

SHADOWS OF PSYCHOTHERAPY: ON MOURNING THE LOST CHAIR

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Although converting face-to-face psychotherapy to psychoanalysis with the same patient has become a common clinical fact, its process is rarely described in the analytic literature. This article defines this process as an example of frame modification and tries to analyze different levels of psychic work implied for the patient by such a change. A clinical illustration demonstrates the reprocessing of what a patient can defensively deposit in the initial frame of psychotherapy and the remobilization into the transference of previously silently enacted fantasies.

Keywords: couch, psychoanalytic setting, face-to-face, symbolization, frame

Passer d'une psychothérapie en face-à-face à une psychanalyse avec un même patient est une pratique courante qui n'a été que peu décrite dans la littérature analytique. Cet article définit ce processus comme un cas de modification du cadre et tente d'analyser les divers niveaux d'élaboration psychique qu'il suscite chez le patient. Une illustration clinique démontre comment ce que le patient avait défensivement déposé dans le cadre psychothérapeutique peut être ré-élaboré et comment certains fantasmes auparavant mis en acte en silence peuvent se remobiliser dans le transfert.

Mots clés: divan, dispositif psychanalytique, face-à-face, symbolisation, cadre

[W]ithout exerting any other kind of influence he invites them to recline in a comfortable position on a couch, while he himself is seated on a chair

behind them outside their field of vision. He does not ask them to close their eyes, and avoids touching them as well as any other form of procedure which might remind them of hypnosis. The consultation thus proceeds like a conversation between two equally wakeful persons, one of whom is spared every muscular exertion and every distracting sensory impression which might draw his attention from his own mental activity.

—Strachey (1904, p. 250)

INTRODUCTION

Although converting face-to-face psychotherapy to psychoanalysis with the same patient has become a common clinical fact, its process is rarely described in the analytic literature. This article will explore the unconscious significance of this “migration” from a weekly face-to-face psychotherapy to analysis four times weekly on the couch. Since this conversion can be defined as an example of frame modification, we shall first review recent psychoanalytic understandings about the analytic frame. We shall then be in a better position to analyze, with the help of a clinical illustration, different levels of psychic work implied for the patient (and the analyst) by such a change.

PSYCHOANALYSIS OF THE ANALYTIC FRAME

The history and prehistory of the analytic setting show us how theories of mental suffering and theories of cure find their concretization in the spatiality and materiality of clinical frames (Roussillon, 1995; Chertok & de Saussure, 1973). The creation of the classical psychoanalytic setting described above resulted from Freud’s reworking of the limits of the hypnotic theories and setting in an effort to cure neurotic illness. Similarly, extension of the analytic work (Stone, 1954; Grand, 1995) to different populations (psychotics, borderlines, children, groups, families) have led clinicians to introduce changes in the parameters defining the frame of the classical cure and to attempt theorizing about these changes. The patients they worked with often manifested some difficulties in accepting the classical analytic frame. Different uses of the frame could be identified according to different psychopathological structures or to different phases of psychological functioning. Over the last decade, literature on psychotherapy and psychoanalysis have helped to articulate a better differentiation of their respective frames and how they affect the degree, intensity, depth, and duration of transference–counter-transference regressive manifestations.

Conversely, shifting from psychotherapy to psychoanalysis has become a common clinical fact over the years. Many patients have experienced a significantly long period of face-to-face psychotherapy before adopting the couch. Literature about this “migration” stays relatively sparse and fragmentary.

Kulish (1996) notes how few detailed clinical accounts of such transformation in the setting and frame of the psychoanalytic work have yet been published. The first studies about “conversion” from psychotherapy to psychoanalysis focused on its general impact on the development of the analytic process and the potential influence (“contamination”) on the emergence, unfolding and working through of the patient’s transference, on its analyzability and on the capacity for the analyst to maintain an analytic stance (Oremland & Fisher, 1987). They stressed the need to understand the conditions that underpin the analytic process and how the change of setting might affect the nature and content of the analytic work. This shift indeed transforms the modes of perception, listening, and communication of the analytic dyad, their emotional position, and overall psychological mobility (free association, free-floating attention) (Caligor, Hamilton, Schneier, Donovan, Luber, & Roose, 2003).

