Right now I'm sitting in the bookshelf:

patients' use of the physical space in psychotherapy

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Dimensions of Psychotherapy, Dimensions of Experience

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About the Author

Geoffrey Anderson, PhD is a Clinical Psychologist in private practice in Omaha, NE. A fellow of IPI he is also a Lecturer in Psychiatry at Creighton University and Director of the Center for Psychotherapy and Psychoanalysis.

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Considering space from a psychoanalytic perspective, we are called to wonder about the nature of our experience of the physical world. What does the clinical evidence suggest to us about the nature of space

as a human experience? In this chapter I explore how psychoanalysis and particularly object relations theory has viewed this question. I examine the notion of space as a relational construct governed by the earliest object acquisition. Then, clinical material is presented to demonstrate how the internal object world affects the perception and use of space in the transference. Finally, I explore what these uses of space in the transference mean for us as clinicians.

PSYCHOANALYTIC THEORIES REGARDING SPACE

Beginning with Freud, psychoanalysis has taken the approach that space is a developed characteristic of the human mind. Freud postulated that as the mind reached out to grasp the world around it, the mind projected its own sense of self into the unknown, creating the sense of space (Freud 1941). With this notion Freud brought to psychoanalysis the concept of space as the mind's relationship with the unknown. While physical space is not a frequent topic of psychoanalytic writers, there are many works which

explore the phenomena associated with our subjective experience of space.

In an early paper by Schilder, it was postulated that humans perceived space dualistically (Schilder 1935). Specifically he stated that we not only experience an external space but also a space filled by the body. Schilder described the individual's subjective bodily experience as consisting of two types of space as well. The first of these he labeled perceptual space, which he linked to the ego. This is the conscious space of ordinary reality that

we share with others. The second type of space he labeled the id space. Here reality breaks down under the influences of identifications, projections, and primal urges. Schilder's work goes on to explore how this id space was affected by different forms of psychological disturbance. The change within the id space brought on associated distortions of the use of the perceptual space by patients (Schilder 1935). Schilder saw these distortions in the use of space as attempts to control the distance between the ego and the object of

desire. As I will show below, these types of distortions can be useful to the clinician in determining the course of the treatment.

In another paper on space, Berne (1956) looks at the regressive and creative uses of space depending on the psychic structure and development of the individual analysand. Berne described three psychological uses of space. These are: the exploration of space, the measurement of space and the utilization of space. Berne's incorporation of regression in the

service of the ego into his concept of space indicates that internal representations of space are not static. In psychological health internal space has the flexibility to 'come apart' and return to an organized state in a different configuration. When internal space does become static, either through the impact of trauma or as a defense against anxiety, the individual may develop idiosyncratic perceptions of and reactions to both internal and external space.

These papers provide us with the beginnings of understanding space as an internal psychological construct. So far we see two types of internal space. One structured by the ego and the demands of reality and one structured by the id and the demands of internal needs and urges. Schilder in particular locates these needs and urges in relation to desired objects. So we have an internal space that is organized around our relationships to our objects. Space then is not only developed as a projection of the psychical apparatus as Freud suggested but is further

developed by the introjection of objects into an internal relational space. With the development of the relational theories of the object relations theorists, space becomes an explicitly relational construct affected by the processes of projection and introjection.

Melanie Klein's work took psychoanalysis in an entirely new direction when she became one of the first clinicians to analyze children. Her theories led to understanding the earliest forms of psychological

defenses (Klein 1946). One of the most basic of the psychological defenses illuminated by Klein was splitting. When splitting occurs the internal space is divided. The reason to divide the internal space is to protect a loved object from hateful feelings. In this way a good object (the caregiver or part of the caregiver's body) can be maintained even when it performs not-good acts. Once this division takes place, intolerable internal experiences such as rage against a loved caregiver can be projected into the external world. Another form of early defense

is dissociation. In dissociation the intolerable internal state is left in the body and the subject or self leaves the body behind until the internal or external threat is over. While Klein did not specifically address this defense, it has become a much-discussed topic in recent years, especially in instances of trauma (Scharff and Scharff 1994). The difference in dissociation is that there is much less of an ego experience within the internal space than there is with splitting and the space usually held by the ego is also invaded by the bad object experience. The split-off

ego is then experienced as being expelled from the body into a ‘safe’ place until the painful experience ends. These two examples of primitive defenses play an important role in the development of the experience of an internal space. Later object relations writers such as Winnicott and Bion added to our understanding of the relationship between space and object with new theories based in part on Klein’s work.

