CHAPTER THREE

Changing the frequency, length, and timing of sessions

Frances Salo

This chapter selectively reviews and considers some of the potentially profound aspects of a change in the temporal framework of sessions in analysis and psychotherapy. It aims to explore interventions that many analysts make, sometimes feel that they are “forced” to make, and assess any risks and potential benefits. The dialogue in the analytic space has special features stemming from the special device of analytic time (Puget, 2009), “a time out of time” (Kurtz, 1988, p. 990). When the analyst alters the temporal framework, with its fixed times, length and number of sessions, it affects the patient’s sense of self as a continuity in lived experience through time, through its reverberations of the patient’s history. While a number of analysts have generously shared details of such interventions, for reasons of confidentiality many have not been named.

The analytic session offers the patient the possibility of becoming conscious of his or her unresolved relationship with time (with their history and experience, unresolved pre-Oedipal, Oedipal, and transgenerational conflicts) (Milmaniene, 2009). The set time and length is an essential part of the frame, and the temporal structure of the setting allows the different temporalities of the patient’s internal
world to become conscious to the patient and the analyst. Containing and challenging the patient is what underlies the high frequency of analysis (Rose, 1997). The importance of the temporal framework is far removed from any implications about the use of time as trivial, as often explored in literary works. There is extensive literature on psychoanalytic perspectives on the sense of time and of timelessness in the unconscious—the only temporal dimension the unconscious takes is that time does not pass (Pontalis, 1997). There is similar literature on the part that time plays in analysis (e.g., Arlow, 1986; Green, 2002; Hartocollis, 1983), and on the meaning of time within the culture (Akhtar, 1999a, 1999b). In comparison, detailed literature as relevant to the focus of this chapter is relatively less; while references to it permeate the clinical literature it may not have been examined as fully as it might have been.

The mother’s care, Winnicott (1961) wrote, enabled the infant to “catch hold of time” and research suggests that infants are aware from birth of rhythm and time. Stern (1985) suggested that the infant’s sense of self is constructed out of memories of their affects and histories. The analyst’s intervention meets a layering cascade of fantasies and life experienced. A four-year-old boy patient who was terminating in analysis told me, “Don’t think that this place is an airport”, meaning that children are not like aeroplanes running according to a schedule; a six-year-old girl who had been adopted at two years of age told me, “You have to remember so much harder when you are adopted” and an eleven-year-old boy who had been placed in a children’s home told me, “time disappeared” when he could no longer remember his sister’s face from a few months previous. For each of these children, time had a highly personal significance with which they would respond to any interventions.

I propose to consider in this chapter the topics of changing the time, length, frequency and timing of sessions and conclude with termination of analysis. Consequences of interventions to a previously agreed-on frequency will be covered but not the arguments underlying the number of sessions offered per week. When the analyst changes times, how does the patient hear it—is the analyst changing the contract, saying that time and his/her mind is not available? The frequency and duration of sessions may be more context-dependent than analysts often acknowledge. The number of sessions per week, for example, whether it is four or five sessions, may vary according to
country, local culture, and the personal circumstances of the analyst. In considering any changes to the usual temporal frame, it is important to consider the context of the analysis—the strengths and vulnerabilities of the patient and the history of their analysis or therapy.

**Varying session time**

Sometimes sessions are varied for ostensibly practical reasons such as when an analyst shortens a child’s session time by five minutes in response to a parent’s request because of a change in the school timetable. Requests to change times of session, however, whether on the part of the analyst or patient and whether on a one-off basis or permanent, inherently face many transference-countertransference difficulties. Many analysts, if the patient requests a change in the times of sessions for external reasons that seem reasonable, usually offer such changes if they can be accommodated within their schedule. Some, however, do not for various reasons: Laufer (1991, personal communication) described not always offering a patient a makeup session as this offer could unhelpfully increase the envy of the analyst perceived as having an endless cornucopia.