This article will not address the growing literature on the “creation” of psychoanalytic patients (Rothstein, 1995; Levine, 2010). Nor will it analyze the controversial specificity of psychoanalysis and its differentiation from psychotherapy (Blass, 2010; Kächele, 2010; Widlöcher, 2010). The focus will be primarily on the unconscious meanings of the therapeutic setting, with clinical material illustrating perturbations and transformations in symbolic process that occurred during and after one patient’s transition from weekly psychotherapy, in the seated, face-to-face position, to psychoanalysis on the couch, four times a week.

The psychoanalytic situation can be understood according to the interaction between its process (set of variables) and its frame (set of constants), the “non-process” within whose bounds the process takes place. Analytic process can unfold only when the internal environment in which the patient lives is transferred onto the analytic situation. Many authors have described a specific transference, an often secret or latent cathexis of the contextual level of therapy (Bleger, 1966; Donnet, 1995; Green, 1990, 2000; Reid, 1996; Roussillon, 1995). They emphasized how some patients who, having experienced radical environmental modifications (hospitalization, migration, divorced parents) show an exquisite sensitivity to slight change in the analytic setting (Godfrind, 1995). The meaning of the frame differs when it is maintained as a silent background, then is changed, becomes a variable, and is reprocessed (Bleger, 1966). Conversion from psychotherapy to psychoanalysis implies such a reprocessing of the frame.

Bleger suggests that by its immutability, the frame becomes the depository of the most regressive, primitive, and undifferentiated organization of the personality (its psychotic part). It then contains the non-solved

part of the primitive symbiotic links with the mother's body and constitutes a non-ego (or meta-ego) underpinning the ego's functioning. This transferred "ghost world" maintains a background of fusion ("ego-body-world") where the body-space and the body setting are non-differentiated. Any variation in the frame brings the non-ego to a crisis, by contradicting the fusion. The frame then starts to "cry." Confronted with a catastrophic break in its limits, the ego is forced to re-elaborate either by re-introjecting the split-off psychotic parts (often through hypochondriacal symptoms) or by installing new defences against their integration (immobilization, re-projection). The ego's limits are then recovered. The process of conversion thus corresponds to what Roussillon called a "borderline situation," at the limit of analyzability, placing the frame—the precondition of analyzability—in crisis. Symbiosis must be paradoxically re-established (within an unambiguous, unchanging, and unaltered frame) in order to be analyzable and transformable. This poses some technical problems when disruption is introduced by the analyst, as in the process of conversion from psychotherapy to psychoanalysis.

This change will indeed affect the intensity (force) and meaning of the transference-counter-transference experience (manifest or latent). Since the frame is a "force field" (Green, 2000), conversion will change the dynamic interplay of forces mobilized in the transference and immobilized (pent up) in the frame. "Conversion" will also affect the matrix of analyzability, interpretability, and symbolization, the signification process as well as some of the symbolic content. It will change the transference and counter-transference meaning of the frame and of its modification or conservation, which then risk becoming a symptomatic (Kulish speaks of as a phobic avoidance) or silent enactment (Goldberger, 1995).

THE WORK OF CONVERSION

Understanding the "work of conversion" depends on conceptualization of the effect each setting has on psychic processes. How is psychic functioning affected by the position of the body, the degree of activity-passivity it induces, and the type of underpinning and recourses it allows? One of the most under-theorized or repressed aspects of this change is the analysis of the condensed meaning of the sitting position (Celenza, 2005), historically overshadowed by the fetishized use of the couch. Cournot (1998) has underlined how sitting face-to-face offers the possibility of using perception (vision) of the presence of the other (external reality) and usual social modes of mastery to underpin the symbolization process. The induced state of passivity is then minimal and more easily manageable (by perceptual

control and vigilance). By contrast, the recumbent position offers the possibility of installation in a passivity that is potentially rich in affective emergence of brute excitation (by limiting motricity and perception, erasing the body of the analyst).