Winnicott developed the concepts of the holding environment (Winnicott

1960) and the transitional space (Winnicott 1953). The holding environment includes the infant's experience of both the physical and emotional bond with the mother as a space in which the infant exists. In the holding environment, Winnicott has presented a notion of a relational space created by the caregivers that can then be taken in (introjected) by the infant. Transitional space on the other hand is an imaginary zone the infant creates between complete dependence on the mother and the independence of thought and experience of a separate

self. Winnicott was clear in his belief that this was not inner reality, nor was it external life. It was a third space of between, one in which the boundary between subject and object is experienced. We can see here a relational concept that is very similar to Berne's notion of the use of space in which to build or create. If the holding environment is working well enough this space is one in which the child can begin to have its own thoughts and creations.

Bion (1962) added the concept of the container and the contained to the psychoanalytic theory of space. His idea is basically this: the infant will at times have overwhelming physical and emotional experiences. When such an event occurs the infant needs to have a container in the form of another human being who can take in the experience and make it tolerable by soothing the infant and giving back the affect as normal and survivable. We see in this theory a notion of the expelling (projecting) of unwanted affect out into an unknown nothing. The

container (caregiver) who takes in the affect becomes an external object capable of incorporating the unwanted affect. The incorporated affect is then introjected or taken back into the psychic structure of the infant and creates an internal space capable of withstanding the affect from within. This ‘new’ internal space exists within an internal relationship between ego and object. It replaces the feeling of dread that is experienced when space can only be the experience of the unknown. The new experience is one of knowing and security in relationship

with the internalized experience of care.

Expanding on Klein, Winnicott, and Bion, Bick (1968) postulated a theory regarding the formation of the internal psychological space in the developing infant. She concluded that in its most primitive form the personality has no sense of a binding force that holds it together and only a passive sense of a 'skin' boundary. The capacity to feel an active force holding the self together was dependent on taking in (introjection) an external object. The

infant self's incorporation of (identification with) the binding function of the object (most likely the experience of being held together by the mother) gives rise to the experience of internal and external space.

Bick considered this introjection of a containing object to be of great diagnostic importance in terms of the level of functioning in patients and a predictor of their capacity to participate in treatment. Those persons who had not incorporated the

containing object were subject to catastrophic anxieties and experiences of unintegration (no existence of a cohesive whole) of the self. In contrast, those persons who had incorporated the containing object were subject to active defensive operations such as projection and experiences of disintegration (the loss of a previously existing cohesive whole) of the self. Among patients who did not experience the containing object, Bick noticed a frantic search for a sensual object that could hold the attention and stave off the feelings of

nonexistence. These patients often required some sort of tactile self-stimulation in order to soothe the tremendous anxieties associated with nonexistence.

The psychoanalytic theories reviewed above provide a picture of how human beings develop an internal space. It is a complex process of interaction with the external space of the perceived world and the internal space of conscious and unconscious experience. The successful development of a capacity to integrate

and make use of space is dependent upon the negotiation of the early child/caregiver relationship. Disruptions in the early development of this internal/external space lead to impairment of the person's capacity for relationship as an adult. Depending on the timing, nature and severity of these disruptions serious impairment in cognitive and emotional processes may also result. Patients presenting for psychotherapy who display such disruptions are often unable to make direct use of the relationship in the therapy process. As a result they may

shift their reactions to the experience of the physical space of the office of the therapist as the focus of the transference. In the next section I explore clinical material that illustrates these transference phenomena.

THE PATIENT'S USE OF THE PHYSICAL SPACE OF THE OFFICE

Patients who use a part of the office as a projective container often pick a feature or item in the office to represent some internal psychological conflict. They may be afraid to project the conflict into the person of the

therapist, as then they would have to be in too close a relation to the therapist or perhaps feel guilty about the way they are using the therapist. It seems safer to project the conflict into a part of the physical space. The following example illustrates this use of the office space.

Use of the space as projective container

Mr D was a 47-year-old man with a long history of psychological treatment. He had seen a number of therapists prior to beginning treatment

with me. As a child Mr D would come home from school to find his mother depressed and lying on the couch. All the drapes would be drawn and the lights off. He was terrified of the day he might come home and discover her dead body. He had repeated this arrangement in his current marriage where his wife had made numerous suicide attempts and was emotionally unavailable to him. Mr D's father was a silent angry man who would go out to the backyard when he was upset and chop wood for the fireplace. Mr D felt him to be entirely unavailable, 'almost

like he lived on a different planet.' Mr D had recurrent periods of depression and severe anxiety, which at times bordered on agoraphobia. He could vividly describe the physical experience of depression and anxiety. The image of his persistent anxiety was 'There is a table that has a hump in the center. It is covered with marbles and I have to constantly run around the table pushing the marbles back into the center so they won't fall off.'

