THERAPISTS' PERCEPTIONS OF OUT OF SESSION FRAME DEVIATIONS

BY: FARAAZ MAHOMED
0307067V

SUPERVISOR: DR. CAROL LONG

UNIVERSITY OF THE WITWATERSRAND
DEPARTMENT OF PSYCHOLOGY

Submitted to the Faculty of Arts in Partial Fulfilment of the requirements of a Master of Arts Degree in Clinical Psychology

2008

ABSTRACT

This study explores the complex and relatively under-researched topic of out of session frame deviations. It considers the role of frame deviations in psychodynamic psychotherapy and the various conceptualisations of the frame, examining the debate between the ideas of a flexible and 'elastic' frame and a more unchanging and 'impenetrable' frame. The study uses a qualitative design to examine therapists' understandings of out of session frame deviations as they have experienced them in practice. Six psychodynamic psychotherapists were interviewed and asked for their perceptions regarding out of session frame deviations. What emerged from the analysis of the interview material were diverse experiences of the types of frame deviations outside of the consulting room, by both therapist and patient. In addition, therapists felt that out of session frame deviations might have an impact on the therapeutic process, depending on their unconscious roots and on particular factors that were unique to the relationship. Therapists had strong countertransference reactions to out of session frame deviations and their handling of the deviations was often informed by these reactions. The handling of out of session frame deviations was also seen as specific to the relationship and, therefore, unique in each instance. Therapists' perceptions of patient dynamics as they related to out of session frame deviations illustrated the varied functions that the deviations may serve and demonstrated that transference was sometimes prominent in the deviations. Therapists also emphasised the flexibility of the psychotherapy frame itself. The study illustrated that out of session frame deviations are important and relate significantly to the process of psychodynamic psychotherapy. They produce uncertainties and ambiguities for therapists in practice and should be examined closely rather than being overlooked.

ACKNOWLEDGEMENTS

- Thank you to all of the therapists that participated in the study. I am grateful for their time and their input.
- Thanks to my supervisor, Carol Long, for all of her wisdom, patience and effort throughout.
- Thanks to Shaaks for always making me laugh and listening to me talk about the frame over endless cups of coffee and pretending to be interested.
- Thank you to my parents who supported me and told me I could do it, even when I thought I couldn't.
- Thanks to all of my friends, whose support and encouragement has been amazing. I am blessed to have you in my life.
- Thanks to my classmates for listening to every far-fetched idea and complaint I had.
- Thank you also to the University of the Witwatersrand for the Postgraduate Merit Award which helped me to complete my degree.

DECLARATION

I declare that this research report is my own, unaided work. It is being submitted for the degree of Master of Arts in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

_____

Faraaz Mahomed

_____

Date

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

The subject of frame deviations has presented challenges and opportunities for psychotherapists since Freud's (1911-1913) 'recommendations to physicians practicing psychoanalysis'. The application of the frame in practice has often been challenging and unclear (Zinovieff, 2004). This has resulted in several contentious and somewhat competing viewpoints regarding the flexibility of the frame and the handling of frame deviations (Luca, 2004).

Frame deviations have become a common occurrence in therapy, with Pollard (2004: 98) calling them "unavoidable" in the context of contemporary psychodynamic psychotherapy. Furthermore, frame deviations, themselves, have become an area of great interest in the psychodynamic literature as a result of their seeming inevitability (Thomson, 2006; Gabbard & Lester, 2003; Pollard, 2004; Fingfield, 1999). However, one area that has received relatively little attention is the subject of frame deviations outside of the therapy session. These are important occurrences and, therefore, need to be investigated and theorised.

For these reasons, the present study is particularly concerned with frame deviations that occur outside the boundaried space of the consulting room. The meaning and implications of these deviations are of interest as they raise important questions of technique as well as theory and practice. This research was, therefore, focused on that topic and considered the various understandings that therapists had of out of session frame deviations as well as how they were responded to. The study produced results of an interpretive as well as a descriptive nature that illustrated the complexities that therapists face when dealing with frame deviations that do not lend themselves to the relative 'safety' of the consulting room (Langs, 1981).

AIMS

The aims of this study are to examine therapists' perceptions of out of session frame deviations in practice and the complexities that arise out of these deviations. An exploration of therapists' perceptions and experiences of the nature of frame deviations outside of the session is intended. In addition, the aims are to consider the implications of those deviations for the broader process of psychotherapy and to elucidate how the deviations relate to psychotherapy within the session. Therapists' personal countertransferential reactions to out of session frame deviations as well as their professional handling of the deviations will also be explored. Another aim of this research is to consider the dynamics of patients with regard to out of session frame deviations. This will include an exploration of the possible functions of out of session frame deviations for patients and an exploration of transference enactments in out of session frame deviations.

RATIONALE

Frame deviations outside of the therapeutic session are of particular importance because they occur in a space that does not have the holding features that the frame within the session has. Therefore, there are unique difficulties that present themselves in that area. Moreover, the current advances in technology mean that out of session frame deviations have become more common and more diverse in nature (Dooley, 2006). Out of session frame deviations are, therefore, a considerably important area that has produced some interesting, though sparse, data thus far. Current debates around psychodynamic therapy technique as well as the nature of the frame itself have meant that the study of frame deviations can contribute to theoretical as well as technical knowledge on the subject.

The concept of the frame has become a fluid and much-debated area in the psychodynamic fraternity (Beveridge, 2004). Debates around the flexibility of the

frame are common (Luca, 2004). Whereas some theorists prefer the idea of the "impenetrable" frame (Langs, 1981: 67), others are more dynamic in terms of their understanding of the construct. Smith-Pickard (2004: 142) for example, advocates a flexible, "extemporaneous frame" whilst Luca (2004: 19) calls for an "elastic frame". The question of what the frame is and how it is managed in practice as opposed to theory is, however, not as easily discernable.

The contact that occurs between therapist and patient outside of the consulting room is an important area that has received some attention in the past (Dooley, 2006; Furlong, 1992). However, this is an area that has not been fully explored and that lends itself to further inquiry. Moreover, given the 'thirdness' of the space that exists between 'out of session' and 'in-session', there is reason to broaden the scope of study so that out of session frame deviations are understood in their own right rather than being confined to a secondary area of enquiry. The manner in which out of session frame deviations are understood and handled by therapists has often formed a secondary subject for study in psychodynamic literature (Kernberg, 2004; Pollard, 2004). It would be useful to illustrate the complexities of this topic in a richer and more detailed manner that affords it its own 'space'.

Out of session frame deviations are a somewhat under-studied topic in the psychodynamic literature. The practicalities of working with these phenomena present technical questions that have, thus far, not been fully answered (Furlong, 1992). Moreover, the debates around the constitution of the frame are, essentially, also debates around how frame deviations should be understood and treated. Therefore, an exploration of these topics is needed to elucidate therapists' experiences of out of session frame deviations in practice. This study will add to a literature base on the subject of out of session frame deviations by describing them (and their diverse nature) and by interpreting therapists' experiences of them. In doing so, it will provide much-needed information on the subject of frame deviations that lack the holding environment which the

consulting room provides and, hopefully, serve as a basis for future study into the matter.

The unconscious material contained in out of session frame deviations has been explored somewhat (Dooley, 2006; Brockbank, 2004). However, the subject does warrant further inquiry that relates specifically to the content outside of the session and the manner in which it relates to the content within session. This is of particular importance, as it will assist therapists in gaining understandings of their patients beyond the realm of communications within the consulting room. Moreover, any process that assists in understanding the unconscious dynamics of patients should be considered and engaged in so as to assist in the therapeutic progression (Luca, 2004).

Frame deviations by therapists are also a somewhat common occurrence (Brockbank, 2004). They constitute both conscious and unconscious material that should be explored in the interests of strengthening the therapeutic alliance (McWilliams, 2004). The manner in which therapists react to patients' deviations is a legitimate matter for inquiry as the complexities of handling deviations that occur in what Zinovieff (2004: 45) calls the "unsafe space" (outside of the therapy session) lend themselves to further study. The subject matter is indicative of the frame's permeable nature and this results in frame deviations that occur in a space that is difficult for therapists as well as patients because they do not 'have' the safety of the frame as they do in-session (Beveridge, 2004). As a result, understanding what therapists 'do' in those instances will address a topic that has, thus far, not been explored in detail (Dooley, 2006; Brockbank, 2004).

It is largely considered a fallacy that therapy ends as the session ends (Cox, 1978). Therefore, it would be an oversight to dismiss the study of events outside of session as unnecessary. On the contrary, occurrences outside of the consulting room are of great importance and should be included in the study of psychodynamic psychotherapy technique.

CONTEXT OF THE STUDY

This study is situated within the context of psychodynamic theory and practice. The study involved interviewing experienced psychodynamic psychotherapists in a place that was familiar and convenient to them. Invariably, that space was the consulting room of the therapist in question. This, in itself, is indicative of the importance of the consulting room and its boundaries to psychodynamic therapists. Zinovieff (2004: 43) for example, sees the consulting room as a space that allows the therapist to "establish the status of psychotherapy", that is, to set it apart from other spaces that are not conducive to psychoanalysis. Therefore, the physical settings in which interviews were conducted were a space where "people are analyst and analysand" (Zinovieff, 2004: 43), suggesting a 'professionally-framed' interview process with therapists in their trained roles.

The context of the study also includes the roles of the researcher and the research subject. This study was unique in that the subjects of inquiry were therapists (who were directly interviewed) as well as patients (as spoken about by their therapists), a form of 'subversive' interviewing (Kazdin, 2004). The role of the researcher was also the role of a student in Clinical Psychology at the University of the Witwatersrand, where psychodynamic psychotherapy is the primary approach taught, with an emphasis on the frame as a fundamental aspect of psychotherapy, thus engaging the interest of the researcher in this particular area.

The context of psychodynamic psychotherapy is itself, a theoretical quandary as several forms and interpretations of the construct emerge from the term 'psychodynamic psychotherapy'. However, primary to all of these interpretations is a fundamental positioning of unconscious functioning and its relation to conscious expression (Lemma, 2003). Therefore, this study contextualises itself within that broader understanding of the psychodynamic tradition instead of focusing exclusively on one particular model, thereby offering a view of

psychodynamic psychotherapy as practiced. As Gibson, Sandenbergh and Swartz (2001) suggest, the practice of psychodynamic psychotherapy in South Africa uses variations of all of the psychodynamic models rather than any one particular theoretical standpoint as this would be impractical and somewhat exclusionary. Therefore, for the purposes of practicality as well as applicability, the broad framework of 'psychodynamic psychotherapy' is emphasised.

STRUCTURE OF THE REPORT

The subsequent sections of this report are structured into four chapters. Chapter 2, which follows the introduction, describes the extant literature on the subject of the psychotherapy frame and out of session frame deviations. It discusses the debates around the psychodynamic frame and frame deviations. The literature review then discusses the theoretical and technical issues regarding the handling of out of session frame deviations in practice, followed by an exploration of the types of out of session frame deviations and their possible motivations. Finally, the chapter considers transference and countertransference as they pertain to out of session frame deviations.

Chapter 3 is a presentation of the methods employed to conduct the study, including the central research questions. Sampling and data collection are discussed before the discussion turns to thematic content analysis. Here, the methods employed for this particular study are elucidated and related to the methodological literature. Reliability and validity and their application to qualitative research are explored and ethical considerations are scrutinised.

The report then presents the results of the study in Chapter 4. Four central themes are discussed: therapists' perceptions of the types of out of session frame deviations; their understandings of the possible implications of out of session frame deviations for psychotherapy; their reactions to out of session frame deviations and their perceptions regarding patient dynamics and how they

relate to out of session frame deviations. Examples and quotes are used throughout to illustrate therapists' perceptions in their own words.

Chapter 5 considers the findings in relation to the theoretical material as well as the research questions. The implications of the results are discussed as are the limitations of the study and suggestions for areas of further study that arose out of the findings. Finally, the chapter considers the conclusions that may be drawn as a result of the current study.

CHAPTER 2: LITERATURE REVIEW

This chapter offers an introduction to the literature that currently exists on the subject of out of session frame deviations. It will begin by examining the psychotherapy frame itself. Frame deviations will then be considered and the technical and theoretical literature regarding the handling of frame deviations outside of the session will be explored. Literature related to the types of out of session frame deviations and the possible motivations for them will then be presented. Finally, aspects related to patients' and therapists' dynamics, particularly transference and countertransference as they relate to out of session frame deviations will be explored.

THE PSYCHOTHERAPY FRAME

Though the idea of the frame began with Freud (1911-1913) himself, the term 'frame' is credited to Marion Milner (1952) and her paper, *'Aspects of symbolism and comprehension of the not-self'*. The psychotherapy frame is interpreted in several ways but it is generally considered to consist of the boundaries of the therapeutic space and the conditions which allow for the best results of psychoanalysis (McWilliams, 2004). Therefore, the frame, on a physical level, is the therapist's consultation room. It refers also to the fee arrangements around therapy and the space of the therapist relative to the patient. The latter refers to therapists' specific boundaries related to physical contact, the positioning of furniture and similar boundaries (Compton, 1990). In addition, the frame is a 'set of rules' for both therapist and patient (Menninger, 1958). It delineates the manner in which they interact and the psychological boundaries that exist for the facilitation of free association. (Cox, 1978). These include the principles of abstinence and the 'aseptic' or neutral analytic stance, whereby the patient is able to remain assured of the therapist's impartiality (Menninger, 1958).

The importance of keeping to the frame is one of the most central tenets of psychodynamic psychotherapy. Freud (1911-1913) considered the frame to be a significant aspect of the process. His famous fifty minute session, the therapy space's layout and design (such as the couch) and similar aspects are of tremendous importance to the stability of the therapeutic process and to continuity from one session to another (Gabbard, 2004). Freud (1958: 22) felt the frame to be of such great importance that he termed therapy 'leasing out an hour' of the therapist's time, no more, no less, regardless of whether the patient was there or not. The frame has, therefore, become a central component of the therapeutic relationship as it provides for a continuous and unchanging relationship, providing stability as well as clinical professionalism for the patient.

