Changing Spaces:

the impact of a change in the psychotherapeutic setting

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Dimensions of Psychotherapy, Dimensions of Experience

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A psychotherapist's move to a new office might seem like a simple, uncomplicated act. However, the act of changing the physical space, that is, the external setting, is really multi-layered and quite complex.

In this chapter, I define the psychoanalytic notion of setting and explore the implications of a change in setting. I use three clinical vignettes to illustrate how a change in the physical setting of my office generated a multitude of responses and unconscious phantasies in my patients. The patients' reactions reflected their levels of psychic functioning as well as the therapeutic issues with which they were dealing at the time of the change. My own fantasies, hopes, anxieties and reactions to the move

formed the context in which I experienced the patients' reactions.

COMPONENTS OF THE SETTING

The terms setting and frame are defined and used in a variety of ways and even at times used interchangeably. From my perspective, frame is one of the components of the setting. The frame consists of those non-process, external constants which are needed for the process of psychotherapy to develop and within which it can. These constants, which

define the therapeutic space, are made up of elements of place and time such as the location of the office, the furnishings in the office (see also Anderson, Chapter 5 in this volume), the stable schedule of appointments, as well as the treatment modality, and the fee arrangements.

In addition to the frame, the other dimension of setting is the therapist's attitude, state of mind and way of working. It involves the therapist's openness and emotional availability for unconscious communications, the

therapist's conscious attitudes and unconscious phantasies and the therapist's theoretical orientation, which is the lens through which the patient-therapist interaction is understood. These two dimensions, the frame and the therapist's state of mind, make up the setting, are inseparable and reflect each other.

PSYCHOANALYTIC PERSPECTIVES ON SETTING

There are a number of different psychoanalytic perspectives on setting and frame. Winnicott described setting

as ‘the summation of all of the details of management’ (Winnicott 1956: 297). It includes all of the ground rules for interacting, such as limiting communication to the consulting room, confidentiality, interventions geared toward interpretation, and anonymity.

Psychoanalytic theory stresses the importance of establishing and holding to a consistent setting. When the setting is stable and secure, it is the silent backdrop for the therapeutic work and although serving an essential

function it goes unnoticed. In Bleger's terms the setting is 'dumb but not non-existent' (Bleger 1967: 511). He points out that while the muteness of the setting functions as a backdrop against which the process can develop, it still has unconscious meaning and serves as a container of psychotic anxieties.

Langs describes the frame as 'the psychological boundaries and agreed upon conditions under which therapy will take place' (Scharff and Scharff 1992: 92). The establishment and maintenance of a secure frame

‘generate a trust of the therapist and a sense of safety that fosters the communication of the patient’s unconscious fantasies …’ (Langs 1978: 110).

A recurrent notion in the literature is that the setting contains and defines multiple realities. Modell asserts that ‘the psychoanalytic setting frames a level of reality separate from that of ordinary life—an area of illusion; within this area of the psychoanalytic setting, there are further transformations of levels of reality’

(Modell 1989: 71). For Bleger, the frame provides constraints and constants, which help distinguish the unique and illusory realities of the therapy from the reality of ordinary life (Modell 1989). McDougall uses the analogy of the theater as a metaphor for psychic reality and compares the illusion of theater with the illusion of transference (McDougall 1989). Milner uses the analogy of the frame of a painting to demarcate the separate realities:

> The frame marks off the different kind of reality that is within it from that

> which is outside it: but a temporal spatial frame also marks off the special kind of reality of a psychoanalytic session. And in psychoanalysis it is the existence of this frame that makes possible the full development of that creative illusion that analysts call transference.
>
> (Milner 1955: 86)

That demarcation is essential in safeguarding the transference and in allowing both therapist and patient to move from an ordinary relationship to the transferential relationship and back again.

