

Kegerreis, S. (2013). 'When I Can Come on Time I'll Be Ready to Finish': Meanings of Lateness in Psychoanalytic Psychotherapy. *Brit. J. Psychother.*, 29(4):449-465.



(2013). *British Journal of Psychotherapy*, 29(4):449-465

Clinical Practice

'When I Can Come on Time I'll Be Ready to Finish': Meanings of Lateness in Psychoanalytic Psychotherapy

Sue Kegerreis 

This paper considers some aspects of the meaning of chronic lateness in psychoanalytic psychotherapy. The central role of time in psychoanalytic work and the significance of enactments around the analytic frame are considered. Using clinical material the writer explores how lateness can be understood as an expression of global difficulties in accepting and adapting to the demands of reality as well as a wide range of complex object-relationship difficulties. Some of the technical and countertransference complexities of dealing with lateness are discussed. Lateness is seen to project intolerable experiences into the therapist, to demonstrate the patient's intense difficulties in imagining and tolerating a productive couple, to re-enact a sadomasochistic dynamic from the patient's past and to re-encounter/re-address the patient's early experiences of rejection and oedipal rivalries. The eventual synchronization of therapist and patient's times is explored as a major achievement in the patient's increasing capacity for relating.

SUE KEGERREIS is Director and Senior Lecturer at the Centre for Psychoanalytic Studies at the University of Essex. She trained as a child and adolescent psychotherapist at the Tavistock Clinic and as an adult psychoanalytic psychotherapist with the Lincoln Clinic and Centre for Psychotherapy (now part of the British Psychotherapy Foundation). She has practised privately and in a range of other settings: school, hospital and CAMHS, as well as teaching on many courses, both clinical and applied. She has published widely in professional journals and her book *Psychodynamic Counselling with Children and Adolescents* was published in 2010 (Palgrave Macmillan). Address for correspondence: 67 Addison Gardens, London W14 0DT. [skeger@essex.ac.uk]

- 449 -

Introduction

In this paper I will explore some ways of understanding what is going on when a patient is persistently late for psychoanalytic psychotherapy sessions. Time is a crucial aspect of the setting; how a patient relates to the time boundary - arriving early or late, leaving early or lingering, being punctual to the minute or getting the time wrong - is a lively and ever available indicator of the state of the patient's object relationships. In this paper I will give a brief discussion of general issues relating to time in the literature, and then use material from patients to illuminate the complexity and shifting meaning of lateness in their treatment and the complexity of addressing it effectively.

The Centrality of Time as a Concept

As Arlow (1986) says: 'Hardly any other profession functions in as intimate and consistent an involvement with time as does psychoanalysis. Considerations of time figure prominently in every aspect of our work' (p. 507). Time is central to the whole psychoanalytic project, emphasizing as it does the active role of the past in the present. The development of a sense of a self with continuity through time is a crucial achievement of infancy (Stern, 1985; Winnicott, 1945) and the subjective nature of our experience of time, sometimes stretched out or absent, sometimes fast or disjointed, has often featured in studies of patient material (Freud, A., 1965; Hartocollis, 1983). Dissociative experiences disrupt our sense of the continuity of time (Campbell, 2006; Sinason, 1992). Furthermore, and more relevant to the subject of this paper, there has been an emphasis on our relationship with time as an ongoing element of our grasp of reality and a means of articulating our object relationships (e.g. Morris, 1983).

However, despite the richness of the literature on how our experience and relationship with time can be understood psychoanalytically, and of course the innumerable articles

that mention lateness in specific instances during a therapy, there is relatively little in the literature that focuses on chronic and extreme lateness. Notable exceptions are Morris (1983), Meissner (2006) and Piovano (2008).

