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Frame as Fractal

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In response to Tony Bass's "When the Frame Doesn't Fit the Picture."

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Tony Bass's article opens a dialogue in multiple dimensions that follow on his exploration of the frame as simultaneously structure and process. His argument begins with Freud's description of elements of the analytic frame, and continues in a kind of underground dialogue between the "rigid, rule bound" classical group of Freudians (clearly not the heroes of Bass's piece) and the evolving ideas that have a necessary impact on conceptions of frame for the "flexible, thoughtful" relational analysts and their analytic ancestors.

My own heritage, beginning with my training in medical school, in an analytically-based psychiatric residency, and on into analytic training valued the tensile strength of the frame. It was work with psychotic and borderline patients especially early in my training that made me see the frame as an essential structure for dealing with patients whose early experience was fraught with trauma and inconsistency, and who

could do no better than to bring the internalization of that experience to treatment in or outside a hospital.

Despite an overall sense of agreement, I have a major caveat to Bass's paper, that is highlighted by the brief closing dialogue with his discussant, Susi Nebiosi about the importance of changing training for new therapists and analysts, and is even more emphasized by the discussion by Laor. It is one thing to talk about training and supervising relatively advanced analysts – and quite a another to deal with training the bulk of relatively new therapists who are drawn to analytic ways of working but who have never been trained in the importance of setting limits with patients who tromp all over therapists' limits in the service of what the patient calls humanity, understanding, or some such heavily affective word that mainly serves to attack the structuring function of the anti-libidinal side of relating. This problem is an inherent liability which Bass, Nebiosi and expecially Laor have not considered or allowed for - and that unanswered, this liability could quickly seep into their training programs to haunt newer or younger trainees who would be quietly or noisily swamped. The new value would be "flexibility" rather than firmness. It is rather like the debate between rigid feeding of infants by a schedule rather than demand feeding. Any experienced mother knows (I hope) that she has to provide a structure or she will never get any sleep, have time for an adult partner, nor feel her advanced maturity is leading the way.

Here is what I have in mind: In a group supervision with four experienced therapists, a borderline patient one of them brought to the group demanded phone access to the therapist. It emerged that all of them when had been taught in previous supervisions to allow such access, to work interpretively with the phone calls, and to treat

them as legitimate needs of the patient. This patient also drove by the therapist's house frequently, demanded extra and longer sessions, and on one occasion accosted the therapist's unsuspecting husband with questions about their personal life, which he answered in an innocent and unsuspecting way. The therapist, not surprisingly, felt overwhelmed, rather eaten alive by this patient, and all four supervisees identified with her feeling, having been there themselves. These were not unthinking colleagues, but rather ones whose training had been uninformed by the structuring function of setting limits. While this has not been described as an aspect of analytic therapy, I believe it most certainly is, and that its power, indeed its necessity, follows from the need to relate to all patients – not only the borderline, psychotic or personality-disordered ones – with both sides of any relationship, the side that invites openings into more openness and trust, and the side that invites patients to live by, accept, understand, and eventually embrace the necessary limits of any important relationship.

When I was able to help this therapist set limits on her patient, limits imposed out of the need of the therapist for a frame -- a boundary around her own personal and professional life, the patient grew – predictably – angrier, brought more of the side of deprivation and trauma into the transference, and began to do therapeutic work of a caliber unknown in the several previous years of therapy.

A frame that thrives on limits has an honorable ancestry in the “rigid, classical” structuring process I and so many of us learned from our teachers. This is, no less, a frame whose structure is informed by the evolution in understanding of the last sixty years of writing about other factors. I date the beginning of this evolution from

Winnicott's (1946) short piece, "Hate in the countertransference," which was not about analytic work at all, but about a delinquent, unstructured, horrendously aggressive boy whom Winnicott and his wife essentially adopted, and who needed, more than anything, structured limits in order to build a new "frame of mind" from which to relate to Winnicott and then to others.

So that is my extremely serious caveat to Bass's piece and to Laor's and Nebiosi's commentaries. It is the reason I am worried about establishing that "co-constructed flexibility rules the day" before we teach the reasons for beginning from a frame that structures therapies, that gives the new and the experienced therapist a sound footing on which to begin, and a rock of salvation when things go badly wrong.

