Time and Endurance in Psychotherapy

Lea Setton
Jill Savege Scharff

Dimensions of Psychotherapy, Dimensions of Experience

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About the Author

Jill Savege Scharff, MD is Co-Director of IPI, Clinical Professor of Psychiatry, Georgetown University, Teaching Analyst at the Washington Psychoanalytic Institute, and Series Co-editor of the Library of Object Relations at Jason Aronson. Her latest book co-edited with S. Tsigounis is *Self Hatred in Psychoanalysis: Detoxifying the Persecutory Object* (2003).

Lea Setton, PhD is a faculty member of IPI, professor at the University Santa Maria La Antigua and at the State University of Panama. She practices individual, couple, and family therapy in Panama City.

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INTRODUCTION

In this chapter, we explore the therapeutic effect of the passage of time and the therapist's relationship to time. We review the literature on the role of time in the development of psychic structure in childhood and in psychotherapy, and then present the case history of Gertrude, a woman

patient in psychodynamic once weekly psychotherapy with one of us (LS). Holding and containment over time, the main ingredients of Gertrude's treatment in the first two years, fostered a remarkable, unlikely degree of improvement in Gertrude. We will conclude with a vignette of a session from the second year of treatment to show how Gertrude's play with time delivered the problem directly into the transference and so provided material that will be the basis for interpretation to come—when the time is right.

THE ROLE OF TIME IN THE DEVELOPMENT OF THE PSYCHIC STRUCTURE

From the beginning of life, the passage of time provides a context and a marker for the development of the psyche. In the neonatal period, the experience of time is marked by physiological processes, which occur over time according to an innate rhythm of their own (Gifford 1960), from experiencing the time between hunger and feeding (Sachs 1925) and the length of separation from the mother (Spitz 1965). As the infant

grows, feeling now this way and now that way, being held and lying alone, the passage of time marks the periods of hunger and satiation, separation and reunion in relation to the mothering person. Enduring delays imposed by the mother or enjoying gratification of needs, the infant participates in cycles of frustration and satisfaction in arriving at unity with the good object (Erikson 1956). When infants' active protests bring relief, they learn that the good object will come soon. This gradually establishes the sense of time (Hartocollis 1974) through waiting,

anticipating pain and separation, and expecting satisfaction and connection. Primitive affective states connected to bad object experience differentiate over time into specific affects such as anxiety, depression, and boredom, in extreme cases leading to borderline personality disorder (Hartocollis 1972, 1975).

A sense of reality and a sense of time appear simultaneously in the system of perceptual consciousness once the infant is capable of conscious perceptions (Bonaparte 1940). In the

unconscious, Freud thought, there is no awareness of time: mental processes revealed in dreams are not organized along timelines, and they are not altered by the passage of time (Freud 1915). Perhaps it is more accurate to say that the sense of time in unconscious processes is governed by primary process and so follows different rules than chronological time. An unconscious fantasy of timelessness is based in a wish that mother and child remain united (Bergler and Roheim 1946). When mother and child are not endlessly

united, the infant's need is frustrated, and the ego is filled with its energy. The self may then feel threatened and helpless, as if flooded rather than filled with experience to process.

As time passes, the infant learns that distress leads to various outcomes. The infant self connected to a bad object by feelings of frustration which flood the self and lead to feelings of helplessness may disintegrate into a bad self. To maintain a good feeling inside the self, infants learn to hold on for future gratification by hallucinating

a good object based on a memory of satisfaction. Then they learn that the same object can be experienced as good and bad at different moments. This attainment of object constancy is correlated with the achievement of a sense of time (Colarusso 1979). At the age of 15-18 months infants develop capacities for being aware of time and understanding concepts of object, space, and causality, which together enable them to understand objective time (Piaget 1937).

In Freudian theory, the sense of time is described as an autonomous ego function, deriving from repeated experience over the course of the psycho-sexual stages of development. During the anal phase, exploratory toddlers become increasingly aware of their mothers' 'No!' and 'Now!' The innate rhythm of physiological processes is shaped by the psychological task of producing on time to please the parent. Mastery over the body and the demands of time brings autonomy and self-esteem and has an organizing effect on the

formation of the self. During the oedipal phase of psycho-sexual development, as the child identifies with the parental preferences, the superego develops and emphasizes the awareness of time and the need to follow its dictates (Hartocollis 1974). The internal representation of parental authority governs the realistic sense of time in the healthy person (Loewald 1962). The superego influences the ability to endure stressful experiences and think through decisions, and helps the organism adapt to and conceptualize time (Hartocollis 1974).