Time and Reality

Freud pointed out that: 'There is nothing in the id (the system *Ucs.*) that corresponds to the idea of time; there is no recognition of the passage of time' (1932, p. 74). It is part of the job of the ego to encounter the external world and bring an awareness of time as a result. Recognition of the reality of time is therefore intimately involved in the relationship between primary and secondary processes, in the struggle between the pleasure and the reality principle (Freud, 1911). In Kleinian terms, accepting the reality of time is part of the accommodation to reality associated with the depressive position (Klein, 1940). The acknowledgement of the reality of time has an intimate relationship with issues of separateness and loss. Lombardi writes that in primitive

- 450 -

mental states 'the physical measurement of time was experienced as the prime representative of the reality of loss, i.e. of the limits that reality imposed on the limitless demands of the patient' (2003b, p. 853).

In relation to this, awareness of time has been closely linked to the appreciation of the inevitability of death. Denial of the reality of time or omnipotent attempts to master time can be seen as a refusal of this most fundamental element of our human existence - Money-Kyrle's (1968) third 'fact of life'. Hartocollis (1983) writes about how being late for appointments or failing to meet deadlines serves to protect compulsive individuals from the anxiety-provoking idea of time and its equivalent, death. Accepting the reality of time passing can for many patients mean acquiescing in a relationship to reality that is unbearable, and considerable effort is expended in omnipotent attempts to deny its existence.

A version of this can be seen in patients who use magical thinking to express their defiance of reality. Some patients are habitually late, not centrally because of the immediate interpersonal dynamics of the therapy, but because it is intolerable for them to accept limitations on their omnipotent fantasies - they cannot accept the reality of how much time is needed to get from A to B. Mr S, a somewhat narcissistic patient in his 40s, was very often late in this way. Whether he used public transport or came by car, he would repeatedly expect trains, buses or traffic to function miraculously in his favour. He expressed continual amazement and indignation when his - to him reasonable - ideas of how the journey should go were not borne out in reality. His lateness at this stage of his therapy was illustrative of the way in which time was, as Oberndorf (1941) delineates, an aspect of reality to which he was not prepared or able to adapt. His refusal to take account of the realities of city life was intimately bound up with his pervasive omnipotent defences against a deep terror of vulnerability and contingency. Morris (1983) describes something similar when he writes of a woman patient that: 'Realistic time experience and behaviour would pose the threat of her awareness of her separateness, loss and rage, affect states she was terrified she could not control' (p. 669).

Time is also a resource and a 'currency'. Fenichel (1945) wrote about how

anal personalities are as disturbed in their attitude toward time as they are in their attitude toward money: in respect to time, too, they may be stingy or prodigal or both alternately; they may be punctual or unpunctual; they may sometimes be accurate to the fraction of a minute, and at other times grossly unreliable. (p. 282)

This highlights how the way we relate to time is intimately bound up with our relationship with our own resources as well as in our relationship with each other. Encountering and managing the finiteness of time is a lifelong task for all of us, and has profound implications for how we run our lives. Time acts both as a currency in our relationships with others and as a most fundamental element in our relationship with ourselves.

Time and our relationship with it are therefore always there to be worked with in therapy. Lombardi sees a deeply disturbed relationship with time as a key feature of both the difficulties his patients have with reality, and of the analytic work he can do

- 451 -

with them as their use and abuse of time represent and embody their psychotic processes. 'The theme of temporality and its related conflicts seems ... to be an often relevant catalyst in the development of those many difficult cases which create powerful hurdles to progression and change' (Lombardi, 2003a, p. 1532). He sees time as having a crucial structuring and containing function - which also helps explain why it can be attacked and, in omnipotent phantasy, overcome - and working with it is therefore a key element in analytic work. He says that: 'Promoting the awareness of temporality is equivalent to that aspect of the work on *K* [Knowledge] that facilitates tolerance to frustration and acts as a catalyst for the functioning and growth of the non-psychotic part of the personality' (Lombardi, 2003a, p. 1535).

Acting Out around the Therapeutic Frame

The therapeutic setting is perfectly designed to highlight the difficulties our patients have in negotiating both internal relationships and the boundary between themselves and others. While undoubtedly some treatments do not have acting out around time as a key feature, and there are so many other ways in which conflicts can be enacted, there can be few in which it has never arisen at all.