The function and elements of the setting can also be understood in terms

of Winnicott's (1965) concept of the holding environment and Bion's (1962) concept of containment. An analogy can be drawn between the holding environment provided by the mother for the infant and the physical space provided for the patient by the therapist. The infant comes to rely on the consistency and predictability of the holding environment to provide protection and a sense of safety. Winnicott described holding as the externally observable aspects of the caretaking provided by the mother to facilitate the infant's growth. It is

through these external objects and interactions that the baby experiences the relationship with the mother. Similarly, the therapist's provision of a special holding environment provides the patient with the necessary support and safety to do the work of psychotherapy. The patient uses these external objects and interactions with the therapist to experience their relationship. The patient, like the infant, comes to rely on the consistency and predictability of the holding environment to provide protection and a sense of safety.

The concept of containment refers more to internal unconscious processes. Bion developed the notion to describe the unconscious process whereby the projected anxieties of the infant are taken in by the mother, digested and eventually returned in modified and less overwhelming form. The mother becomes the container and the anxieties are the contained. Containment in psychotherapy is the aspect of setting internal to the therapist. It is the process of taking in and metabolizing the patient's inner

world and then giving meaning to unconscious experience.

PSYCHOANALYTIC PERSPECTIVES ON A CHANGE IN THE SETTING

When the setting is altered in any way, even when it is planned and when it would not be considered acting out, the silent background becomes a foreground that requires attention. In other words, when setting is disrupted it becomes process (Etchegoyen 1991; Bleger 1967). The disruption of the frame may bring into focus the more primitive, psychotic aspects of the

personality. It may disrupt the phantasy of narcissistic fusion, and elicit unconscious and conscious feelings in the patient. The patient's sense of safety may be disturbed, not only because of the actual change in the arrangements but also because the change brings about the painful reality of the separateness between the patient and therapist as well as a shift in the therapist's state of mind. A change in the frame may alter the patient's experience and image of the therapist, both externally and internally. The

patient feels he is no longer in the room with the same therapist.

Langs writes about the complexity of feelings that are generated by any change in the frame. The patient might feel that the therapist is intruding into his autonomy, is being controlling, seductive, hostile or disrespectful. Feeling less safe and more mistrustful, the patient might, at one extreme, deny the impact of the change. Conversely, the patient might need to exaggerate the impact of the change (Langs 1979).

Understanding the disruptive effect of a change in the setting becomes the pressing therapeutic task. The therapist must understand communication subsequent to a change in the setting as a reaction to that change. The patient's responses will include both accurate conscious and unconscious perceptions of the meaning of the change as well as distorted phantasies (Langs 1978).

The re-establishment of a safe therapeutic space and a feeling of containment cannot occur until the

conscious meanings and unconscious phantasies of the patient are understood and addressed in language that is geared to the patient's level of psychic functioning at the time of, and in response to, the change. Patients functioning in the Kleinian paranoid/ schizoid position would be impacted differently than those functioning in the depressive position. Those in the paranoid/schizoid position would be more prone to feel that something was being done to them and react with splitting, denial and feelings of persecution. Those in the depressive

position would more likely have a more measured reaction and use introjection and repression and experience feelings of guilt and concern.

Setting changes give the therapist a unique opportunity to access issues unnoticed until then. In addition, the technique of interpretation is essential for reinforcing the frame and for providing safety to patients as they experience shifting levels of reality, including those of both time and space. Interpretation of the experience helps

to reconstitute the patient and to re-secure the frame. The act of interpretation carries the implicit message that the therapist is still functioning and has a mind to think (Modell 1988). By taking in, and working with, the interpretation, the patient uses the space that has been created for thinking.

A CHANGE IN THE SETTING

For me, the move to my own office represented a significant and very positive change. A year earlier, I entered full-time private practice,

leaving a faculty position in the Department of Psychiatry at Georgetown University, a position I had held for ten years. At that time, I decided to sublease space part-time in the city near the University in addition to the part-time space in the suburbs I had been using while at the University.

At the time of the move to my own office, I was consolidating my practice into one location. For the first time I selected, furnished and decorated a space to reflect my personality and my

notion of a therapeutic environment conducive to clinical work.

THE IMPACT ON PATIENTS: THREE CLINICAL VIGNETTES

As I waited for the first patient I was to see in my new office space, I was feeling a great sense of satisfaction and exhilaration. In addition to being pleased with the location of my office, I thought I had created a comfortable and tasteful atmosphere. I was relieved that preparations had gone smoothly before I began seeing my patients. However,

my office was considerably smaller than any of the spaces I had subleased.

