Love, S. (1977). The Broken Appointment: A Non-Verbal Message. Mod. Psychoanal., 2:67-79.

Modern Psychoanalysis

(1977). Modern Psychoanalysis, 2:67-79

The Broken Appointment: A Non-Verbal Message

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A broken appointment, as other manifest behavior, often has quite different meanings to different patients. In addition, it may have different significance for the same patient at various phases in treatment. This is still more complicated in child treatment since the child's broken appointment may often be a manifestation of the parent's disguised feelings about the therapy.

Many successfully helped families have had a large number of broken appointments during the course of therapy. Yet we often fail with other families who reveal their unfortunate treatment experiences by suddenly breaking appointments. It would appear that a statistical approach offers little or no possibility of establishing (1) the underlying meaning of the broken appointment to the individual family; (2) the meaning of the broken appointment to the individual members of the family; and (3) the meaning of the broken appointment with regard to the process of therapy.

Some patients give several days' notice before canceling. Others telephone to cancel on the day of their interview, yet allow enough time to change their mind. Still others may telephone after their appointment time and offer an explanation for their absence. Some fail to keep their appointments and may not telephone at all. When contacted by their therapist, they may say they "forgot." A few of the patients who break off contact abruptly may be unreachable by telephone and letter, and just disappear from treatment.

Some patients may cancel appointments and say that they are seeking or have obtained work, Children may telephone and say they cannot come because they have to attend some school activity. The patient may telephone and request a make-up time. A parent may telephone to cancel, change, or break her child's appointment. An adolescent child may call to cancel her mother's appointment, and so forth.

Broken appointments may indicate a cessation of verbal intercourse, yet the patient is simultaneously conveying a nonverbal message. This primitive type of communication may mask the patient's wish to be rejected, an infantile wish to act out revengefully, castration feelings associated with traumatic preoedipal experiences, or feelings around unfortunate prior treatment experiences, as well as unmet developmental needs. In addition, the patient's use of the more archaic types of defense (projection, denial, and externalization of inner conflicts) is often exemplified in the broken-appointment behavior.

For example, a pre-adolescent patient, Bob, telephoned to break his appointment, stating that he would not be in for his session because there was no money available for his fare; neither he nor his mother had any. The therapist suggested that he might borrow some money in the neighborhood, and that when he came to the social work agency, he would be given fare both ways. Bob maintained that there was no possible way for him to obtain the necessary fare. What may have activated this behavior? One speculation might be that lack of money was the real reason the youngster had not kept his appointment. However, it is possible that Bob used money and time as vehicles to indirectly express his defiance of treatment; that is, they may represent a resistance phenomena, Since Bob mentioned his mother's lack of money, we might also hypothesize that his behavior may have mirrored his mother's feelings, and that he actually may have obtained her sanction for his behavior.

The concept of resistance (manifestations in the treatment relationship of a pathological defense mechanism) is one of the basic planks contributed by psychoanalysis and successfully used to understand and to help patients. **Menninger (1958)** wrote, Resistance is not something that crops up occasionally to "impede" the course of treatment; it is omnipresent. It is a fascinating,

dramatic production, on a par with the creation of a dream, in that the patient's resistances make use of his typical defenses and more stable character traits.

Hyman Spotnitz, (1961) *states,*

The development of resistance is inevitable. Patients are incapable of engaging consistently in the kind of communications demanded of them at the beginning of treatment until they have successfully completed it. The early psychoanalysts generally discouraged resistant behavior, they tried to overcome it as quickly as possible through their interpretations because it prevented the patient from functioning as an emotionally mature and well-adjusted person.

He goes on to say,

A significant change has taken place in the handling of resistances with the increasing recognition that they have a distinct social and personal value... Moreover, the patterns of resistant behavior in which they engage give us many clues to their problems, just as pain and fever alert us to the ills of the body. Consequently, analytic therapists today regard resistances as disguised or primitive forms of communication rather than as obstacles to recovery.

Unmet developmental needs often reveal themselves in treatment as underlying causes of the resistances connected with patients' difficulties in being cooperative and rational around time and fee. The following is a case illustration of the possible relationship between spoon-feeding and fees.