Now to the agreements: When Tony Bass and I began a dialogue of mutual respect on the similarities and differences of "Relational" and "Object Relational" approaches a couple of years ago, he had the idea that my approach would be one that perhaps overvalued a fairly inflexible frame, one that in his terms, tended to impose a non-negotiable frame on most patients. I feared that his flexibility would shortcut the flushing out of aggression in the transference, and other depth encounters. We do not disagree about the human subjective partnership involved in being, as I have termed it (1994,) "partners of the moment." Parents and babies are full human partners in subjective exchanges at all levels, co-constructing, not only the moment-to-moment exchanges, but the evolution of two minds in which the parent must take the lead in constructing not only the infant and growing child's mind, but the aspect we might term the child's evolving "frame of mind" that shapes the meaning of all internal and external experience, including relationships.

The frame, as described and beautifully explored in Bass's paper, is a fractal. That is to say, in terms of chaos theory (Scharff and Scharff, 1998, 2006) it is a group of structuring functions that hold the shape of a therapeutic encounter, and at the same time reflects the interplay of minds which makes up any therapy, resembling the issues of the therapy at all other levels, unconscious, interactive, one-person and two-person psychologies, pre-oedipal and oedipal, drive, defense, and interaction. It forms a pattern at the same time that it seems to impose pattern. This paradox is inherent in chaos theory's term "strange attractor" that captures the way a system seems to be patterned in a way that is actually produced by the dynamic function of the system itself. Without delving into chaos theory here, let me say that this paradigm supports and expresses the way that the frame can never only "fit the picture." The frame equally expresses the picture. So here I am in complete agreement with Bass. The frame begins, perhaps, as the structure the therapist brings to the work, but the interplay always contains the combined seeds of the patient's and the therapist's unconscious dynamics. It is rather like Sylvan Tompkins' (Demos ? 1987) contention that the depth life, the unconscious life we most seek to understand in analysis, is often most read on the surface of a person's face. Just as the face is a place where surface and depth come together, at the same time it is a signaling device to convey a wealth of affective right brain unconscious experience to other persons. Surface and depth, face and the dynamic unconscious, frame and content: These are no longer separable in modern theory or therapy. Like the proverbial horse and carriage, you can't have one without the other.

So now a few words about my own evolution in regard to the frame, which in view of the foregoing comments, also constitutes much about my evolving view of analytic process.

Like Bass, I think of myself as having a significant respect for the frame. I don't believe in self-revelation, with the significant exception of episodic but important revelations about my state of mind in relation to the patient and our interaction. This is a significant evolution beyond my early training, representing years of work on theories of the role of countertransference and projective and introjective identification (Scharff and Scharff, 1998.) But associating to Bass's paper has showed me a different aspect of my therapeutic evolution, the negotiation of the frame that has structured and been part of the evolution of many therapies.

For example: I have never been impressed by the logic of the inviolability of the analytic relationship that eschews, even forbids, contact with a patient's family. My first case as a resident (Scharff and Scharff 1987, etc) featured an intensive analytic psychotherapy with a borderline adolescent, conjoint family therapy with her parents and siblings, and many years after termination, a brief correspondence and evaluation that resulted in her entering psychoanalysis as an adult. Child therapists often do family work with their individual child patient's families. Although in some cases this is clinically contraindicated, the decision about when this is so is a matter for clinical judgment, not for an imposed framework. (Scharff and Scharff 1987.)

Then there is the matter of taking individual patients into psychotherapy or psychoanalysis after a phase of couple therapy. I have done so fairly often. Let me describe the evolution of one case that captures aspects of the evolution of the work

around the frame, and work supported by the frame. To my thinking, it captures both areas of agreement and reservation with Bass.

Mrs. Meyer said early on that she did not want to become “my patient from Hell”. I began seeing her and her husband in couple therapy for difficulty in their sexual life. She could manage to enjoy sex if she initiated, which she did rarely, but not if he did. Quickly the couple therapy unearthed the significant in-depth issues for both of them, but they were able to take back many elements they had deposited in each other as projective identifications. Because he had a therapist he liked while she did not, once matters they imposed on each other had eased, we agreed I would see her in thrice-weekly analysis. During that first phase of work in the couple therapy, Mrs. Meyer had been mainly compliant, agreeing readily, for instance, to pay my fee, which was higher than usual fees, and attending all sessions promptly, with adequate and polite notice if she or her husband were called out of town for their work, but paying for missed sessions if we were unable to reschedule. Notably however, a few times, Mrs. Meyer would take something I said amiss and would react angrily, feeling misunderstood. These misunderstandings seemed to come out of the blue, to rent a tear in an otherwise close and idealizing alliance.