Bleger (1967) writes of how it is through the analytic frame that split-off, psychotic parts of the personality are expressed. If, as Morris (1983) writes, analytic time involves a regression to the childhood origins of the sense of time, including a regression to the symbiotic phase of mother-infant relatedness, then it is going to be the case that it is through the experience of analytic time that the fundamental work progresses. In many cases, such as those I describe in more detail in this paper, there is a powerful sense that if the patient could come on time in a relatively straightforward way, a considerable proportion of the therapeutic task would have been achieved.

In patients who present with major difficulties in time-keeping, Lombardi takes the view that: 'The essential task of the analyst is to produce a meeting of the time of the patient with the time of the analyst' (Personal communication via Alejandro Reyes). There have been many metaphors used to represent the essence of the therapeutic encounter with productive therapy represented as a feed - the patient being able to take in and digest (e.g. Lawrence, 2002, 2008; Williams, 1997), or as creative intercourse - two people getting together and producing something new in a mutually satisfying encounter. Here I am stressing and illustrating another - that of the developing synchronization *in time* of the therapist and patient where the capacity of the patient to work with and within the rhythm of the therapy, as it were to 'dance' together, is a key indicator of progress.

This kind of worked through synchronization naturally needs to be differentiated from compliance, and from other ways of being driven to keep to the frame. A patient who is always on time may not be expressing a healthy state of mind, particularly if this carries with it anxiety and an element of compulsiveness. It can be a relief if an obsessional or persecuted patient manages to risk being a little late, as this might signify a relaxation of an overly severe superego, whether primarily experienced internally or projected into a frighteningly punitive therapist (Kegerreis, 2010). A

- 452 -

different dynamic was presented by a patient who was always, without fail, on time, usually without any fuss, although on occasion she would show anxiety if this had been in jeopardy. This punctuality demonstrated a feature of all her central relationships in which she would manifestly do everything 'right', while secretly being in a destructively hostile and resistant state of mind. No one could ever accuse her of not doing what she should, and she clung to these outward manifestations of co-operation and goodwill lest anyone might spot the hidden, unconscious undermining that interfered with genuine fruitful contact. The fact that a patient can manage this aspect of the therapeutic frame well cannot therefore be considered as some objective measure of healthy relatedness. However, a persistent refusal or failure to manage the time boundaries of the sessions can safely be taken as a measure of a relational disturbance.

Time and Oedipal Dynamics

Meerloo (1948) and Lewin (1950) both wrote about how time could be equated with father's demands and become a metaphor for the father and the reality principle, the adult expectation to renounce one's infantile pleasures for the sake of adaptation to reality. 'Time as the father is the intruder into the timeless relation with the mother' (Lewin, 1950, p. 310). Not being on time then can express aggression against the father or thence any authority. The time-boundary of the session creates an arena for the battle with the oedipal father, and a way of exploring whether and how each patient has managed, and been helped or hindered in their early life, in their negotiation of such power dynamics.

The therapist's control over the end of the session will always be full of meaning. As Winnicott (1947) said, the end of the session can be the analyst's expression of his hate, and certainly can be experienced by the patient as being redolent with all other rejections and demotions from prime position in mother's mind. To state the obvious, the actual beginning of the session is within the patient's area of power, and so is often irresistible as a way of giving expression to the experienced power relations in the therapy.

Meissner writes:

The time element quickly became the focus for issues of dominance and submission and control in the analysis. The scheduling requirements, despite the negotiating process by which we decided them, were viewed as an exercise of my power and control. In regard to the actual hours, he declared that if I had power to decide the end of the hour, he could have power of deciding when the hour was to begin. (2006, p. 625)

Thus the way in which a patient manages the beginning of sessions easily becomes the most eloquent of communications of these power relationships.