A mother, Mrs. S., telephoned to plead for help with her ten-year-old son, Saul, who was refusing to eat. The mother said she was so desperate that she would keep any appointment time. A Friday time was offered, but she preferred a Monday appointment instead. Later, Mrs. S. telephoned asking for the appointment to be changed back to the Friday time.

In her first office interview with this therapist, Mrs. S. told of her shame that she still had to spoon-feed her son. The child had apparently always been a poor eater. When Saul was born, the mother felt “lost,” for there was no mother present to teach her how to care for a child. Prior to Saul's birth, the maternal grandmother had been killed by the Nazis in a concentration camp. Because she did not know the proper method of feeding the child solid foods, the

mother would put oatmeal into his bottle. When he vomited, she would feel helpless and begin to cry. Mrs. S. said she had the same feeding difficulties when she was a child.

Mother, father, and Saul, their only child, had emigrated to the United States seven years previously. At that time the child was so undernourished that at the mother's request, the Social Service Department of a City Hospital arranged for his placement in a foster home. The child gained weight during the separation, but the feeding difficulty reappeared when he returned home. The mother was then referred by the medical social worker for psychiatric treatment. Mrs. S. received psychotherapy for about a year at the hospital psychiatric clinic. She left this treatment after a vacation separation from her psychiatrist, feeling she needed “medicine, not talk.” She went to her family physician who, because of her severe anxiety, prescribed a tranquilizer. Her condition improved temporarily. When the family physician went on vacation, Mrs. S. consulted Saul's teacher about his feeding problem. The teacher, in return, referred the mother to our agency.

In the initial interview, before a fee had been established, Mrs. S. requested free treatment. In the second interview, she said she could afford two dollars weekly. She went on to tell of battles over food with her son. He bribed her, saying that he wouldn't eat without a gift. Mrs. S. submitted in order that the child would eat something. The father, also seen in this second interview, complained about his fights with Saul over Saul's refusal to properly wash his hands, especially before meals. The father wanted both his wife and son to receive treatment, since his son was making his wife “very nervous.” Saul was later seen in the interview. He was a healthy, good-looking boy, although somewhat small and slender for his age, and appeared shy and submissive. He thought his mother made too much “fuss” about his eating. He wanted help to overcome his fear of fighting back against older children in his neighborhood who sometimes hit him.

There was a lapse of two months due to summer vacation. In the meantime the child guidance agency established a fee of five dollars. Following vacation, the therapist telephoned Mrs. S. for an appointment so that the fee could be discussed with her. Over the telephone, Mrs. S. said there was so much improvement in the boy that she didn't know whether it “made sense” to use our services. In

response to the therapist's comment that with such improvement perhaps indeed it didn't "make sense," Mrs. S. decided the improvement might be only temporary; she was interested in arranging another appointment.

Mrs. S. began the next interview by asking what the therapist had in mind by calling her for the appointment. The therapist asked what her ideas were about this. She said she thought it might have something to do with the "price" for treatment, which had not been discussed. She expressed a wish to be treated without charge. When told that the fee was set at five dollars, Mrs. S. asked what she would receive for the money. She said she was agreeable to paying three dollars and we could settle the matter immediately. The therapist informed her that the fee could not be reduced. Mrs. S. responded by asserting that she knew of other clinics which would treat her for less money. In response to the therapist's observation on her freedom of choice, Mrs. S. said that she knew of cases at other clinics where there was no improvement shown. She said she was considering coming for treatment at the agency but asked, "Is that the final fee, five dollars?" When she was informed that five dollars was the fee, she said she was going to think it over and would let the therapist know at a later date. The therapist said that she could let him know at any time. Mrs. S. then said she was going to search for another clinic. If she couldn't receive treatment for three dollars or less elsewhere she would settle for this agency. In response to the therapist's statement that this was up to her to decide, she asked if she could telephone in a month to advise the agency of her decision. The therapist told her that there was a long waiting list and there was a possibility of no available service in a month. Mrs. S. said she would telephone the next day. In fact, she wished to call the therapist that evening if he would give her his home phone number. The next day Mrs. S. telephoned the office, saying she was desperate and eager for our service. She was willing and able to pay the five dollar fee.