George, a man in his early forties, who was being seen in twice-weekly individual therapy, had denied any feelings in anticipation of the move. He could not allow himself to be at all curious and insisted that the space where we met made no difference to him. While one might think that this could mean that only the relationship mattered, for this schizoid man who attacked links, even the relationship mattering was persistently denied.

On entering the office, George's first comments were 'I'm observing the room. It looks, I guess it's more convenient for me so it's nice. It smells freshly painted. It looks like you are sharing the office with other people. I guess I think that makes sense to do. Like before I got married I shared a house with four other guys. That made it affordable to be able to live there.' A moment later he likened my sharing a suite to his father's situation as he neared retirement from his medical practice. 'When he was nearing retirement he could barely pay

the rent and the insurance. So, unless you are seeing ten patients a day, which would be hard, this makes sense.'

I understood this to mean that as a result of the change in space, George had a phantasy that he now had a therapist who could barely get by on limited resources and could only afford to do what people did at either end of their personal and professional development. I experienced George as putting me in a diminished position, making an envious attack on my

capacities, and attempting to spoil the pleasure I could get from this move. His contempt reflected his envy of my growth, his pervasive difficulty experiencing good objects and his pattern of spoiling relationships and experiences. It was not that his reactions were unexpected, as I had many experiences of being devalued by George. This time I was hit in a different way. The difference had to do with my own narcissistic vulnerability. I was aware that his attack shook my own connection with this good experience. This example highlights

the shared vulnerability of patient and therapist in the face of a change in setting. My psychological interior had also changed.

A second patient, Allison, a 40-year-old woman, had been in twice weekly individual treatment for a number of years, and therefore had seen me in my subleased offices as well as in my office at the university. Prior to the move she expressed excitement and anticipation at being able to finally see me in a space of my own which reflected my personality. I

understood this as a reflection of her curiosity, her wish to know me in a more intimate way, and her phantasy of getting into my mind and my personal space.

Since a postcard of Freud's couch had been visible in my university office, Allison had wondered if my office would look like his, full of tapestries and interesting artifacts. She also looked forward to the office being closer to both of our homes, a feeling which reflected her phantasy that there would be less distance between us.

There was some anxiety expressed as she noted that after so many years of stability I was making a second change just a year after the first one. She countered her anxiety that I was becoming unstable with the notion that I was making moves for the better. The therapy had enabled her to resolve her significant depression and to reduce her anxiety enough to add part-time employment to her roles of mother and wife. She hoped that she would feel strong enough to move to full-time employment and spoke of my being a positive role model for growth.

When Allison, who stands just five feet tall, entered the office, she noted with pleasure the return of the Freud postcard which she had not seen during the prior year in the subleased spaces. She was reconnecting with a lost good object. As she sat down on one of the two love-seats she uttered: 'Well. You obviously did not choose this furniture with me in mind,' reflecting her thought that the furniture was meant for taller people. Allison was expressing hurt and the phantasy that she no longer had a therapist who held her in mind. An additional

statement that the desk was not the right proportion for the space reflected the feeling that things did not fit together and also reflected her feelings of hostility toward me.

I was surprised by this hostility and Allison, too, was perplexed by the intensity and aggression in her reactions. I recalled how differently I had experienced her negative comments about the furniture in the subleased office we had most recently been meeting in. I realized that it had been easy for me to not experience

those comments as hostile since I shared her assessment of the office decor and since, after all, I could deny she was talking about me. Now, however, it was a different matter. I was being maligned and my space was being attacked. I experienced countertransference feelings I had not experienced when it was my colleague's office being attacked. I had missed the split.

When I addressed the hostility in her words, I knew and Allison appeared to feel that I was speaking

from a different internal space. Allison then became anxious as she experienced me as a more threatening figure, which was partially a projection of her own anger and aggressiveness. She was able to own her aggressiveness and spoke of her capacity to spoil the accomplishments of others out of her strong envy as well as her feelings of inadequacy. I also understood that the feeling of things not fitting together not only referred to our relationship but also referred to her internal world and the way the more grateful, depressive part and the more

primitive envious part did not fit together.