Langs (1976) describes three ground rules for maintaining the frame: the physical space (such as place and time), the therapeutic relationship (such as no touching) and those related specifically to the therapist's interventions. This means that the therapist's interventions should be particularly geared towards the movement of the patient from conscious to unconscious material and should not impede the ability of the patient to associate freely. The therapist does this by being neutral and engaging in the analysis of the patient in a manner that is consistent and that feels safe (Beatrice, 1984) For Langs (1976), a psychodynamic frame exists when these rules have been fulfilled.

The psychotherapy frame is concerned with "exploring the relationship between real, external people and the internal images and residues of relations with them and the significance of these residues for psychic functioning" (Greenberg & Mitchell, 1983: 4). In other words, the frame allows for what is real and unreal, conscious and unconscious to be understood in relation to each other. The frame serves that purpose by being safe and constant enough for the patient to trangress boundaries between conscious and unconscious, because there is a holding environment (Greenberg & Mitchell, 1983). In addition, the frame provides a Winnicottian (1965) transitional space, a room or a time or even a

language that is unique to the therapeutic relationship and, therefore, allows for the patient to reach unconscious feelings in a non-threatening space (Dooley, 2006). Brockbank (2004) asserts that the frame is central to the process of psychotherapy and that it is very much a fundamental aspect of the therapeutic relationship. She mentions that it is "…part of the relationship itself, just as where a couple go out to and when, is part of their relationship." (Brockbank, 2004: 89).

While patients are able to transgress the boundary between conscious and unconscious, they are also able to transgress against the frame itself. The motivations and desires that are realised in frame 'deviations' as they are called result in the 'breaking' of the frame in order to resist the discovery of unconscious material (Keene, 1984). Therefore, the frame, though secure and reliable, is often quite threatening to patients who fear the consequences that it will elicit because of this very stability and protective holding (Langs, 1981). Likewise, the mere experience of being held is, itself, anxiety provoking and may lead to what Luca (2004: 17) calls "obliteration of the frame" in order to break that experience of being held or to rebel against it. The frame, in this conception, is a specific time-limited entity that begins and ends when therapy begins and ends. However, as Langs (1981) notes, the frame is both an internal protective feature as well as an external boundary. Therefore, violations around the frame are possible both on an internal level (within the session) and on an external level (outside of the session).

Langs (1981) saw the frame as a protective feature that was able to hold the patient's unconscious content. At the same time, however, the frame is a protective mechanism that keeps threats and impingements out (Keene, 1984). The patient is made to feel safe by allowing an environment where there is a constant sense of being held and where the outside 'real' world cannot intrude. It therefore seems that the frame is a continuous entity. In addition, as Jacobs (1990) indicates, therapy is a process-driven progression. The process does not end when the session ends. Instead, it continues between sessions. The frame,

as a fundamental aspect of the process, may be thought to continue between sessions as well. Similarly, there is the possibility of breaking, transgressing or obliterating the frame outside of the consulting room and that, too, is of significance (Luca, 2004).

The above assertions notwithstanding, there is something of a dearth in the literature around where the 'outside' of the session and the 'inside' of the session separate. Whilst this distinction may seem self-evident, there are instances when the nature of the frame is less clear and the boundaries between 'out of session' and 'within session' are more opaque. Hoag (1992: 418), for example, asserts that the frame "sets the analytic relationship apart from other segments of the patient's life". There is a separateness that is implied by that statement, an assumption that the therapeutic boundaries are able to be finitely delineated. However, this belies the fluidity and flexibility of the psychodynamic frame, what Luca (2004: 19) calls an "elastic frame". Smith-Pickard (2004: 132) calls it the "extemporaneous frame", suggesting that "the frame cannot be delineated and decided prior to the therapeutic encounter". Instead, he argues that it should be decided on an 'ad hoc' basis, based on the needs of the patient (Smith-Pickard, 2004). Moreover, this position is indicative of the ambiguity and fluidity of the therapeutic frame and of the 'session' itself. It seems, then, that the issue of what constitutes 'out of session' and 'within session' can be particularly indistinct at times.

Theorists in the psychodynamic tradition adopt differing positions regarding how rigid the frame should be. Classical analysts are often of the view that the frame should be particularly strict and consistent and that any changes should not be allowed (Beveridge, 2004). Others are more liberal and tend to see the frame as a living entity that mediates the therapeutic relationship. Klein, for example, often made changes to the frame in her practice, including bringing toys into the consulting room which is now a staple of child therapy (Klein, 1932). Many strands of contemporary psychodynamic psychotherapy theory suggest an

individualised understanding of the frame that is somewhat more liberal and that it is suited to the patient's individual needs (McWillams, 2004). As Velario (2004: 117) states, "…dogmatic interpretation promotes conformity rather than growth and constricts the therapist's ability to be appropriately responsive to the patient." Therefore, the frame in this sense should be seen as flexible rather than rigid, alive rather that 'moribund'.

The debate around the flexibility of the frame and around how and when to delineate it is one that has continued since Ferenczi's (1928) advocation of 'elasticity'. However, as Beveridge (2004) notes, that position was something of a 'rebellion' and the unbending psychoanalytic frame went 'unchallenged' for half a century. More recently, the frame has been conceptualised and reconceptualised on several occasions (Beveridge, 2004) and this has resulted in varied understandings of the psychodynamic frame and somewhat competing viewpoints. The "elastic" frame (Luca, 2004: 19) is countered by the "impenetrable frame" (Langs, 1981: 67), whereby the boundaries of the relationship should never change. Farriolo (2004) refers to the debate as a 'conundrum', a technical struggle that has yet to be fully settled. The debate as to the manner in which the frame is managed is also a debate on the subject of frame deviations and therapists' management of them. These subjects form the bases of the next two sections.

FRAME DEVIATIONS

"As the therapeutic frame represents the constraints and boundaries around the patient's access to the therapist and the practical and emotional management of the alliance, it is often along the perimeter of this frame that a relational 'push and 'pull' will begin" (Beveridge, 2004: 149)

Frame deviations are particularly telling aspects of the therapeutic relationship and the patient's unconscious functioning (Chused, 1991). The nature of frame deviations is diverse. These may take the form of physical contact, such as handshakes or hugs, late and early arrivals and other behaviours that constitute a 'breaking of the rules' within the therapeutic setting. Gabbard (2004), for example, talks about patients undressing within the therapy room as a frame violation. These violations are believed to contain references to the patient's latent desires and they provide a means of interpreting behaviours as well as thoughts and emotions (Gabbard, 2004).

A frame deviation or violation or, as Luca (2004: 18) calls it, a "frame modification" has traditionally been seen as a 'breaking of the rules of psychotherapy'. The word 'deviation' itself has a somewhat derogatory connotation, suggesting a divergence from the ideal standard of behaviour (Khan, 1984). However, the position that frame deviations are routinely negative has been increasingly challenged (Spinelli, 2001). Lomas (1987) for example, emphasised the need for therapists to allow 'creative play' around the frame and to see deviations as workable unconscious material.

Literature that pertains to frame deviations suggests that they are a regular occurrence within the therapeutic setting. Cheifetz (1984) sees the frame deviation as a natural occurrence that is not a deviation in the negative sense but, rather, a regular and important aspect of therapy that allows the therapist to address latent material through manifest actions. This approach to frame deviations is useful, considering that the frame is seen as more of an ideal than a fixed, immobile entity (Jacobs, 1990). Furthermore, frame deviations are thought of as having some or other function, rather than being random and unrelated events (Cheifetz, 1984; Beveridge, 2004). If that is the case, the therapist could (and, perhaps, should) consider the purpose and function of a frame deviation as part of the 'acting out' process.

As mentioned earlier, the frame exists both as a protector of the internal against what is outside as well as a boundary that keeps what is inside from 'spilling over' into the external world (Langs, 1980; Luca, 2004). Therefore, it seems reasonable to assume that a frame deviation can occur both within and outside of the boundary of the psychotherapy session. Indeed, Dooley (2006: 134) refers to emailing patients as an "adjustment" of the frame. Likewise, Valerio (2004) refers to issues around payment as 'frame deviations' because they exist in a world outside the holding space of the therapy room. Moreover, they occur in the patient's external world where the possibility of transference interpretation and containment in the 'safe' space of the consulting room is lessened if not excluded (Valerio, 2004). These examples are indicative of frame deviations more clearly outside of the session. However, those that occur in the opaque boundaries between 'outside' and 'inside' sessions, within the extemporaneous frame, are less widely documented.

The nature of the frame is, itself, ambiguous at times. It follows, then, that some out of session frame deviations would be particularly difficult to establish. Arriving late, for example, is placed precariously as the unconscious 'decision' to arrive late occurs outside of the session (Gray, 1994). Moreover, the late arrival is an intrusion of sorts on the frame from the outside (ie. the late arrival occurred because of a process that began outside of the frame) rather than an 'obliteration' from within the frame (such as an attempted handshake) (Luca, 2004). Therefore, this study uses that position to distinguish more precarious frame deviations as 'out of session'. For example, a patient who calls their therapist in the evening would be committing an out of session frame deviation. Likewise, a patient who does not arrive is clearly violating the frame (Kernberg, 2004). In recent years, SMS (Short Message Service) messages between patient and therapist have also become a significant form of deviating from the frame as have emails, illustrating the new possibilities for frame deviations as a result of technological advances (Dooley, 2006).

Luca (2004) cautions against over-interpreting frame deviations as latent content rather than reality based processes. There are no uniform criteria to assess what makes a frame deviation meaningful or significant (Gabbard & Lester, 2003). However, Langs (1981) suggests that it should have some value for the clinical picture and Luca (2004) maintains that frame deviations reflect a psychic influence if they are patterned or if the therapist has a noteworthy reaction to them. Therefore, the suggestion appears to be that there is no uniform manner in which to assess the unconscious base for frame deviations. Overall, there is a great deal of ambiguity and, perhaps, uncertainty regarding the boundary between 'out of session' and 'in-session' and between reality and the unconscious. Considering the frame's purpose of delineating both of these aspects, there is reason to question the existence of a singular or uniform approach to the frame (Gabbard & Lester, 2003).

Therapists often commit frame deviations themselves, such as revealing information about themselves, calling a patient to cancel an appointment or the oft-cited example of therapists engaging in sexual relationships with patients (Gabbard, 1993). Even the example of Klein bringing toys into the therapeutic space may be considered a constructive manner of deviating from the frame (Dooley, 2006). Another example is Brockbank's (2004) discussion of the impact of therapist illness on psychotherapy.

Brockbank (2004) concludes that the impact of the out of session frame deviations committed by the therapist rather than the patient is patient-specific. For example, she states that an ambivalent patient experienced the deviation (therapist cancellation as a result of illness) as an abandonment (Brockbank, 2004). Another patient felt as though he had been denied the opportunity to express his anger at the therapist (which he had been doing by missing sessions and arriving late) (Brockbank, 2004).

Dooley (2006) uses the example of an SMS to a patient as an unconscious attempt at keeping the patient 'in mind'. She states that the SMS, as a deviation was both beneficial to therapy at times whilst being detrimental at other times. The deviations by the therapist in this case had a significant bearing on the process of psychotherapy in a manner similar to out of session frame deviations by patients, a position also held by Brown & Krausz (1984). The discussion now turns to the existing literature concerning how out of session frame deviations should be handled.

TECHNICAL AND THEORETICAL CONSIDERATIONS REGARDING THE HANDLING OF OUT OF SESSION FRAME DEVIATIONS

As mentioned, there are some competing viewpoints as to the flexibility that the frame should allow for. Similarly, several positions exist regarding the manner in which a frame deviation should be handled (Keene, 1984).

Traditional psychoanalytic technique often favours a somewhat unchanging attitude to frame deviations that corresponds with the 'impenetrable' frame (Epstein, 1994; Lubin, 1984). Therefore, deviations from the frame are not tolerated but, rather, acted against. The frame is kept in a manner that sees deviations as 'challenges' that should not be engaged but, instead, ignored or rectified (Goldman, 2003). That position is countered by a less rigid understanding of frame deviations. Smith-Pickard (2004) for example, describes engaging in or attempting to understand frame deviations as 'therapeutically sound'. Similarly, they are seen as important and rich information for the therapist by theorists such as Kohut (1978) and Ferenczi (1928).

In the teaching of psychodynamic practice, the issue of how to handle a frame deviation is seemingly firm and unchanging (Gabbard, 2004; Langs, 1981). The stance is more traditional and somewhat rigid at times. The need to preserve the frame is seen as essential (Goldman, 2003). In actual practice, however, the

literature is more diverse. Dooley (2006) entertained SMS messages by her patients and then engaged in them herself. Luca (2004) as well, engaged in out of session contact such as telephone calls with patients and Gray (1994) has entertained deviations by patients because they were seen as beneficial to the process of psychotherapy and enhanced the therapist's understanding of her patient. The interests of the patient appear to be the determining factor in the manner in which frame deviations are responded to by this particular therapist (Gray, 1994). However, the subject of handling frame deviations has primarily considered the phenomenon as it occurs within the consulting room (Gabbard, 2004; McWilliams, 2004; Cox, 1978; Menninger, 1958). It therefore seems that further inquiry would be useful to ascertain therapists' approaches to frame deviations outside of the session in practice as opposed to theory. The discussion now turns to particular forms of out of session frame deviations and literature related to factors that may motivate them.

TYPES OF OUT OF SESSION FRAME DEVIATIONS AND THEIR POSSIBLE MOTIVATIONS

Some of the more common forms of out of session frame deviations involve interaction between sessions. Telephone calls have long been seen as a difficult area for psychodynamic psychotherapists to navigate. This form of interaction is often essential and, yet, is not conducive to the idea of a stable 'impenetrable' psychodynamic frame because it does not meet Langs' (1976) criteria. This suggests that that they lie in something of a 'grey area' for psychotherapists (Dooley, 2006). That form of communication has now been joined by a number of other communicative tools such as the advent of email, SMS and even Facebook[1] as frame-challenging phenomena (Dooley, 2006).

[1] Facebook is a social networking website which allows users to view the profiles of other members, to become 'friends' with other members and to peruse the 'friend lists' of other users.