The materiality (spatiality) of the setting directly concerns the physical underpinning of the psychic apparatus. It has an impact on the patient's physical experience of it by soliciting his sensori-motricity to a different degree. On the motor level it will affect the body's mobility (immobility), and on the perceptual level it will predispose to particular vertices (influencing the mobility of attention and vigilance). The frame contains "in action" a theory (a symbolization) of how to symbolize (Roussillon, 1995). The restriction of motricity in the recumbent position symbolizes how symbolization is an internal motricity. Restriction of perception symbolizes how mentalization is a perception turned inward of the loss and the absence of the object. The setting also concerns the cultural codification of bodily communication (such as postural), and thus the social (institutional) underpinning of the psyche. Change in setting will thus force a work of "double dis-underpinning" (Reid, 1988). The frame disruption introduced by the analyst thus affects conditions of the analytic work of interpretation and induces (forces) its own symbolization. It raises the question of the pre-symbolic and symbolic meaning of this change for the patient and for the analyst while changing the nature of their work of symbolization.

Anzieu (1986) emphasized the homology between the psychoanalytical frame and the topographical structure of the psychic apparatus (corporeal or skin ego) composed of two psychic envelopes. The first functions as an excitation barrier (protective screen and quantitative filter) under the constancy principle. The material setting of the analytic frame concretizes the rule of abstinence, which minimizes exogenous stimulation and maximizes attention to internal excitations. The second envelope works under a differentiation principle as a surface of reception and inscription of signifiers (qualitative filter, projective screen, and support for projection of visual and tactile images). These inscriptions keep traces of the history of the subject by a plurality of inscriptions. Major psychopathological organizations can be described by the degree of differentiation and type of articulation between these two envelopes (e.g., confusion, subordination, permutation). For instance, the hysteric will not differentiate excitation and communication and paradoxically will use hyper-excitation to seek for communication of meaning.

The change of setting will affect what Ogden (1991) calls the "matrix of transference," where psychological meaning is constructed as a result of

the dynamic interplay of different modes of symbolization. Each mode can be described according to the degree of elaboration of the change of setting it allows (of space, time, activity, passivity, etc.), the distinctiveness of its anxiety and defences, and the type of traumas it reveals. The patient will inevitably transfer onto the setting her own internal space of symbolization. This specific transference onto the frame holds the history of the subject's relationship with symbolization, the history of how her environment did or did not underpin her infantile symbolization system, how it was symbolizing or anti-symbolizing (confusing). The patient will repeat in relation to the therapeutic frame the essential elements of the traumas of symbolization she encountered (Roussillon, 1999).

SOMATIC PRE-SYMBOLIZATION

Many authors have tried to describe the most primitive mode of attributing meaning to experience (Bick, 1968; Gaddini, 1987; Grotstein, 1981; Ogden, 1989; Pines, 1991; Tustin, 1986). They postulate a first level of mentalization that does not imply symbolic meaning and stays dominated by sensation. It consists of a pre-symbolic (pre-fantasmatic) ordering of sensory experiences and their connection into bounded surfaces. Sensorial impressions are bound together, creating autistic felt shapes, sensation-shapes or autistic objects (Tustin, 1986). Only things that can be touched and handled to produce sensation will have meaning. Tustin gives the example of how the experience of sitting can be reduced to the sensation, mainly at the surface of the skin, with no sense of the chair outside of this sensation (no sense of thingness). Searles (1960) insisted on the existence of a specific mode of relating to things in themselves that is not a representation of the mother or of one's own body. This pre-ideational mode of mental functioning stays under the primacy of the repetition tendency (beyond the pleasure principle) and corresponds to what Ogden (1989) called the "autistic-contiguous position," Bleger (1981) the "glischro-carycal position," and Caillot and Decherf (1982) the "narcissistic-paradoxical position."

Studying these initial phases of the mind's development, Gaddini (1987) notes how changes in the environment (such as from an intrauterine to extra-uterine milieu) cannot be appropriated mentally as quickly as they occur physically. The primitive mind tends to magically make its own (by assimilation to the self or extension of the self) parts of the environment (of the mother's body). Primitive perception is essentially "physically imitative" and consists of modifying one's body according to stimuli (such as to the presence *or* the absence of mothering). Everything with which the infant perceptually enters in contact represents not the environment but

the boundaries of the self. "The incapacity to maintain a seated position and to hold one's head erect, in the first months of life, is like the concrete (physiological) expression of [the primary need for holding and for a boundary-environment]" (p. 319).