Initially, Mrs. S. pleaded for help. However, because of her particular pathology, she wavered in her acceptance of treatment. Suffering from feelings of abandonment, she seemed impulsively driven to prematurely terminate, after vacation separations, any treatment she had been receiving. In her interview, she showed that her conflicts with her son around his eating difficulties were now

displaced to the time of appointments, amount of fee, and acceptance or rejection of treatment itself. Apparently she used her son to act out her own pathology. Like her son, she appeared impelled to refuse or bargain for the psychological nourishment she urgently needed. Mrs. S. seemed to require a psychological situation where she would experience firmness about the fee, yet at the same time feel at liberty to choose the treatment "food" she needed for healthy development. She could then make a constructive decision in favor of continuing therapy for herself and her son.

Whereas more mature patients are often helped to recognize the pattern of their resistance and its course, an interpretive, "feeding" method is often not as workable with more disturbed patients. The idea that the interpretations of archaic defenses often fall on deaf ears and may even amplify patients' opposition to treatment has been described in greater detail elsewhere (**Clevans, 1957**, Love and Mayer, 1955, **Love and Feldman, 1961**, **Meadow, 1974**, **Nelson, 1957**).

Historically, social work has been a "giving" profession. In the past, social workers gave time and money, as well as baskets of food to the needy. However, this kind of giving was not always responsive to the patient's need for growth. As social workers were trained in the modern psychoanalytic team approach and began to use these contributions, their "giving" began to be understood as possible manifestations of countertransference.

In the modern psychoanalytic frame of reference, broken appointments can now be studied and understood more objectively as manifestations of patients' pathological defenses requiring a highly differentiated approach. Selected clinical material from two case histories in various phases of treatment will be presented for illustration and discussion.

Case 1

Mrs. G., age thirty-nine, was diagnosed as a borderline psychotic woman with depressions. She had suffered the loss of her mother in earliest infancy.

Mrs. G. telephoned before her appointment (the thirty-fourth

interview in her second year of treatment) and left a message that she could not keep it. When the therapist telephoned her, she said that her reason for not coming in was that she had to wait for a very important telephone call concerning a new job for her husband. When asked why she regarded this as more important than treatment, she requested a make-up time. When the therapist said it was more desirable for successful treatment that she come in for her regular appointment, Mrs. G. said that if

the therapist felt so definite, she would be in.

Mrs. G. was fifteen minutes early for the appointment. She began by speaking of her behavior. She had told a lie. It was not true that she was waiting for a telephone call in connection with any job for her husband. He wanted to buy a new suit and to visit some friends and had asked her to accompany him. He told her, “Mr. Love missed an appointment with you, now miss one with him.” She felt that if she reported this, she would not be excused. She said she regarded money as more important than treatment, and hoped the therapist would also have this view. She complained about her husband's position and their lack of sufficient income.

She went on to say that originally she had requested that the agency provide help with her nine-year-old son Billy's withdrawal tendencies. As treatment proceeded, she realized that she was unhappy in her marital relationship, especially about her husband's lack of ambition. She then spontaneously told a story of a rich uncle who treated them poorly several years ago, when they visited his home. She felt it was because of their lack of money. At first she didn't perceive that she was being treated badly until her husband pointed this out to her. She felt that if she had more money, she would be more accepted. When asked whether the treatment she was receiving at the agency reminded her of her rejecting uncle, she said thoughtfully, “No.” If she had money, she wouldn't come to a social worker; she would go to a psychiatrist and pay $50 an hour. She then became openly critical of the therapist. She felt he was “cold,” a “machine.” He didn't answer questions. She asked the color of the therapist's suit, saying she was color blind, and felt resentment when the therapist questioned her request for such “simple” information. She continued to complain that the therapist had canceled an earlier appointment, and said that he had some nerve

telling her that treatment was more important when he didn't regard it as more important on that day. She said angrily, “If you want me to regard treatment as important, you better do the same.” She said that when she was angry with people, she did not usually express her feelings. She tended to withdraw and feel miserable. She was concerned about her angry outburst today and wondered if the walls were soundproof. She feared that the intensity of her outburst might have been disrupting and harmful to others. In her next treatment interview, Mrs. G. spontaneously reported that she was more able to control her impulse to beat her son.