Mr D hated the process of psychotherapy. He truly felt miserable when relating his past experiences and felt that this was getting him nowhere. He was suspicious and mistrustful of me. He would say, 'Here I am all shitty and messy and there you are all clean and smug.' He would then retreat into silence. He could not make use of any interpretations about him feeling me as being unavailable like his father. The idea of being directly angry with me and seeing if I would survive this and remain available was outside his comprehension. He often complained

about the decor of my office as being so gloomy and depressing.

One day I invited Mr D to tell me what was depressing about the office. Mr D looked around at the pictures in my office. One by one he described the persons depicted in the pictures. ‘That one looks far away and not all there, like he would look right through you and not even see you. That one looks really mean and scary, almost evil. That one looks like my mother. I can’t tell if she is angry or sad but just looking at it makes me feel really

scared.' I suggested to him that his experience of feeling trapped with a depressed mother had been very sad and frightening for him. He started to weep briefly. Following this experience Mr D. began to slowly see more and more connections between his experiences with his depressed mother and how he related to people in his everyday life. He began to slowly understand how he viewed a relationship as being primarily the need to take care of an unavailable other whom he hated for giving him so little. Mr D's use of the paintings as a

container into which he could project his fear and anger allowed him more room in his internal space to explore his feelings about his mother. Prior to this event he had been too afraid to use me in this manner. As a result of the experience of communicating how he used the office space he began to make use of me as a direct projective container. He started to directly express feelings about our relationship that contained the transference elements of his fear of abandonment and his fear that anger was irresolvable in relationships. With this shift in his

use of me, Mr D experienced fewer episodes of disintegration during the therapy hour.

Use of the space as dissociative container

In contrast to the example above, patients who have experienced significant trauma in their early life frequently use dissociation as a defense. As noted previously, this is a defense in which they split off the traumatic experience as the self occupies an external space outside of the body. These patients often get a

look in their eyes like nobody's home and the therapist may experience a boredom or deadening of sensation. When patients can later verbalize what occurred during these experiences they describe placing all or part of themselves into a space or external object in an attempt to escape from the terror and pain of the trauma. These patients frequently lack the ability to discriminate between 'there and then' and 'here and now'. As a result they may react to remembering trauma as if it is occurring in the present. They may quickly lapse into a dissociative state

when trying to express what happened to them (see also Stadter, Chapter 2 in this volume).

Ms C was a 35-year-old woman who was violently abused by her biological father during a single episode as an infant. He threw her across the room because she wouldn't stop crying. He died shortly after that in an accident at work. Several years later her mother remarried and her experiences with her stepfather caused me to think of a concentration camp. He would watch her secretly at all

hours when he was home. She was afraid of insects and rodents and he would torture her with them. Her stepfather would devise extreme punishments such as making her sit in one spot on her folded legs for hours without moving. If she moved or complained he would beat her. She had to sleep naked and he would enter her room at night and look at her body while she feigned sleep. He bathed her and penetrated her anally and vaginally with a soapy finger to 'wash them'. He beat her regularly for real and imagined infractions of his rules.

He further humiliated her by not subjecting her brother to the same rules. She was singled out for punishment and abuse simply because she was a girl.

While describing the incidents of abuse Ms C would trail off and get a dreamy far away look in her eyes. She would take one of the pillows on the couch and crush it to her chest. She would then trace the embroidery on the pillow over and over with her finger. Some of the early sessions were excruciating for both of us, as they

would lapse into long periods of silence filled with feelings of dread and horror. Later as Ms C began to verbalize her experience during these periods she would tell me ‘Right now I am sitting in the bookshelf. Right in that little space down in the bottom shelf where it is dark and no one can see me.’ ‘Maybe if he can’t see me he won’t be able to hurt me anymore.’ ‘Maybe it will all go away and have never happened if I just sit out there long enough.’

As time went on in our work together, Ms C began to speak of her fear of our relationship. She longed for a connection with me but she was filled with dread that she would damage me if she became close to me. She had perverse fantasies of our being taken hostage by terrorists and her being forced to perform sexual acts on me at gunpoint. She was caught between her fears that I would hurt her and her fears that she would hurt me. Equally powerful were her fears of stimulating me or being stimulated by me. Her belief was that all human

contact was an exchange of pain. Unfortunately she was also stimulated by pain and felt horror and shame about this. Her use of the physical space of the office as a container allowed her to keep coming back three times a week. Without the space in the bookshelf where she could keep her most vulnerable aspects of herself, she didn't feel safe with me. She could not have progressed in her work without having that spot in the bookshelf.