In discussing her deep hurt that my furniture selection meant she did not hold first place in my mind, she connected to feeling displaced by the birth of her younger siblings. She felt that I, like her mother, had rejected her and her needs in favor of the needs of her larger, that is, more important siblings. Allison elaborated on the feeling that she no longer fit into her mother's lap in the same way as she had before the birth of her siblings.

For this patient, there was an alteration in her basic sense of security which had to do with the loss of closeness to the mother's body. The change in setting disrupted the illusion of being the most important, and brought up old painful memories which left her once again feeling betrayed and displaced.

Allison also expressed disappointment that the office decor was not more like Freud's, specifically that I had only one tapestry rug. Allison denied that there might be longing to lie on a couch and

disappointment that there were two love-seats instead of a couch. I had to wonder silently about my own wishes and my own disappointment at not creating an analytic space with a couch like Freud's.

This patient is an example of the myriad of emotions which the change in setting can evoke: envy, anger, admiration, guilt, and identification with an object capable of growth and change. It shows how the change in location and in my internal ownership

of the space influenced how both of us experienced the change.

I was seeing the third patient, Rebecca, a woman in her late forties, in four-times-a-week analytic psychotherapy. Rebecca, who had a PhD, held a high-level position in organizational development. She was married to a mathematician, many years her senior, and they had an adolescent son. The marriage was characterized by conflict centering on space and time. Regarding time, the patient had the experience of a

husband who couldn't keep time commitments and left her disoriented and unable to operate within a reliable time frame. In terms of space, the patient had the experience of an emotionally controlling, tyrannical husband who took over the physical space with objects that he could neither part with nor put away. It left her uncertain as to how to find an internal space for herself in the midst of the chaotic and unpredictable external space.

Rebecca was a bright, anxious woman, who worked hard in the sessions to try to figure things out. She spoke in a rapid, anxious manner, producing an abundance of rich material. The outpouring conveyed to me the patient's lack of internal space and her experience of being overwhelmed by her internal world. As the therapy progressed, my feeling of being continuously flooded subsided. The shift was related to an increase in the frequency of sessions as well as to my developing a greater capacity to introject the projected

anxiety and, eventually, to interpret the experience to her.

At the time of my move, Rebecca was in the process of trying to extricate herself from her marriage and was in the throes of internal and external struggles to make that happen. She understood that she was terrified to be alone and that leaving the marriage meant facing both her claustrophobic and agoraphobic anxieties. Those anxieties were reflected in the way she navigated the world and the therapy.

Over the course of years of psychotherapy, Rebecca had threatened several times to terminate treatment. The threats occurred when she experienced overwhelming primitive anxiety, was overwhelmed by life circumstances and fearful that she was not up to the challenge of the therapy work. There were times when I was taken over by Rebecca's intense, disorganizing anxieties, experiences which at times were difficult to bear, in part because they threatened my own confidence in being able to do the work.

When I decided on the location of my office, I had some concern since it meant a longer commute for her from both home and work. In the transference, she was more openly acknowledging dependency and vulnerability, as well as her fears of rejection and retaliation. During the period when I knew but had not yet informed Rebecca of the move, she said, 'It's embarrassing to me for you to know I feel that way (dependent). You could use it against me. What if you go away? What if you moved? You're not going to move away, are

you?' Rebecca was speaking to her fear that I would take advantage of her vulnerability and retaliate for her unconscious aggressive phantasies towards me. Rebecca was relieved to hear that the move she feared did not mean literally losing me.

Her intense anxiety and confusion were immediately apparent in the first session in the new space. As she took water from a water-cooler located outside my office, her confusion was reflected in not knowing which color spigot distinguished hot from cold. In

the office Rebecca asked whether it mattered where she sat, reflecting her uncertainty as to the ground rules in the new setting and her searching to feel contained by having an element of the frame re-established.