By its invariance, the therapeutic setting participates in the constitution of this background of sensory boundedness, in the installation of a "sensory floor" (Grotstein, 1981) where the patient can ground himself in bodily sensation and find a safe place to exist, live, and feel, as a pre-condition of ulterior symbolization and of the unfolding of the analytic process. Grotstein evokes the situation of the baby sitting on the mother's lap and leaning on her belly as a prototypic experience of a "background object of primary identification" underpinning the baby's sense of security and unity.

Failure in this pre-symbolic binding (induced by premature and traumatic perception of bodily separateness from mother) will result in disruption of bodily cohesion and boundedness (dismantlement, annihilation) and a catastrophic change in the shape of one's surface (being torn, punctured by black holes, stripped raw). This generates experiences of absolute meaninglessness (absurdity, nonsense, madness) and incommunicability. The loss of sensory groundedness will be felt as the primitive agonies (Winnicott, 1974) of timeless and placeless sensations of disappearing, leaking of the body content, dissolving, falling into shapeless, unbounded, infinite space. Anzieu (1979, p. 209, my translation) notes how "the pathogenic situation of non-emission and non-reception by the mother of bodily signs adapted to the child's needs" can be revived by the lying position. Quinodoz (1990) described an experience of vertigo (by fusion or expansion of the self) by one of her patients as a breakdown of himself *and* of the couch with which he was confused.

Primitive defences will be erected in an effort to reconstruct the sensory floor by plugging the "holes" in the self in order to provide a never-changing world of absolute predictability and protection. They can be retraced in a self-soothing auto-sensuous use of soft autistic shapes and a self-reassuring use of solid autistic objects. They can also be found in the use of second skin formation (Bick, 1968; Pines, 1991) and "self-holding" (compulsive wrapping in clothes, perceptual gripping). They can express themselves by a defensive adherence to the surface of an object in order to restore integrity of skin surface (adhesive equation) and by compliant imitation in order to hold onto and become the quality of the surface of the adhered object (imitation of the armchair or the analyst's sitting posture).

Taylor (1987, p. 149) notes that "when sensuousness remains unregulated and untransformed into dreams, fantasies, and play (i.e. transitional

phenomena), it may become directed toward bodily organs and functions and result in hypochondria or psychosomatic disease.” Gaddini (1987) sees in some early psychophysical syndromes (merycism, atopical dermatitis, bronchial asthma, and stuttering) expressions (imitation) in a concrete pre-verbal and pre-symbolic “language” of lost physical experiences induced by precocious detachment from the maternal body-environment (for example, as the result of the mother’s illness, or rapid new pregnancy). These early detachments are experienced as catastrophic loss of the omnipotent self. Commemorative physical symptoms constantly keep in the perceptual field concrete traces of these experiences. Like Bleger, Gaddini warns that the silent operation of magical assimilation-extension can transform the analytic setting into a functional area for the self’s magical omnipotence.

Primary traumas can be secondarily sexualized in an attempt to master them and can be used to explain the intensity of some perverse (masochistic, fetishistic) use of perception and motricity that manifest themselves in an immobilization of the analytic process (frozen) by a silent and rigid fetishization of the setting (Roussillon, 1999).

PRIMARY SYMBOLIZATION

The integration of the modification of the frame into the foreground held by fantasized scenarios and the capacity to use the perception of environmental changes to enrich this fantasized world depend on the patient’s capacity for symbolization. Authors have described the onset of symbolic meaning as a process where motor moves are transformed into visual ones. Transference will begin to express traumatic non-symbolization or de-symbolization. This primary symbolization of experience stays concrete, immediate, and unhistorical. It corresponds to what Segal (1957) described as “symbolic equation,” which does not discriminate between symbol and symbolized. Winnicott (1947/1958, p. 199) stated that “for the neurotic, the couch and warmth and comfort can be symbolical of the mother’s love; for the psychotic it would be more true to say that these things are the analyst’s physical expression of love. The couch is the analyst’s lap or womb, and the warmth is the live warmth of the analyst’s body. And so on.”