After we moved to individual work, these episodes gradually became more frequent, evolving into full-scale rage attacks that had their origin in the undertow from her too-good-to-be-true behavior, her attempts to be the good child, in a family with a rigid structure within a conservative religious tradition, that had been punctuated several times by traumatic losses and equally traumatic efforts at unconscious repair. We counted chief among these the sudden, unpredictable losses, her young and idealized father’s

death when she was 10, a move from Israel to the US because of her mother's need to find full-time employment after the father's death, and sexual seduction by her step-father.

The therapy gradually became a living hell. Beyond my experience with my first borderline patient I mentioned above, I have not been so thoroughly tested by any patient whose therapy survived. But we both had agreed, verbally and non-verbally, that this regressive descent to circles of hell seemed to be required for her growth. It had something intrinsic to do with her sexual constraint, too, but we could not say just what. Increasingly, she was furious at me for putting my foot in my mouth. She brought vituperation to the sessions, skipped sessions, often without the courtesy of calling before or during the session so that I would sit there waiting for her at her rejecting beck-and-call. Once in the office, she would sit silently, sometimes sleep, stare out past me, and if I said something wrong, which was highly likely when I said anything, snarl at me. She would also miss hours without calling to tell me she was not coming, saying afterwards that she needed a vacation from the work. She never protested paying for these hours, but she did regularly pay me late. I never doubted that she would pay, but we both knew she was giving the frame many dents which could not, in this long period, be discussed adequately. As the months wore on, she escalated the verbal violence, the diminishing degradation of me, and then began to leave, slamming the door. My patience grew thin, and I thought how she had taught me to hate her in return. While I had an image of her other, cooperative and growth-loving self in mind in the way that parents of rebellious, nearly terminally obnoxious adolescents must, I felt my tie to her and her good objects was wearing thin. Finally, one day she hurled a few expletives as she left half-way

through the session (which she had done a few times), but on this day she slammed the door so hard I was afraid the door would come off the frame and the nearby bookcase topple. In the next session, I told her that was no longer permissible. If she slammed the door again, I would have to end the treatment because I could not myself stand the risk to my office. She told me that she resented my setting the limit, that it was like the Supreme Court imposing limits on freedom when they outlawed certain practices,, even though the content of the speech and acts themselves were repellant to her. Soon after, she once again railed against me and left in the middle of the session, not slamming the door, but shouting that my treatment had been of absolutely no use to her. I was not to take any solace in the idea that I had been helpful to her, because I had not. She was quitting on the spot.

I quickly calculated which patient to call to offer him the very advantageous hours Mrs. Meyer was vacating, intending to do so in order that they would be filled before she could call to ask to come back, intending at least to deprive her of the privilege of these desirable times with me. I was, of course, furious and out of patience. But, fortunately, she called within ten minutes to ask to keep her regular times. It was the turning point. She and we had hit bottom, and over a number of years after that, keeping the frame the same, she worked assiduously to understand more. Each time she achieved a new level of understanding that might have allowed her to quit with the reasonable achievement of a new level of adjustment, she considered terminating, then reluctantly opted to continue. In each ensuing period, she worked in more depth. In the final iteration of this pattern, she brought in her sexual history in a detail denied our dialogue until then, told me of the exciting eroticism of her early relationship with her husband in the form of a picture that

had been in their bedroom of her, that while it did not show her body, clearly indicated she had been nude and aroused when he had taken it. Banished to a drawer for many years, it now came back to their bathroom, the only place to which their children were denied entrance, and she linked the pleasure it contained to the constraint of the episode of her step-father's attempted seduction and her mother's refusal to understand the event when she was fourteen. Only now could she allow me in on both scenes and both states of mind, the erotic pull and the fearful withdrawal. Sometime after this work, she could consider termination because she had reoriented her life, enjoyed her family and marriage much more, had come to terms with her professional successes and limits, and because she could work with me within the limits and possibilities of the frame and our shared frames of mind. She said, "I adore coming here. I could come forever. But I also need to know I can do this on my own, I can leave home having gotten enough. I know I could come back, and I will if I find I need to. But it's quite possible I won't need to. We're had a good experience, for which I am profoundly grateful."

And I was grateful to her as well, and said so. I had learned more than I meant to about the power of hate, and about the necessity to experience her hate and my own. I mean that I knew that when we started, but only in the abstract way we carry theoretically and even the abstracted way we carry experience from work with one patient to that of another. But experiencing the power of our encounter, frequently at the limits of the frame, to promote growth in each of us, was a rare and precious experience, one that resonates with Winnicott's paper on hate, and one I continue to treasure in the same way that I continue to treasure my beginning experience with that first borderline patient from whom I also learned so much.

