of inadequacy. In contrast, they describe "ideal therapists" as far more similar inside and outside the hour than they are themselves. ("Ideal therapists" are, however, expected to be more affectively expressive outside clinical hours than inside.)

Therapists generally see their own behavior inside the hour in positive terms but use far more negative adjectives to describe themselves outside the hour. In our experience, male therapists give their behavior outside the clinical setting the most scathing reviews. Most therapists seem to share the view of well-known psychoanalyst Roy Schafer (1983), that "within the clinical setting we are often better people than in our personal lives" (p. 291).

In contrast to their views of themselves, therapists imagine that their patients have very high opinions of them outside the clinical setting. They imagine that their patients see them as mature, balanced, sensitive, caring, intelligent, happy, and secure. While most therapists see themselves as actually embodying these qualities at times, they describe themselves (when not working) as often acting in ways that are immature, unbalanced, narcissistic, confused, and anxious. The contrast between how we imagine our patients see us and how we at times see ourselves contributes to therapists fearing involuntary exposure to their patients.

Much has been written about how therapists should conduct themselves within the clinical hour to maximize their effectiveness. Our experience exploring extratherapeutic encounters suggests that while studied therapeutic postures often facilitate treatment, they may also represent defensive stances designed to protect the therapist from difficult feelings of exposure and shame. By reflecting on our images of ourselves inside and outside the clinical hour and our feelings about chance encounters, we can gain insight into which parts of our professional persona are there

to support our work and which parts stem from our fears, self-criticism, and difficulty accepting unexamined aspects of ourselves.

In the end, the Wizard of Oz was probably most helpful to Dorothy and company once his curtain was pulled aside. While therapists' self-disclosure is a therapeutic tool that should be used judiciously, self-deception is rarely useful. We hope that other therapists can add the exploration of extratherapeutic encounters to their repertoires of awareness-enhancing activities. We hope, too, that reading about other therapists' fantasies and feelings can help us all to feel less ashamed and to support one another in exploring our own hearts and minds as well as our therapeutic relationships.

EXERCISES

Please take a few moments now to close your eyes, attend to your breathing, and relax. As you approach the following exercises, try to be open and honest with yourself—nobody else will see your responses. We all know how to focus on our patients' difficulties. This is an opportunity to focus on our own. While your first response to an exercise may be, "This doesn't apply to me—I've worked these things through," try to stay with each image for a little while to examine any subtle reactions that may arise.

Guided Fantasies

Imagine yourself in the following situation with a patient whom you would feel particularly uncomfortable encountering:

> You've decided to go see a very controversial film. Some critics consider it art, others state that it is pure pornography. While you're waiting for the film to begin, your patient walks over, says hello, and sits down near your seat.

(Please take a few moments to close your eyes and experience the scene.)
Now take out a piece of paper and jot down the following:

1. Your patient's name.
2. Your inner feelings during the imagined encounter.
3. Your outward behavior during the imagined encounter.

How do you understand your feelings? What do your reactions to this fantasy suggest about your personal issues vis-à-vis your patient? Please take a few moments to consider these questions and jot down your answers. When you are finished, please read on.

* * *

Now imagine yourself in the next situation with a patient whom you'd feel particularly uncomfortable encountering:

> You have recently joined a health club. After a heavy workout, you undress and head to the sauna. Once inside, you notice your patient lying down on a nearby bench.

(Again, please close your eyes to experience the scene.)
Now, again, take out a piece of paper and jot down the following:

1. Your patient's name.
2. Your inner feelings during the imagined encounter.
3. Your outward behavior during the imagined encounter.

How do you understand these feelings? What do they suggest about your personal issues vis-à-vis this patient?

* * *

Please follow the same instructions for the following situations, choosing patients whom you would rather not encounter outside the clinical hour:

> Imagine that a close relative of yours has died. Your patient reads the obituary in the paper and decides to attend the funeral service. As you are leaving the service, your patient approaches you.

* * *

> Imagine that you are walking in a busy public place with a close friend or family member. The two of you are having an argument that is escalating painfully. As you pause to make a point, you notice that a patient of yours has been walking just behind you.

* * *

> Imagine that you are in a store with your child who is having a loud tantrum. You are getting more and more agitated as your attempts to calm your child fail. You are finding yourself saying things that therapists advise

their patients not to say. You notice that a patient of yours has been standing nearby, apparently watching.

* * *

For the final situation, recall the most uncomfortable actual encounter you had with a patient outside the clinical hour.

Again take out a piece of paper and jot down the following:

1. Your patient's name.
2. Your inner feelings during the encounter.
3. Your outward behavior during the encounter.

How do you understand these feelings? What do they suggest about your personal issues vis-à-vis this patient?

* * *

Now consider all your patients:

1. Which patients would you generally not like to encounter outside the therapy hour?
2. What about encountering these patients feels uncomfortable?
3. Are there other patients you would not mind encountering outside the therapy hour?
4. What about encountering these patients feels more comfortable?

* * *

Now take a few moments to imagine one or more particular places or activities in which you would especially not want to encounter patients:

1. What about encountering a patient in these places or activities feels especially uncomfortable?
2. Are there other places or activities in which you would generally not mind such encounters?
3. What about these places or activities makes you feel more comfortable?

The Therapist's Image

You may have noticed in the previous exercises that real or imagined extratherapeutic encounters illuminate concerns about the images we wish to present to patients. The following exercise is designed to explore this realm.

Please fill in the following grid using a few descriptive adjectives in each box:

	Inside a Clinical Hour	Outside a Clinical Hour
An Ideal Therapist		
Your Patients' Image of You		
Your Image of Yourself		

1. How do your images of the ideal therapist, your patients' views of you, and your view of yourself inside the clinical hour compare?
2. How do your images of the ideal therapist, your patients' views of you, and your view of yourself outside the clinical hour compare?
3. Do these comparisons help to illuminate any issues or concerns for you?

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