In adolescence, there must be adequate resolution of superego guilt and ego problems of autonomy if there is to be a well-established sense of time; otherwise the teenager will be unconsciously late to court parental involvement and possibly punishment (Seton 1974). If time remains a diffuse concept, the young person's ego will not be able to maintain perspective on the functioning of self and other (Erikson 1956). Distortions in the sense of time and concomitant variables in affect, caused by unconscious fantasies and defenses,

reflect the integrity of the person's object relations and ego organization (Hartocollis 1975).

THE IMPORTANCE OF TIME IN THE PSYCHOANALYTIC SESSION

The psychoanalytic therapeutic framework is closely involved with time (Abraham 1976). Attention to time sets the frame within which analysis or therapy can reliably occur. The time interval between sessions calls forth the psychic structure required for imposing delay between impulse and action (Freud 1933). The

beginning and end of the session (and of the treatment as a whole) form a boundary that provides a hard edge against which to measure the patient's reactions to the requirements of the other. For instance, some patients come early; some are late; others do not accept the end of the session. Their attitudes toward the time boundary are products of their object relationships and conflicts. Time represents reality and otherness.

The therapeutic alliance assures the patient of continuity. For some

patients, continuity gives the illusion of immortality and a timeless state of fusion, a fantasy that is interrupted by termination of treatment, or indeed by the end of each session. Acceptance of the reality of time undoes this illusion and leads to development and maturity. For other patients, commitment to continuity of care has to be proved over time before trust develops. For instance, a patient with insecure attachment requires a therapist who provides long-term availability, flexibility, and tolerance of chaos and fragmentation (Slade 1999). Feeling

accepted and understood by the therapist as the years go by, the patient symbolically recovers the lost object (Anzieu 1970). The patient's resistance to the emergence of repressed issues slowly decreases in response to trust building over time as well as resulting from accurate interpretation.

THE TIMELINE OF INTERPRETATION

Interpretation occurs along a continuum from clarification, elaboration, and reconstruction, facilitating the patient's

expressiveness, communication, and further associations. Exact interpretation of conflict in the transference makes conscious the patient's behavior and feelings and helps the patient gain insight into the origins of their difficulties (Gabbard 1994). But the therapist has to take time to get to know the patient before being in a position to make an interpretation. The therapist listens continuously for multiple levels of significance stemming from various stages in the patient's development, and then facilitates the working

through of the effects of the interpretation (Schlesinger 1996).

TIME TO GATHER THE TRANSFERENCE

It takes time for the patient to focus the conflict on the person of the therapist, and for the therapist to take hold of the projective identifications in the here-and-now of the transference so that experiences from an earlier time can be reworked in the present. Some patients, like the one to be presented, fend off interpretations until they are ready, and need to hear them

approached from different vertices, many different times, phrased in many different ways, before they can accept them and integrate them as insights that reorganize the mind.

TIMING OF INTERPRETATIONS

Becoming aware of the passage of time and of differences in the experience with the therapist and with the interpretive process from one time to another, the patient confronts a new reality within which to rebuild the self. Interpretation at the right moment provides the patient with a model of

operating with awareness of the significance of time, understanding of the links between past and present experience and their influence on future hopes and fears, and sensitivity to the other's needs over time. The patient's internalization of the therapeutic attitude to time and timing moves the self toward reorganization in recognition of the self's relationship to others and to the demands of reality. The right moment for therapists to interpret is the moment at which they know what they think and can articulate it and the patient is at the

point of comprehending the interpretation: the material has to be almost conscious and relatively accessible to patient awareness—and that takes time.

CLINICAL EXAMPLE OF GERTRUDE IN WEEKLY PSYCHOTHERAPY WITH LEA SETTON

Over the course of two years of weekly treatment with Gertrude, pathological organizations and psychic retreats were evident, but Gertrude would not engage in interpretive work on them. The main component of

therapeutic action was the passage of time during which she experienced my (LS) consistent presence and containment of her stormy transference.

Gertrude is a 35-year-old lesbian with borderline functioning and frequent suicidal thoughts. She is obese and walks in a lumbering way. She came into treatment because of suicidal feelings connected to a repetitive post-traumatic memory, following a car accident in which her car was hit by a driver who then

ploughed his car into her mother's beach house. This memory reappeared in Gertrude's recurring dream of a car accident in which she saw blood everywhere, which left her feeling suicidal. Gertrude said that she hadn't killed herself, only because she didn't want to make her father suffer. She said, 'It isn't the right time, my father would be left alone. I am waiting for the right time and the right place.' She was paradoxically timing her suicide to protect her from her self-destructiveness.

This dream is a replay of aggressive feelings toward her mother, and a longing to protect her father. She is pulled to suicide to kill off the angry internal mother. Her feeling that it was not the right time protected the internal father, and preserved the hope of a loving internal couple, and so there would never be a right time to kill herself. But it was not possible to say such things to Gertrude. I simply had to accept her desire to die, and the lack of a right time.