Langs (1989) in his study of patients’ responses to frame breaks, stated that every accommodation to a requested frame break was always followed by associations which suggested that patients viewed it as measure of the analyst’s insecurity in the role, an inability to hold the patient, and perhaps as exploitation, seduction or use of power. Further study of the patients’ associations indicated that the analyst should have refused and kept the frame intact. Langs gave an example of a patient whose analyst inadvertently kept the patient ten minutes over the agreed-upon time limit and while subsequent associations could suggest symbolic material around fear of the father’s castration, Langs, preferring to work in the here-and-now of a “communicative analysis”, related it back to the frame break as he felt most patients wish to revert to the original frame. One question is whether there are developmental considerations to take into account, for example, when an adolescent patient is rebellious about an early morning time as he wants to sleep in. Does occasionally offering a later time when possible safeguard the analysis in recognition that sometimes the patient needs to feel that their difficulties have been heard and responded to.
courteously or is this an enactment? This question will be returned to in the discussion.

Some analysts have described initiating the offer of another time when the patient indicates that they are unable to come to a session. Jacobs (2001) described his taking a corrective initiative on an occasion when he interpreted that a patient had not asked for a change of time out of her anxiety about him. Once she had accepted his offer of a time she could then bring her feeling that he covered up his irritation with her and he came to agree with her and to feel his offer was an enactment. Similarly, Meissner (2007) described the offer of a substitute time to a patient had the effect of putting pressure on the patient who had wanted to skip the hour, but he accepted the time. Meissner thought that he himself had unconsciously created an authoritarian impasse that violated the patient’s autonomy. He considered it was an enactment and changed his practice to not offer a change of time unless requested by the patient.

Slightly differently, an analyst’s offer to let a patient make up the sessions she would otherwise lose if she went on vacation allowed an analytic dyad a way out of a technical difficulty. Geerkin (2010) described how her young adult patient, Beatrice, had wanted to take a holiday and accused the analyst of taking her parents’ money for sessions that she did not attend. The offer to make up missed sessions was regarded as “a creative solution”, in which the patient’s parents did not “waste their money”, the analyst did not lose her fees, and the young woman could set off on holiday. This “exchange of gifts” freed up the situation by partly satisfyingly the patient’s demands and it was felt that it allowed the analysis to continue. Barredo (2010) commented that Geerken had showed “a willingness to give up her need to control the situation and let herself be surprised by the suggested solution” and this allowed her “to find the ‘rhythm’” and take up her role as analyst again, which enabled forward movement and new topics to emerge.

An analyst’s change of times or cancellations are likely to be met by the patient with feelings of being slighted and hurt, and of feeling special, grateful, and envious. Schwaber (1996) gave an example of when she made a couple of changes to her schedule that she thought would be acceptable to her patient; in the next session the patient was in a confused state, immersed in implicit memories from a time when she was four years old and her mother had temporarily lost her. This helpfully brought into the transference the fear of the anger of
the mother/analyst and the sense that her time and her possessions were given to other people.

In another case, a series of cancelled sessions by the analyst led the patient to feel abandoned by the analyst, and he became covertly vengeful towards him, paying his account late and missing sessions (Beattie, 2005). He also developed what appeared to be a near-psychotic thought disorder. This, however, enabled the idealizing transference and his guilt to be analysed. Ferro (2005) describes a perhaps relatively inexperienced analyst cancelling an appointment and offering to replace it with a session later in the evening. The patient accepted but felt that she had to submit, recovered her wish to be more relaxed like her analyst and then was able to bring in her feared violent and mad split-off aspects, with material suggestive that she felt her analyst stole from her and should be tried in court. While on the one hand, Ferro describes the offer of time as a kind of abuse on the analyst’s part, it however initiated material that could be productively used. To sum up, Meissner (2007) stated that the analyst coming late or interrupting the schedule can be taken by the patient as their not being invested enough to be keep their side of the contract and is never positive to or contributory to the effective work of the analysis. He pointed out that when patients speak out of a transference context about the analyst neglecting them with his or her time away from the practice, they may have a point that the analyst needs to consider. However, it seems that in many of the examples given the analytic process had continued and perhaps even been freed up with the changed session time, and this point will be returned to in the Discussion.