The communications mentioned above are often laden with unconscious meaning (Bailey, Yager & Jenson, 2002). They may communicate the patient's need for intimacy and closeness to the therapist and, therefore, serve as transitional objects themselves, allowing the patient to leave their thoughts and feelings for the therapist at any time they wish (Bailey et al., 2002). This, says Bauer (2002) is a useful and empowering process for the patient and offers some insight into what needs they may feel are unfulfilled in their relationships and in themselves. The benefits notwithstanding, Fingfield (1999) questions the validity of information gleaned from sources outside of the therapeutic process as they do not occur in the process of analysis but, rather, in the 'conscious' realm. However, as Dooley (2006) notes, these forms of communication are not outside of the process. For patients, they are very important aspects of psychotherapy and they form a part of the process rather than being removed from it.

Ingrassia (2003) studied the use of letters as adjunctive tools between psychotherapist and patient. Patients who missed sessions or ended therapy often sent letters to their therapists as a means of reparation, perhaps in the unconscious (or conscious) hope that the therapist would write back. Here, there is a deviation within another deviation and it serves the purpose of actually attempting to repair the first violation (Ingrassia, 2003).

One of the most common forms of out of session frame deviations is an accidental meeting between therapist and patient. These may sometimes be orchestrated by the patient but the purely accidental kind is also a regular feature, particularly in small communities and institutional settings (Pollard, 2004). The unconscious machinations that seem to pervade these meetings have been documented in some cases.

Freud's (1905) famous case of Dora may have been thought of as unplanned contact. The subject saw an article about her therapist in the newspaper and then decided that she did not want to end therapy (Freud, 1905). Pollard (2004)

hypothesises that Dora needed to return to therapy one last time in order to reparate for the attacks she had made on her therapist earlier in therapy. In that sense, the out of session frame deviation did not have any value other than to catalyse a reaction in the patient that was possibly already there. Even so, the frame deviation itself was significant enough to cause Dora to react (Gabbard, 1995).

A similar case is narrated by Pollard (2004) about a psychotherapist who met her patient in a swimming pool changing room. They were both naked at the time. The patient never returned to therapy and the author wonders about the psychodynamic implications of the deviation and whether the unplanned meeting resulted in the patient being unwilling or unable to return to therapy. Pollard (2004) hypothesises that the patient was unpleasantly struck by the humanity of her therapist. The frame deviation, then, served the purpose of humanising the therapist, something which obviously caused some anxiety for her patient and resulted in the discontinuation of therapy (Pollard, 2004). Here, too, the deviation, though out of session, did have a significant bearing on the process rather than being ‘removed’, as suggested by Fingfield (1999).

Furlong (1992) suggests that the missed session is a conspicuous and theoretically important area of investigation. The analysis of the unconscious motivation for the deviation is, however, not explored in depth by the author (Furlong, 1992). Counselman and Gans (1999) viewed the missed session as a frame deviation that communicated an acting out response, possibly including dissatisfaction with the process, resistance to change and rebelliousness towards authority. The motivations for the acting out response notwithstanding, that particular form of communication is an important area of interest. Gabbard (2004) sees frame deviations as acting out (or acting in when in-session), that is, as the expression of unconscious desires and the latent affect states of an inidividual through actions.

Mendelsohn (1991) refers to the acting out process as a communicative expression that the patient is often unaware of. Considering acting out as one possible function of the frame deviation, it may be useful to consider some of the purposes that acting out may serve. Possible functions that the acting out may have include:

- The sublimation of otherwise unacceptable ego desires where the patient's aggressive or libidinal impulses manifest in more acceptable but, nonetheless, rebellious ways;
- A compromised 'play' response that allows the individual to enact what he or she cannot say because the superego will not allow it;
- A transformation of instinctual impulses into actions as a means of defending against anxiety and preventing the manifestation of less tolerable gestures and behaviours;
- A breakdown of the 'symbolic function' and its purpose of 'acting out internally' leading to a need for discharge to alleviate intolerable tension by means of 'acting out externally';
- A result of poor 'ego structuralisation' which leads to behaviour as the only means of satisfying the id impulse (Mendelsohn, 1991: 154).

These are not mutually exclusive, nor do they exist as fixed entities but, rather, move, change and adapt throughout the therapeutic process. One example is a patient who has disclosed something 'monumental' to the therapist and then misses the next session. Here, the patient may be acting out to avoid anxiety (Mendelsohn, 1991). Such behaviours are naturally defensive as the anxiety provoked during therapeutic change is an unnerving and unwelcome visitor upon the patient (Mendelsohn, 1991). This, argues Mendelsohn (1991), is but one of many possible functions of the patient's frame deviation.

Mendelsohn (1991) suggests that, the functions of acting out behaviour notwithstanding, the cause of it is essentially some aspect of the therapist-patient

relationship. Moreover, the therapist might collude with the acting out process, implicitly encouraging the patient's manifestation of unconscious transference responses. The therapist does this by allowing excessive frame deviation, rewarding it through the process by continuing therapy without addressing the root of the behaviour (Mendelsohn, 1991). This reflects the importance of the therapist-patient relationship when considering out of session frame deviations (Mendelsohn, 1991). The subject of the therapist's impact on the enactment of out of session frame deviations, therefore, also warrants further enquiry.

Unconscious communication serves to elucidate aspects of the patient's inner world in a manner that has not yet (or may never be) brought to therapy manifestly (Gedo, 1993). A number of these communications do occur within the therapeutic hour. However, there are various communications that may not require face-to-face contact in order to be related. Langs (1981) considered non-arrival to the therapy session to be a manifestation of a 'communicative resistance'. Here, the assumption is that there is something being 'said' to the therapist when the patient does not arrive for a session. The point made by Langs (1981) is that the patient is resistant to therapy and, therefore, overtly manifests his resistance by not coming to session. This seems to suggest that the frame deviation, though out of session, has a significant bearing on the psychotherapy process, a position that is implied but not thoroughly investigated (Langs, 1981).

Dooley (2006) elaborates on the idea that 'meaning' can be unconsciously conveyed between therapist and patient, even outside of the consulting room. Email, for example, is seen as an important and 'meaningful' adjunctive tool that allows the patient to remain connected to the therapist between sessions (Dooley, 2006). The suggestion is that unconscious communication is strong and useful when it occurs outside of the session. This is countered by Gammon and Rosenvinge's (2000) position that electronically-mediated communication is a hindrance to the progression of psychodynamic psychotherapy rather than a

facilitator of it, as the communication is one of 'nothingness'. It seems that, here too, there is some debate as to the importance of the communication that may occur in out of session frame deviations, suggesting further study is necessary. Several psychotherapists now use email and other out of session interactions as adjunctive tools with their patients (Dooley, 2006). The frequency of these interactions (which are deviations), however, sometimes becomes inappropriate and uncomfortable for the therapist, with the patient 'abusing' the allowance made by the therapist (Caspar, 2004, Wolf, 2003). The therapist then feels intruded upon or violated because the boundary which was set for the patient is no longer sacred (Caspar, 2004). Valerio (2004) discusses out of session contact as a 'break' from the frame but, also, as a break from reality. The contact in this case takes the form of excessive telephone calls between therapist and client that, to the therapist, feel overwhelming and intrusive because of their extent. Similarly, Sabbadini (1989) discusses a patient who was unable (or unwilling) to leave the therapeutic space, resulting in a sense of intrusion upon the therapist's space. Unconsciously, Wolf (2003) argues that these intrusions are deliberately enacted by the patient though, at a conscious level, this is not the case. Motivations may include a deliberate attack on the boundaries, a rebellion or an inability to restrain one's impulse to have 'more' of the therapist (Smith-Pickard, 2004). Here, there is an explicit assumption that the patient is motivated to enact a deviation because of an unconscious desire, suggesting that these possible motivations should be investigated further as well. The discussion now turns to transference and countertransference as they relate to out of session frame deviations.

TRANSFERENCE AND COUNTERTRANSFERENCE AS THEY RELATE TO OUT OF SESSION FRAME DEVIATIONS

Attempts by the patient to disrupt the frame are often thought to have transferential roots (Valerio, 2004; Thompson, 2006). An example would be Kernberg's (2004) case of a patient who begins to arrive late as an attempt to

attack the authority of the therapist. That same patient had a similar motivation in his dealings with a parent who was deemed controlling. In that sense, the frame deviation was arriving late and its purpose was to 'hurt' the therapist's potency (Kernberg, 2004).

Similarly, Dooley (2006) reports that out of session frame deviations involving electronic communication illustrated several transferential dynamics, such as the patient who needs to be close to the therapist because she will not survive without her or the patient who attacks the therapist with seemingly envious messages. This was similar to the manner in which the same patient suffered a markedly conflictual relationship with her own mother (Dooley, 2006).

The case of Dora, as well, reveals some transferential dynamics whereby Dora feared the destruction of her therapist because of her attacks on her father (Pollard, 2004). It seems, then, that several transference reactions are enacted in out of session frame deviations and these may be read in much the same way that transference reactions within the session would be (Pollard, 2004)

Countertransference reactions are equally prominent in out of session frame deviations. Ernest Jones, a colleague of Freud's, reports having allowed his patient to use his summer home because he was smitten with her after she had fallen in love with him, reflecting an erotic countertransference (cited in Freud & Jones, 1993). Similarly, countertransference is a significant part of the process in several other documented cases as well. Dooley (2006) reports feeling hurt and attacked by her patient's messages. The countertransference here, then, was that the therapist had become the mother-figure. Countertransference is, therefore, a strong presence in out of session frame deviations.

Pollard (2004) talks about the therapist's need to 'save'. The patient has become so dependent upon the therapist that the therapist now feels as though it is his responsibility to continue parenting the needy patient. This, says Pollard (2004) is

a counterproductive countertransference which replays itself perpetually because the therapist fails to confront it. Therefore, the out of session frame deviations such as phone calls between patient and therapist continue unabated (Pollard, 2004).

The examples above illustrate some important transferential and countertransferential issues as they relate to out of session frame deviations. They demonstrate the presence of these phenomena in the deviations. However, with the exception of Dooley (2006) they consider transference and countertransference outside of the session as an aside to similar enactments within the session. Therefore, there is reason to examine the topic further in a detailed manner that relates to transference and countertransference particularly outside of the session.

SUMMARY

This chapter has covered several aspects related to the frame as well as out of session frame deviations. Most notable in the literature presented has been a debate around how the frame and frame deviations should be handled in practice. Moreover, the literature on the specific topic of out of session frame deviations appears to illustrate several viewpoints, suggesting that the topic should be investigated further and that practical understandings of the matter should be explored regarding the variety of out of session frame deviations as well as the motivations that may elicit them and the transferential and countertransferential phenomena that relate to them. In addition, the dearth of literature on the subject as an independent area of inquiry suggests that out of session frame deviations should be examined closely and in greater depth than has been done before, whilst also considering the implications of out of session frame deviations for the broad and multifaceted process of psychodynamic psychotherapy.

CHAPTER 3: METHOD

This chapter outlines the study's research questions as well as the methodological approach used. The chapter will also discuss the qualitative approach to scientific inquiry and detail why it was deemed appropriate as a research approach. The sampling selection and the analytic procedure adopted by the researcher will also be explored, as well as a discussion of reliability and validity as they apply to this study. Lastly, the ethical concerns raised by this study will be addressed.

RESEARCH QUESTIONS

1. What are therapists' perceptions regarding the types of frame deviations that they have experienced outside of session time?
2. What are therapists' understandings of the possible implications of out of session frame deviations for psychotherapy?
3. How do therapists handle out of session frame deviations?
4. What are therapists personal countertransferential reactions to out of session frame deviations?
5. What are therapists perceptions of the possible functions of out of session frame deviations for patients?
6. How do therapists understand patient dynamics (including transference) as they relate to out of session frame deviations?
7. What are the particular challenges that out of session frame deviations present for therapists?
8. How do out of session frame deviations relate to the broader process of psychodynamic psychotherapy?

RESEARCH APPROACH

This study used qualitative research methods to elucidate the possible range and functions of frame deviations outside of the psychotherapy session. The

qualitative approach utilises an in-depth analysis of a small number of subjects. This form of research design is usually non-experimental and longitudinal (Kazdin, 2004). Qualitative research is often advocated when data is considered to suit an idiographic, holistic approach as opposed to looking at a particular set of variables on a single occasion (Yin, 1984). As such, in-depth interviews were chosen as the research required detail and the inclusion of subtler ideas and concepts that might have been neglected in the statistical method (Kazdin, 2004). The study analysed data gathered from these interviews using thematic content analysis.

No hypothesis as such was being tested, nor was any intervention or process being 'proven'. The qualitative interview method was, therefore, suitable as it allowed for detail and depth on a descriptive level whilst also allowing for interpretation of data when necessary (Yin, 1984).

SAMPLING

The sample consisted of experienced psychodynamic psychotherapists. This refers to therapists who have been practising in the broad psychodynamic tradition for at least two years. This particular sample was chosen because the nature of the study was informed by psychodynamic principles. In addition, the experience criterion was used because it allowed for a more broad and well-founded understanding than would be attainable from beginning therapists. Moreover, the experience criterion allowed for a wide variety of patients to be discussed in the interview, meaning that therapists' perceptions would have been diverse, thereby enhancing generalisability. Two years was seen as a sufficient duration for therapists to have gained the necessary experience.There were no age or gender criteria as these were deemed unnecessary. As it happened, three male and three female therapists were interviewed. Culture and race were fairly homogenous within the sample. Five of the therapists were White while one was Asian. This has implications for validity which will be discussed later.

Therapists were approached after recommendations by the supervisor of this research to ensure that they were experienced in psychodynamic psychotherapy technique and interpretation. Thereafter, a snowball sampling technique was employed using recommendations garnered from earlier subjects whilst ensuring that the two basic criteria were still met. This sampling procedure may be deemed a non-probability purposive sample as it does not make use of a random sampling technique but, rather, deliberately samples on the basis of particular criteria (Maxwell, 1996). However, the use of this method is justified by the need for experienced psychodynamic psychotherapists to answer the research questions. (Kazdin, 2004). Therefore, a random sample would have been inappropriate for the purpose of fulfilling the aims of this study.

