Chapter #24

A THERAPIST'S STRUGGLE TO ESTABLISH THE PSYCHOANALYTIC FRAME

Sevilay Sitrava
University of Exeter, United Kingdom

ABSTRACT
This paper concerns two aspects of my psychoanalytic psychotherapy work with D, who was 20 years old. I saw him once a week for two years. During the first year, we tried to establish a framework for the therapy. In the second year of the psychotherapy, we were able to establish the psychoanalytic frame, and D had progressed to associate freely during the sessions. This had led the psychotherapy process to a more efficient point. I will focus on two of the material settings of this frame; fixed session day and time; and the psychic element of free association. My main focus on this paper is on D's acting-out towards the time elements of the frame, and free association. I will explain how they were, or were not worked through, and what I encountered as an inexperienced therapist.

Keywords: psychoanalytic frame, frame, acting-out, psychoanalytic psychotherapy, free association.

1. INTRODUCTION

This paper concerns two aspects of my psychoanalytic psychotherapy work with D, who was 20 years old when I started working with him at the very beginning of my clinical practice. I continued seeing him once a week with for two years until the psychotherapy ended prematurely. During the first year, we tried to establish a framework for the therapy. I will focus on two of the material settings of this frame; fixed session day and time; and the psychic element of free association. Specifically, I will focus on D's acting-out towards the time elements of the frame, and the free association. I will explain how these difficulties were addressed, or in some instances not addressed, and what I encountered as an inexperienced therapist. Furthermore, I will comment on the effectiveness of writing a single case research paper about a patient and therapist.

2. BACKGROUND

D was one of the first five patients that I worked with at the very beginning of my master's degree studies in Clinical Psychology, which was a decade ago. He was 20 years old, but seemed younger at first sight because of his physical appearance. He applied for psychotherapy because he had been suffering from Obsession Compulsion and Body Dysmorphic Disorders for over three years. As a result of these disorders, he spent considerable time thinking about himself, his relationships with others, and his physical appearance. Moreover, he lacked self-confidence and self-esteem. He described himself as lonely and anxious, unable to make new friends at university or develop a romantic relationship. According to D, the reason for the lack of a romantic relationship was his physical appearance. This belief led him to have a rhinoplasty operation three months before he applied for psychotherapy. After the surgery, he had expected his life to change

for the better, but it did not. So, he decided to visit a psychotherapist to 'learn' the appropriate behaviours he should display towards women in order to establish a romantic relationship.

D was an only child. His mother was an accountant and his father was a literature teacher. He described his mother as dominant; she always wanted him to do everything in the way that she wanted. Nevertheless, he portrayed his relationship with his mother as very intimate, explaining that his mother knew everything about his life. Although they sometimes argued about D's choice of romantic partners, D told me that he valued his mother's opinions because she was older and more experienced than he was. Occasionally, however, this relationship with his mother bothered him, because he felt a lack of freedom. For instance, one evening, he was lying on his bed in his bedroom with the door shut, suddenly his mother entered the room without knocking, and tried to make D get up and talk to her about his problems, but he was sleepy and found this conversation boring and intrusive. He explained that although his mother lacked certain boundaries, he loved her very much and considered her to be his life coach. D was his mother's narcissistic extension and he was trying to behave in the way she desired. This had an impact on any potential romantic relationship; D explained that he felt paralysed when he met women, because his 'life coach' was not with him to give him instruction. Therefore, he needed to 'learn' the appropriate behaviours towards women for when he was apart from his mother. As his therapist, he expected me to teach him these behaviours.

While D had a lot to say about his mother, he said very little about his father. He told me that his father was an introverted, calm, and quiet person and they had a shallow relationship. His father was like an invisible man. They did not share anything except watching and talking about the football matches. His father had little interest in D's life, therefore when D had problems; his mother was the only person from whom he could seek help.

3. ISSUES RELATED TO THE FRAME

There are various concepts that contribute to the psychoanalytic state such as: free association; transference; frequency of sessions; and setting. The psychoanalytic frame is the basis, which allows for, and facilitates the functions of psychoanalytic work (Quinodoz, 2006). Winnicott (1955) describes the setting as the totality of all the details regarding the management of the therapeutic process. The psychoanalytic frame is essential for the existence of psychoanalysis and/or psychoanalytic therapy and its effectiveness. This frame provides for the patient the environment in which they can freely verbalize their inner conflicts and emotional disturbances, which can then be understood and worked through with the therapist within the boundaries (Bleger, 1967; Viderman, 1979; Quinodoz, 1992). Through the establishment and maintenance of the frame, boundaries are set within which transference occurs. These boundaries provide an environment in which the patient is free to talk about everything, rather than displaying them non-verbally. Freud (1911) discussed the boundary between thought and action from the point of view of the differences between the pleasure principle and the principle of reality. The frame distinguishes the verbal and nonverbal materials. Within the established frame, the boundaries between thoughts and actions are important. The therapist interprets the emotions and thoughts of the patient through verbalization, and the patient is expected to work through these therapeutic materials within the frame. If patients cannot manage to verbalize their disturbances, they may show their feelings by acting out towards the frame.

