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Making Interpretations and Securing the Frame: Sources of Danger for Psychotherapists

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The basic sources of anxiety and danger experienced by psychotherapists and psychoanalysts in their work with patients are examined. Psychotherapy and psychoanalysis, since they are on a continuum, will be used interchangeably in this paper. Among the sources of such danger are the therapist's use of the two most basic interventions as required by the therapeutic needs of the patient: interpretations and securing the ground rules or framework of the ideal treatment situation and relationship. It is proposed that the present standards of interpretation and ground rules, as they characterize current psychotherapeutic practice, have been fashioned in significant measure by needs within psychotherapists to defend against their own anxieties related to the emergence and realization of their own madness within the course of a therapeutic interaction with a patient.

Freud's (1926) basic model of the role of anxiety in symptom formation, while considerably elaborated upon by subsequent writers, still serves as a basic model for conceptualizing issues of intrapsychic and interpersonal conflict, self-danger, and anxiety. In essence, Freud proposed that an individual reacts to potential or actual danger situations (traumatic experiences) with a signal of anxiety that mobilizes defensive responses. If these activated functions lead to successful adaptation, no symptoms emerge. If, on the other hand, the defensive responses are insufficient to resolve the conflict, symptoms appear as reflections of compromise formations that portray the nature of the danger situation itself, the mobilized instinctual drive and superego reactions, as well as the activated defenses and other responses of the ego. In its simplest form, then, the basic model is that individuals respond to danger situa-

tions with anxiety that mobilizes defenses that may be expressed either intrapsychically and/or interpersonally.

A clarification of the nature of the therapeutic interaction through studies developed from the communicative approach of classical psychoanalysis has led to a clearer understanding of actual and potential danger situations for psychoanalysts and psychotherapists in their work with their patients. The basic communicative model postulates that the madness (a term that will be used for all forms of psychopathology, intrapsychic and interpersonal, somatic, psychological, and otherwise) in the patient (as well as his sanity and cure) is most significantly stimulated by the interventions of the therapist—the adaptation-evoking intervention contexts to which patients respond through both symptoms and communicative material. Once a patient enters psychotherapy, the interventions of the therapist are the most powerful stimuli for both the emergence of symptomatic responses in the patient and the conscious and unconscious communications that illuminate the meanings and functions of these symptoms (expressions of madness). On this basis, it is possible clinically to sort out a basic listening-formulating process that leads to the development of valid interventions—efforts by the therapist that are confirmed indirectly and unconsciously by the patient.

The patient-therapist interaction is a spiralling, conscious and especially unconscious, communicative interplay. The therapist's interventions (adaptive contexts, adaptation-evoking contexts, intervention contents—all synonyms) contain a variety of conscious and unconscious implications. The patient responds to these interventions in communicative fashion. For practical clinical purposes, we may separate out two interrelated forms of communication: (1) symptoms and gross behavioral resistances (indicators or therapeutic contexts—expressions of patient madness that call for intervention) and (2) other associations and behaviors that carry latent or encoded messages within their manifest contents. These latter expressions were termed *derivatives* by Freud (1900, 1908) in that they are manifest elements that are derived from unconscious contents. In illuminating the madness of a patient, a therapist hopes to identify the adaptation-evoking context that has stimulated the patient's reactions and to explain the unconscious basis of an indicator in light of a decoding of the patients derivative material—a process that uses the implications of the therapist's intervention as the decoding key.

By utilizing this means of organizing and conceptualizing the implications of the patient's symptoms and material, the therapist develops

formulations that pertain to active issues within the therapeutic interactions from moment to moment. Among the most important discoveries to emerge from this type of interactional or communicative listening is the finding that the most critical responses of the patient to the interventions of the therapist involve *unconscious perceptions*—symptomatic and associational reactions that contain valid readings of the actual implications of the therapist's interventional efforts in derivative form.

Unconscious perceptions are consistently the patient's initial response to all therapeutic efforts. They are determined first, by the implications (the universal meanings) of a particular intervention and secondly, by the nature of the patient's own inner madness—unconscious fantasies, memories, self-state, and other propensities. This latter factor determines which of the universal meanings of an intervention context the patient selectively perceives and then represents in his or her associations in derivative fashion.

In substance, then, the basic model of patient adaptation involves an initial reaction of selected unconscious perceptions of the implications of an intervention by a therapist, chosen entirely unconsciously but primarily in terms of the patient's own inner disturbance. Such responses are consistently disguised or encoded, and are contained in narratives and images from the patient. Once an unconscious perception has registered outside of awareness and has been communicated through words, feelings, and behaviors, the patient may react further in several different ways. Among these, most important are behavioral responses, the influence of conscious and unconscious fantasies and memories, efforts to harm or help the therapist (especially the latter, carried out through models of rectification and the offer of derivatively conveyed correctives), and the emergence of distortions and misperceptions.