Sampling continued until data saturation had occurred. This was to allow for an in-depth analysis based on detail rather than universal applicability (Kazdin, 2004). Six interviews were conducted altogether and this was deemed sufficient to answer the research questions of this study. In addition, the number of participants was kept to a relatively small number because of the need to avoid 'dilution' of data, that is, a lack of depth because the volume of data does not allow for it (Berg, 2001).

METHOD OF DATA COLLECTION

Data for this study consisted of transcribed interview material regarding therapists' perceptions of out of session frame deviations and how these relate to the broader process of psychodynamic psychotherapy. Subjects were asked to participate in a semi-structured, open-ended interview of approximately one hour's duration.

A semi-structured interview was the measure of choice. This was because of the nature of the research questions which were open-ended and did not assume any particular results. The interview schedule was constructed using the

research questions as the guideline in consultation with the supervisor of this research. An open-ended method was chosen to “offer the respondents an opportunity to expand on their answers, to express feelings, motives or behaviours quite spontaneously” (Rosenthal & Rosnow, 1991: 179).

The interview schedule was drafted and then refined in consultation with the supervisor of the research in order to assure that the questions were applicable and relevant to the subject of inquiry. Questions related to therapists’ perceptions of out of session frame deviations as well as their reactions to the deviations and the possible implications of the deviations for psychotherapy. These questions were developed as a result of the need to flesh out therapists’ experiences and to foreground out of session frame deviations as the most central aspect of the study.

Transference and countertransference reactions with regard to out of session frame deviations were also explored. Therapists were asked for their understanding of patient dynamics as they related to out of session frame deviations and about their perceptions of the possible functions that those deviations might have served. Moreover, therapists were asked to consider how their experiences of out of session frame deviations related to the manifest content that was elicited within sessions. These aspects were deemed appropriate because they corresponded closely to the aims of the study and to the psychodynamic literature on the subject. In addition, there was an emphasis on the deviations themselves as the central focus of inquiry.

In an effort to allow for an in-depth analysis, therapists were asked for information at a generic level and then requested to consider some specific patients where out-of-session frame deviations were pertinent (though not necessarily prolific) without including any identifying data. In this portion, the nature of the interview was less structured and the data collection was to be

informed by the responses of the therapist and the nature of the specific case being discussed. A sample interview schedule is appended (Appendix D).

Therapists were approached either by telephone or in person and asked to participate with a brief description of the study. Those therapists who agreed were interviewed in their consulting rooms, as this was most convenient for them and it also located the interviews within the frame of their practice and centralised their practical experiences.

Therapists were provided with Participant Information Sheets (Appendix A) and informed of their right to withdraw from the research at any point. They were also specifically asked to refrain from identifying any patients, thereby ensuring the anonymity of the patients being discussed (McLeod, 2001). Participants were then asked to sign Informed Consent forms, both for the interview itself (Appendix B) and for the recording of the interview (Appendix C). All interviews were recorded electronically to allow for subsequent transcription. Interviews lasted between fifty minutes and one hour, depending on the level of elaboration of the therapists interviewed.

Recordings of the interviews were then transcribed word-for-word by the researcher. This process also served as the first step in the data immersion process discussed in detail below (McLeod, 2001). Transcripts were also provided to the supervisor of this study. However, these excluded identifying information as some participants were known to the supervisor and identification would have hampered their anonymity (Brinkmann & Kvale, 2008).

METHOD OF DATA ANALYSIS

The interview data was analysed using thematic content analysis. This is a qualitative method that still relies on systematisation and can, therefore, be considered reliable and effective (Neuman, 1994). Thematic content analysis is

widely used in the field of psychology to investigate both latent and manifest content contained in occurences of communicative language (such as interviews) (Kazdin, 2004). An emergent design was used to harvest themes from the data. In this case, all texts were analysed to allow for inclusivity and to ensure that biases were kept to a minimum (Kazdin, 2004).

A meaning-based rather than a frequency-based analysis was deemed necessary, given the subject matter of the research. Therefore, any particular theme was considered in relation to all of the other themes to ensure that the meaning was accurately attributed (Neuman, 1994). This meant that it was not necessary to count the number of times each theme appeared but, rather, to include as many meaningful and relevant themes as possible. The emergent method was chosen so as to not direct the research towards any particular answers but, rather, to establish what was being said regardless of expectations (Miles & Huberman, 1994).

The data being analysed in this case were the transcribed interviews. Data immersion began in the process of transcribing the interviews, thereby aiding familiarisation with the data (McLeod, 2001). This was followed by consultation with the supervisor of the research to discuss the transcripts and gain another perspective on the data (Adams, 1990). Reading and re-reading of transcripts followed to reach a state of ‘saturated immersion’ (Miles & Huberman, 1994).

Immersion in the data was necessary to allow for an inclusive and detailed understanding of the concepts presented in the interviews. In doing so, the researcher first looked at the data and then categorised it by searching for themes and subthemes in the transcripts and highlighting particular quotes that exemplified those themes. The data was then looked at for a second time to ensure that it was correctly analysed. In addition, consultation with the supervisor of this research indicated that the themes that were garnered were valid as they had been independently gleaned by both. This occurred after the immersion

process, whereby the researcher, in consultation with the supervisor, found four particular themes to be inclusive and relevant to the data, after two previous attempts at other, less inclusive approaches.

As Wimmer and Dominick (1983) suggest, a process of 'trial and error' is common in this type of research. Therefore, the process of choosing themes was a cyclical process. The quotes and examples often remained the same whilst the manner of understanding and arranging them changed until an inclusive arrangement was found. The quotes, themselves, can be found throughout the report and exemplify as well as justify the manner in which the data was analysed and the themes that emerged (Terre Blanche, Durrheim & Kelly, 2006)

The data were categorised into four themes, namely:

- Types of out of session frame deviations;
- Possible implications of out of session frame deviations for formulation and practice;
- Therapists' reactions to out of session frame deviations and;
- Therapists' perceptions of patient dynamics related to out of session frame deviations.

This organisation meant that the themes were relevant given the subject matter and the study's central focus, out of session frame deviations.Themes were then analysed before conclusions or generalisations could be made.

Thematic content analysis was a suitable analytic technique given the nature of the data being analysed as well as the research questions mentioned. Moreover, the technique allowed for more objectively testable and reliable data analysis than any other qualitative method without sacrificing the idiosyncracity of the information (Neuman, 1994).

RELIABILITY AND VALIDITY

Patton (2002) states that validity and reliability are two factors which any qualitative researcher should be concerned about when designing studies, analysing results or even when judging the quality of a study. This corresponds to the question, “How can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?” (Lincoln & Guba, 1985: 290). To answer this question, Healy and Perry (2000) assert that the quality of a study in each paradigm should be judged by its own paradigmatic terms and definitions. For example, while ‘reliability’ and ‘validity’ are essential measures for quality in quantitative research, in qualitative research terms such as credibility, neutrality, consistency or dependability, applicability and transferability are the essential measures for judging the quality of research (Lincoln & Guba, 1985).

Lincoln and Guba (1985) use the term ‘dependability’, which closely corresponds to the notion of ‘reliability’ in quantitative research. This can be used to examine both the process and the product of the research for consistency (Hoepfl, 1997). Thus with qualitative research, consistency of data is achieved when the research is verified through an examination of items such as raw data (Campbell, 1996). Consistency refers to the fact that the data would be interpreted in the same manner over time and between interpreters. Thus, by comparing the interpretations given to data with the raw data, one would be able to determine the accuracy of interpretations.

The concept of validity is not a single, fixed or universal concept, but ‘rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects’ (Winter, 2000: 1). Although some qualitative researchers have argued that the term ‘validity’ is not applicable to qualitative research, some form of ‘check’ or measure for qualitative research is needed. Many researchers have developed their own concepts of validity and have often adopted what they consider more appropriate terms (quality, rigor, trustworthiness) (Lincoln & Guba, 1985).

I. Maintaining quality in the current study

The researcher ensured quality by comparing the data from the current study with the relevant literature. This comparison of data with the literature enabled the researcher to establish whether participants reflected trends found in other studies. In addition, inferred meaning was considered in relation to manifest content. This process ensured that the meaning attached to the data was specific to the understanding provided by the participants. It also limited the possibility interpretive bias distorting participants' reported perceptions (Hoepfl, 1997). At the same time, the use of several interviews and a 'drawing out' of emergent themes meant that validity was somewhat strengthened and generalisability was made more possible as the results were not anticipated but, rather, emerged (Henwood, 1996).

The small sample size was, perhaps, a detriment to the quality (external validity) of the study. This study, however, was not intended to be generalisable at the expense of detail. Rather, the quality (internal validity) of the study is enhanced because of the detailed approach and the use of quotes and examples from the albeit small sample (as is typical of qualitative research) (Henwood, 1996). Cultural biases may have been prevalent in this study because of the seeming bias towards White therapists. However, as Ahmed and Pillay (2004) suggest, the psychodynamic fraternity within South Africa is primarily made up of White therapists. Therefore, the sampling bias was an unavoidable probability.

II. Maintaining dependability in the current study

The researcher maintained dependability by reading and re-reading the transcribed material. This enabled the researcher to ensure that the initial interpretation attached to the data was consistent and as accurate as possible. In addition, the supervisor of this research was consulted to determine if the themes identified were commonly found. In that sense, a form of inter-rater consistency was established (Winter, 2000). Examples from the data are used frequently to illustrate the manner in which conclusions were

drawn. This ensures that conclusions made can be justified and that there is evidence to support their inclusion.

Dependability was also strengthened through the 'trial and error' process of data analysis and the emphasis on out of session frame deviations as the central focus of the research. These elements ensured that the data was interpreted in a manner that could be replicated as they ensured that the process of analysis was sufficiently rigorous and more inclusive than other approaches.

ETHICAL CONSIDERATIONS

This study may be considered ethically sound in that several safeguards were put in place to ensure that ethical standards were upheld. Subjects were asked to respect the confidentiality of their patients by not providing any revealing information. In addition to that, they were assured of their own right to confidentiality as no identifying criteria were asked for with regards to the therapists or patients concerned. Therefore, while there may have been some concern that patients' content was being accessed without their knowledge, the participants of this research were the therapists. These were trained professionals who were aware of ethical standards and principles and they were, therefore, able to ensure that the highest level of ethical responsibility was adhered to (Kazdin, 2004). The identities of all of the subjects were known only to the researcher. The supervisor of the research had access to transcripts but these did not reflect the identities of the participants. Pseudonyms are not used in the report as 'personalising' the subjects was deemed unnecessary or even counter-productive, given that the subject matter required anonymity in the research report (Rapaport & Gill, 1959). Transcripts will be destroyed upon completion of this report. Therapists were informed that this report may be used for academic publication in future but that identifying criteria would not be included in any such work.

Participants were handed information sheets (Appendix A) detailing the nature and purpose of the study. Informed consent forms (Appendices B & C) were signed by all participants in this study after an explanation of their implications. They were guaranteed the right to withdraw their consent (The Professional Board for Psychology, 1999). The participants were asked to keep the information sheets and to contact the researcher should they wish to do so for any reason. The permission of the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand was sought for this study before data collection began. The subjects concerned were not reasonably considered to be at risk as a result of taking part in this research. This is because they were aware of their rights and because they are experienced psychotherapists who, themselves, are in ongoing supervision and psychotherapy (Brinkmann & Kvale, 2008).

CHAPTER 4: RESULTS

Out of session frame deviations presented varied and unique challenges for the therapists interviewed. While there was some degree of commonality in the experiences of therapists, the aim of the study was not to offer a general or uniform understanding of universal perceptions of out of session frame deviations. Instead, an approach that emphasised depth and idiosyncrasy was chosen as a result of the complexity of the topic and the diverse range of issues that arose as the data emerged.

As stated, four themes emerged during the analysis of the data. These are:

- Types of out of session frame deviations;
- Possible implications of out of session frame deviations for formulation and practice;
- Therapists' reactions to out of session frame deviations and;
- Therapists' perceptions of patient dynamics related to out of session frame deviations.

In this manner, the analysis centralised the core subject under investigation, out of session frame deviations. The results tended towards individual and specific understandings of these deviations and the nature and fluidity of the subject matter was indicative of the fluidity of the frame itself. A more detailed analysis follows.

TYPES OF OUT OF SESSION FRAME DEVIATIONS

Out of session frame deviations were fairly diverse in their nature and seemed to occur relatively frequently. This section will investigate the nature of out of session frame deviations and consider the conclusions that may be drawn about

out of session frame deviations as well as therapists' perceptions about the frame itself.

The types of out of session frame deviations were varied and produced challenges as well as opportunities for therapists. Several out of session frame deviations involved communicating with the therapist between sessions, through telephone calls, emails or SMS. For example, one therapist spoke about a patient who called several times in the evenings after sessions:

> *"…it was this whole thing of falling in love with your therapist and wanting to phone her in the evenings and then talk about other stuff like music and, you know."*

The example illustrates the unconscious content included in the frame deviation. Clearly, there is a deviation from the therapeutic frame and the therapist is able to interpret and understand it. This particular therapist saw out of session phone calls as the most common deviation. Another therapist spoke about SMS as an especially common occurrence:

> *"…SMS seems to be one of the most popular ones because if the patient has your cellphone number, some form of SMS seems to be the most likely."*

The quote above also illustrates the importance of technologically or electronically mediated communication between therapist and patient. This is particularly interesting, given that technological advances offer new forms of communication between patient and therapist, which appears to have made the possibility of out of session contact far greater. Indeed, one therapist spoke about patients who had searched for his profile on Facebook:

"…I've just thought of an area of frame deviations that has become increasingly interesting and important, is Facebook. Because there have been several patients who have tried to find me on Facebook and have found me. I've really struggled with the kind of, should I take my profile off? Should I go kind of incognito, there's an attempt to, I think that's very interesting because there's an attempt to access more of the therapist, to find, to know him more, to get closer to him."