From the beginning of my clinical practice, I had a clear idea about establishing and maintaining the psychoanalytic frame. My clinical practice and my own psychoanalysis process taught me that the frame was one of the main factors in psychoanalytic psychotherapy. Therefore, I easily internalized the frame and worked in accordance with it but for D, the rules of the therapist constituted the frame and these should be followed, but could also be violated. He was used to obeying the rules within the relationship with his mother. His mother had strict rules for D, and for him to attain the feeling of being cared for and loved, he had only one resource; his mother. Thus, he could not disobey his mother's rules. Although he sometimes complained about his mother's behaviour, D was used to having no boundaries within his intimate relationship with his mother; thus, when he faced a boundary, for example, with a woman, he felt rejected and unloved.

In the consulting room, this situation occurred since D considered the frame to be my rules. He was partially compliant with the frame but another side of him violated these rules, as in the way he had behaved with his mother. For example, two months after the psychotherapy process began, D asked for a change in the frequency of the sessions. The frame regarding the frequency of the sessions was once a week, yet D wanted to come to sessions every two weeks. When he verbalized this desire, I tried to maintain the weekly sessions, and understand the request of D in a therapeutic way. Yet, he was never satisfied with this, and he responded by not appearing at the next weekly session. I assumed that he was experiencing strong feelings such as refusal, abandonment, and anger; just as he underwent with his mother. This behavioural pattern occurred from time to time during the first year of therapy. In one session, he requested a change in the frame of the therapy, without working on this desire; he did not attend the next session or sometimes two consecutive sessions. After these missed sessions, he would arrive on time or earlier, and explain his reasons for his absence. Typically, he blamed his absences on being sick or unable to talk. In another example, he said that he had a guest and he could not inform me because his phone was out of service. When I tried to work through the reasons for his absence, he resisted discussing them. He insisted that he had not been able to attend the session for the given reasons. Although I tried to work through his absences with the frame, I did not succeed.

As an inexperienced clinician, I had strong feelings regarding the irregularity of my sessions with D. I felt I was unable to establish the frame, and, consequently, could not work through this material in an adequate and effective way. Subsequently, I realized that D's behaviour was a maternal projection on me. As described earlier, D's mother suddenly entered his room intrusively without knocking the door and she insisted on convincing D to tell her his troubles in life. Yet, D could not argue with his mother regarding his issues because of his mother's intrusive attitudes. The same pattern occurred in the consulting room. He projected onto me of the mother who does not respect his boundaries and who invades his bedroom-mind without warning, demanding to know about his troubles. D's relationship with his mother was sufficiently symbiotic to be able to create boundaries for D and mother. If he felt a boundary within the relationship with his mother, his obsessions rose, resulting in strong feelings. The same pattern occurred in the therapy process. D gave being sick as the reason for not coming to his sessions and this sounded like an excuse a young child would give. He was not grown up enough to take responsibility for the contract he had agreed with his therapist. His request for a different frequency of sessions was refused and the therapist's 'rule' was valid. Therefore, he experienced the boundaries in the relationship within which he was free to verbalize his thoughts, feelings, desires, fantasies, and dreams. To combine free association and boundaries was too difficult for him.