Primary symbolization is a mode of mental functioning that integrates the repetition tendency under the dominance of the pleasure principle and autoeroticism. It corresponds to the paranoid-schizoid mode of experiencing. The agency of pleasurable perceptual or motor experience will be attributed to the ego, while the agency of painful or unpleasurable experience will be attributed to the non-ego (Freud, 1915). As (empty) tri-dimensional

space begins to be represented, some distancing and rapprochement movements will be passively experienced (being dropped, things being propelled from the self, being sucked in). This corresponds to Quinodoz's description of vertigo by dropping or by aspiration. Lost objects are not mourned but recreated or restored magically in fantasy.

Failure in the process of primary symbolization (primary traumas) of early traumatic experiences (primitive agonies) will nevertheless leave unintegrable split-off traces of absolute meaningless ("endless dead end") either permanently activated or reactivated. It will manifest in anxieties of impending annihilation, of disconnectedness, disintegration, or fragmentation of self and object (falling apart), of shapelessness, and a collapse into a world of things in themselves. These traces will return in non-representational forms of perception (corporal hallucinations), motor acts, or speech acts (Reid, 1996). The subject will defend against the return of these "wandering" traumatic traces mainly in an enactive incorporative or evacuative omnipotent way (splitting and projective identification), thus using the language of action (symbolic equation) to reinstall what Reid called a "dyadic mode of psychic functioning."

Steiner (1993) has also described a "borderline position" where the sense of agency of mobility is more integrated, permitting fantasies of active flight from dangerous experiences and active return to "psychic retreat." This corresponds to Quinodoz's description of vertigo provoked by a fantasy alternating captivity and escape, which implies a dis-idealization or denigrating of fusion.

SECONDARY SYMBOLIZATION

The secondary symbolization process, corresponding to the reach of the depressive position and the phallic and genital positions (Caillot & Decherf, 1982), transforms visual images and language of action into word representation, thus allowing ambivalently desired motions and perceptions to become permissible and subjectively owned. This mode of symbolization integrates historicity, facilitates mourning, and is governed by introjective identification (Ogden, 1991). Failure in this process corresponds to the repression of conflictual visual representations, resulting in what Roussillon (1999) calls "secondary traumas." The return of repressed desires will provoke an anxiety of having attacked or driven away the ambivalently loved object in fantasy. The following clinical illustration of a case of conversion from psychotherapy to psychoanalysis will offer matters to reflect on the transferability of the prior transference on the setting (from sitting to lying down, from armchair to couch) and to conceptualize

the nature of the psychic elaboration of the lost experience of the face-to-face setting.

CLINICAL ILLUSTRATION

Mrs. A undertook a long psychotherapeutic journey before beginning her analysis with me. Her life had been punctuated by many traumatic events involving a highly dysfunctional family. She suffered from acute anxiety states accompanied by a series of painful and enigmatic psychosomatic manifestations. Her "self-cure" relied mostly on phobic and avoidant solutions. We worked together for several years in weekly face-to-face psychoanalytic psychotherapy. Our work mostly helped her diminish her depressive mood and phobic attitudes. A new and more satisfying equilibrium seemed to have been installed in her life and she decided to interrupt her psychotherapy, acknowledging that her differentiating process with her family was precarious.

But a major psychosomatic disorganization and her enmeshment in family conflicts brought her back to psychotherapy years later. She was deepening her work with me, when she suffered the sudden loss of her father, adding a complicated mourning process to her difficulties. When she expressed the need for more frequent sessions, I offered her the possibility of an analysis, which we started six months later.

Mrs. A began her analysis with manifest signs of resistance to the installation of the analytic frame. She advanced the date of the agreed beginning of treatment and postponed for two weeks her use of the lying down position by clinging to the face-to-face setting. She felt overwhelmed by the increase in frequency of the meetings to four times a week and decided she would try the couch after taming that new rhythm. The night before her first analytic session she dreamed she was lying at her father's place in his deathbed, terrified of hearing her other self, sitting beside the bed, talking to her. If the couch represented for her a place to let herself cry, she feared the transition from the chair to the couch where I could make her fall into emptiness. She experienced the couch as a loss of control over me and what could happen to her (fear of being intruded upon). She admitted she had constantly kept an eye on me and realized the force of her hyper-controlled frame, where she was used to "decant everything" alone. She complained things were happening too fast to control anymore and that she was having trouble sleeping. There followed a series of dreams where she was either on a roller-coaster ride or high-speed skating on rollerblades in a roller dome. There was always something happening to stop her from setting herself down. She fantasized about leaving everything and running away.