Discussion

Since Mrs. G. was about to act out rather than directly verbalize her anger at the therapist and wish for revenge for his missed appointment with her, she needed to feel wanted in treatment, although she invited rejection by telephoning to cancel her appointment. She could then reveal some awareness of her pathological need to lie. The verbalization of her resentment and infantile need to hurt others revengefully not only gave evidence of progressive communication in treatment, but helped her to improve in her functioning as a mother.

Case 2

David, age nine, was referred by his mother. He had been expelled from public school, two Yeshivas, and two overnight camps. He spit at, hit, and fought with children and his teachers. He masturbated compulsively and openly at home and in school and would also suck his thumb and fingers and bite his nails. He was enuretic, cried easily, and had a compulsion to touch things. There were no popular responses on his Rorschach. The uneven nature of his intellectual functioning, his peculiarities of affect, and his marked infantilism were suggestive to our psychologist of a child who was “living in a cocoon.”

David had never been toilet-trained for bladder control,

although his mother reported that she started training him at eight months of age and was severely punitive about this. At the age of two, he achieved bowel control. Until he was three, he often slept with his mother in her bed. He slept in the parental bedroom until age seven.

A psychiatrist diagnosed David as suffering from childhood schizophrenia, symbiotic type:

This case is an excellent example of a symbiotic mother-child relationship resulting in extensive pathology in the child. The mother is a rigid, phallic woman who has imposed tremendous demands on the child and has never

permitted him to individuate himself from her. Throughout their contacts with the agency, it has been difficult, if not impossible, to separate the mother's feelings and behavior from those of the child. Her seductive behavior toward the boy had resulted in an overwhelming castration anxiety against which his compulsive masturbation appeared to be a defense. Of major importance in the genesis of this child's problems was the early punitive toilet training at the age of eight months. It appeared that as a result of this experience, David had never succeeded in establishing reaction formations against his anal drives. Instead, they were acted out directly and, indeed, it seemed that he was capable of relating to other people only on this anal-sadistic level. Behind this, however, were feelings of overwhelming oral deprivation.

The primary objective of treatment in this case should be the separation and individualization of this child from his mother. Work with the mother, who is a hostile, dependent individual, extremely rigid and defensive, should be directed toward this end. She should be guided toward permitting this child greater freedom from her overwhelming demands and from her inconsistent handling. For the child, every effort should be made to reinforce the primitive relationship he had established with his therapist. If this could be done, it would be possible to modify his anal sadistic behavior.

Interview 28, second year of treatment. David did not come for his appointment, nor did he telephone. After some waiting, the therapist telephoned his home. His mother answered. She said he didn't come because he didn't know the exact time of this appointment. The therapist asked to speak with David. He said in a teasing manner

that he didn't come because he didn't want to. The therapist said that he didn't have to if he didn't want to. David then agreed to come in the following week for an appointment.

Interview 29. When David did not arrive on time, the therapist telephoned his home. His mother said he was on the way. She asked to arrange a regular appointment for him, and the therapist said that this would be discussed with David. As soon as David arrived, he began by expressing his anger against the "boss" who was behind the therapist's boss who forced him to come. He said this boss should "only go to hell." He complained he had been helped only very little. He was angry because he was forced to come. He made a slip of the tongue, indicating he wanted more time.

David telephoned after he left the appointment, saying that his mother forced him to come. He didn't want to, but he couldn't help himself. He turned to his mother while on the phone and told her, "Mr. Love said I don't have to come if I don't want to." She then said he must go. He said he would come in the next time only because his mother forced him to.