Varying session length

Varying the length of sessions needs first to be set against the cultural context in which the analyst works. For example, in some countries, e.g., the United Kingdom, the fifty-minute session is standard, whereas in others it may customarily be less. It may be forty-five-minutes to fit in with the analyst’s timetable or when that is the length of time for which an insurance company or other agency pays a rebate. The practice of having no break between sessions produces resentment in patients who feel that the analyst is preoccupied with managing the transition and has hostilely deprived them of time (Greenson, 1974). Here I shall mainly explore the analyst increasing or decreasing the frequency of
sessions. Lacan thought that the session should not end routinely but as a significant act when important material emerged. “The interruption would then acquire the value of an interpretation” (Aisenstein, 2010, p. 463). This technique has been critiqued by many analysts including Etchegoyen (1991) as carrying a “heavy burden of a training through rewards and punishments” (p. 513). The shortened or less frequent sessions of the Lacanian approach will not be discussed in detail here as it does not seem appropriate to extract this from a whole body of theory, explicated for example, by Etchegoyen (1991) and Green (2002).

Developmentally, it would be expectable that therapists engaging in parent-infant or child therapy would work with sessions of variable length in order to fit in with the needs of the infant or child. With some child patients, many therapists recognize that at certain times it may be more therapeutic to finish the session earlier than the standard length. With a six-year-old boy in analysis, who was referred for a “fetish” for stroking women’s long hair and dressing up in their clothes, I came to recognize that a fifty-minute session felt persecuting and I adjusted session times closer to a thirty-minute one. Sometimes, with a child who has become out-of-control in a session, rather than battle on, an analyst might stop a session early and explain why. At a particular point in the analysis of a six-year-old patient, he kicked me hard and with the pain I felt hurt and angry. I decided to stop the session early explaining that I needed to be able to think and we would meet again the following day but not go on seeing each other that day. As Winnicott (1947) wrote, the analyst needs to be able to hate the patient yet temper his or her hate.

Some analysts have described that their intervention consists of a more or less implicit agreement with the patient not to intervene if the patient needs to end the session say a couple of minutes early out of extreme anxiety or their need to control. What is critical is that in time this can be interpreted or the patient comes to understand for themselves the need to control. In one case, a patient had needed to change analyst for training purposes and had not fully made the analysis his own. His leaving analytic sessions a couple of minutes early for a number of years was multidetermined; it functioned as a pocket of resistance as well as giving the analyst the experience of helplessness. The analyst interpreted if it seemed appropriate, but chose mainly to bear in the countertransference the experience that the patient needed to communicate. Freud’s (1913) technique included “occasionally” prolonging a session to longer than one hour with less communicative
patients, “because the best part of an hour is gone before they begin to open up” (pp. 127–128). Winnicott thought that sessions with very regressed patients with borderline personality difficulties needed to be longer than an hour and variations should tend towards lengthening the session with perhaps a longer space between sessions (Green, 2002). A number of analysts have acknowledged briefly extending the session to give the patient an extra two to five minutes at a time of particular stress or vulnerability, if the material was important and until a reasonable point of closure was reached. These occasions are mostly not reported as having negative effects but positive ones. If a patient tries actively to extend the length of the session, the analyst can either keep to the frame or extend the time. Extending the time may acknowledge in a helpful way the patient’s needs and wishes but also contribute to countertransference difficulties: analyst and patient may engage in a transference-countertransference enactment which the patient experiences for example as a seduction.

Kurtz (1988) gives a vignette in which both the time of the session and its length were altered. He recounted how he went over the end of the session without realizing it, which resulted in his male patient bringing material about a car crash he had witnessed as a child. In the next session, Kurtz suggested they move the patient’s session to the end of the day to keep this flexibility possible, for a patient who struggled against feeling inhibited. The patient was at times able to experience feelings more fully and gradually this tended to happen more often and in shorter time spans. In parallel, the handling of the end changed. “I allowed myself to be guided either by my feeling that the natural end had come or that it would not be reached in the length of time I was willing to continue. (‘Natural,’ here, indicates the achievement of a state of mutual satisfaction such as that of a symbiotically attuned mother and infant.)” (p. 994). The patient had experienced endings as painful and asked the analyst to prepare him for them shortly beforehand and was gradually able to do this himself. Increasingly, sessions ended within the standard time and he asked for an earlier, more convenient time. Kurtz, while suggesting that this might be viewed as a special case, nevertheless, saw this as embodying a universal principle that if the analyst provides a framework with a beginning and end, the patient will structure the session in ways that reveal his feelings. Using a flexible hour may or may not be needed “but, provided the analyst’s own time sense is open, the patient will eventually be able to take clock time into account without losing its affective measure” (pp. 994–995).
If patients are caught up in intense affect at the end of the session, they may need a few minutes to compose themselves. This is different from the experience of a number of patients who, in the midst of intense transference feelings, particularly in a regressed state, were unable to leave the consulting room. While extending the time tends to lead to countertransference problems, it is sometimes inevitable and has to be managed. Coltart (1989, personal communication) reported a dramatic example when a patient refused to leave her analyst’s living quarters (above her office) for the best part of a day. Rather than calling the police, which Coltart knew from the patient’s part history would have a negative effect, she chose to allow her to say until her mental state had improved.