The installation on the couch also triggered in her a series of painful and paralyzing memories of traumatic “bedside scenes” (hospitalizations, parental fights at night). All symbolized failures in the caring and protective quality of her environment for her dependency needs and vulnerability. Parental and medical care had been too often either intrusive or absent. In analysis, she generally avoided addressing her dependency needs to me, fearing I would get fed up (*tanné*) with her (like she felt her husband was) and drop her. During the analytic hours, she oscillated between a state of agitated and paralyzed withdrawal. In a dream, she was on a perforated and deflating waterbed, at risk of drowning herself, and thinking she should have had the most comfortable bed of the house. She reluctantly admitted to me she would need me “to never let her down.”

Thinking and talking about her instinctual world was an ordeal for her. She dreaded its potential violent or mad quality and often imagined herself running out of the office, yelling, crying, or vomiting in a kind of cathartic undifferentiated somato-psychic discharge. Her associations were filled with traumatic violent scenes symbolizing the persecutory nature of her instinctual world and its transference mobilization. She often experienced the analytic process as one of torture in which she was passively exposed like a paralyzed prisoner or a hostage. She then hated me for making her think about things she would rather avoid remembering (and reliving). In a dream she exchanged positions with me and triumphantly commented that I also had difficulties in my childhood. She significantly felt more vulnerable on the couch. She experienced a split between her ordinary life and her need to stay bound to her fragile family.

Sessions were often accompanied by somatic symptoms exhausting her and making her terribly anxious, fearing (sometimes hoping) for her own death. Her body seemed then to come to the rescue as a way of linking some experience of terror, helplessness, and distress (like “ghosts in the flesh”) that was hard to metabolize. There seemed to be some kind of embodiment of painful memories, where parts of her body were used to recall traits of her family members (rhythm, unpredictability, unintelligibility). These bodily experiences also seemed to be involved in the process of her own individuation: her sicknesses identified (confused?) her with the other sick family members as if her individual body represented her whole family with its suffering members. Her body also seemed to be included in the course of the complicated mourning process of her recently dead father (cryptic incorporation?). The lying position of her body on the couch reminded her of her father’s last moment on his deathbed.

The night before her return from the first summer break in her analysis, she dreamed of an earthquake. When she came back, she sat on the armchair, pleading for a break from the couch where she felt paralyzed by her memories of her excessively clutching father with whom she feared being identified. She felt overwhelmed, often dropping things and falling. Her somatic symptoms remained ambiguous and she dreaded becoming increasingly sick and unable to find relief. She fantasized gripping me to tell me not to let her fall. She suffered from what she called “mysterious pain crises.” She felt raw, skinless. Her heart pain reminded her of aches she had had at other periods of her life. Most of all, she dreaded losing her mobility (the use of her legs) if she rested them on the couch. She complained that the frequency of analytic sessions left her with too little time to think things over.

There followed a period where she went back to the couch, often withdrawn, wrapped up in her coat. Sometimes immobile, sometimes rocking her feet or playing with her jewellery (earrings, ring) or her own fingers. Mrs. A was afraid I would get fed up, exhausted or irritated with her, and let her down, that I would not be strong enough and collapse in front of her. I often had the impression Mrs. A was sparing me, though once she expressed her anger for not having protected her from painful events, even when she came four times a week.

During that period of withdrawal, another series of unforeseen stressful events made her rely again on the sitting position for a few sessions, but this time with her back against the wall, while staying on the couch. She feared the recumbent position as a paralyzing exposure to my unpredictable attacks. She added she needed to sit without necessarily needing to see me. Her body “yelled” louder. She linked her somatic symptoms to repressed cries of pain, rage, and surprise, but also to a feeling of constant rawness. She also linked her not using the blanket on the couch to her avoidance of reusing a similar blanket in which she wrapped herself the night her father was dying and which felt was the only thing that kept her from falling apart. She was too angry to lie down, blaming me for not protecting her from life events. Lying down made her feel depressed and more vulnerable to the risk of being defeated and forced to shoulder (*endosser*) distorted views of herself. She would remain standing and not surrender, as a way of reassuring herself about her autonomy (sacrificing her need “to lean” on me). This sitting “standing up” meant she kept the use of her legs and differentiated herself from her sick, handicapped, or dead family members.