4. ISSUES RELATED TO FREE ASSOCIATION

D was unsuccessful at free association in the psychotherapy process. While talking to me, D spent much of his time thinking about what to say. He was aware of this and also told me that he was very cautious about the words he used. He had two reasons for this: first, he did not want me to misunderstand him; second, he was trying to find the 'correct' responses. His way of speaking did not allow him to regress and associate freely. Moreover, his extreme self-control did not permit his unconscious representations to emerge. Since D's mother was the one who created a set of rules in her relationship with D, he did not feel free to talk about anything, only what his mother wanted him to. Sometimes, it seemed that he was struck by strong feelings, and could not escape. For example, towards the eighth month of the psychotherapy process, D was talking about his old friends and his high school years. Suddenly he directly asked me the name of my high school. While I was trying to understand the meaning this question had for him, he insisted on asking the same question again and again. I did not answer him, and he became furious with me. His voice grew louder, and he complained about our one-sided relationship. He complained that he always talked about himself, but I said nothing about myself and he needed to hear something from me. He wondered if I experienced similar kinds of issues at his age. He was interested in what was happening to others, to me, rather than himself; thus, it was too difficult for him to regress and associate freely. His demand for me to name my school seemed like a role reversal in which D projected onto me his experience of being on the receiving end of the mother's intrusive demands and he enacted the role, suddenly intruding into my bedroom-mind. Furthermore, since D was suffering from the lack of a romantic relationship, he asked me questions regarding women because I was a woman. He directly asked questions which stood for trying to understand the women via his psychotherapist, me. Moreover, he was used to getting clues from his mother in any kinds of topics, especially romantic relationships. He tried to have a same kind of relationship with me, as his psychotherapist. When I did not answer his direct questions, but rather tried to understand the reasons for asking these kinds of questions and interpreting his attitudes, he was not able to tune in the process and try to understand what was going on in his internal world. Rather, he insisted on being angry with me, and he felt under nurtured. He thought I, his psychotherapist, had the answers to his questions, but I did not 'give' them to him because I did not want to nurture him with my experiences and knowledge. Instead, according to him, I left him alone with his problems, and was not helpful to him. For this reason, he stopped talking to me about his romantic relationships for a long time. He did not feel that he was being nurtured by me, and I did not 'give' him the specific clues he sought. Therefore, he did not want to 'give' me his thoughts, feelings and/or experiences with women neither.

He wanted to be close to me and mutually share problems; otherwise, he would be afraid of being weak and engulfed. Since I did not tell him about myself, he became very angry with me. Instead of explaining his strong feelings, he demonstrated them by missing the next session. His anger resonated with me in relation to the frame in terms of the element of payment for the sessions. The rules of the university determined that patients did not pay for the therapy sessions held in Psychological Counselling Centre of the university. This was a contradiction with the ideal components of psychoanalytic frame. As Bleger (1967) commented the psychoanalytic frame consists of constants and variables, such as the role of the psychoanalyst, time elements, setting, and money. One of the other variables of the psychoanalytic frame is the psychoanalytic contract, agreed with the therapist and patient. This agreement should be based on mutual exchange of money and time

(Grinberg, Langer, Liberman, & De Rodrigué, 1967). Yet, in this case, parts of the agreement had been determined by another authority and caused a problematic situation. I found myself feeling anger towards the university authority since in addition to my rules; there were those of another authority in that consulting room. Thus, I found my feelings paralleled D's feelings when he requested a change in frame. While I was writing this paper, I realized that I partially held the university authority responsible for not being able to work with D properly. I found myself thinking that if the patient had even made a small payment this would have imposed a sanction on him. This may show my identification with the feelings D projected onto me about the rules. He was angry with me, and he projected onto me being the intrusive mother, not allowing him to have a private zone. Regarding fees, I was angry with the university authority and projected onto authority being intrusive, and not allowing me to do my job properly. Since these projected feelings were too difficult to handle, I might have projected these feelings onto the university authority.

5. PROGRESSION OF THE PSYCHOTHERAPY

In the first ten months of the therapeutic process with D, he did not often engage in physical exercise. While we were working through his irregularity in attending the sessions and his unwillingness to engage in free association, he began thinking about his gym attendance. Going to gym was a concrete example for him, and therefore he was able to find the way to verbalize his feelings. When he exercised, he felt relaxed, more comfortable, and self-confident; thus, in the sessions we could work through his inner conflicts with the help of his interest in sport. At the end of the first year of therapy, he had internalized the time elements of the frame being punctual and rarely missing sessions. If he needed to cancel a session, he obeyed the rules of cancellation. Although he still had some problems regarding free association, but was slowly managing to do it. He became better able to discuss his problems, thoughts, feelings freely and he was able to talk about and discuss his dreams. He had started to talk about his girlfriends and the way that he communicated with the girls, without searching the wrong and right sides in my point of view. He had started to talk about his sexual life. He had experienced his first sexual intercourse while he was in the psychotherapy, which was an indication of the fact that he was psychologically 'growing up' and he was not seeking another person to help him decide what to do and what not to do.

Regarding his dreams, he became able to focus on what was happening in his internal world and what he was experiencing in his life, as opposed to what I gave him as the psychotherapist. He did not look to me for responses or to lead him in life. Instead, he had become autonomous and experienced the life accordingly. These changes and progresses in D's life were invaluable and inevitable for him, and for me, as his psychotherapist,. He could have had a different lens for himself; these progresses were enough to start a change in his life. Nevertheless, he needed to work on these issues more.