Managing Time as a Measure of Independence

For Meissner's patient it was essential for him to feel that he had some power to decide when the session began, to assert a crucial independence. For others,

- 453 -

conversely, being able to manage time would demonstrate the capacity to become an independent self-regulating individual - something which they badly want to disavow. Lateness can, like the inability to manage financial affairs, be used explicitly to express a protest about any expectation of this.

As an illustration, Mrs R was habitually late for almost everything, and usually about 15-20 minutes late for her weekly sessions. She agonized constantly about her inability to get anywhere on time as this exemplified her not being able to cope in an adult fashion. Interestingly, the thought of arriving about five minutes late was intolerable, as this would mean that in fact she could have come on time if she had really wanted to. Her extreme lateness signified that she 'had a real problem', rather than being something potentially within her power to change. Were she to come on time, a whole raft of expectations that she could take on adult responsibilities would follow. She went to great lengths to make sure she could not get to her sessions - or anything else - on time. She would, for instance, stay up until 3 in the morning obsessively cleaning her flat, ensuring she was exhausted and fit for nothing in the morning when she needed to take her children to school. The obsessional cleaning had many layers of meaning but one key element in it was the necessity for her of making her less effective the following day. Getting up in the morning and feeling ready for the day would entail the expectation that she could cope with the ordinary demands of life, so she badly needed a concrete reason why she was manifestly unfit to do so.

Mrs R's lateness to sessions was not, at least in this early phase, most usefully taken up in terms of her week-by-week relationship with me or with the therapy, but in overall relation to herself and her sense of competence and her fear of what I/others might otherwise expect of her. We may surmise that for this patient: 'To be defective and dependent was to ensure mother's concern, while to function autonomously threatened the loss of maternal support and love' (Morris, 1983, p. 668). Being late was a generalized protest and an expression of grievance against those who expected her to become adult with her own responsibilities, of whom I was only one.

Technical Considerations

Working effectively with persistent lateness requires subtle differentiations in technique to reflect the particular dynamics involved. It can be hard to find a way of taking it up sufficiently robustly without creating a persecutory dynamic. We are constantly challenged by our late-coming patients' apparent rejection or undervaluing of what we have to offer, and this combines directly with our own narcissistic configuration. Langs (1978) points out that analysts have their own 'collective countertransference difficulties' (p. 105) in dealing with the frame. It is not only the projections of the patient that influence how this dynamic gets played out. Our own tendencies to either be over-accepting towards - or over-reacting to - 'ill-treatment' of us by our patients are always implicated and will lend their own flavour to how these issues are worked through in each unique dyad. We might be more susceptible to becoming masochistic and accepting ill-treatment with too little protest (Mattinson, 1975), or alternatively more likely to become intolerant so that we become too fixed on this one symptom. As

- 454 -

trainees we may be so doubtful of our value as therapists that it is difficult to manage robustly the patients' expressions of aggression and contempt, especially if we need patients to continue their therapy to complete our training. However, the opposite tendency - to take up the attack implied in the lateness too fiercely or too directly just to do with the therapy can be an equal danger. With one patient, the emphasis developed in the supervision was on her persistent lateness being an expression of her in effect 'not being a patient' and was therefore to be interpreted almost to the exclusion of anything else. This fed into intractable dynamics around her feeling that I had no understanding of the chaotic nature of her life, in which she was routinely bullied and undermined by an employer whose demands on her impinged on her capacity to be on time. The triad of her, my supervisor and myself became imbued with these bullying and undermining dynamics and, sadly, the treatment was broken off prematurely.

Knowing our own tendencies is key to being able to detect with more accuracy how our reactions to the lateness inform us about the patient's projections. Careful attention to the countertransference is, as always, essential to clarify what is being created in the dyad. Registering whether we are relieved, anxious, cast down, humiliated or passively accepting of our patients' lateness (and of course infinite varieties of subtler permutations) will be key to both the meaning and the processing of what is going on. With Ms P, another habitually late patient, I noticed the point at which instead of waiting attentively I started to be a little tardy in taking up my place in the therapy room, and then when I found myself taking something to read with me. Reflecting on these manoeuvres gave me insight into our mutual wish to protect our relationship from a full appreciation of her

panic-stricken attack on real connection between us. It echoed her way of developing mild adulterous fantasies as a protection against the apparent defections of her husband. I was occupying myself in a faintly 'unfaithful' way in order not to take seriously a deeply corrosive turning away from a needed object. I needed to become far more robust in tackling this rather than falling further into becoming passive and accepting of her lateness.