If an analyst runs over time this will also produce reactions to what may seem a trivial, inadvertent break of routine. Lichtenberg and Slap (1977) report an occasion when an analyst, who was engrossed in his efforts to understand a dream related by a young woman late in the hour, allowed the session to run over by five minutes. This patient, relying on the analyst’s integrity, had previously suggested that they spend an analytic hour in a nearby hotel. That night the patient had a dream that she was being chased through a subway by delinquents whom she associated to characters in a novel who had been part of her adolescent masturbation fantasies. She then recalled the extra few minutes, and with feeling made the connection between the past sexual fantasies and her current wishes. Subsequently, she took a more analytically productive attitude towards her erotic feelings for the analyst.

While an analyst’s lateness for a session is not a planned intervention, there are a number of recorded occasions of an analyst being a few minutes late for a session and the patient’s extreme sensitivity to this—in one case with an analyst who took five seconds longer than usual to answer the doorbell. When an analyst has been say, five minutes late, the analyst’s offer to make it up at the end may well be heard not only as fair but also as the analyst’s exercise of power in a situation where they are felt to be indifferent to the patient, and as such pulls material into the sessions.

**Varying frequency of sessions**

From a North American perspective, Meissner (2007) reported that many analysts find reducing slightly in frequency to enable patients
to continue in treatment until they could resume a four-times-a-week schedule does not seem to make much difference. From a similar perspective, Ehrlich (2010) discussed a case when the patient presented with financial difficulties, and the analyst considering reducing to a lesser frequency could have resulted from the analyst not being able to fully keep the patient’s analysis in mind. The increase from three- or four-times-a-week intensity to five-times-a-week is usually noted to make a difference, mainly in intensification of the transference. Interruptions in sessions because of the analyst’s pregnancy have been reported as having a productive effect in enabling the patient to work through related difficulties (Reenkola, 2010). Respecting the patient’s judgment about their needs and requests to vary the frequency of sessions is sometimes thought to be paramount. Puget (2009) described how some patients request therapy with her after having had analyses with other analysts and feel that they want to concentrate on what is happening for them in the present rather than on the past; she came to feel that it was appropriate for the analyst to actively accept this.

The analyst’s thoughtful response to the “presence of absence” is called for when the patient does not attend for what may be quite some considerable time but there seems to be an analytic process underway. Symington (personal communication) described a patient who had previously been in analysis with another colleague and, after starting analysis with Symington, wanted to reduce the frequency of the sessions. He agreed, feeling that it was important for her to develop a sense of autonomy of her self. The patient continued to reduce the frequency of her sessions to about once a month and then gradually was able to ask for them to be increased back to the initial frequency. Symington felt that this had had a therapeutic outcome. Similarly, an analytic therapist described a patient with borderline personality difficulties who, at a time when the patient was extremely fragile, was mildly abusive with her on the phone and then did not attend for three weeks. The therapist was able to keep sessions available, knowing that this was a pattern in the past and aware that not all therapists are in a position to do this if there are financial constraints or perhaps are less experienced. Two analysts described patients not attending for several months although in each case the analyst kept their sessions for them and felt that there was an analytic process of some kind in place. In one case a cheque for payment of sessions was posted to the analyst at the end of each month for three months without the patient having attended sessions. When the
patients returned to analysis, they felt that it was important to have been allowed to complete this experience, and their analyst concurred.