The fact that the therapist sees this form of deviation as *'increasingly interesting and important'* is indicative of the heightened accessibility of the therapist to the patient. This example also demonstrates the difficulties that therapists experience with out of session frame deviations. It creates a dilemma, or *'struggle'* for the therapist. The issue of how out of session frame deviations are handled and what their potential meaning is will be addressed in detail later.

Several out of session frame deviations involved patients arriving late or not arriving for sessions. One therapist had the following to say on determining late arrivals as deviations from the frame:

"… it's a more difficult one to call but I would certainly consider a pattern of arriving late or arriving late after a particularly salient discovery"

It seems that arriving late is a frame deviation if this therapist sees a *'pattern'* or if there is some reason that may be seen by the therapist for that lateness. This raises an important point, that therapists were generally quite cautious not to *'over-interpret'* events such as lateness as unconsciously motivated. Therapists were careful to look at the *'real life'* motivations for the deviations as well, as evidenced by the quote below:

> *"…life does happen. It does happen that they SMS in a hurry and the SMS comes out funny so I think it's also important to respect that reality and to also sort of check out a frame deviation quite carefully."*

It seems that a more cautious interpretation is favoured by this therapist who places importance on respecting the patient enough to not simply attribute their behaviour to unconscious dynamics. This quote suggests that the therapist places a great deal of esteem in the patient.

The subject of late arrivals also brings up another important area of debate. That is, the question of what constitutes 'out of session' as opposed to 'in-session' frame deviations. This distinction was often difficult to make and that difficulty illustrates the fluidity and ambiguity of the frame itself. The example suggests that coming late may be thought of as out of session because therapy is not 'in session', that is, because the unconscious dynamics of the relationship are not yet within the bounded space of the consulting room. Several examples of the ambiguity of this distinction were put forward. For example, one therapist discusses a patient who *'stormed out'* of session in a rage:

> *"The patient was overwhelmed by an affect storm in the actual therapy and became quite enraged with me and got up and left and then didn't return to the therapy for a number of weeks and it did pose particular difficulties, that it was obviously very direct, sort of easy to understand because it's so in your face, a foul confrontation followed by an avoidance or a punishment and that required a telephonic contact for each of the sessions that he didn't arrive."*

This example describes several out of session deviations including not arriving for sessions and telephonic contact. In the case of the 'original' deviation (leaving the session), the deviation was out of session purely because it occurred within session time but broke the boundaries of the therapeutic space. In addition, the

consequences of that deviation were felt outside of the session and resulted in other similar deviations. It seems, then, that the distinction between what constitutes an 'out of session' frame deviation is fairly ambiguous, a result of the frame itself often being an ambiguous entity. For instance, one therapist discussed the example of conversations with patients in the foyer before entering the consulting room as out of session frame deviations:

> *"…what happens on the way is kind of a mine field because it sort of happens in the session but for me it's kind of outside of the session and I can't contain it, you can't process it and there's other people around and it's not therapy, you're walking side by side or whatever it is, um, so I find that difficult to deal with but, ja, I think the difficulty with those out of the session things is that you're kind of caught off guard and it's more difficult to contain and I know for me that's where I'm more likely to slip out of the frame as well. You don't have the safety of the frame, you don't have the time and the dynamics."*

The therapist comments that she feels '*caught off guard'* by the frame deviation. She feels unable to contain the frame deviations and work with them because they are so seemingly separate from what happens in the room. In addition, she seems to be advocating a more professional and almost distant relationship where therapist and patient are not *'side by side'*. The deviations also serve the purpose of distracting her from a professional stance, resulting in her *'slipping out'* of the frame. Here, there is an implication that out of session frame deviations are 'problems' because they induce deviations in the therapist as well. Notably, she asserts that what happens outside of the room is *'not therapy'*. Even so, it may serve to be a part of the therapeutic process.

The same sort of frame deviation (discussions before entering the consulting room) was not as problematic for another therapist. She said:

> *"I generally see that as a warming up. You're coming into an environment where you're going to shift into a different space, into a different way of thinking and I think sometimes it's almost like that rapport, that sort of rebuilding connection. I will greet a patient, a patient will greet me, you're not gonna ask them how their week was and stuff, you know you will have that sort of interaction prior to going into a session as such and, for me, I see that as just normal, not necessarily as a frame deviation"*

This quotation illustrates that frame deviations and the frame itself are fluid entities that change and that have different boundaries for different therapists. The ambiguity of the frame and the shifting distinction between 'out of session' and 'in-session' deviations is further illustrated by a therapist who discusses receiving gifts from a patient:

> *"…it became apparent that it was, in fact, gift giving as opposed to therapeutic product you know and often times, she would have fantasies of giving me things and me using them in my personal life like she painted me a picture and then she had fantasies that I would put it up on my wall, and she would give me a painting with a frame and a hook at the back to hang it up and I would think well I'm not gonna hang that anywhere but I guess the fantasy was that I would."*

In this example, the therapist was given gifts for her personal use rather than for therapeutic purposes. The patient wished to be 'kept in mind' between sessions and enacted this desire through gift-giving with the knowledge that the gifts would be present (even if unused) between sessions. Therefore, this too may be considered out of session. It seems that time and space are both important in terms of what constitutes the frame and what makes a frame deviation 'out of session'. A particularly useful example of that point is to be found in the example of a therapist who watched DVD's with her patient during session time but outside of the consulting room:

"…we would watch it together which was very interesting because it would still be during the session but then we would leave the therapy room and we would go into another room together and watch the DVD and obviously that's a major deviation and then us being in a different room together, different seating arrangements, obviously very different dynamics so although she communicated so much through DVDs, it was also a case of it would get us out of the room together."

In this example, the deviation occurred within session time but not within the session space. Therefore, like many of the deviations presented, the 'out of session' composition of the deviation is as ambiguous as the frame itself.

Deviations by therapists were also a prominent feature in the interview material. Several therapists spoke about the possibility of meeting patients in public and instances when this did happen. One therapist spoke about meeting her patient in public as follows:

"She would come to sessions and tell me that she worked in a store on weekends and I was at a particular shopping centre and I saw her at the store and I greeted her, you know, we were there and she greeted me and that was that. Now what was very interesting about that frame deviation is that it gave me a different perspective on her, I saw her quite differently."

This therapist feels that the frame deviation, though unintended, was useful. Whilst this use and function will be discussed below, out of session frame deviations by therapists were a fairly common occurrence. In the excerpt presented below, a therapist discusses using frame deviations for the purpose of meeting a patient's needs:

"…I've used an SMS in a very kind of frame deviation kind of way but sometimes to allow patients to feel that they can have contact with me so

I'll say send me an SMS or leave me a message on my phone and I'll get the message but I won't respond to it, but that it is a place where you can leave your thoughts. Certainly where some patients are suicidal, I feel that that would be important to do so that would be a kind of therapeutic break orchestrated by the therapist and those…those breaks have served a function."

The impact of technology is felt here too. The ability to receive SMS messages and to use them therapeutically illustrates that technology has become increasingly present in the therapeutic process. This example also demonstrates that out of session frame deviations, whether by therapist or patient, are important processes that have a bearing on therapeutic practice. In this case that purpose is a therapeutic intervention strategy. The study now turns to what the possible implications of out of session frame deviations are for therapeutic formulation and practice.

POSSIBLE IMPLICATIONS OF OUT OF SESSION FRAME DEVIATIONS FOR FORMULATION AND PRACTICE

Important throughout the interviews was a sense that therapists perceived out of session frame deviations as fluid processes that moulded and changed as therapy evolved. Perceptions were often not 'textbook' but shifting and unique, both to the therapist and to the patient. Essentially, they were unique to the relationship. One therapist felt that frame deviations were seen in an unnecessarily negative light as illustrated in the quote below:

"You have to use your clinical judgment to know whether that's going to benefit the process or not and that's very difficult to know. I guess analytically, though, people would prefer to hold the frame. That is the more traditional stance. I think it would be frowned upon. I mean, you think

about the word deviation it sounds like it has a very pejorative meaning attached to it, already you've departed from the ideal so to speak."

The therapist suggests that frame deviations need not always be seen as negative. Instead, the use of clinical judgment is advocated. Moreover, there is room for the possibility that frame deviations are, in fact, beneficial.

Several of the examples presented above have already suggested some form of implication for therapy that has arisen from an out of session frame deviation. For example, the therapist who saw her patient in public was able to have a different perspective of the patient because of the experience. Similarly, another therapist gives the example of a patient (and her mother) whom she had met in public. The patient never returned to therapy. This is what she had to say:

"I bumped into someone at the [event] *and I actually didn't recognize her and she recognized me and she was with her mother and she introduced me to her mother, and her mother had known about the therapy and she said oh thank you for looking after my daughter and she said oh yes I'll see you and she didn't come back to therapy after that so I thought that that was interesting."*

Here the therapist and the patient have both committed an out of session frame deviation, with significant repercussions, resulting in a premature termination. The meaning of the encounter for the therapist seemed to be that it was quite innocuous on the surface but the patient's subsequent response (ie. not coming back to therapy) suggested that there was a definite shift in the relationship. Therefore, this implies that out of session frame deviations can have a notable bearing on therapeutic practice and contribute significantly to therapists' understandings of their patients.

Therapists also perceived frame deviations as sometimes having a negative effect on the process. In the example below, a therapist talks about the implications of cancelling on patients:

> *"Um, that is something that one needs to try and avoid at all costs because it always has a negative effect on the process. Um, people want to own the space. Um, if you cancel they feel that you think that the stuff that they're working with is not important enough."*

The therapist is conscious of the *'negative effect'* that frame deviations have and that there is something hurtful, neglectful even, of the patient when the therapist cancels a session. There is also an allusion that the deviation in this instance has a significant negative implication for the therapeutic process rather than being harmless or unrelated to what happens within the consulting room.

Another example is a patient who offered her therapist a gift before the therapist went on maternity leave:

> *"I could see her attempt to give me a gift as an attempt to kind of remind me even when I'm away of her, that I used the blanket she gave me. You know, that I carry something of hers into another part of my life, um that's quite constrained from who she is or the space I share with her."*

Here, the function of the deviation is to be kept in mind as well. The therapist accepted the gift and described it as a fairly *'harmless gesture'* because she had known this particular patient for a long period of time. The therapist felt that the deviation, in this case, had little or no direct implication for the therapeutic process because the patient was so familiar to the therapist and because she felt no *'need to interpret'* the gift. However, the therapist felt that she might have handled the situation differently, and the gift might have had a different implication, if she had received it from another patient. She stresses the patient's

unique dynamics and how these are significant in determining the implications of the enactment of out of session frame deviations.

Patient specificity was a particularly important aspect of therapists' explanations of out of session frame deviations. They often looked at the patient's individual dynamics (which will be discussed later) as important factors in frame deviations, as well as how the frame itself should be managed to have the best possible results for therapy. Here is what one therapist had to say:

> *"For some patients it's absolutely important that the frame is very firm, extremely tight from the second of starting until the second of finishing, patients really need that for therapy to function. You know, some patients require a more gentle, maternal negotiation of the boundary issue, if a patient is very distraught at the end of the session to kind of allow them to gather themselves in a way that can allow them to feel more contained and held."*

Here, it is suggested that patients' needs are what determine the *'paternal'* rigid boundary or the *'maternal'* gentle boundary. The frame is not simply a fixed entity that cannot be accommodating. Therefore, the manner in which the frame is managed and out of session frame deviations are understood also have significant implications for the therapeutic process and assist the therapist in his task of *'containing'* as well as understanding the patient. It seems, then, that the implications of frame deviations for the therapeutic process are manifold, depending on the patient's dynamics but, also, on the therapist's reactions and responses. The latter forms the basis of the third theme, presented below.

THERAPISTS' REACTIONS TO OUT OF SESSION FRAME DEVIATIONS

Therapists reactions to deviations were quite complex and reflected both elements of technique as well as emotional responses. This section offers an

exploration both of how frame deviations are handled and of therapists' countertransferential reactions to out of session frame deviations.

The manner in which to handle a frame deviation was complex and proved to be case-specific in most instances. In the quote presented below, a therapist gives the example of a couple she was seeing. The wife emailed her and disclosed that she had been having an affair. On the subject of how it was handled, she said:

> *"…something sensitive like that, then I would deal with it in the email but I've spoken about this and about the impact on the therapy. Then after I told her that I didn't think it would be conducive if she carries on with this, and after that I ended it, I said this is my opinion, this is what you should do about it but please don't email me anymore because I don't want to talk to you secretively and then she stopped."*

Here, the therapist felt that she had to intervene between sessions, despite the obvious *'sensitivity'* of the matter. She describes a feeling of discomfort at having to deal with her patient *'secretively'* and her response seems to have been somewhat directive. The therapist's understanding of the situation was that the matter needed attention and warranted an out of session frame deviation. This suggests that sometimes frame deviations are, in fact, justifiable courses of action. Even so, in this instance there was a visible reluctance to enact the deviation. This also illustrates how the element of clinical judgment is seen as a fundamental aspect of dealing with out of session frame deviations.

In other instances, frame deviations were allowed and entertained because this was deemed useful. In the following quote, a therapist speaks about receiving emails from a patient who could not speak about his feelings in session:

> *"It was difficult for him to tell me in session, in words, I think it was easier for him cos he seemed to be on an Asperger's spectrum so it was very*

difficult for him to communicate that so I guess he just found it easier in his writings."

There is a perception for this therapist that the frame deviation was a useful and purposeful tool that was serving to communicate to the therapist in a manner which could not occur in session. Moreover, the manner in which the frame deviation is talked about conveys a position of permissiveness and compassion rather than being overly critical or rigid by simply not allowing the patient to express himself. Similarly, another therapist discusses a patient whom she felt *'needed'* to be spoken to on the phone between sessions after a stressful event and so she allowed the frame deviations to continue:

"…it was for her a continuation of the therapeutic process so my role there was to contain that, but for her it was an overwhelming, the emotional impact of that was big. I think that's why she phoned and I mean that's generally my experience of, when a patient phones it's around something that has just broken through their defences."