The use of this model may well render obsolete the term transference and its companion and less often used term, nontransference. The communicative approach claims to have validated the thesis that patients initially react to the conscious and especially unconscious implications of the therapist's interventions with sound, valid, and telling unconscious perceptions that are selected from the universal implications of a particular intervention in terms of the patient's own madness. Using earlier language, this would imply that the initial response to all therapeutic interventions falls into the realm of nontransference. Further, many of the reactions to these encoded perceptions are quite valid and adaptive, and do not contain a measure of madness or distortion

except for the selective factor already noted. It would therefore follow that many responses to encoded perceptions similarly fall into the realm of nontransference as well.

As noted, however, some responses of patients to valid but encoded perceptions are exaggerated and distorted, and are significantly influenced by the patient's pathological unconscious fantasies and memories. These responses would fall into the realm of transference. However, the same studies have shown that a patient's reading of the unconscious implications of interventions by the therapist can reach into many dimensions of human interaction, and that furthermore, it is often difficult to be certain where an exaggeration of these unconscious meanings has actually taken place.

Setting this particular debate aside, the key finding is that an interpretation by a therapist that takes into account the patient's encoded responses to the therapist's interventions will help a patient to understand both the unconscious implications of the stimulus (the adaptive context) as well as the patient's own unconscious response or contribution. In this way, both the projective and introjective sides of madness are taken into account, and all interpretations offered by the therapist embody what has previously been considered elements of transference and nontransference, countertransference and noncountertransference. This understanding is applied to the discussion of anxieties in therapists regarding the proper and accurate formulation of the material from the patient and the use of interpretations.

A second major area of contribution from the communicative approach has unfolded through an analysis of the patient's direct and especially derivative (unconscious) reactions to all vicissitudes involving the ground rules of psychotherapy. The therapist's management of these basic tenets are core communications that have a significant influence on every dimension of the therapeutic relationship and experience. It is in this area that the therapist establishes the basic rules of relatedness, the nature of the therapeutic interpersonal boundaries, the nature of the curative work, the roles and functions of both participants to treatment, the self-enhancing hold of the patient, and the unconscious implications of the therapist's active efforts. Management of the frame is at the heart of the mode of relatedness in psychotherapy and psychoanalysis. It is also the means by which a therapist expresses the most significant inputs regarding the nature of the adaptive capacities within himself as they pertain to his own self-state and madness or sanity.

The secure frame is constituted by the firm application of the ideal ground rules of psychotherapy. It entails a fixed fee, setting, length of

sessions, and frequency of hours. The patient is placed on the couch with the therapist out of sight behind him. The patient makes use of the fundamental rule of free association, and the therapist utilizes evenly hovering, free-floating attention and empathy. There is also the absence of physical contact, the therapist's neutrality (the use of appropriate silences, interpretation-reconstructions, and positive managements of the ground rules) and relative anonymity, total privacy, a one-to-one relationship, and total confidentiality. The patient is responsible for all sessions for which the therapist is available. A therapeutic situation in which each of these ground rules have been clearly established may be termed a *secure-frame treatment situation*. A treatment situation in which one or more of these basic ground rules is fundamentally violated may be termed a *deviant-frame psychotherapeutic situation*. Each of these basic treatment modalities create anxiety and danger for both patient and therapist, while affording both a measure of safety and defense.

In brief, the secure-frame situation creates a dangerous *claustrum* that mobilizes the patient's basic phobic-paranoid-schizoid anxieties. The patient unconsciously feels entrapped by the conditions of the treatment, and develops morbid fears of the *claustrum* either in terms of abandonment and annihilation through deprivation and starvation, and/or annihilation through violence on the part of the therapist. Also dreaded is the emergence of terrifying and primitive instinctual drive derivatives and impulses—both sexual and aggressive. It is, however, these very anxieties that mobilize the patient's madness and his related unconscious communications, thereby rendering such issues available for interpretive and holding responses by the therapist. (While this discussion is focused on the patient, it is to be remembered that comparable dangers face the therapist as well.)

In terms of positive holding and containing, the secure frame offers the patient a sense of basic trust of the therapist, who is able to establish clear boundaries, a cohesive sense of self, and a strong hold for the patient. The secure frame also provides an image of the therapist as capable of managing his madness and self-state. It enables the patient to see the therapist as reliable and, in related fashion, provides the patient with a strong and clear sense of reality, clear and precise interpersonal (and self-object) boundaries, and otherwise offers an ego- and self-enhancing experience and image of the therapist. It is these positive components that enable the patient to continue in treatment and to deal with the simultaneous anxieties and dangers created by the conditions of treatment.

The deviant-frame therapist is viewed as untrustworthy, confused

as to interpersonal boundaries, ambiguous in regard to reality, in a state of self-confusion, and relatively unable to offer the patient a secure hold or a sense of containment—and also in difficulty regarding the management of his own madness. There is a basic background of mistrust and a fundamental sense of a lack of safety. In addition, each deviation from the ideal frame carried out by a therapist produces an unconscious image within the patient of the therapist as someone engaged in perverse forms of gratification at the expense of the patient. The therapist is viewed often as pathologically misusing the patient as his self-object for the satisfaction of his own narcissistic needs.