Several analysts have found that for patients in a relatively severe regressed state, for example, a neurotic patient during a period of intense infantile transference neurosis or in patients with borderline personality difficulties, separation from the analyst can result in disorientation and other difficulties. A psychiatrist described in supervision a very deprived patient with whom she had been working for a number of years and would increase the number of sessions at times of need. She commented, “We often meet four times a week before a break, up from once or twice a week, and I don’t know where I stand”. This apparently not-knowing state belied the fact that this seemed appropriate for this patient at this point when she had allowed herself to become more vulnerable and dependent on her analytic therapist. With the increase of sessions, this patient opened up in following sessions and brought new material from an early level. Greenson (1967) felt that it may be necessary to see such patients during a weekend or to have telephone contact with them and that sometimes knowing the analyst’s whereabouts made it unnecessary to arrange for a substitute to replace him. (Greenson also noted the technical aspect of countertransference responses in those analysts who seem compelled to work on Sundays.) He thought that the question of who is leaving whom can be an important technical point with very sick patients and to spare such a patient the feeling of acute abandonment, he often found it advisable to allow them to leave for a brief holiday a day or so earlier than he did. Differently, with a patient who in intensive sessions began to decompensate, Spero (1993) suggested that they discontinued the analysis as such but continued on a session-to-session basis until the patient could follow the schedule.

Attempts to acquire more of the analyst’s time through extra-analytic contacts have changed with increased technological developments, with requests for telephone calls, emails, or getting the analyst to respond to a text message via mobile phone (an SMS) that the patient has sent, particularly outside the time of their session if they have not attended or to prompt them in advance to come to a session (Stone, 2009).

Sometimes an analytic therapist feels that it is necessary to make an extra-analytic contact to keep the patient alive. Nathan (2010) described a dramatic intervention in a psychotherapy case. “I made a sudden and unannounced emergency intervention into the life of the suicidal patient …. At the time I felt I had contravened the psychoanalytic canons of practice. However, I could no longer bear the anxiety, the
fear that my patient could kill herself and place her children at risk. The intensity of the anxiety, amongst other analytic considerations, I believed was diagnostic of an imminent suicide . . . . The work demands at times that one must be prepared to be able not to bear uncertainty in the face of imminent death or injury or abuse” (p. 12). She therefore arranged extra contact with the patient and her family. Akhtar (1999a, 1999b), in support of a flexible approach wrote that, “If the analyst can manage to have both flexibility of perspective and a tempered yet deep regard for the spirit over the letter of the analytic rules and guidelines, he will be able to come up with what is technically needed” (p. 147).

**Varying session timing**

This section, which awaits fuller discussion, refers only to how therapists might cluster sessions in unusual ways, or with long and/or irregular gaps between consultations or moving sessions to a particular time of the day. While most analysts might prefer to give each patient the same time every day or to have psychotherapy sessions on consecutive days rather than spread out throughout the week, to maximize their effect, other analysts actively consider that in varying the times, different aspects of the personality can be seen as people do not function the same way at different times of the day (Etchegoyen, 1991). Winnicott is well known for seeing patients with long and/or irregular gaps between consultations when patients had to travel long distances to see him or during World War II when the regularity of consultations was interrupted. As noted before, he thought that with some patients, sessions should tend towards being longer with perhaps a longer space between them. Currently, when a patient has to travel long distances for their analysis, sometimes between countries, the practice of shuttle analysis and concentrated analysis has developed to assist in such cases. Here the temporal framework has changed massively. Qualitative research with such analysands suggests, nevertheless, that the motivation on their part is so strong that it can compensate for the disadvantages of this arrangement (Etchegoyen, 1991; Szonyi & Stajner-Popovic, 2008).

**Termination varied or decided by the analyst**

Here those terminations which are either varied or imposed by the analyst are referred to, rather than mutually agreed upon terminations. In analytic training, it used to be taught that the prospect of termination
would ideally arise about the same time in the mind of the patient and in the analyst, or at least would be initiated by the patient and that the analyst does not usually set a termination date alone. Green (2002) thought, however, that it is more likely to be the analyst who, several years after the start of the analysis, feels like raising the question of termination with the patient who is by then well into the timelessness of the analysis. One analyst described how after eight years of analysis, when the patient did not consciously have the idea of terminating in her mind, he was prompted in response to an intuition about the material to suggest a termination date two years ahead, which seemed beneficial in the analytic process. Some patients need at times to increase the frequency, while others need to reduce the frequency to face the reality of the separation (Firestein, 1969); other analysts describe sitting the patient up, before reducing frequency and duration of sessions analysis.