I haven't said much yet about the actual frame, because I wanted to outline first the evolution in the patient's and my frames of mind during this long treatment. Mrs. Meyer said from the beginning she could not lie down. I preferred that she did. I prefer the way I feel more in touch without being looked at, but I could accept this condition, one often necessary with adolescents and with patients who have suffered significant trauma. I never fight about this question, although most of my adult analytic patients lie down. She would only come three times a week. I prefer four. She countered with the exigencies of her job, which had some reality to them. She agreed to my fee, which was higher than the usual fee, and which meant that, according to the conditions of her insurance, she could not use it at all.

Then, as things began to break down into more aggressive exchanges, she also began to attack the frame. I expect such attacks for the very reasons Bass has outlined, that process and structure are intricately related. She did not want to come three times a week, and the fee was now excessive. I did not experience these as mutual negotiations, but as externalizations of her attack on the part of herself that had previously cooperated with me. She forced (I certainly felt forced) a consultation with a colleague over my ability to withstand her attacks and to understand her in any useful way. The consultation was, as is so often true, extremely helpful. My colleague understood that underneath her attack lay her urgent, frantic devotion to me and the desperate hope that our work could help her. But the colleague suggested to her and to me that she did not have to come three times a week. Here I felt undermined, but the suggestion acted in the way of a kind of forced negotiation, a kind of equivalent of what Bass describes of mutually unsatisfying compromise that allows work to proceed through an impasse. Soon after I agreed to this

compromise, Mrs. Meyer asked that we work for an hour each of the two times weekly, thereby reconfiguring our time together with only a slight shortening of it on a weekly basis from the original. So we moved to two sixty minute sessions a week instead of the previous three forty-five minute ones, a loss of fifteen minutes a week, compensated for by an increase in the comfort and depth of her work. All this was before the episode of quitting, which was in large measure enabled by this change in the frame. This negotiation of the frame seems to me to be similar to those Bass and Nebiosi describe, although aspects of it were not analyzed until very late in our work.

On other aspects of the frame, she sat as far across the room from me as the geography of the room allowed, pulling up an available footstool, and staring out through a window into my garden, hardly ever looking at me. In this way, she formed her own version of an analytic couch, one that worked for both of us, and that happened to duplicate a physical situation adopted by Fairbairn (1958) in preference to his use of the couch. He felt it gave the patient the option of engaging the analyst without the imposed deprivation of the face, and it seemed to work in this way for Mrs. Meyer.

She blocked the ordinary increases in fees I “negotiated” with most other patients. She skipped sessions in the way I described above, but paid for them without complaint. She paid late frequently, although I never doubted she would pay. This was a compromise I allowed reluctantly. On the other hand, late in the therapy, she confronted me for not confronting her about this pattern, and then, as a result of her turning the tables on me in this way, we explored the dynamic testing of me as a father who would tolerate her misbehavior without turning on her, and she then paid in a timely way from that point on. Late in the therapy, having felt I could not discuss raising the fee in any

significant way with her over a period of about five years, I felt we had moved past that unspoken shared inability. She agreed, we analyzed many of the issues previously held out of discussion, she agreed to a reasonable increase. While I never made up the part of the fee lost in not raising my fee earlier, I felt I could absorb that loss, with the compensation of satisfactory work to show instead.

At the end of the treatment, the fee raised, she missed no sessions in the whimsical way she had before, we had a new shared frame of mind, as sense of mutual respect and satisfaction, and a shared mutual fondness, verbalized on her part, but clear in the usual, although restrained, expressions on my part about our work. Once, late in the day, she got angry at me on one occasion. I said it reminded me of those days from hell. "Oh, yes," she said. "But I thought I got over it quickly and without worrying either of us." I had to agree.

By painting these two evolutions of this treatment, the one of the content, and the other of the frame itself, I hope I have conveyed that I am in firm agreement with Bass that the frame and the picture are fractal, co-evolving elements, mutually influencing and mutually influenced. Because they are fractal images of each other, the description of each contains a way of understanding the evolution of the other.