On the other hand, the deviant frame offers the patient several pathological forms of defense. First and foremost, each deviation by a therapist provides the patient with counterphobic (antiphobic) and manic defenses that relieve the patient's claustrophobic anxieties. Many deviations also provide the patient with a sense of fusion and merger that undoes basic separation anxieties as well. Such deviations also provide the patient with a variety of pathological gratifications and specific pathological defenses, corrupt superego sanctions, mad forms of narcissistic gratification, and with a reassuringly mad conscious and unconscious image of the therapist. As a result, deviant frame therapy may provide a measure of relief from symptoms to patients, though it will do so in general without basic insight or self and ego integration (Langs 1984).

FEAR OF THE VALID INTERPRETATION

Strachey (1934), in a citation alluding to a comment by Melanie Klein, provided the fundamental insight, virtually ignored to this day, that psychoanalysts and psychotherapists are fearful of making valid interpretations. Strachey was alluding in particular to mutative interpretations, those that involve activated id wishes directed toward the analyst within the therapeutic interaction. It was his contention that analysts prefer to do most anything else—comment on outside relationships, manipulate the patient, offer support, or whatever—rather than intervene in this sphere. Strachey noted that a mutative interpretation is actually a test of the analyst's own internal balances and capacities.

A mutative interpretation bears a notable resemblance to a communicative interpretation. Both involve activated wishes and expressions in the patient as directed toward the therapist, though the mutative interpretation was understood at the time mainly in terms of the patient's unconscious fantasies and needs. The adaptive context interpretation considers this component, but stresses the patient's valid encoded perceptions of the therapist in more cogent form. Thus, an adaptive context interpretation takes into account, and leads the therapist to experience, both the patient's often telling and disturbing encoded perceptions of the therapist (which must be stated directly and consciously by the therapist), as well as any mobilized unconscious fantasies and memories. As such, this type of interpretation places an extraordinary demand upon the therapist and is likely to constitute an anxiety-provoking danger situation that may disturb the therapist in areas where he is still vulnerable to countertransference (therapist madness). Indeed, to this day therapists attempt to avoid this type of interpretation and prefer virtually any other activity to its utilization.

This understanding lends insight into much of the literature on noninterpretive interventions and has a bearing on misconceptions regarding the nature of truly valid interpretations and reconstructions, which must be cast with the therapeutic interaction—the interventions of the therapist—as their initial focal point. This type of interpretation is founded on the therapist's capacity to experience the patient's narcissistic, sexual, and aggressive needs, as well as the therapist's own pathological and nonpathological expressions in these areas—much of it unconsciously perceived and communicated in derivative form to the therapist. Fears of loss of control and identity, of fragmentation of self and dread of the mobilized intrapsychic conflicts, fantasies, memories, and perceptions, abound. For the therapist, the creation of a valid interpretation is indeed an anxiety-provoking measure.

This helps explain a rather striking communicative finding regarding therapists (e.g., supervisees) who prove capable of mobilizing their resources to the point where they are able to make an adaptive context interpretation that obtains encoded or derivative (quite unconscious and indirect) psychoanalytic validation from the patient. In almost all instances, the intervention from the therapist that follows the validated interpretation is characteristically deviant, quite poor, and often at a level far below the recent general work of the therapist. This appears to confirm clinically the thesis that the mobilization of resources and the experience of the offer of a valid interpretation that takes into account the patient's unconscious perceptions and fantasies in regard to the therapist is indeed a major source of anxiety and danger for the therapist. Such work often leads to temporary regressive and defensive reactions in the psychotherapist—a flight from painful interactional truths.

This trend has been established through repeated supervisory observations, but a single condensed illustration must suffice. It is taken from

the work of a rather gifted woman psychotherapist with some clinical experience in working with the communicative approach. In time, she proved capable of securing the ground rules of the psychotherapeutic work with her patients and of offering interventions that obtained encoded validation. For some time, in each instance, there followed the type of deterioration in her efforts alluded to above.

Case Illustration

A young man is in twice-weekly psychotherapy at a reduced fee. One session took place toward the beginning of October. The therapist had been on vacation for most of August, though she had returned for a single session with the patient at the end of that month. The patient did not appear for that particular hour. Subsequently, he indicated his confusion as to whether the therapist had returned from her vacation, though he suspected that she had indeed done so. Nonetheless, he remained uncertain as to whether he would be responsible for the session if he had missed it, since he had not been sure as to whether he had an hour on the day in question. The patient's associations and the therapist's brief interventions in his area had left the matter ambiguous as the time of the session at hand. The patient had offered the therapist a check for his September sessions but had not included payment for the hour missed in August. The therapist left the check on her desk, indicating a need to explore this issue.

The patient began his hour by talking about his efforts to develop a small business as an independent trucker. He had been renting his truck, but would come to the truck yard only to find that all of the trucks had been rented out. In almost secretive fashion, the owner of the rental agency had suggested that the patient lease the truck so that he would always have a vehicle available and in the long run, could earn more money. Under pressure, the patient finally gave in, but then became anxious over the additional responsibility and worry.