Interview 30. David telephoned before coming into the agency, leaving a message that he wanted a two o'clock rather than a three o'clock appointment, but then came five minutes late for the regular three o'clock appointment. He came to the door, hesitating to enter. When he was invited in, he said, "Why should I? My mother forces me." He wished the therapist, his mother, and Mrs. Yonata Feldman (his mother's therapist) would all drop dead. When told he had a right to feel angry if forced to do something he didn't want to do, he wrote on a note, "I p—on you," went into Mrs. Feldman's room, and put it on her desk. He came back into the treatment room and threw clay all around the room. He listened intently when the therapist spoke with him about toilet-training experiences. He then found fingerpaints in the room and showed an interest in using them. He made quite a mess and threatened to smear the paint on the therapist's suit. At the end of the session he commented sarcastically, "Is this why my mother pays ten dollars, so I can use fingerpaint?"

Interview 31. David, accompanied by his mother, was prompt for this stormy session. He yelled that he didn't want to come, that she was forcing him, and he hated it. He saw Mrs. Feldman in the

waiting room and began hitting her. He asked the therapist to see both his mother and himself. The interview was held with both of them in the room.

David began to play with fingerpaints and clay. He dipped paint on the clay and smeared it on the table. Mrs. M. commented she never was allowed to play with this material when she was a child. David asked the therapist to teach his mother about "not making him come" to the agency if he didn't want to do so. He became enraged as he spoke and threw the clay on the floor. He smashed an empty fingerpaint bottle against the wall. His mother then criticized him. He cried that he didn't know why he behaved like this and continued to fingerpaint. When his mother looked disgusted and told him not to get it on his pants, he yelled at her to drop dead. He cried to the therapist, "Teach her what you taught me." In response to the

his pants, he yelled at her to drop dead. He cried to the therapist, "Teach her what you taught me." In response to the therapist's shared ideas about toilet training with Mrs. M., she commented she never played with clay as a child. She never knew about such things. After some further discussion between the mother and the therapist about training matters, David calmed down considerably, as he continued to use the fingerpaints. Toward the latter part of the interview, the child and the mother left, apparently more content with each other.

Interview 32. David, prompt for his appointment, began by asking what the therapist had done on Thanksgiving. He looked out the window, and admired the cars passing in the street below, and asked if the therapist had a Buick. He said that a relative of his, whom he liked a great deal, owned a Buick, and he expressed the hope to own a car when he grew up.

Discussion

Mrs. M. used the time of her son's appointment to convey her own difficulties in differentiating herself from him. Her attempts to control David's appointment times were frustrated. David broke, canceled, and requested changes in the time of his appointments in order to express his symbiotic tie to his mother and to re-enact his traumatic toilet-training experience at the age of eight months. Since the toilet training was forced, he needed to experience treatment as a

voluntary relationship. He could then express infantile rage. In progressing from defiant acting out, he moved toward more cooperative, positive, verbal behavior in and outside of treatment.

Summary

It is unscientific to add up numbers of broken appointments from statistical sheets and from this addition expect to arrive at any valid psychoanalytic generalizations. The case material would seem to indicate that there is a therapeutic solution to the puzzle of the broken appointment from an appraisal of individual case situations. The solution encompasses three main steps: (a) understanding the archaic language of resistance that children and their parents may use in breaking appointments; (b) differentiating developmental lacks and maturational needs; and (c) giving the proper responses to resolve the resistance.

Therapists may often feel that they failed to help when their patients break appointments. However, practice-oriented modern psychoanalytic experience indicates that this behavior in treatment can often provide an additional opportunity for the analyst to assess and resolve a particular resistance which the patient expresses by breaking an appointment at a particular time in his treatment. What Freud wrote in 1914 appears still valid today:

> *The greater the resistance the more extensively will action be substituted for recollection. For the analytic physician, recollection in the old style, reproduction in the mind remains the goal of his endeavors. He sets up a perpetual struggle with the patient to keep all the impulses which he would like to carry into action within the boundaries of his mind and when it is possible to divert into the work of recollection any impulse which the patient wants to discharge in action, he celebrates it as a special triumph.*

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Article Citation [Who Cited This?]

Love, S. (1977). The Broken Appointment: A Non-Verbal Message. *Mod. Psychoanal.*, 2:67-79

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