On the other hand, to the discussion of my disagreement, I want to say that mutual negotiation is not all there is to it. There are times parents absolutely must say "No." And there are times the analyst must set limits. If this works, then mutuality becomes possible because of the limits, not the other way around. With highly cooperative patients, this hardly ever comes up. But I believe that it is often a therapist's training and subsequent comfort on the issue of setting limits with the frame that makes it often

unnecessary that it even come up, that makes a degree of holding possible that would not otherwise become available. I value that kind of mutuality just as much as the kind that seems, on the face of it, more openly mutual, but that can disguise a depth condition of the lack of a frame of mind that can support growth and development.

This discussion will, I hope, make it clear what my problem is with Ilana Laor's paper that seems to follow Bass's exposition, and reads like an expansion of his basic idea on the need for a flexible frame that echoes the basic structure of the analytic situation as she sees it, one that follows Aron's principles of mutuality of regulation, recognition and influence. It is hard to disagree with this exposition of the mutuality with asymmetry that she espouses, but I believe that her examples show how she misses some crucial points. No one can any longer quarrel with the idea of the essential mutuality of human relationships. However, the description of asymmetry in relationships that she describes ignores any unconscious exchange in the mode of the container/ contained described by Bion. Here the basic asymmetry is that the parent (or therapist) has the essentially asymmetric role of allowing the patient's or child's primitive, constrained and self-limiting anxieties, affects and object relational structures to resonate with her own, in order to allow her more mature and structured inner world to structure that of the child or patient. This is a mutual process with an inherent difference beyond a simple permissive openness to an unthought mutuality. What I have to say about the need to structure and set limits applies to the externalization of internal factors that often makes treatment possible. I found Laor's two examples unconvincing. In the first the patient made the unusual offer of paying more by paying for missed sessions. My own policy is to charge for such missed sessions. But what if a patient like her refused. Would I "negotiate" as

though I had to in order to prove my “flexible mutuality?” Usually not, unless the patient’s financial circumstances had taken a major setback which she had not herself set in motion. While there are situations in which I would agree readily not to charge (college students who leave town or the death of a family member, for example), I usually state this condition as one of those of my practice. Not surprisingly, there are patients who don’t really like this policy, and it brings out anger in many, but if I let them cancel whenever they choose to or have to travel, I must either accept less income or raise the fee. Not every therapist can enforce this policy, but over the years it has worked, most of the time, for me. When I have relaxed it, I have often regretted doing so because more often than not, it soon becomes a place for painful enactments without the traction for understanding. For instance, I did tolerate not raising the fee for Mrs. Meyer because the fee was a satisfactory one for me, although not all I came to wish. But I would not have tolerated her offer to “negotiate” lowering it or not paying for missed sessions – and that attitude would have had to be taken mutually into account. While Laor’s first example is presented as being about a flexible frame, there is really no demonstration of a working process with the patient, but rather more of an acquiescence. Loer’s second patient, Yassi, didn’t really negotiate either. He accepted her recommendation for a longer therapy – and then he changed his mind and quit. It does not sound as though she had much choice. While this is often true with adolescents and young adults, and while, of course we have to accept these things because we have no choice, there is no evidence in her writing that she attempted to work with the meaning, although perhaps she did and the attempt failed. Rather, as I hear it, she has termed a disappointing loss one of “mutual respect.” I would have to see quite a lot more evidence. It is of course possible the patient

may come back for another round of treatment – serial brief therapy in the way Stadter (1996) has described. But let's not call this a victory for the flexible frame, but rather a disappointing accommodation that is forced on the therapist.

Susi Nebiosi's review relates both these articles to more of the literature concerning mutuality in the construction of subjective processes in therapeutic work. She is fully supportive of the arguments in both papers, and her expansion of the meaning of mutual processes is a welcome addition. However, it will be apparent that I do not agree with the way she has supported Laor's examples on the same basis as those of Bass. I do not feel we can afford to jettison the crucial role of structuring in therapeutic endeavors. Like parents raising a child – both of whom are wholly human – we carry a responsibility for structuring therapies even while, at the same time being open to exploring the patient's subjective experience of that structuring. Nebiosi's own example showed that she did structure the initial phase of the therapy with her patient, and that she was later able to associate to that experience and work to explore its meaning to the patient. She held the frame, and the treatment benefited thereby deepened in the fullness of time.

Bass's paper and the discussions that follow it have given us all a wonderful opportunity to examine the frame as structure and process, as thing in itself and as fractal of the whole therapeutic project. I'm grateful to all of the authors and to the editors for allowing me to join in this dialogue.

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Ilana Laor "The Therapist, the Patient and the Therapeutic Setting: Mutual Construction of the Setting as a Therapeutic Factor"

The wisdom of sharing a frame

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