It appears that, in this case, the therapist felt as though it was her duty to engage in the frame deviation because it served the best interests of the patient by containing her *'until the next session'*. There is a suggestion that out of session frame deviations are sometimes necessary for the patient's well-being. This is, however, not always the case, as illustrated by the example of a patient who often arrived at the therapist's office even though there was no session:

"…he would pop up and I think that the whole thing was about pushing out of the frame, making me feel uncomfortable and with him it was constantly trying to stick to the frame, just this constant barrage of personal questions, are you single are you Christian, are you this, are you that. So it was a constant need to break the frame and push me out of it."

In this case, the therapist did not entertain the frame deviations, neither outside the consulting room nor within it. It was not seen as constructive to the therapeutic process. This example also illustrates the difficulty that arises when the frame is deliberately deviated from. The therapist in this case felt extreme discomfort and struggled to keep the frame, feeling as though the patient was being deliberately *'manipulative'* and *'intrusive'.* In this instance, the therapist felt that it was not productive to simply allow a frame deviation to be enacted. Therefore, the manner in which the deviation is handled is largely dependent upon the patient-specific dynamics and clinical judgment based on the therapist's knowledge of those dynamics.

The above example also illustrates the importance of therapists' reactions and personal feelings around out of session frame deviations. In the example, the therapist felt violated herself, rather than the frame being the object of violation. This proved to be a consistent feeling with a number of therapists. In the example presented below, the therapist felt 'abused' by her patient:

> *"I had a patient once who brought me poetry. That was very disturbing because the poetry was very grotesque poetry but we worked with that within the session but that was more exhibitionism and abuse of the therapist than therapeutically helpful."*

This therapist felt harmed by the patient, as though she was deliberately being victimised and that feeling lingered even outside of the therapeutic hour. Out of session frame deviations often brought about strong feelings for therapists. The deviations appear to elicit reactions that illustrate the very 'alive' nature of the relationship between therapist and patient. These countertransference reactions were often spoken about in interviews. In another example, one therapist spoke about feeling irritated by a patient who had phoned him on a Friday night:

"I think I was quite irritated with his phone call. I didn't wanna hear from that couple again. They were difficult, they were, they didn't shift very much, they were just really irritating. And then for him to call me at that particular time, I was just, I said you'd better call the call centre and have a discussion with someone else."

Here, the therapist feels annoyed at the violation of his personal space and at the couple's inability to *'shift'*. In the excerpt that follows, the same therapist discusses a patient who had called after having already terminated:

"…I was really just wanting to get rid of her. I thought I would when I ended but she called again. There I just wanted to get rid of her because she was a bit of a nuisance and she was setting me up because none of my efforts were making any difference anyway so why is she calling me now, you know."

The quotes suggest that this therapist has had similar reactions to several patients. This reflects countertransference based on elements of what the therapist calls his *'own stuff'*. Moreover, the examples presented illustrate the profound effect that some out of session frame deviations have on therapists. They reported feeling strong reactions to a number of the frame deviations committed by individual patients and to have significant difficulty when dealing with these specific deviations. For example, one therapist discusses being called outside of session time and her feelings around that:

"…I get annoyed and it's that thing about can't you let go of me, that thing that I from my background, that I struggled with, people, I had a lot of young brothers and a sister and they always wanted to be cared for so that sense of I've done enough now, for now. Leave me alone, you know"

This particular therapist relates her response to her unique circumstances, creating a difficulty with a specific type of patient. Clearly, there are elements of therapists' personal dynamics that play a part and the dynamics of a specific patient seem to bring about strong emotional reactions in therapists, based on their own experiences and nuanced dynamics. This is important because the manner in which out of session frame deviations are understood and handled appears to be somewhat reliant not simply on patient-specific factors but, also, on therapist-specific factors.

The example of the therapist whose patients found his Facebook profile was discussed above. On the subject of the therapist's feelings about that form of out of session frame deviation, he had the following to say:

> *"…it's a little close to home so I mean it would be quite, for me, certainly it would be worked with very strictly, but it's a little too real life to allow the patient to reflect on their own projections. It's a little too close, I mean that might be the kind of father boundary that says, you know, this doesn't feel okay."*

The therapist describes a sense of unease at the patient having such unabated access to him outside of the therapeutic hour. This deviation feels intrusive and somewhat violating. His discomfort also seems to determine his 'choice' of the *'father boundary'* illustrating that therapists' feelings also impact on the manner in which frame deviations are handled. Management of the frame and frame deviations, therefore, seems to also be informed by the therapist's specific dynamics. The complexity and uniqueness involved in handling these distinctive violations is also significant.

The following excerpt relates to an example of a consistently late patient where the therapist recognised her difficulties in setting boundaries and her unconscious collusion with her patient's behaviour, much like the patient's parent

had done. She has taken on the role of an over-indulgent parent in the countertransference:

> *"… it might be that there's an assumption of me accommodating that particular patient, that I'm not setting firm enough boundaries. I'm not requiring the patient to do her part, if you know what I mean, that I'm an overindulgent parent if you will*
> *F: By not setting clearer boundaries?*
> *S: Mmm, that I'm sort of letting her get away with it, which I would need to reflect on*
> *F: So in that case, it's like she wants to be… policed as you said earlier*
> *S: Maybe she wants to be policed or she just wants to be indulged and I'm indulging her. Maybe I need to set firmer boundaries, cos I'm not confronting her, it's almost like I'm not noticing. It's almost like I'm caught in that countertransference and when I think about that patient, it's not the only way that she just assumes I'll be there for her, indulge her."*

In this case, the therapists' countertransference meant that she did not respond to the out of session frame deviation but, rather, let it continue. This example illustrates how out of session frame deviations are sometimes reacted to (or not) by therapists when there are countertransference reactions involved. Therefore, countertransference has a bearing on the manner in which the deviations impact on the therapeutic process and on the manner in which the therapist handles the deviations.

From the above examples, it can be seen that countertransference is an important aspect of the process where out of session frame deviations are concerned and that therapists often had very complex and meaningful countertransferential reactions to their patients' deviations which, in turn, had implications for therapy. Moreover, the countertransference reactions illustrate that what happens outside of the session also has a strong unconscious

component and may sometimes be thought of as part of the therapy process. In this section, therapists' unconscious dynamics have been explored. The discussion now turns to the perceived unconscious dynamics of patients as they relate to out of session frame deviations.

THERAPISTS' UNDERSTANDINGS OF PATIENT DYNAMICS RELATED TO OUT OF SESSION FRAME DEVIATIONS

This section examines therapists' perceptions of the unconscious motivations that might prompt out of session frame deviations by patients. The section aims to answer the question of possible functions of out of session frame deviations for patients and to examine aspects of patients' unconscious dynamics, most notably transference as it relates to out of session frame deviations.

Here, too, there is a caution by therapists not to over-interpret but to consider the possibility of *'real life'* being an important factor. One therapist had the following to say:

> *"The truth is there are, I will concede that there are a number of frame deviations that are simply practical, um, that just reflect the practicality of a person's life and you will see that when they communicate."*

The therapist indicates that the possibility of *'real life'* having motivated a deviation should be considered. He also seems to suggest that there must be a patient-specific approach rather than a prescriptive stance.

Therapists often considered the possible transference reactions contained in out of session frame deviations. They saw in out of session frame deviations a reaction to relational patterns that had existed before. In the example below, the therapist makes a direct link between the patient storming out of session and

transferential rage. The quote below describes his thoughts on the patient's communication to him:

> *"He was saying fuck you, I hate you, you are judging me and criticising me like my parents do and I hate you and I'd really like to kill you but instead of doing something destructive I'm gonna leave and I'm gonna punish you."*

The therapist describes a relational dynamic that is related to the patient's unique circumstances. The therapist has become a parental figure that has induced conflicting feelings of rage and a need to preserve the relationship. This example also illustrates the intense affect that seems to have brought about the deviation. The patient is engaged in what the therapist called an *'affect storm'*, a rage that is deeply meaningful for the patient. Affect, then, also has an important part to play in out of session frame deviations. As mentioned, while the deviation began within the session, its consequences were far-reaching and ended outside of it.

The patient who called his therapist because of an erotic transference has already been mentioned. On the subject of the transference which motivated the deviations, the therapist had the following to say:

> *"…it was this whole thing of falling in love with your therapist and wanting to phone her in the evenings and then talk about other stuff like music and… the whole thing about the intimacy of the relationship, almost wanting to date your therapist because they are so close that she might also feel the same way."*

The therapist does not express discomfort or anxiety but, rather, sees it as a part of the therapeutic process that assists her in understanding the patient. She allows the transference to continue outside of session time. This example also illustrates the continuity of the tranferential relationship between sessions. It does

not end as the session ends but the patient enacts it in his out of session frame deviations quite plainly. This, too, gives an important indication of the ambiguity of the frame and the manner in which that ambiguity manifests in out of session frame deviations.

The results tended towards an individualised understanding of the transferential dynamics that were enacted in out of session frame deviations. Similarly, the possible functions of out of session frame deviations were seen as patient-specific and determined, somewhat, by the relationship. For example, a therapist discusses the patient who used DVDs as a tool to communicate with her, to 'shift' the relationship, quite literally out of the consulting room:

> *"…I mean the content of the DVD would say so much, I guess about the strength of her feelings, it was a way for her to express herself. Also, she knew it was frame stuff cos she knew that I was taking it home, to my personal home, maybe she had fantasies about that but it was something that we had shared, that no one else knew about, no one else had watched it, um, there were some quite graphic and shocking images on the DVD so it was about tolerating that I guess"*

This example suggests the unconscious motivations that seem to have been at play for the patient. Once again, affect is seen as important. Similarly, there was a seeming motivation to getting closer to the therapist, having something that they could *'share'* and that heightened the intimacy between therapist and patient. In addition, the therapist talks about tolerating the images in the DVD because of the patient's unconsciously motivated attempt at shocking her. The purposes, then, may have been manifold for the patient but what seems evident is that these were important and purposeful communications that were manifested in out of session frame deviations. Thus the possible functions of the deviations in this case were diverse.

Therapists gave interesting and complex examples to illustrate why patients deviated from the frame as well as what the deviations may have served to communicate. In one example, the therapist discusses a patient who was *'prepsychotic'* and 'used' the frame deviation to maintain reality as well as to communicate a sense of trust and need for the therapist through her telephone calls:

> *"The communication was…that I trust that you know what you're doing and I need you now, I need you to…keep this relationship going because there are huge problems of trust when it comes to schizophrenic people so she was communicating that I, I want to check if you're still there, I want to see if you will do what you promised to do."*

The therapist discusses something of a 'test' to maintain reality for the patient, a communication of a need as well as a sense of trust in the therapist. Here, too, there seem to be multiple functions for this single frame deviation. Equally prominent was a sense that the deviations were useful communications that assisted the therapist in understanding the patient's unique and idiosyncratic dynamics. One therapist said the following of frame deviations which occurred outside of the session:

> *"* [They are] *very valuable and certainly communications that I will work with like any other kind of communication, dreams, associations, relationships."*

These deviations offer useful information for the therapist and serve a unique and distinctive purpose for the patient. Most notably, therapists suggested that patients were communicating some sort of emotion or response that could not be verbalised through enactment of the frame deviation. For instance, one therapist talked about the idea that *'everything means something'* by describing a patient

who unconsciously reveals his ambivalence by not writing down his appointment time and then calling to enquire about it repeatedly:

> *"…in this case when you explore it, it really becomes clear that the person has some ambivalence about being in therapy, that whatever the issues under discussion are, are something that he would like to avoid thinking about so when he makes the appointment, he reveals his ambivalence by not writing the appointment down in his diary and also not rehearsing the date and time in his mind so by the time the day comes, he's sort of this vague sense but he doesn't quite know what it is. So there it reveals ambivalence."*

The therapist describes a patient whose enactment of the frame deviation is unconscious. The patient, himself, is unaware of his own behaviour and the dynamics that have brought it about. Even so, there is some function that is being served by the deviation itself. Ambivalence about therapy and the process was an important aspect in several interviews. For one therapist, this manifested in out of session frame deviations that are quite inconsistent with the manner in which the patient presents in session, by being compliant inside of the consulting room and then being rebellious outside of it, by avoiding payment. The purpose of the deviation is, for this therapist, to communicate uncertainty as well as to deepen the therapist's understanding of the patient's unconscious dynamics. The following quote is indicative of that point for one therapist:

> *"…a frame deviation is a communication around aggression or ambivalence or, er, a part of that person that they're withholding from the therapist, maybe because they want to protect the therapeutic space or maybe because they don't want to express that aggression to you. So the attacks almost occur outside and that's difficult because you get a patient that seems so compliant and yet you've got this niggling feeling that there's something not nice, really not nice that's happening in the therapy."*

Here, the therapist seems to be suggesting that the contrast serves a purpose for the patient. She appears to have several hypotheses around what that purpose may be but there is a sense that the patient deviates from the frame and is inconsistent in their presentation because of a relational dynamic between the patient and the therapist. She expresses a sense that there is a unique difficulty with out of session frame deviations with regard to these types of patients where the contrast is quite apparent. Moreover, the therapist feels that a communication is taking place and that out of session communication is, perhaps, equally important to the communication that occurs within the session.

The therapist who had a seemingly harmless meeting with her patient and her mother in public but, then, never saw her again had the following to say on the subject of the contrast:

> *"…on the surface of it the experience was congruent. She'd spoken about her mom and how she loves her and how they talk about therapy and then that's what it seemed like but then the fact that she didn't come back. Um, I dunno if, I dunno…"*

Here, the therapist is left with a new understanding, or lack thereof, of her patient. The out of session frame deviation seems to have been something of a catalyst for a reaction in the patient that made her unwilling or unable to return. This was an unplanned out of session frame deviation and it seems to have left the therapist with a feeling of uncertainty and perplexing questions as to what the meaning of that particular deviation was for her patient. Whilst it would be impossible to gain a thorough understanding of the patient, the example does illustrate that frame deviations do have a significant bearing on the continuation of the therapeutic process and they often reveal the 'other side' of patients' dynamics.