The premature end of the sessions with D was because I had completed my master's degree, and my work in the university psychological counselling centre had ended. I told D my last day of work in the university six months before leaving, thus providing time to work through the related issues. I suggested D that I could continue to work together in private practice. Although he very much wanted to continue working with me, he did not accept because he would not pay for the therapy. He did not want to 'give' more things.

6. REFLECTIONS

These strong feelings, which emerged in both the patient and myself made the psychotherapy process with D difficult. Since I was an inexperienced clinician and the frame was already internalized with me, I considered D to be a rebellious patient with his difficult questions and trying to drive me into a corner. He questioned my working style, which made me feel angry and trapped. Although he complained that we did not share anything, we did share some strong feelings but could not verbalize these to each other. In the process of writing about this case for this paper, I realized many more things regarding the patient and myself. For me, the frame was one of the accepted aspects of the therapy and there was no need to argue about it. Yet, with this paper, I recognized that there was not just one frame. As Bleger (1967) noted, psychoanalysts, and I would add psychotherapists, have an inner frame, but they cannot ignore the patient's frame that they unconsciously bring with them to the first session. The psychoanalytic contract should be undertaken with the frames of both parties. If not, as in my case reported here, the frame becomes a particular and difficult issue, which influences the first year of the therapy process. Nonetheless, these negative situations have become a valuable experience about which I was able to write a paper many years later.

In terms of writing a single case research paper, I, as a clinical psychologist, psychoanalytic psychotherapist encountered some of the important points of the methodology of single case research. During the sessions, I had an idea about the progress and prognosis of the patient, but at some points I had failed. This situation paralleled the "negative capability and psychoanalysis" (Taylor, 2010, p. 405). Taylor (2010) argued that as a researcher we try to obtain the results that we expect, and accordingly we ask the appropriate research questions and thereby set the design. If there are results, which contradict our previous assumptions, then it becomes confusing. This negative capability parallels the work with patients in the consulting room. In the formative sessions with clients, psychoanalysts formulate opinions of the patient and in the light of this formulation assume that we will receive the responses from the patients that support our predetermined perspective. We expect to hear issues from the patient in the way we have assumed; thus, we diagnose the patient in the way we have formulated them. Accordingly, we anticipate that the patient will bring into the session the kinds of therapeutic issues as we expected. If something strange happens, which we did not anticipate hearing according to our formulation and way of thinking about the patient, we may find ourselves in a position which estranges us from the patient. We would get lost in the details given by the patient without understanding them. The same pattern can be experienced as a researcher. The research techniques, in the forefront, may appeal to the researcher in the process of choosing the appropriate methodology design. This would steer the researcher away from the important hypotheses, which should lead the research, and instead the methodological design of the study could become prominent. This is related with the ability of including or not including the negative events related to a clinical event or in academic research (Taylor, 2010).

Combining the psychoanalytic psychotherapy and research in this paper allowed me to go through the methodological and psychoanalytic issues at the same time. Holding the third position as a researcher and a more experienced psychoanalytic psychotherapist offers me plenty of theoretical and methodological materials and sources of research were conducted for a very long period of time. This experience allowed me to overcome the negative capability issues outlined by Taylor (2010).

7. CONCLUSION

In this paper, I discussed the difficulties that I had encountered when I was an inexperienced therapist. Although a psychotherapy process includes a dyad, therapist and the client, the dynamics of the psychotherapy would be constituted according to these two persons. Additionally, the personal dynamics of the therapist, being aware of these dynamics, owning an appropriate lens as a therapist and being aware of the transference and counter-transference issues come to the forefront. Although these features depend on the unique dyad, this paper may give ideas regarding the psychotherapeutic process with a patient who had inner conflicts and had been resistant to deal with his inner world.

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AUTHOR INFORMATION

Full name: Sevilay Sitrava
Institutional affiliation: Department of Psychology, University of Exeter
Institutional address: Washington Singer Building, Perry Road, Exeter EX4 4QG United Kingdom
Email address: ss708@exeter.ac.uk
Short biographical sketch: Sitrava is a postgraduate researcher in the programme of Doctorate of Clinical Practice in University of Exeter. She is a clinical psychologist and working with adults, couples, and families. She is currently conducting her dissertation, which is about adult attachment in romantic relationships, and which is a mixed-methods study, combining quantitative and qualitative methodologies. Her interests of areas are adult attachment, psychoanalysis and qualitative methodology.