The patient had met a woman at a bar who had given him some "speed". He was still coming down off of the drug, so he felt he was rambling in the hour. He had trouble free associating, but was thinking of going to school to become a social worker.

He had gotten into a hassle with his girlfriend over money that he had borrowed from her and hadn't returned. She needed the money because she was quitting her job. The patient had always had it pretty easy with money. When his grandmother died she left him some money and his father sent him a check every month. There hadn't been a check that month, which reminded the patient that he still owed the therapist some money,

though just how much he wasn't sure. He was still not clear as to whether he should pay for that session in August since he wasn't sure about it. He had called his father about the money, but it bugged the patient to have to do that. This was his father's way of keeping his claws in him and controlling him through money and giving him things. His mother kept it that way as well. It really got to him.

The therapist intervened at this point and stated that the patient was having trouble talking freely because of the influence of the drug and that he felt that he was rambling. His difficulty might relate to some of the other things he had talked about. Money seemed very much on his mind, particularly the thought of being pressured to spend his own money in order to lease something that will bring more responsibility. He had connected that money to the money that he owed the therapist and he had thought about being charged or not being charged for a session. He then thought of his father as well as his mother, and how they had always used money and gave him things to control him and get their claws in him. The therapist suggested that the way she had been handling the financial arrangements may have had the same effect—that she had been very inconsistent around money and his payments to her, and that the patient seemed to sense that she might well be doing the same thing as his parents, using all of it to keep him under her control.

The patient stated that he was aware that he was being seen at a low fee. His parents had always done that to him. They offered to pay for his graduate school but he would rather not go to school at all than do it that way. Every Christmas his parents would give him all these presents he didn't ask for and then think they could run his life. He was now reminded of the apartment that he lived in, where the rent was extraordinarily low. He had been given a special deal and had promised to fix up the apartment, but it was really a matter of favoritism. The apartment was supposed to be saved for low-income people, but the landlord had liked him. He didn't really like living there because he had to worry about things falling in the halls and rats and roaches and such. He probably could never live like that again. Other people do live better, and the patient wondered why he doesn't care.

The therapist suggested that the patient was now adding something more about the fee arrangement. It seemed to repeat the situation with the apartment where somehow he was getting something at a low price as a special deal that was meant for people with more financial difficulty than himself. He seemed to feel that it was a matter of special interest and was not really right. He had enjoyed this kind of arrangement, but on a deeper

level he seemed to wonder if there really was something wrong with the whole situation, including its basic structure, since it was damaged and infested.

The patient responded that somehow he was now thinking of this friend of his who thinks that where you live is very important. The man had gone out and gotten a really good job, and had really used his great talents; he had not stayed in a limited position like the patient. The patient knows that he (himself) is bright, but this guy is at a much higher level and really makes good use of his capabilities. Anyhow, the friend pays a lot of money for his apartment, but he lives real well. The patient wondered why he thought of this at that point.

It was now toward the end of the hour. The therapist suggested that in light of what he had said about payment and some of the possible meanings of those things that don't cost much, it seemed that they should open up the question of the patient's fee and see where it went. She then added that the patient had asked about payment for the session in August. She told him that she had indeed been there for the session, and that the patient was responsible for any session that he had missed.

The therapist had extended the session some two to three minutes in making her last intervention. The patient noticed that the time had been extended and commented upon it. He said that he would pay for the additional session the next hour and that was alright. At that point, he left the session.

In this particular session, the major patient indicators involve the patient's request for a low fee and his coming into the session while still high on drugs. There is also the patient's failure to pay for the missed hour. These are symptoms and gross behavioral resistances (frame breaks) that merit interpretation in light of the interventions of the therapist and the patient's derivative communications.

The main adaptive contexts for this hour include: (1) the low fee charged by the therapist, and (2) the check that was left out for the patient to take back because it was insufficient in light of the number of hours for which the patient was responsible. Eventually, the patient represents both of these intervention contexts manifestly by alluding directly to each. This type of direct representation facilitates interpretative and framework management intervention.

The material of this hour organizes well as derivative expressions that reflect valid selected unconscious perceptions of the therapist in light of her interventions, generating a highly meaningful and coalescing derivative complex. It is to be noted that the therapist had previously intervened in a manner that had begun to suggest that the patient's low

fee required rectification in light of recent additional income that he was earning. Thus, the idea of leasing a truck involves assuming a greater and definitive responsibility for one's possessions, and therefore suggests an unconscious perception of the therapist as someone who has been interpretatively helping the patient move toward an appropriate increase in his low fee (a move toward rectifying the frame). The same derivative pertains to the therapist's expectation that the patient will pay for his missed session—that he maintain such responsibility.