Much recent literature on termination has focused on interruptions, “impasses” and re-analyses (Kogan, 2010). When the analyst responds to an analytic impasse with an ultimatum about the need to either work analytically or to terminate, this may propel the patient to be able to move through a potentially destructive phase and resume analytic work. Initiating termination is “a parameter of treatment, which analysts may resort to, in order to counteract the effects of timelessness when those effects have become undesirable, counterproductive, or self-defeating” (Hartocollis, 2003, p. 949). But Freud’s (1918) setting a time limit in the Wolf man’s analysis can be viewed as a “forced termination” and considerable negative potential traced (Novick, 1997).

Analytic interventions that attempt to move the process of termination out of an impasse may be further tailored for the individual patient. Meissner (2007) describes how with a patient whose analysis he had assessed as stalling, he suggested reducing the frequency from five to four hours a week to lessen the attachment to him (although he did not initiate setting a termination date). The patient, after expressing his hurt and anger, quickly came to a resigned acceptance and continued the four-hours-a-week schedule for the remaining four years of analysis but with continued reverberations about missing the closer contact of the five-hour schedule. One analyst described an inhibited patient in analysis for many years who was reluctant to terminate. In an attempt to get beyond a strong resistance and drawing on Ferenczi’s idea of raising the clinical temperature in the analysis of the regressed patient
to come closer to the resisted affect, the analyst suggested that she might scream. While the patient was cross at the ending, she knew that even if another year was offered, she would still have to face at some point how impossible she found it to end. Initiating the termination process may convey to the patient that the analyst has processed guilt about the analysis ending and is relatively satisfied with what has been achieved. To scream meant the patient could experience her emotional pain about loss rather than defending herself from it and could end the analysis with sadness. In a continual dialectic between a more classical technique and the view that it is important for the analyst to retain their flexibility, views about practice proliferate. While some patients have difficulty committing to the undefined period required for analysis, two analysts recently acknowledged as though their stance was unusual and not quite correct, their active acceptance of a time limit imposed at the outset by the patient who said that because of a pre-arranged work posting they would only reside for two years in the town where the analyst practiced. In both cases the analysts felt that an analysis under those conditions worked well.

Most analysts tell their patients that they will see them after termination if they need further help. One analytic therapist described a situation where her ex-patient requested a further two sessions because her mother had died; the therapist agreed and offered twelve sessions. The therapist then described feeling in a panic that this would not be enough time to process the mother’s death and discussed in supervision whether she should continue to work with her ex-patient or refer on to another therapist. It seemed important in this case to do the latter, as the patient knew that the therapist had partially retired. As clinical observations of analyst-initiated post-termination contacts suggest that these are not damaging but usually consolidate gains, facilitate self-analytic function and posttermination mourning (Schachter & Johan, 1989), recommended that in the termination phase, the analyst offers a single face-to-face extra-termination contact within the year to assess gains (and help the patient achieve further help if needed), and only at the patient’s request. Women analysts were more likely to have post-termination contact with their analysands than men analysts, and this gender difference needs further elucidation.

Finally, some patients may need intermittent analysis. Green (2002) suggests that although there are analyses that seem to end well, often additional analyses are necessary before it is possible to finish
definitively. He thought that when there are resistances which may prove insurmountable and play a useful role in the subject’s equilibrium, it is probably wiser to “free” the patient and to suspend the analytic process, while waiting until circumstances create the need to take it up again. This is only appropriate with patients when the analyst does not feel that terminating is likely to have damaging effects, seriously compromising future prospects or health. In such cases the analyst would show, but without applying pressure, that s/he disagrees with the patient’s wish to end the analysis. Green thought that an analysis extending over different time periods is more likely to bring about structural changes than a single analysis in an intense rhythm of five times a week. He therefore thought that the analyst, while remaining open to the possibility of psychic movement at a later stage, needs to be able to accede if the patient wants to terminate (or interrupt), and if this is achieved in a good-enough way it may facilitate the patient having more analysis.

Discussion

As Meissner (2007) put it succinctly, manipulations of the analytic schedule, even for the best of reasons, cannot be done without cost: requests on the part of either analyst or patient to change times of session, whether on a one-off basis or permanently, inherently face potential transference-countertransference difficulties. A temporal variation alters the framework of treatment and therefore changes the analytic situation. A number of the instances may be viewed as amounting to enactments along a spectrum. They raise questions about why analysts vary their technique. What is the extent of analytic disclosure about this and has it been relatively guarded?