However, Meissner (2006) considers that his patient badly needed to keep the area of autonomy expressed by his lateness, and implies that to over-emphasize its negative interpersonal meaning would have been unhelpful. Going further in his warnings about the technical mistakes that can easily be made, Bird (1957) emphasizes that with narcissistic patients:

[I]f coming late is interpreted as a defense against either positive or negative feelings for the analyst, the patient will have no part of it and will feel extremely threatened. Instead of making the usual interpretation, it is better to interpret the purely narcissistic meaning of the act of coming late: the patient is late, not because he fears his positive feelings for the analyst or because he is angry with the analyst (both undoubtedly true at a deeper layer), but simply because he wants to do what he wants to do when he wants to do it, and because he doesn't care a whit about the analyst. (p. 640)

- 455 -

It Takes Two to Tango: Perils of Connecting

In order to explore further some of the ways in which lateness to sessions can be understood I will describe at some length my work (as a training case) with a young woman who was habitually between 8 and 20 minutes late for almost every session for the first year and a half - sometimes less but occasionally much more. From there onwards the lateness was less extreme, with stretches where she was almost on time.

Exploring the meanings of her lateness exposed deep anxieties about the state of her object, the damaged and distorted couple in her inner world, and her heavy use of omnipotence and manic defences to protect her against the dangers of dependency. All these dimensions of her inner world found expression through her inability to come to the sessions on time.

History

Ms T aged 29 was the only daughter of a couple who split up when she was 3. Before Ms T's birth mother had had at least two abortions and another termination after her birth. After the divorce, mother went on to have a series of lovers of both genders and father had a succession of girlfriends. In childhood Ms T apparently managed at school while being possessively jealous with mother at home. She was an angry adolescent, getting into plate-smashing rages with mother, and thinks she was instrumental in mother splitting up with many partners. Her relationship with her mother was always intense, with her often sleeping in mother's bed. In adolescence she was confused and troubled by her mother's sexuality, which she tried to conceal from friends. She buried herself in work and did not have a boyfriend until her mid-20s. She had some therapy as an adolescent, owing to her mother's concern about weight loss and being so immersed in work. She had another period of anorexia after she had left her home town.

Starting Therapy

The initial meeting seemed extremely unpromising. She arrived 7 minutes late after already opting for a meeting a week later than had originally been offered. It was full of warnings that she might not engage. She had a characteristic way of responding throughout the interview in which she seemed to parry in one way or another any comment I made:

I opened by saying it was quite a while since she had met the assessor who had referred her to me. She shrugged slightly as if to disagree. She then said she had not been thinking about it much at all. She had been very busy in the meantime with her work. I asked her how she felt about coming to see me now. She said I knew she had a history of starting therapy and not continuing. She gave a quick outline, talking about the therapist she had not liked. I said she was anxious as to what it would be like with me. She parried, saying not anxious, but it was a commitment that felt difficult. She wanted to do it, felt she had to do it. Her mother had said she should do it, and so she was going to go ahead.

- 456 -

I said that sounded a bit as if she was coming to therapy for her mother, rather than for herself. She said it was the two years' commitment that put her off. She had

had therapy for short whiles before, but two years seemed like a very long time.

I said she was warning me and herself that she wasn't sure she would be able to manage it. She smiled and said, yes, she was warning me.