Gertrude comes from a highly dysfunctional family with a mother who criticizes her looks and her performance. Her mother is always angry and her father is bitter, silent, and preoccupied with work problems. Gertrude feels unloved. For instance, when I recommended a psychiatric consultation, her mother and her brother both refused to take Gertrude to the appointment even though they knew she was suicidal. They did not offer to pay for the therapy, they did not ask how it was going, and they did not ask her how she felt. This made

her feel that they did not care about her. She had been in a relationship with a woman who has two children, and this was her only sexual relationship with a woman. It made her feel guilty to be replacing her mother's love with this woman's love. She said that she couldn't talk about it because she didn't understand how it happened. Gertrude did not accept that it was a homosexual relationship, and she pretended that the sexual aspect of their friendship was not continuing. On the other hand she drew attention to her genital experience by

complaining how much she hurt after she awoke to find that she had scratched the top of her thigh so hard that she broke the skin. Because her self-inflicted wound was so close to the genital area, I had the impression that she wanted to remove her genitals from her body to get rid of what she was feeling there.

Process of the first year of therapy

Gertrude usually conversed about the happenings of the week in terms of her life at home with her mother,

father, and brother, visits to her aunt, and occasionally her schoolwork, her lesbian friend/former partner, and any heterosexual dates she had. She worked on her difficulty becoming independent and succeeding at school, but she did open up on the issue of her homosexuality and its meaning for her.

Gertrude complained about her family being like a madhouse, always in chaos, with a mother who shouts, a father who stays silent, and a brother who stays out until midnight and returns like a ghost. She complained of

the house not being clean, there being no food in the refrigerator, not even cold water. On the other hand she liked her room and felt comfortable there, but she did not sleep well, and she always felt hungry. The lack of provisions in the home reflected Gertrude's feeling rejected by her mother. Gertrude felt that her mother attacked her looks, devalued her work, and thought that everything she did was wrong. Gertrude felt sad, and yet she could not cry. She talked about being close to a supportive, motherly aunt on her father's side. She wished

that her aunt could have been her mother, but she often refused invitations to her house or went there reluctantly, I think, because she was afraid of loving her, and then being rejected as happens with her mother. She used to hate her mother, but after a year of therapy she felt more separate from her and more able to love her.

Gertrude was generally rude and aggressive toward me, as her mother was to her. She was suicidal but she refused medication. She brought all her miserable behavior to me. I felt so

put off by her that it was difficult to stay in touch with her suffering. She complained that she didn't feel well, that I didn't care, and that I didn't understand anything. In every session, she wanted to leave. She used to say, 'Can I go now?' and I would say, 'It's your decision, but if you want to stay, we have another 15 minutes to work.' And she always stayed. She was always fed up with treatment and sick of me. She tried to get rid of me by leaving the session, and yet so as not to miss me she sent me hundreds of e-mails. I did not want to encourage the

e-mails, but I did read them. The only way I could tolerate her was to connect with her suffering as expressed in the e-mails because my countertransference to her in person was so burdensome. It was not that she said anything different in the e-mails; it was just easier because I could skim the electronic format and I did not have to be with her and look at her.

Like her mother, Gertrude gets angry easily and attacks herself as her mother did her. When Gertrude lost many documents and missed many

classes in her first semester, I pointed out that this was an attack on herself and a way of undermining her ability to succeed. She dismissed my comments angrily, but in the second semester, she improved her attendance to meet the minimum so that she could receive her grades, and by the end of the first year she graduated with a Master's degree.

Process of the second year of therapy

Gertrude got a good job, but she continued to think of dying in a car

accident and could not enjoy her accomplishment. I felt anxious, because her need to die so as to escape her desperate feelings seemed highly possible. Conversing and eating in company were difficult for her, because she ate slowly and got angry about the food. Gertrude was angry for months when one of her bosses kept teasing her about her weight, and she was tempted to quit the job. I addressed her dislike of herself, her inability to tolerate frustration, her embarrassment being with other people, and her fear of being out of

control in public. Gertrude was still at risk for destroying the excellent opportunities at this company instead of learning to deal with the conflicts of the workplace. Nevertheless, she was doing well at work and getting lots of good feedback.

Gertrude cancelled her sessions if she did not like my comments about her self-destructive behaviors such as obesity, smoking, and missing staff meetings after she had been successful at work. She would not take the recommended medication, she would

not move out to live independently, and she hid information from me. When I asked about her intimate life, she told me nothing, and said angrily, 'Why does the cat have to have a fifth leg?' This common Spanish idiom suggested a phallic intrusiveness that she experienced if I attempted to penetrate her defenses. She blocked my transference interpretations, sabotaged the therapy, and then complained that she did not feel any better. Her anger with her boss and her hatred of her mother were transferred to me in sessions where she

continuously attacked our work. It wasn't easy to tolerate this, but I hung on believing that she needed continuing proof of my commitment to her, however awful she was to me, for however long it took, before this would yield to interpretation.