Handling patient requests for modification of the frame has been taken as evidence at least in part of the patient’s anxiety and conflicts, and correspondingly the analyst’s inclination to initiate changes to the external frame should at least be considered a signal of the analyst’s fears and a possible enactment of conflict or trauma (Ehrlich, 2010). Ehrlich found, however, that when making the offer to increase sessions patients became more engaged and hopeful, and the work deepened. A main point discussed here is whether temporal variations are to be viewed as a breach of the setting or are rather to be regarded as analyst and analytic situation having a flexible frame (or both)? Do changes
in the setting imply, as many analysts suggest, a moving away from rigorous psychoanalytic practice, defined as aiming to elicit transfer- ence (Aisenstein & Smadja, 2010)? Or, as Ferenczi argued, is it a move away from rigidity to an independent stance of occasionally encour- aging the patient to do certain things, i.e., as an analyst who takes an active stance but without actually making suggestions to the patient. Kurtz (1988) discussed two views of time exemplified particularly by two major schools, the classic analytic, in which the patient’s behaviour is understood as resistance to be interpreted, whereas in the self psychology approach the infantile developmental needs are viewed as having been revived and therefore need appropriate handling to be met sufficiently for growth to proceed. Making exceptions to the temporal framework of sessions would then follow from the second approach. Thus Kurtz’s offering a patient a flexible session at a time of need con- stitutes a parameter only if the fixed time session is taken as a rule, in which case the outcome is the only test for the validity of altering it.

Let us turn now to whether the outcome if known seems to be a therapeutic one. The fantasized meaning of temporal change for both analyst and patient—whether the analyst initiates the interventions (or co-creates them)—affects the patient with ongoing reverberating resonances in the transference-countertransference and intersubjectively. Currently, there is considerable support for the view that this co-creation may be the only way that the patient can bring material that is “beyond words”. Many analysts have the experience that some temporal enactments when they, for example, misread the clock and finish the session a few minutes early or late or make a mistake about ses- sion times, have the effect of helpfully bringing into the session mate- rial about a parent who was felt not to be caring enough to be in touch with the child’s needs. This seems more to do with enactment rather than acting out (Etchegoyen, 1991). What appears to be a transference- countertransference stalemate is often the heart of the analytic work and if this is what precipitates the intervention may be very infor- mative. Many transference-countertransference difficulties prove fruitful for the work proceeding. The patient’s response is the key factor and if there is a therapeutic outcome this suggests that the patient’s fantasies have a more benign outcome. One may think here of Winnicott’s (1971) concept of the necessity for the infant to feel that the object, the mother, survives the infant’s aggression and the corresponding importance for the patient to feel, if the frame is changed, that the analyst’s mind
survives. An intervention by the analyst to the temporal framework as an object in the transference relationship may feel to the patient to be an individually tailored intervention and therefore to have some similarities with Green’s (2002) objectalizing function—the key issue in development of the transforming drive activity by the intervention of the object in its relation to time. That is, similar to the Independents’ concept of becoming the analyst that the patient needs.

If we study closely what happens following an intervention to the temporal frame, the affect storm often quickly releases useful material to work with. What emerges as a theme is how often an intervention is reported as helping the material move along, as grist to the mill. Viewing an enactment as communicative information allows the possibility for a more nuanced view of a temporal intervention. An intervention in the temporal framework may help a patient who feels that there was a failure of the environment in infancy, to feel that he or she has been heard (Green, 2002).

Conclusion

Psychoanalysis is a deepening of a relationship between two people to explore the meaning of the patient’s concerns. Interventions and alterations to the temporal framework have the potential to have considerable transference-countertransference effects on the relationship, clearly facing the patient with “the time of the Other” (Green, 2002). To summarize the chapter: the different interventions to the temporal framework have been considered in the light of the literature and what analysts share privately, and in particular the fantasized meaning to analyst and patient, the layers of resonances in the transference-countertransference and intersubjectively to begin to assess how often they were judged to be therapeutic.
PART II

ALTERATIONS OF THE METHOD