The next main set of themes (and it will not be possible to analyze every aspect of this material) involves money that has been lent to the patient and not returned, and the patient's inheritance and checks from family members. Here, the main image proposes that gifts of this kind are used to control the patient and to keep his parents' claws in him. The main raw message (decoded from these disguised derivatives) is to the effect that should the therapist continue with the low fee or not charge the patient for the missed hour, she would be lending him money that he would never return and providing him with gifts that are ultimately destructive and self-serving (misusing the patient as a narcissistic self-object).

At this point, the therapist intervened with an interpretation that attempted to understand the unconscious basis for the patient's resistance in coming to the session under the influence of drugs, as well as both of the fee issues—the low fee and the payment due for the missed hour. The intervention is an excellent one in that it attempts to explain the latent factors in these indicators in light of the therapist's interventions—her proposing the low fee and not as yet making clear the patient's responsibility for the missed hour—a step that would be carried out entirely at the behest of the patient's derivative material. These interventions organize the encoded material in terms of unconscious perceptions of the therapist and responsive proposals of rectification (correctives). As a result of this intervention, the therapist obtained striking encoded validation. The patient thought directly of the low fee and stated that he would rather not go to graduate school if his parents were to pay his way. This is in an especially strong additional model of rectification. The patient then added that his parents attempted to run his life through Christmas gifts, another image related to the underlying destructive qualities of the low fee and the absent payment for the missed hour. He then shifted to a fresh set of derivative images that dealt with low-fee space and how it is potentially physically damaging as well as infested. The patient wondered why he accepts living under such conditions—proposing in derivative form still another model of rectification.

At this juncture, the therapist extended her interpretation with an

additional understanding of the patient's derivative communications—both his encoded perceptions and his models of rectification. The intervention is once again well validated through the patient's subsequent derivative material, both in the interpersonal sphere (the allusion to the very bright friend) and in terms of cognitive derivatives (the image of the really nice apartment—i.e., therapeutic setting—that the patient would have if he were to pay a higher rental fee—i.e., he would then be contained within a more effective therapeutic space).

It is at this point that the therapist regressed in regard to technique. First, she proposed a reexamination of the patient's fee. This is a valid intervention, though it should have been shaped by the patient's own derivative models of rectification rather than seeming to be a sudden unilateral proposal by the therapist. To this point, however, there is only a slight question in technique. There then followed two gross errors: first, the direct answer to the patient's earlier question to the effect that he is responsible for his missed session, and second, the extension of the session for two to three minutes.

In regard to the first error, the patient's derivative material was sufficient to demonstrate to him his own evident unconscious realization that he had indeed missed the session in August, was responsible for the therapist's fee for that hour, and that failure to charge him would be viewed as a manipulative and destructive gift offered as a means of controlling him and sticking the therapist's claws into him. As for the second intervention, the extension of the hour, the therapist had rationalized to herself a need to clarify the fee issues at hand, and against her better judgment she had extended the session beyond its point of closure. She was immediately upset when the patient noticed the extension and called it to her attention.

Upon reflection, the therapist realized that she had been disturbed by the images of roaches and vermin in the patient's apartment, associations that gave her a sense of the diseased qualities of the conditions of treatment that she had created for this patient. She also had an uneasy feeling in response to the patient's highly positive image of herself as reflected in encoded form in the patient's final comments about his friend. The idea of securing a very private therapeutic space for this patient and of being seen in a very positive light by him had evoked a measure of anxiety that the therapist later traced to concerns about being viewed as especially attractive by her patient.

The material suggests that a valid interpretation of unconscious perceptions requires personal insight by the therapist into highly disturbing aspects of his or her interventions—here, the implications of the low fee in terms of the destructive image of the patient's parents

and the terrible image of his living quarters. It proved necessary for the therapist to be capable of translating this disguised conscious message into a disturbing, underlying raw image (to decode the derivatives), and to then be able to interpret these images to the patient without a confessional quality or an attempt to deny these attributes perceived within herself. It is often extremely difficult for therapists to accept negative and destructive (self-demeaning and conflictual) unconscious perceptions, since they are at a variance with the therapist's own ideal self-image. Clearly, this type of narcissistic defense must be resolved in order to carry out sound listening and interpretive work.

It is noteworthy that one consequence of the first validated intervention was the emergence of especially disturbing unconscious perceptions of the therapist from the patient. This is characteristic of reactions to valid interventions, and the images involved may be aggressive, sexual, self-demeaning, regressive, and primitive in nature. Often, therapists avoid valid interventions of this kind because of a fear of the material that will then be exposed as the patient's repressive and denial defenses are modified. Further, once such affects and associations do emerge, the therapist is motivated to depart from valid technique in order to escape the implications of the fresh material and to provide the patient with distraction and defense.

In this situation, the therapist was able to tolerate these emergent images and to further interpret their implications in a second intervention. The result was additional validation, and a shift then to images that reflected unconscious admiration. Based on earlier sessions, the therapist had good reason to feel that beneath this admiration (idealization) were intense sexual fantasies and desires. Sensing these qualities, the therapist was unable to tolerate her own burgeoning conscious and unconscious response. Her narcissistic anxieties and intrapsychic conflicts were mobilized and her countertransferences (madness) exerted their influence. This led her to one marginal and two clearly erroneous interventions—each designed unconsciously to diminish the patient's idealizing and unfolding sexual images and desires directed toward herself—and thereby shifted the patient toward hostile responses and other distractions (lie-barrier defenses).