THE CLINICAL IMPORTANCE OF THE USE OF SPACE

These examples of the patient's use of the physical space provide a look at two different ways of organizing transference reactions. The example of Mr D illustrates the use of splitting and projection in an attempt to manage feelings of disintegration under stress. Objects in the physical space were used to contain the internal experiences of fear and rage that might either damage the needed object of the therapist or trigger a retaliatory attack. Mr D was able to experience an internal space that was threatened by his negative feelings. His desire to

protect the good object (his hope that I might be able to help him) from the bad object (his own hatred and envy of me being able to help him) necessitated the split inside his internal space. He was able to hold himself together outside of therapy and did quite well at work and in caretaking for his depressed wife. Ms C, in contrast, seemed unable to hold herself together inside or outside of the therapy. Her experience under stress was one of unintegration (see also Hopper, Chapter 7 in this volume). She was unable to work or function in her

marriage. She could not separate good and bad experiences as all stimuli and reactions seemed to flood together into a terrifying ‘soup’ inside of her. Her use of the pillow is clearly in the manner of the need for a sensual object to hold the attention as described by Bick above. In addition her use of the space in the bookshelf was in the manner of finding an external skin space, which would provide a safe haven for her disembodied self. Here, the function of the projection is the protection of good objects from bad feelings inside the internal space. The

function of the dissociation is to frantically search for containment for an overwhelmed self with no internal space.

How do these findings affect the manner in which we work with such patients? With patients like Ms C who present an unintegrated self the psychotherapy must progress slowly and often entails long hours of sitting with the patient's massed confusion of affective experience (see also Setton and Scharff, Chapter 4 in this volume). Two primary tasks emerge in such

cases. The first is to provide a safe space for the self by sitting without judgment and providing some measure of reality testing when asked. It is often my experience that such patients will present distorted notions of how life works and how other people think and then seek reassurance that everyone thinks this way. In those moments it is often possible to gently say: no, many people do not have the same thoughts or experiences as the patient does in that situation. Depending on the patient's response this may be the end of the exchange.

Sometimes they will ask how others may respond in such situations and a normalizing response could be given. An example of this from Ms C's case was when she described how a 'friend' would come to her house and verbally attack her for behaving in a manner different from how the 'friend' would behave. In this case the friend attacked Ms C for not feeding her dog correctly (when she actually was). Ms C then made a statement that the friend must be correct in her criticism and that Ms C should not feel angry because 'everyone would act this way, right?' I

responded, ‘No, not everyone would treat others like this.’ I also said that sometimes it is appropriate to feel anger at others when they treat us badly. Ms C seemed genuinely surprised by this.

The second primary task with unintegrated patients is to help them sort out their confused affective responses. These patients have little developed internal space which they often experience as filled with chaos. They may feel angry and sad at the same time. Or they may feel happy and

unhappy about the same event. They are usually quite confused about having multiple or conflicting feelings. Having the feelings named and set next to each other by the therapist slowly helps them define their emotional reactions. At other times, patients may have a clearly defined emotional reaction that seems appropriate to the situation but they say they feel nothing. Sometimes just describing for them the behavioral antecedents of the emotion helps them to recognize that they are experiencing a feeling. The role of treatment here is

to help the patient slowly incorporate an internal experience of cohesion and containment. Until this occurs, interpreting actions in light of resistance or defenses is often useless, or worse, and provokes a withdrawal, dissociation, or burst of unintegrated rage.

Mr D presents a different clinical picture and different needs in the psychotherapy. Mr D's anxiety provoked strong defensive reactions to the therapy and to his own aggressive and depressed feelings. By his own

admission he was struggling to hold everything together and not disintegrate. His internal space was threatened by dangers from without. Mr D, however, could tolerate interpretations which highlighted internal conflicts. When the timing was right Mr D could be invited to move into his projections and verbalize them using the objects in the office. This in turn could be interpreted regarding his disavowed feelings of depression and pain. Mr D could cry and feel contained by the revelation of his pain rather than feeling

overwhelmed by it. By building on such experiences, Mr D expanded his internal space in a way that allowed him to begin to see his projective process and the way it was affecting his current interpersonal relationships. A dialogue between the therapist and the patient about their interactions could begin at that point. As this occurred, the focus of the transference was moved from the physical space of the office to the relational focus of the interaction between the therapist and the patient.

By discriminating between those patients who have integrated a containing experience and those who have not, the therapist can make important decisions regarding the approach to treatment. With the examples given above, a picture of the ways in which patients make use of the office space has emerged. The manner in which patients with disturbed relational abilities do so can inform the therapist about the basic underlying structure of their inner world. Mr D and Ms C also demonstrate how seemingly nonrelational behaviors

often carry relational meaning. By accurately assessing such behaviors the therapist can choose whether or not it is appropriate to make an interpretation versus making an intervention designed to support and contain. Such distinctions in intervention are often subtle but are important to the patient who is struggling just to remain in the room with us.

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