SUMMARY

Perhaps the most prominent feature of the data is that they emphasise a specificity and uniqueness within the therapeutic relationship. Patient-specific conclusions are often drawn by therapists about the manner in which they react to deviations as well as the possible functions that out of session frame deviations may have. Similarly, therapist-specific issues related to the manner in which therapists reacted to out of session frame deviations and their own enactments of out of session frame deviations were evident throughout. The relationship was seen as a critical factor and the uniqueness of that relationship was foregrounded by therapists. Furthermore, therapists spoke of flexibility, fluidity and ambiguity around the frame itself and around the distinction between an ‘out of session’ as opposed to an ‘in-session’ frame deviation. It seems that there is no uniform application of the frame and that therapists’ perceptions and understandings of contact outside of sessions varied significantly because their ideas of the frame varied somewhat as well. Overall, the results showed that out of session frame deviations are common, diverse in nature and relate considerably to the process of psychotherapy within sessions by being purposeful and offering new or different understandings of patient dynamics.

CHAPTER 5: DISCUSSION

This research was intended to offer an understanding of therapists' perceptions on the subject of out of session frame deviations. The study focused on the manner in which out of session frame deviations were experienced and understood by therapists as well as an exploration of the complexities of therapists' reactions to the deviations. The discussion will focus on these factors and the conclusions that may be drawn from the results.

SUMMARY OF THE RESULTS AND AN EXAMINATION OF THEIR IMPLICATIONS

Therapists experienced varied forms of out of session frame deviations, committed by themselves and by patients, from SMS messages to the use of Facebook and from late arrivals to conversations before entering the consulting room. The nature of the deviations was diverse but so, too, were understandings of the frame and the manner in which it was managed. Overall, the results indicated a lack of uniformity in understandings of the frame and out of session frame deviations. This was indicated, for example, in the case of conversations in the foyer, which elicited different reactions from different therapists. The boundary between 'out of session' and 'in-session' was also brought up as an area of ambiguity.

The results tended towards the idea that out of session frame deviations were significant factors and had important implications for the therapeutic process. These deviations often assisted therapists in understanding or containing their patients. At other times, they had what one therapist called a *'negative effect'* and may have been a hindrance to the therapeutic process. This was also true of therapists' own out of session frame deviations. There were also instances when out of session frame deviations were seen as relatively *'harmless'*, such as the therapist who received a blanket from her patient.

Overall, the results favoured an individualised understanding of the out of session frame deviations that was particular to therapist and client alike. A relationship-specific approach was also emphasised in therapists' reactions to the deviations. The manner in which out of session frame deviations were handled was unique to each case, with the deviations being entertained at times and disallowed at other times. Therapists had strong personal reactions to out of session frame deviations, reflecting that countertransference reactions were significant factors in how therapists handled the frame and frame deviations.

Therapists perceived out of session frame deviations as having strong unconscious content (when not *'practical'* or *'real life'*) and revealing key information about patient dynamics. Transference was important and out of session frame deviations often contained transferential material. Out of session frame deviations largely served a function for patients but that function was specific to the relationship and context. Moreover, several examples illustrated that an out of session frame deviation might have more than one function.

Out of session frame deviations were experienced in some way by all of the therapists interviewed. Moreover, all of the interviewees had several examples to support their experiences. This is indicative of the frequency and variety of out of session frame deviations that are experienced by therapists. The nature of the deviations was diverse and illustrated the potential that exists for out of session frame deviations to be enacted, both by patients and by therapists. Several instances of the deviations were clearly out of session. However, not all of the deviations were easily distinguished as 'out of session'. Instead, therapists often spoke about the somewhat blurred boundary between 'out of session' and 'in-session'. This is important as it illustrates that the frame and out of session frame deviations are not understood in a uniform manner. Instead, the results indicated that the deviations produced uncertainties for therapists because of this lack of uniformity.

Perhaps, the most striking example of the ambiguous nature of the frame was the therapist who mentioned watching DVDs with her patient. Here, the deviation was out of session despite the fact that it occurred within the therapeutic hour. Similarly, the example of the therapist who spoke about her discomfort in dealing with conversations in the foyer demonstrated that the frame and frame deviations were fluid entities that did not always have clear and finite boundaries. This is in keeping with the 'elastic frame' that Luca (2004) advocates rather than the Langsian (1981) 'impenetrable' frame. Moreover, the case of the conversations in the foyer also illustrates the complex reactions that therapists have to frame deviations. The sense of uncertainty around practical and technical considerations is evident, belying the idea of technical uniformity (Goldman, 2003) and, instead, emphasising flexibility to match the flexibility of the frame itself (Smith-Pickard, 2004). This study, therefore, illustrates the wide variety of technical and theoretical dilemmas that out of session frame deviations produce for therapists.

Therapists often mentioned that out of session frame deviations involved an overt communication, such as email, SMS or even the Facebook example mentioned. Here, the impact and role of technology and its facilitation of out of session frame deviations is increasingly important. Indeed, as Dooley (2006) mentions, technology is challenging the frame but also recreating it. New possibilities have been created as a result of technological advances, both for therapeutic interaction and for various 'new' frame deviations. Therefore, the impact of technology was also seen as a significant factor in the deviations and this illustrates the widened possibilities of enacting out of session frame deviations as well as the new *'mine fields'* or, indeed, opportunities that may arise as a result. In addition, the results indicate that these communications are of significance and are often considered by therapists for their latent content. Therefore, this study illustrates that, in practice, therapists consider out of session frame deviations as important and purposeful.

Therapists felt that frame deviations should not be overlooked but, rather, that they relate quite significantly to the process of psychotherapy. They are significant contributors to the therapist's understanding of the patient and are to be expected and made sense of rather than looked at pejoratively without any interpretation. At times, they also have negative effects. In each case, they are of great importance, which corroborates the position of Lomas (1987) who states that they offer useful material to work with. Even so, therapists were careful not to over-interpret frame deviations as being unconsciously motivated. The possibility of *'real life'* eliciting a frame deviation was important and this suggests that not all frame deviations constitute a meaning-based, unconsciously derived communication to the therapist, validating Luca's (2004) suggestion that frame deviations should be examined as practicalities first. Essentially, what the results emphasised was the difficulty that therapists had when trying to make sense of the deviations because they are such a complex and under-theorised topic.

When they were deemed to be unconsciously motivated, the frame deviations largely provided valuable insight and constituted a purposeful interaction for the patient in the views of the therapists interviewed. That purpose and function was seen as idiosyncratic and relationship-specific, with the patients' unconscious dynamics often being 'played out' in their actions. For Mendelsohn (1991), the process of acting out is indicative of a response that cannot be verbalised and is, therefore, enacted behaviourally. Several therapists concurred, saying that the out of session deviations communicated to them something that patients were not comfortable saying in session. However, there were several possible functions of out of session frame deviations rather than a standardised explanation. Therapists emphasised that each patient's dynamics would have to be understood rather than applying *'blanket'* answers to the question of the function of the frame deviation. Brockbank (2004) agrees with this position, suggesting that patients have unique and varied reactions because of their own specific backgrounds. Therapists' own out of session frame deviations were also often purposeful and served therapeutic functions, such as the example of SMSs

by suicidal clients being invited by the therapist. This is in keeping with Dooley's (2006) understanding of the possibility of frame deviations as 'meaningful' interactions and is somewhat challenging of the 'impenetrable' frame as the ideal (Langs, 1981).

The manner in which the deviations were handled was reliant not only on the needs of the patient but, also, on the personal countertransferential reactions of the therapist. This was clear in the example of the consistently late patient, whereby the deviations continued because the therapists' countertransference accommodated them. Therapists had strong reactions to a number of out of session frame deviations. Feelings of intrusion were common as were feelings of irritation. Overall, out of session frame deviations were significant in that they elicited strong reactions from therapists and created particular difficulties because they were not able to be *'contained'* in the manner that in-session deviations could be. Pollard (2004) discusses countertransference to out of session frame deviations but, here, the results suggest that countertransference impacts not simply on the relationship but also on the therapists' technique when dealing with out of session frame deviations. Therefore, therapists' feelings of technical uncertainty over how exactly deviations should be handled at times, and what to 'do' with them, are also consequences of their own countertransference reactions. This suggests that out of session frame deviations, whilst under-researched, are fundamental aspects of the therapeutic process and elicit strong reactions from therapists rather than being *'peripheral'* factors.

Therapists often entertained out of session frame deviations because they were deemed beneficial to the process of psychotherapy. This is in keeping with similar findings elsewhere, such as Dooley (2006) who found that out of session frame deviations were important transitional objects. At other times, however, therapists felt it inappropriate to allow the deviations to continue unabated or to not respond to them, such as the therapist who asked her patient not to email her

'secretively'. The significance of clinical judgment was raised here as an important factor in terms of how to handle out of session frame deviations. Therapists' understandings of particular patients and their own specific dynamics were important as well. Therefore, this too is indicative of a relationship-specific approach to out of session frame deviations that often is not concurrent with psychoanalytic theory which emphasises a consistent manner of dealing with frame deviations (Langs, 1981; Goldman, 2003). In practice, it seems the issue of how to deal with out of session frame deviations is complex and presents technical dilemmas for therapists, as illustrated by the results of this study.

Therapists' perceptions of patient dynamics and motivations for committing out of session frame deviations were idiosyncratic. Therapists did seem to agree that out of session frame deviations (at least those that were not *'real life'*) were indicative of patients' unconscious functioning. They described these deviations as communications to the therapist on several occasions and felt that the communications were often valuable and added new information around patient dynamics. Often the information felt incongruous with what had been experienced in session, offering the therapist an idea of the patient that he or she would otherwise not have had. This is in keeping with Mendelsohn's (1991) idea of acting out as a 'true self response' whereby the patient is able to enact creative gestures that cannot be enacted in the 'false self' setting of the consulting room. Included in these communications was transference material as well. The results abound with examples of transference enactments in out of session frame deviations, illustrating the important point that transference is not an exclusively in-session phenomenon. Therapists tended towards relationship-specific understandings here as well. There was no uniform manner of interpreting out of session frame deviations. Therefore, it may be said that out of session frame deviations offer significant unconscious material and relate significantly, though not uniformly, to the processes that occur within the session.

LIMITATIONS OF THE CURRENT RESEARCH

This study had some significant limitations that should be discussed. The small sample of interviewees may be thought of as a hindrance to the generalisability of the findings. However, the purpose of this study was to gain an in-depth understanding of therapists' perceptions of out of session frame deviations rather than drawing universal or near-universal conclusions. In fact, this may actually be thought of as something of a strength as it allowed for the richness of the data to be preserved rather than 'diluted'.

Another significant weakness was the oversight of the researcher regarding the subject of out of session frame deviations committed by therapists. This subject area was overlooked prior to data collection and its inclusion was based on its emergence throughout the interview process. Whilst the data may still be considered to be relevant and important, its direct inclusion in the inquiry might have yielded richer or more vibrant data. Therefore, this is a significant limitation.

The present research was conducted with a view to gauging perceptions rather than a sense of 'reality' as such. In doing so, therapists were asked about their perceptions regarding the dynamics and thought processes (conscious and unconscious) of patients. This presents a distinct limitation as the data presented is based on opinion and on indirect understandings of patient dynamics. However, it would be difficult, if not impossible, to accurately ascertain patient dynamics in a more direct manner with a similar theoretical and practical depth. Therefore, whilst patient dynamics cannot be certain, therapists' perceptions were well-informed by their profound knowledge of patients' unconscious material as well as their well-developed theoretical backgrounds.

SUGGESTED AREAS FOR FUTURE RESEARCH

A longitudinal study based on a particular client would be an especially useful piece of research. This would develop an even deeper understanding of the importance of out of session frame deviations and relate them more closely to patients' in-session material by reflecting the elements of patient dynamics that formed one aspect of the present study.

It may be useful to consider the role of technology and its impact on the psychodynamic frame. While a study by Dooley (2006) has handled this subject, further research into the subject on a broad range of clients may be warranted. In addition, such a study could be focused on the widened possibilities of out of session contact and therapists' feelings on subjects such as Facebook as presented above.

CONCLUSION

This research illustrated the unique meanings and implications of out of session frame deviations as seen in practice, thereby providing a deeper and more intricate understanding of out of session frame deviations. Another contribution of the study is that it illustrates the point that the practice of psychotherapy elicits a great deal of uncertainty and that there are spaces in the therapeutic process that present particular difficulties which have not been adequately explored. The responses of therapists demonstrated that out of session frame deviations were not 'safely' removed but not adequately 'inside' the session either to allow for containment or interpretation. Therefore, they inhabit a unique and obscure space that presents therapists with various practical challenges and opportunities.

Implications for practice are related to the ambiguous and fluid nature of the frame and the particularly complex space that out of session frame deviations

occupy. They may not be *'therapy'*, as one therapist asserted, but they do have a significant bearing on the therapeutic process and they should be treated with delicacy as they offer fundamentally important material. Furthermore, the frame itself should not be seen as a finite or definable entity but, rather, as a fluid and changing boundary that, often, cannot be clearly set.

Out of session frame deviations are especially complicated and, at times, problematic for therapists. They occur in a space that creates ambiguity in the relationship between therapist and patient and blurs the boundaries of the traditional psychodynamic frame. This creates a number of potential difficulties and opportunities for therapists, depending on relationship-specific factors. Overall, what can be seen from the data presented is that these deviations are important and they are often purposeful and reflective of unconscious dynamics of both patients and therapists. In addition, the results indicate that the frame itself, in practice, is fluid and changing and the manner in which out of session frame deviations are enacted and handled is an intricate subject that should not be overlooked.

REFERENCE LIST

Adams, J.L. (1990). *Conceptual blockbusting: A guide to better ideas*. Cambridge: Perseus.

Ahmed, R. & Pillay, A.L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology, 34, 4*, 630-656.

Bailey, R., Yager, J. & Jenson, J. (2002). The psychiatrist as clinical computerologist in the treatment of adolescents: Old barks in new bytes. *The American Journal of Psychiatry, 159*, 1298-1304.

Bauer, K. (2002). Using the internet to empower patients and to develop partnerships with clinicians. *World Hospital and Health Services Administration, 38*, 2-10.

Beatrice, J. (1984). Empathy and the Therapeutic Interaction. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 165-184). New York: Jason Aronson.