In the last four months of the second year, without apparent benefit of interpretive work, Gertrude became less aggressive and her positive qualities came forth. I took these improvements as a response to the benign quality of the time we spent

together. Within the space of our time together, I had made a few interpretations, like the one about losing things as a way of undermining her success, but they were never well received and she did not work with them directly. I think it was my non-toxic presence, my relational stance, operating as an 'interpretation-in-action' that made the difference in her sense of self and in her behavior (Ogden 1994: 108). She became able to care for the welfare of the workers under her authority and considered living independently. Only now are we

in a position to begin dealing with Gertrude's direct object transference to me. In the vignette that follows, we can see Gertrude's behavior within the constraints of time imposed by the session.

Vignette from the end of the second year: emergence of the focused transference

Before the session began, Gertrude, as usual, was hiding by the elevator rather than coming in to the waiting area, which she does ostensibly to avoid seeing someone she might know.

This means that I always have to go out there to invite her into my office. She wants to know that I want her there, because of her fear of rejection. I noticed, as I often did, how obese she is, and it crossed my mind that she walks like a gorilla. I thought of how voracious and bullying she is. She wants to think that she is my only patient. I sensed her feelings of sexual attraction to me, but I didn't comment on them because she has found such comments ridiculous. She does not open up on her homosexual feelings in general, much less about me.

Once in the office, she dove into the cushions of the couch as if she wanted to be inside my womb, and at the same time not let me see her, as if to avoid any recognition of attraction. I felt that she wanted a lot from me. Continuing to look down into the couch, she began to complain about an employee whose exploitative need for too many hours of overtime cost him his job and her friendship. She associated to her parents excluding her from their bedroom. She then described with disgust their dirty house and meager provisions and she complained about

their wishing she would leave. She didn't know what else to say. I said that she might be worried that if she told me what was on her mind, I, like her parents, would ask her to leave. The time was up. I didn't add that she might fear that I would want her to leave because I, like her mother, might not accept her homosexual feelings.

I ended the session on time. Gertrude got up slowly, looked at the disarray on the couch, and said provocatively, 'You will have to put this in order!' I asked her to help.

Smiling, she walked past me to the door, the pillows still awry. She turned around and told me that she had seen her friend and that their homosexual relationship was still going on. The session being over, there was no possibility of working on this. I thought that Gertrude was telling me of her intimate involvement with her friend between sessions as a substitute for working intimately with me in the session. As she told me this and I bent over the couch to straighten the pillows, I felt as if we were together on the couch.

Gertrude played with the time boundary of the session. She brought her transference into therapy before the session began, during it, and at the end of it. She experienced reality as an intrusion (see also Chapter 2 by Stadter and Chapter 3 by Johnson in this volume). She did not want to recognize the need to separate and differentiate. She had trouble admitting her desire for engagement within the time boundary because of the intensity of her hunger and its sexualization and the accompanying fear of its rejection. Her manipulation

of time reflects both a major resistance to the realities of the treatment process and an enactment that delivers her problems into the therapeutic relationship. In my countertransference image of us together on the couch, I respond to her longings to have all my time and to possess me sexually. This is the transference/countertransference dimension to which the passage of time has now brought Gertrude.

In the first two years of therapy, Gertrude, responding to the therapist's sense of time, became aware of the

need to complete her studies in a timely way. She learned to accept the rhythm of the weekly sessions, no longer filling the interval with e-mails. She had learned to anticipate that her need for connection with the good object would be met in her next session. The therapist's concern was reflected in Gertrude's new-found concern for her employees. Gertrude got her life back on track, moved into a position of readiness to live independently, and made considerable gains at work, but she still needed more time to internalize a new way of

being and of relating intimately. The therapist's provision of a steady presence and an extended opening phase set the context for further work on the intrapsychic dimension, and was helpful in effecting external change. Only then could she begin to open her focused transference issues to sustained interpretation.

Patient and therapist are now ready for the 'fifth leg' of the therapeutic journey as the patient begins to demonstrate her sexuality and claim her right to the relationship she wants.

It would not have been possible to get to this point without the preceding time of continuity and containment. Analytic therapy simply takes a long time, and there is no shortcut. The combination of the quality of the time spent and the extended quantity of time produced a unique quality of relationship. Holding, continuity and containment in the treatment over time allowed the patient to create balance between the irreversible, indestructible past and the problems of the present, and gave her mental space to invest in

the therapeutic process and think about a new facet of time: the future.

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