In the transference, she gradually experienced me as more reassuring, helping her to calm down (telling her bedside stories), more tolerant (letting

her “jump on the bed-couch”), and allowing her to feel grown up (“like sitting upon my shoulders”). She dreamed I rescued her after she had fallen in water from a narrow bridge (couch). The increased frequency of the sessions contributed to this new and precarious security and resulted in a decreased anxiety (less defensive hyper vigilance) and a restored self-image and self-esteem (the right to exist, be herself, admit good parts of herself). Nevertheless she saw herself split between feeling better and a “background of despair.”

The more exciting-persecuting-torturing heterosexual object was mostly split off and projected outside in lateral transferences: the doctors (ill-) treating her body. But it was also transferred in part onto my “sadistic-voyeuristic” proposal that she attend sessions four times a week (torture) and lie on the couch (exposed to painful ideas and feelings). She envied my sitting position, fantasized seeing me on the couch “to see how intelligent I would be there.”

The second summer break revived her anger toward me. For a few sessions, she sat on the couch, back to the wall, in a defiant compromise position. She said she could disentangle herself alone. Why was it necessary to lie on the couch anyway? Would not seeing me be enough? She fought against what she called her “bottomless need” to be the centre of attention and her desperate fear of never really being seen or heard. She felt she could crack up and fall anytime. Her family paid only minimal attention to her when she was sick (like them), and she was more able to resist this kind of collusion, as health became more ego-syntonic to her. She feared being speechless, legless, armless (again). As anality emerged from the background and found its figuration in the transference, she became able to verbalize the intense shame the fundamental analytic rule implied for her. Free association felt like a kind of anal incontinence that made her look stupid while her analyst could appear “intelligent.”

In the beginning of her third year of analysis, an unforeseen family crisis overwhelmed her as she re-experienced an unbearable mixture of despair, rage, and helplessness. She became afraid I would become upset, say I did not see the end of her analysis, that she would not get out of it and angrily ask her to leave. She felt angry for my not being there when things went wrong, and for the first time she was really resentful for the lack of understanding she attributed to me. Lying on the couch made her feel too infantilized and invaded by her thoughts of being trapped and exposed. She wanted to end her analysis and could not simply see herself getting off the couch and leaving. She believed she would not be able to tolerate her

anger while in a lying position, so she returned to the face-to-face setting, doubting she would ever return to the couch. She sat up for five months.

The crisis had exacerbated her paranoid mistrust, which extended to me. She needed to be facing me, to keep an eye on me, control me visually, see everything, be hyper-vigilant, while having no one behind her to attack her (protected by a wall). If it were easier to express anger while sitting down, she was afraid I would also become annoyed and angry. If her move was to help her regain mobility (flight-fight), she nevertheless felt kept on hold by the events. Saying she was more affected than she admitted, resisting emotional surrender, she felt paralyzed, gagged, hyperactive, and restless, making no concrete moves to resolve the situation and blaming herself for it. She dreamed of staying suspended in mid-air by force of will, to avoid a skunk. She gradually saw how her heroic self-sufficient cure—to be strong, alone, and by herself—complied with the ghost of her perfect mother and how her melancholic self-blame was a criticism of parental inadequacies. She intuited how she used the sitting position to stay on the throne or pedestal on which she had placed her parents (looking down on her and not looking stupid), while the lying down position and the lack of censorship meant sinking into an anal dump where her shitty thoughts would stick to her, follow her, or attract even more shit. For weeks she oscillated between moving ahead angrily and cracking up on the couch like a shell-less mollusc.

Having to return to analysis after the third summer break left her angry and cynical. But the working through of the collusive compliance to her family's world view permitted her to use the couch again. She half-hated the fact that "it did work" (she could no more avoid her thoughts by looking at the titles of the books on the shelves) and that she heard herself more on the couch. A tension in her fell. During the following weeks, she commented on the sucking or aspiring pull she felt from her family's frame of mind, its constant atmosphere of conspiracy, debt, and treachery, and the injection of a confused sense of responsibility and agency in her. She felt "placed" there like a wet rag, disqualified, forced to abandon her own point of view and to adhere to denial and madness.