In this instance, the second validated intervention mobilized instinctual drive wishes toward the therapist within the patient. This evidently became a danger situation and source of anxiety for the therapist, who then found an interventional means of taking flight and of offering both the patient and herself defensive formations against this emerging material. Patients tend to concentrate their derivative perceptions and communications on errors by the therapists, and such indeed was the

case in the hour that followed. In all, this material illustrates quite well some of the anxieties and danger situations that arise with valid interpretations, and shows in addition some of the unconscious motives within therapists that prompt them to avoid such interventions.

THE FEAR OF THE SECURE FRAME

The preceding case illustration contains, of course, several ground-rule issues. The patient's associations suggest two possibilities, portrayed through condensation, both of which have likely validity.

First, in light of the adaptive context of the low fee, the patient, through his allusion to his apartment, could be portraying both his therapist's and his own needs for a diseased and dangerous claustrum that is self-demeaning and likely to cause rather than resolve disease. In this light, it is possible to better understand the therapist's final errant interventions that were made after the patient had unconsciously portrayed the therapeutic space created by an appropriate increase in his fee as a safe and welcomed claustrum (apartment) that would enhance his self-esteem and enable him to feel that he was functioning at optimum level. Paradoxically, it is this safe and attractive claustrum that appears to have created the sense of danger and anxiety in the therapist, who then attempted to secure this frame in abrupt and disruptive fashion—i.e., in a way that would disturb these very qualities.

It seems likely, therefore, that the patient had unconsciously perceived the therapist's need for a deviant frame and that this particular need was reflected in the difficulties that the therapist had shown in attempting to rectify the ground rules of this treatment in proper interpretive and corrective fashion—i.e., in doing so almost entirely in terms of the patient's own derivative models of rectification and other encoded communications. Beyond this level of anxiety, there may well have been additional fears within both patient and therapist, since it is entirely possible that the dangerous and diseased claustrum also involved the secure frame toward which both were now heading. The material in this particular hour does not make it possible to fully test out this particular hypothesis.

While the secure, ideal frame provides an optimal hold and sense of containment for both patient and therapist, it also creates a powerful danger situation in terms of the anxiety-provoking claustrum that it constitutes. Quite surprisingly, virtually every deviation from the ideal frame is seen as antiphobic in the patient's encoded material, even those that have a minimal bearing on the potentially entrapping qualities of

the treatment conditions. Especially critical in creating the claustrophobic qualities of the psychotherapeutic setting and relationship is the fixed frame (set fee, length of sessions, time, and especially full responsibility for all sessions) and the privacy of the physical setting, including the use of the couch for the patient.

Many of these basic ground rules apply equally to the patient and therapist, creating basic claustrophobic anxieties in the latter as well. It would seem that the many deviations in the ground rules of most training analyses, including the existence of outside contact between a candidate and his analyst, have had an adverse influence on the capacity of analysts to recognize this dimension of the treatment experience, to feel comfortable with themselves and their patients within a secure claustrum, and to prove capable (with the help of the patient's encoded perceptions and fantasies) of maintaining in most instances a secure-frame psychotherapy or psychoanalysis. As a result, a patient will consistently develop strong unconscious perceptions that reflect his view of the therapist's phobic anxieties and need for counterphobic defenses and flight.

In substance, then, a therapist capable of creating a secure frame is seen as having resolved his or her phobic anxieties. With these in abeyance, the secure frame will tend to generate such anxieties within the patient. In contrast, the therapist who finds it necessary to deviate will be seen as defending against phobic anxieties; in addition, under the latter conditions, the patient's own phobic fears are minimized or relatively absent, covered over or camouflaged by those expressed by the therapist. The following vignette illustrates a patient's reactions to efforts by a therapist to secure an ideal frame for his psychotherapy.

Case Illustration

A young man suffering from depression was being seen in once-weekly psychotherapy. The patient was a college student who had missed a session in order to take a midterm examination. The following month, despite his awareness of his responsibility for the hour, he refused to pay for the time. On the surface, he was quite angry with the therapist's position and had attempted to force her into making him an exception.

At this time he began an hour by talking about his refusal to pay for the missed session. He remarked that for the first time the therapist's door was locked when he had arrived for his hour, adding that he liked to nap in the waiting room before his session. He likes his part-time job because he could leave the room in which he worked from time to time so that he did not feel

confined by the four walls. He was glad he could escape, like he did in his childhood when his father tried to put a stranglehold on him. He remembered feeling imprisoned growing up with his father and then recalled his mother's smothering attitude. As a child he had felt quite constricted. He was feeling uncomfortable now because the therapist was staring at him. It reminded him of the psychiatrist in *Ordinary People*, whose cold eyes followed his patient around and pinned him to the wall.