Berg, B.L. (2001). *Qualitative Research Methods for the Social Sciences.* Needham Heights: Allyn & Bacon.

Beveridge, J. (2004). The exclusion zone. In In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 142-164). Hove: Brunner-Routledge.

Brinkmann, S. & Kvale, S. (2008). Ethics in Qualitative Psychological Research. In C. Willig & W. Stainton-Rogers (Eds.). *The Sage Handbook of Qualitative Research in Psychology* (pp. 263-279). London: Sage Publications.

Brockbank, A. (2004).Therapist illness and its impact. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 86-97). Hove: Brunner-Routledge.

Brown, R.D. & Krausz, R. (1984). The Patient's Unconscious Perceptions of the Therapist's Disruptions. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 21-36). New York: Jason Aronson.

Campbell, T. (1996). Technology, multimedia, and qualitative research in education. *Journal of Research on Computing in Education, 30, 9*, 122-133.

Caspar, F. (2004). Technological developments and applications in Clinical Psychology and Psychotherapy. *Journal of Clinical Psychology, 60,* 221-238.

Cheifetz, L.G. (1984). Framework Violations in Psychotherapy with Clinic Patients. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 215-254). New York: Jason Aronson.

Chused, J.F. (1991). The evocative power of enactments. *Journal of the American Psychoanalytic Association, 39*, 615-639.

Compton, A. (1990). Psychoanalytic process. *Psychoanalytic Quarterly, 59*, 585-598.

Counselman, E.F. & Gans, J.S. (1999). The Missed Session in Psychodynamic Group Psychotherapy. *International Journal of Group Psychotherapy, 49, 1,* 3-18.

Cox, M. (1978). *Structuring the Therapeutic Process.* New York: Pergamon Press.

Dooley, H.G. (2006). *The Meaning of Electronically Mediated Communication in Psychodynamic Therapy with Adolescent Girls.* Unpublished Doctoral Thesis: University of Pretoria.

Epstein, R. S. (1994). *Keeping boundaries: Maintaining safety and integrity in the psychotherapeutic process.* Washington: American Psychiatric Press.

Ferenczi, S. (1928). The elasticity of psychoanalytic technique. In J. Borossa (Ed.). *Selected Writings*. London: Penguin. 1999.

Fingfield, D.L. (1999). Computer-assisted therapy: Harbinger of the 21st century?, *Archives of Psychiatric Nursing, 13*, 303-310.

Ferraiolo, S. (2004). You have been framed: maternity and the male psychotherapist. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 67-85). Hove: Brunner-Routledge.

Freud, S. (1905). Fragment of an Analysis of a Case of Hysteria. In J. Strachey (Ed.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (pp. 7-122). London: Hogarth Press. 1953.

Freud, S. (1911-1913). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (pp. 32-47). London: Hogarth Press. 1975.

Freud, S. (1954). *The origins of psychoanalysis*. New York, NY: Basic Books.

Freud, S. (1958). On beginning the treatment. In J. Strachey (Ed.). *The Complete Psychological Works of Sigmund Freud.* (pp. 123-144). London: Hogarth Press.

Freud, S. & Jones, E. (1993). Eros and Thanatos. In R.A. Paskauskas (Ed.). *Complete correspondence of Sigmund Freud and Ernest Jones.* (pp. 110-129). Cambridge: Harvard University Press.

Furlong, A. (1992). Some technical and theoretical considerations regarding the missed session. *International Journal of Psychoanalysis, 73*, 701-718.

Gabbard, G.O. (1993). Once a patient, always a patient: Therapist-patient sex after termination. *The American Psychoanalyst, 26*, 6-7.

Gabbard, G.O. (1995). The early history of boundary violations in psychoanalysis. *Journal of the American Psychoanalytic Association, 43, 4*, 1115-1136.

Gabbard, G.O. (2004). *Long-Term Psychodynamic Psychotherapy: A Basic Text*. Washington: American Psychiatric Publishing Inc.

Gabbard, G.O. & Lester, E.P. (2003). *Boundaries and Boundary Violations in Psychoanalysis.* Washington: American Psychiatric Publishing.

Gammon, D. & Rosenvinge, J.H. (2000). Is the Internet of any help for persons with serious mental disorders? *Tidsskr Nor Laegeforen, 120*, 1890-2000.

Gedo, J.E. (1993). *Beyond Interpretation: Toward a revised theory for psychoanalysis.* Hillsdale: Analytic Press.

Gibson, K., Sandenberg, R. & Swartz, L. (2001). Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists' training. *South African Journal of Psychology, 31, 1*, 29-35.

Goldman, D. (2003). The outrageous prince: Winnicott's uncure of Masud Khan. *British Journal of Psychotherapy, 19, 4*, 483-501.

Gray, A. (1994). *An introduction to the Therapeutic Frame*. London:Routledge.

Greenberg, J.R. & Mitchell, S.A. (1983). *Object relations in psychoanalytic theory.* Cambridge: Harvard University Press.

Healy, M., & Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research*, *3*, *3*, 118-126.

Henwood, K.L. (1996). Qualitative Inquiry: perspectives, methods and psychology. In J.E. Richardson (Ed.). *Handbook of Qualitative Research Methods for Psychology and the Social Sciences.*(pp. 17-39). Leicester: BPS Books.

Hoag, L. (1992). Psychotherapy in the general practice surgery: considerations of the frame. *British Journal of Psychotherapy, 8*, 417-429.

Hoepfl, M. C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education, 9, 1,* 47-63. Retrieved February 25, 1998, from http://scholar.lib.vt.edu/ejournals/JTE/v9n1/pdf/hoepfl.pdf

Ingrassia, A. (2003). The use of letters in NHS psychotherapy: A tool to help with engagement, missed sessions and endings. *British Journal of Psychotherapy, 19*, 355-365.

Jacobs, M. (1990). *Psychodynamic Counselling in Action.* London: Sage.

Kazdin, A.E. (2003). *Research Design in Clinical Psychology*. Boston: Allyn and Bacon.

Keene, C. (1984). Framework Rectification and Transient Negative Effects. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 267-302). New York: Jason Aronson.

Kernberg, O.F. (2004). *Contemporary Controversies in Psychoanalytic Theory, Techniques and their Applications.* New Haven: Yale University Press.

Khan, M.M.R. (1984). Negotiating the Impossible. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 185-194). New York: Jason Aronson.

Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth Press.

Kohut, H. (1978). *The search for the self-Selected writings of Heinz Kohut: 1950-1978*. Madison: International Universities Press.

Langs, R. (1976). *The therapeutic interaction.* New York: Jason Aronson.

Langs, R. (1980). *The Realm of Transference and Countertransference.* New York: Jason Aronson.

Langs, R. (1981). *Resistances and Interventions.* London: Jason Aronson.

Lemma, A. (2003). Introduction to the Practise of Psychoanalytic Psychotherapy. Chichester: John Wiley.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage.

Lomas, P. (1987). *The Limits of Interpretation.* New York: Jason Aronson

Lubin, M. (1984). Views on Neurosis, Listening, and Cure. In J. Raney (Ed.), *Listening and Interpreting: The Challenge of the Work of Robert Langs* (pp. 415-430). New York: Jason Aronson.

Luca, M. (2004).Boundary issues in psychotherapy: from the literal to the figurative frame. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 8-35). Hove: Brunner-Routledge.

Maxwell, J.A. (1996). *Qualitative Research Design.* Newbury Park: Sage Publications.

McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy.* London: Sage Publications.

McWilliams, N. (2004). *Psychoanalytic Psychotherapy: A Practitioner's Guide.* New York: Guildford Press.

Mendelsohn, R. (1991). *Leaps: Facing Risks in Offering a Constructive Therapeutic Response when Unusual Measures are Necessary.* London: Jason Aronson.

Menninger, K.A. (1958). *Theory of Psychoanalytic Technique*. New York: Basic Books.

Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook.* Thousand Oaks: Sage Publications.

Milner, M. (1952). Aspects of symbolism and comprehension of the not-self. *International Journal of Psychoanalysis, 33*, 181-185.

Neuman, W.L. (1994). *Social Research Methods.* Boston: Allyn & Bacon.

Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks: Sage Publications.

Pollard, J. (2004). We must stop meeting like this: unplanned contact between psychotherapist and patient. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 98-115). Hove: Brunner-Routledge.

Rapaport, D. & Gill, M. M. (1959). The points of view and assumptions of metapsychology. In M. M. Goldberg (Ed.). *The collected papers of David Rapaport* (pp. 795-811). New York: Basic Books.

Rosenthal, R. & Rosnow, R.L. (1991). *Essentials of behavioural research: Methods & Data Analysis.* Boston: McGraw-Hill.

Smith-Pickard, P. (2004). Challenging therapy: an existential perspective on the frame. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 128-141). Hove: Brunner-Routledge.

Spinelli, E. (2001). *The Mirror and the Hammer: Challenges to Therapeutic Orthodoxy.* London: Continuum Books.

Terre Blanche, M., Durrheim, K. & Kelly, K. (2006). First steps in Qualitative Data Analysis. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.). *Research in Practice: Applied Methods for the Social Sciences* (pp. 320-344). Cape Town: UCT Press.

The Professional Board for Psychology. (1999). *Ethical Code for Professional Conduct.* Retrieved January 16, 2003 from http://ethics.psych.co.za

Thomson, P. (2006). Psychotherapy with Helen: Negotiating boundary issues with a patient with MS. *Psychodynamic Practice, 12, 2,* 205 – 210.

Valerio, P.F. (2004). Broken boundaries: perverting the therapeutic frame. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 116-127). Hove: Brunner-Routledge.

Wimmer, R.D. & Dominick, J.R. (1983). *Mass Media Research: An Introduction.* Belmont: Wadsworth Publishing Company.

Winnicott, D.W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. London: Hogarth.

Winter, G. (2000). A comparative discussion of the notion of validity in qualitative and Quantitative research. *The Qualitative Report*, *4*. Retrieved February 25, 1998, from http://www.nova.edu/ssss/QR/QR4-3/winter.html

Wolf, A.W. (2003). The technology of psychotherapy. Introduction to the special issue. *Psychotherapy: Theory, Research, Practice, Training, 40*, *1,* 3-7.

Yin, R.K. (1984). *Case Study Research: Designs and Methods.* Beverly Hills: Sage.

Zinovieff, N. (2004). Therapy in general practice. In M. Luca (Ed.).*The Therapeutic Frame in the Clinical Context.* (pp. 36-52). Hove: Brunner-Routledge.

LIST OF APPENDICES

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

PARTICIPANT INFORMATION SHEET

Hi, my name is Faraaz Mahomed and I am conducting research for the purposes of obtaining a Masters Degree in Clinical Psychology at the University of the Witwatersrand. My area of focus is unconscious communication, and how this may be communicated through frame deviations, particularly frame deviations outside of the consulting room such as telephone calls, missed sessions, emails, text messages, cancellations and late arrivals. The aim of the study is to examine the functions that these communications may serve for psychotherapy clients. This is an area which will add to the theory of psychodynamic psychotherapy technique. Therefore, I would like to invite you to participate in this study.

Participation in this research will involve being interviewed. It will take approximately one hour to complete the interview. Participation is voluntary and you have the right to withdraw at any time. No identifying information, such as your name or location will be disseminated and as such your responses will remain confidential. In addition, should you choose to participate, please ensure that the confidentiality of any patient discussed is respected by not including any identifying information of the patient concerned.

If you choose to participate in the study please sign the consent form. If you do return a signed consent form, this will be considered consent to participate in the study. Please note that interviews will be recorded but heard only by myself, with transcripts sent to my supervisor when necessary. Direct quotes from these interviews may be used in the final report but no identifying information will be given. Tapes will be kept in a safe place known only to me and destroyed once the research has been completed.

Your participation in this study would be greatly appreciated. This research will contribute to a larger body of knowledge related to psychodynamic psychotherapy technique and interpretation.

If you would like to receive the results of this study, please feel free to contact me. In addition, the final report may be available in libraries and may be used to publish an article in a journal.

Kind Regards
Faraaz Mahomed
0834459898
Faraazmahomed@webmail.co.za

Supervisor: Dr. Carol Long
(011) 717-4510
carol.long@wits.ac.za

INFORMED CONSENT FORM:

I, _____ hereby consent to the use of data obtained through my interview to be used for the purposes of research to be conducted by Faraaz Mahomed, University of the Witwatersrand, Department of Psychology.

I understand that:

- My confidentiality is guaranteed
- The confidentiality of my clients will be respected as no identifying information is asked for during the interview
- I have the right to withdraw at any time
- I have the right not to answer questions
- Direct quotes from this interview may be used but no identifying information will be given

Date_____

Signature_____

INFORMED CONSENT FORM:

I, _____ hereby consent to the recording of my interview for the purposes of research to be conducted by Faraaz Mahomed, University of the Witwatersrand, Department of Psychology.

I understand that:

- My identity will be protected
- Access to the tapes will be restricted to the researcher
- Transcripts of interviews will be provided to the supervisor of this research but my identity will not be disclosed to said supervisor
- Tapes of interviews will be kept in a safe place known only to the researcher
- Tapes will be destroyed once the research has been completed

Date_____

Signature_____

Interview Schedule

1. What have been your general experiences of frame deviations, particularly those outside of the consulting room? Could you give me some examples?
2. What would you say are the possible functions of these out-of-session frame deviations for patients? Ie. What purpose do they serve?
3. How do you deal with out-of-session frame deviations?
4. What is your understanding of these out-of-session frame deviations?
5. What purpose would you say these out-of-session frame deviations serve?
6. How do the out-of-session frame deviations relate to the process of psychotherapy in session?
7. How do they relate to the content of psychotherapy in session?
8. How do they affect working psychodynamically with clients?
9. What kind of challenges have you experienced working with out-of-session frame deviations?
10. Could you tell me about specific clients where out-of-session frame deviations have been an important part of the process? There is no need to include any identifying criteria.
11. What have been your experiences of out-of-session frame deviations with this particular client?
12. How are these experiences related to the process and content of psychotherapy?
13. What would you consider the functions and purposes of this client's out-of-session frame deviations as unconscious communication?
14. Anything you would like to add?