DISCUSSION

This clinical illustration may help elucidate the levels of psychic work involved in converting face-to-face psychotherapy to psychoanalysis. Over the nine years of face-to-face psychotherapy, Mrs. A and I became accustomed to working together in a shared setting that each of us cathected according to our own personal history but also according to our shared

history. Converting face-to-face psychotherapy to psychoanalysis imposed a different psychic work on both of us. Each of us had deposited in the psychotherapeutic frame our personal “ghost world” of hidden transference to the face-to-face setting. This silent cathexis of an unchanged and unchanging setting allowed us a relative psychosomatic equilibrium that helped us do valuable psychotherapeutic work. Eventually, though only my patient had to relinquish the sitting position, we both had to relinquish our reliance on visual cues to understand each other and had to translate these non-verbal messages into verbal ones.

The change of setting revealed how sitting had allowed the patient’s silent hypercathexis of perception, a kind of visual and proprioceptive hyper-vigilance defensively used against the upsetting resurgence of painful memories of the early environmental disruptions (hospitalization, parental fights) she experienced while in a lying down position (postural-dependant memories?). These disruptions concretized the unavailability, unpredictability, and variability of her objects, which also often manifested by the lying down of these same objects. This variability was split off and projected into her confused body (unpredictable symptoms) relatively mastered by controlling her body setting. Sitting down and witnessing me sitting down was in many ways reassuring. It allowed avoidance of unbearable thoughts and their actualization in the transferential regression. Part of Mrs. A’s self-cure relied on self-holding and self-sufficiency. Instead of “decanting” with me, her inclination was to “decant alone.” The lower frequency of psychotherapeutic séances also favoured this defensive frame.

Mrs. A was terrorized by what would happen to her between the armchair and the couch (falling down, needing me to carry her). She reacted to the loss of the familiar setting with forms of pre-symbolic self-soothing (Tustin, 1986)—the use of sensation shapes (wrapping herself in her long coat), autistic objects (sitting back to the wall, manipulating her jewels), and rhythmic motricity (rocking her feet)—to reassure herself against feelings of psychosomatic disconnectedness, estrangement, and immobilization (paralysis).

As the analytic work progressed, Mrs. A began integrating aspects of her body experience of the physical setting into her associations and memories, as she became able to transform them into visual images, dreams, and fantasies (primary symbolization). Her perceptual experiences of “shapes” previously felt through her psychosomatic symptoms were symbolized differently. Transference began to address traumatic non-symbolized or de-symbolized experiences. Fantasies including identification to parental body parts emerged. The change of setting began to have meaning for her.

Sitting down could then represent enviable omnipotent control (throne) or despised weakness she could experience actively or passively in the transference fantasies. The couch could represent hospital bed, conjugal bed, etc. Verbalization of these fantasies (secondary symbolization) helped reduce the splitting between the idealized and demonized nature of Mrs. A's representation of the couch and armchair settings. She could begin to relinquish omnipotent wishes (magical perfect poise) and subjectively own her more differentiated body (as health became more ego-syntonic for her), giving her freedom to play within both therapeutic settings.

CONCLUSION

The working through of converting psychotherapy to psychoanalysis will follow the reprocessing of what the patient (and the analyst) has deposited in the initial frame of psychotherapy. It will reveal the extent of her symbolization and differentiation capacities and may increase them if the analyst is sensitive to the diversity of psychic manifestations it might induce. Some of these manifestations will express either these capacities or their disruptions (Lear, 2002).

The change in the setting can help reveal the patient's secret defensive perceptual over-cathexis of the immutability of the analytic environment and help "decapsulate" autistic enclaves creating obstacles to the analytic work. The migration from the chair to the couch can also reveal silently enacted fantasies associated to bodily postures and body setting, which were kept split off from the analytic process (enclaves of omnipotence). The re-mobilization of these fantasies into the transference onto the analyst may favour the reduction of splitting and idealization (or demonization) in the use of the physical setting and help a subjective owning (non-compliant, less defensive) of one's more differentiated body.

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