The patient then recalled that his mother had attempted to contact the therapist in order to have a session with her. He was grateful that the therapist had not complied. He didn't understand why his mother stayed with his father. He had revealed suicidal feelings to his mother and told her he had hit his head against the wall. His mother had a lot of rage and could use some therapy. Her ways were nauseating to the patient.

The patient then remembered an uncle who was promiscuous with women, who tended to beat up men who threatened his business, and who had a friend who had drowned. The closed shades in the therapist's office gave the patient a feeling that everything was closing in on him.

The two central intervention contexts for this hour involved efforts by the therapist to secure or maintain the ideal frame: her expectations that the patient accept responsibility for the fee for the missed session and her refusal to see the patient's mother. In response, the patient's imagery was replete with representations of a dangerous claustrum and related anxieties. It is to be noted that this patient had reported no phobic symptoms prior to treatment; responses of this kind appear to be universal.

In substance, the patient first portrays a secure frame as the therapist's locked office and the four walls within which he works, adding an allusion to his need to have a means of escape lest his anxiety become unbearable. There is a genetic link to his relationship to each of his parents: the danger of a stranglehold by his father and smothering by his mother. These images are then linked to the therapist, providing evidence that they pertain to her efforts to secure the frame of this treatment situation. There is a further claustrophobic image in the reference to the psychiatrist who pinned his patient to the wall.

The patient's additional associations appear to represent the fantasy of perceived dangers that the patient experienced within the potential claustrum of his secured psychotherapy. There is the image of suicidal impulses and of hitting his head against the wall—representations of the loss of control of his own violent impulses and a dread that the therapist too might lose control and annihilate the patient. Through the uncle, the theme of violence is given further strength, as is the fear of the loss of control of sexual impulses. The image of the drowning man alludes to fears of smothering and suggests a tie to the fetus within the abdomen of the mother—though the allusion, of course, is not one of safety but of danger (Lewin 1935).

In light of the therapist's efforts to secure the frame, the fantasies and anxieties protrayed in this material appear to belong mainly to the patient, who evidently dreads the secure frame as a place within which he will lose control both aggressively and sexually, and within which he also dreads the therapist's annihilating and sexual impulses. Since the therapist has offered a relationship constituted by basic trust and safety, much of this material stems from the patient's own unconscious fantasies and memories. The material lends insight into the unconscious reasons within patients (and therapists as well) that direct them toward the search for deviant frame therapy or for alterations in the ground rules in relatively secure treatment experiences. Such escapes constitute strong antiphobic defenses and forms of flight that are momentarily reassuring, often to patient and therapist alike.

Case Illustration

A young depressed woman had been seen in a clinic by a woman psychotherapist. Treatment was shifted to the therapist's private office at the patient's request. When the fee was discussed, the therapist proposed a $50 fee, but the patient said she could only afford $30 per session. The therapist agreed to this proposal without further exploration. Soon after this intervention, the patient remembered being in a store, shopping at a sale. The store was crowded and there was a woman with a baby strapped into a stroller. The woman stayed in the store for a long time and the patient began to feel anxious over the baby's confinement. The baby began to cry and the patient had an impulse to set the child free. Instead, her mother finally did so, much to the relief of both the child and the patient.

In this brief excerpt, we see an encoded unconscious perception of a therapist fearful of a secure frame. The adaptive context is the therapist's reduction of the patient's fee without exploration, portrayed here in derivative form by the allusion to the sale. The patient unconsciously perceives the therapist's fear of confinement as conveyed through the image of the baby strapped in the stroller. It is the patient's unconscious view of the therapist that because of these constricting anxieties the therapist has immediately reduced rather than maintained her fee.

When the adaptive context involves securing the frame, most of the expressed phobic anxieties belong to the patient. When the context involves a deviation by the therapist, the primary phobic anxieties are perceived within the therapist. The patient's own phobic conflicts and anxieties are represented by his unconscious selection of phobic images of the therapist, a selectivity that is based on the patient's own unconscious fantasies and memories—his own psychopathology. It is through this selection process that the patient's own difficulties in this area are portrayed. Nonetheless, in intervening, it would be essential to first identify and interpret the patient's unconscious perceptions of the therapist's phobic anxieties and antiphobic defenses, before suggesting that they correspond to a similar constellation within the patient. The following case illustration portrays this type of unconscious perception of a deviant therapist.

Case Illustration

The patient is a young woman, a nurse in three times weekly psychotherapy with a male therapist. The treatment situation is basically deviant in that the therapist provided the patient with a bill with the dates of her sessions and her diagnosis so that she could obtain eighty percent coverage for her hours from an insurance company. At the time of the sessions to be described, the therapist had been hinting that there were some problems in the insurance arrangement that required further analysis and possible rectification.