As Rebecca sat down in the love-seat she said, ‘Well, my first impression is I have to climb up to sit on here as though I’m a little girl. Isn’t that interesting? I’m short but I imagine a little person climbing up on here.’ I thought this was an expression of her experiencing a shift in status

relative to me. That statement as well as concern she had expressed about being late and getting lost in time gave an Alice in Wonderland quality to Rebecca's thinking.

She felt appreciative that we had discussed the move over several months and that she could now acknowledge and express the anxiety, which she could not have done some time ago. Rebecca was speaking to the importance of being prepared for a change in the setting.

The following segments of the session give a flavor of the claustrophobic and agoraphobic aspects of the experience of getting to the new space. They reflect the primitive and disorganizing anxiety of getting lost in external and internal space and of not having any familiar signposts to deal with the disorientation. Rebecca's overwhelming anxiety is reflected in the verbal barrage and in the grammatical breakdown of her speech:

> ‘Anyway, so I came down here to Georgetown Pike. My instinct was

that I don't like this place at all. I really don't like this place at all. I don't like high buildings. I don't really like this city. This is really the city. And there is too many people. There is too many cars. Buildings are very high. I think I could hear myself say, hear you say, but we were in Georgetown. Look at all the people there. And I would say, yeh, but I didn't notice. I'm very aware. I actually think it is busier here, but I am aware of the busyness because I am not coming in on the tube I formed for myself in Georgetown. And I always liked Georgetown. I always disliked Bethesda. Just driving through it. I think that's because of the traffic and the congestion and the sense of it. And when you were in Georgetown you were in a building, although it was big it was all by itself and there was something and I loved the street because there was hardly anyone on it, just a few people. I got

up here. I had to wait to make a right turn where there was all this traffic and all these lights. First thought, I don't really like this place. This is a bad place. Everything I saw made me feel anxious and worse. I saw these houses and I felt bad I didn't have a house like that. I saw the Bethesda Women's Country Club or whatever it was and I thought a women's club. Even a few months ago I would have gone yuck but now I went that is something I would long to be a part of instead of being rejecting of it. I was recognizing that the Women's Club evokes something in me and each thing I saw evokes, it was all very negative but it all made me feel funny. This is a new path. And it forces me to see new things. It forces me to see things I could close my eyes to. Sometimes when I see a Staples I go, oh good, there's a Staples in this neighborhood and it's like an orientation. And, I saw the Staples

> and I didn't even want to see it. I'm seeing too many things ... I can't block enough of it out so I am threatened by it.'

Later in the session, I linked Rebecca's image of being a little girl climbing up on the furniture to her experience of being overwhelmed. I thought she was telling me that, like a little girl, she was being faced with more than she could manage and that I was the one who put her in that position. I spoke to her fear of telling me about her anger as an expression of needing to protect both her and me. Rebecca tentatively acknowledged the

anger which we came to understand as due to her having no choice about the move. She felt that my choice of location simultaneously put more of a distance between us and brought us too close together. On the one hand she had to cover a greater distance to get to me and on the other hand she was in my home territory which put her very close and made her very anxious.

As the impact of the change in setting was explored, Rebecca became less anxious. ‘It’s as though I expected

you to be threatened by what I am saying … my mother wouldn't allow me to be unhappy and deal with the things I was anxious about like where is the bathroom going to be. So maybe when I was little and was going to make any changes, going to school on the first day, going to the doctor's, maybe I could never talk about how anxious that made me. I can just hear her. Don't bother me. Not in so many words but in so many feelings.'

This vignette reflects the importance of helping the patient

understand the impact of the change in setting and demonstrates the containment that putting words to the experience produces.

CONCLUSION

This chapter illustrates the importance of understanding the meaning of setting and the impact of any change to it. The situation of a change in office space was used to illustrate the impact on three different patients. It described a range of responses within the patients, within me and in the transference-

countertransference relationships. It demonstrated the importance of keeping the internal space open for thinking. Setting changes, though disruptive, also provide an exceptional opportunity for new and deeper insight into aspects of the patients' inner worlds. Attention to the impact on both patient and therapist is crucial.

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