The patient began an hour by talking about the death of her mother and her failure to have mourned her. She spoke of her boyfriend and his relative availability and her difficulties in talking about him. The patient then commented on the therapist's recent extended silence in the sessions. The therapist suggested that his silence may be aggravating her feelings of loss regarding the boyfriend and her mother. The patient responded by saying that she felt it difficult to get connected to people, that she didn't like separations, that she felt good coming to her sessions, and that she hoped she would be able to work things out. She then asked the therapist if she could have a bill that would summarize the number of sessions she had had to date so that she could submit it to the insurance carrier. The therapist left the session briefly to obtain the bill from his secretary, who sat in a separate office. He returned with the bill and the hour ended.

The patient was late to the next session and apologized. She felt that her boyfriend was not honest with her and the he was like a bad parent who was always abandoning her. She would like

a handsome man to carry her away, and wished she could put her fantasies of being saved to rest. The therapist suggested that the patient's feelings of not being cared for and of dishonesty must tie somehow to her relationship with him, adding that something seemed to be out of control and that her lateness appeared to be a reaction to feelings that she wasn't adequately being cared for.

In response, the patient indicated that she felt attached in the therapist's office. She remembered two dreams. In the first she had bought a cat with whom she was close. Someone exchanged the cat with another cat. The animal was then in the hold of a ship being destroyed and made into tuna fish. A man was there and the patient told him that her cat needed to be saved. The man said that nothing mattered down there because this was a ship. In the second dream, the patient was married to a nasty doctor whom she had once dated. She didn't like him. In the dream they had a child, a boy who may be a girl. The patient was alone in a bathroom and had to take care of the child. Some men were looking at her and she was frightened. She sensed she had to escape.

The critical intervention context for the second session is the therapist's leaving the consultation room in order to obtain a copy of the patient's bill to give to her. Initially, the patient characterized this action through derivatives as dishonest, bad parenting, and abandonment. There then followed two dreams: in the first, a cat is trapped in the hold of a ship and being destroyed, made into tuna fish; the patient wishes to save the cat but a man says that nothing matters. In the second, the patient has a baby, is alone with it in a bathroom, and is frightened of men who are staring at her—she must escape. Each of these dreams contains a striking representation of a claustrum. In the first situation, there is the danger of annihilation, while in the second, there appears to be a portrayal of birth, care within the claustrum, and then a shift to danger and flight.

Since the adaptive context is the therapist's departure from his consultation room, it follows that the dream material contains selected encoded perceptions of the therapist and his anxieties. Thus, it is the patient's image of the therapist that he attempts to save himself from a claustrum within which he will be destroyed and devoured by leaving the patient's hour. The second dream suggests the patient's unconscious perceptions that the therapist fears impregnating the patient or being impregnated himself (in fantasy), and that he also dreads that the caring qualities of the interaction within the claustrum will be marred by threatening third parties. In all, the dream material, in light of the

adaptive context of the therapist's deviant intervention, strongly conveys the patient's encoded perceptions of the therapist's anxiety-ridden flight from the enclosure of his consultation room.

CONCLUSION

Recent communicative studies of madness (Langs 1984) have shown that both patients and therapists engage in extensive defensive activities in order to avoid the subjective experience of craziness or insanity. The dread of subjectively experienced madness within the therapist appears to account for his fear of offering sound and valid interpretations, as well as similar fears of secure-frame therapy. These morbid anxieties appear to be so universal among therapists that they have gone unnoticed for many years. These fears also help to account for many inappropriate and deviant technical measures that are not in the service of a patient's therapeutic needs. Even those interventions that gratify the patient and receive his conscious approval are shown on an unconscious and derivative level to be highly seductive and destructive, and antithetical to insightful cure. The discovery of these difficulties has been possible only through communicative investigations that concentrate upon the patient's encoded and unconscious perceptions of the therapist in light of his technical measures—his intervention contexts. On that particular level, the clinical findings have been quite consistent and in keeping with the vignettes offered in the present paper.

The clinical finding that therapists dread valid interpretations and secure-frame therapy indicates that the capacity to carry out these technical measures depends upon a resolution of the therapist's own inner madness (countertransference). It suggests as well that the modification of pathological defenses is required to enable a therapist to apply sound techniques in his work with patients. This finding also supports the view that the management of the ground rules of psychotherapy and the formulation and offer of interpretations are dynamic components of the bipersonal field and of the spiralling conscious and unconscious communicative interaction between patient and therapist, with conscious and unconscious inputs from both participants. Such efforts are by no means entirely cognitive. By understanding their use within the total context of the therapeutic interaction it should be possible to further clarify the factors that account for both sound and unsound therapeutic work.

A recent clinical observation serves well to conclude this discussion. Experience with *validated* interventions indicates that many patients

respond to indirectly confirmed interpretations and frame-securing efforts by the therapist with subsequent anxiety, regression, and often with major, disruptive resistances. Patients too dread valid therapeutic work. Evidence suggests that such fears are based on an aversion to the experience of subjective madness; anxiety-provoking envy of, and strong erotic reactions to, the well functioning therapist; and concerns regarding the next level of madness that is likely to be explored. On all sides then, fears of valid therapeutic work are a prominent dimension of the therapeutic experience.

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