During the rest of that first meeting she gave many more indications that the commitment was hard for her. She kept thinking of objections to the regularity of sessions, obviously feeling trapped by the proposed regime. She also gave me many 'instructions' as to what she would and wouldn't like to find in me as a therapist, by describing her negative reactions to aspects of her other therapeutic encounters which included precipitately leaving the latest for being too formal and cold. In addition she also told me that her mother would be paying for the therapy so 'it wouldn't matter so much if she missed sessions as it wouldn't be her money'.

In this meeting she showed clearly her capacity to project her fears of being unwanted and unwanted by seeming unmotivated and full of warnings of how she might withdraw at any moment. My supervisor and I came close to thinking that she was not a viable case as it seemed so unclear whether she would stay in treatment. This was understood in part as an enactment of the abortion scenario before her birth, with her putting me into the position of the aborting mother, unwilling to take on this unrewarding and unpromising baby.

As Waugamann says in his 1992 paper: 'A patient may experience the time course of analysis as a chronological recapitulation of early life. It is as though he or she reacts to the initiation of treatment as a birth' (1992, p. 30). He describes a patient who had felt unwelcome at birth - a failure 'when she had barely started' and who re-experienced this in the early stages of his work with her. Ms T started her therapy with me in a way that strongly re-enacted her phantasies of her beginnings, and by projecting her sense of rejection threatened to provoke a reaction from me that confirmed her deepest fears of being unwanted.

The dynamics of this first encounter were, unsurprisingly, repeated, acted out and elaborated many times during the treatment. She brought herself as a rejectable baby whose fears about being rejected were ruthlessly projected. She showed that it was too dangerous for her to show any signs of keenly wanting anything for herself, although she rarely missed sessions.

The Developing Symptom of Lateness

As the treatment started, she was less overtly ambivalent in her manner, but started what was to be a consistent pattern of significant lateness. Each and every session's lateness had its own unique combination of nuances and flavours, depending on the precise dynamics inside her and between us at the time.

- 457 -

Projection of Need and Vulnerability

At first it seemed mainly to be primarily a way of projecting into me any feelings of bereftness, uncertainty and anxiety. I will illustrate this by a section of Session 8:

She was 10 minutes late. Smiling rather smugly to herself she told me that the wood supplied for her new floor had been wrongly cut. The suppliers were supposed to come and collect it and hadn't done so, so she had told them she was going to sell it to a friend, and they are now all anxious and in a hurry to get it. I said she now feels as if she has become more powerful, able to get a response. She agrees, grinning more, telling me she does have friends who would want it, that it was not just a ploy.

She said she had found it easier to get up today but was still late. I wondered if she had a sense of what the lateness was about. She said it was trying to fit too much in. She had been held up by discussing the disposal of rubble with her neighbours.

I said I thought there was a link here with the story about the wood. In that she had turned the situation around. She had something that just didn't work, had a need for something, but it was turned around into something that was the suppliers' problem. They were made to feel the urgency and the need. Maybe when she is late here she is turning it around, so it is me who is to be uncertain and waiting, not her waiting for her time to come.

We maybe learn here something of her early object relationships, in which being in need is felt to be unbearable, might lead to an awful awareness of lack and therefore has to be exported into someone else. One could go further and surmise that in her early experience she felt teased and exploited by the person who has the power to withhold what you need. She lets me know that she could have come on time but got caught up with neighbours, underlining my role as the one from whom something is withheld.

The story is also poignantly suggestive in that something that was supposed to be good and new, the floorboards, turn out not to fit and to be unwanted. The bitter rejection

implied here, of the unwanted baby who did not fit into the parents' lives, is turned around in phantasy and she takes control, using what power she has to make someone else feel the anxiety and pain.

Re-Enacting a Sado-Masochistic Dynamic

In experiencing her persistent lateness, I was repeatedly put in the position of being the rejected one. There was a constant teasing as to whether she would come and when, with my anxious waiting being apparently essential to her. This had two main functions. On the one hand it obliged me to experience the tantalizing sadistic dynamic that had, we might guess, operated in her early life, with a mother who was occasionally available to her but often so caught up in dramatic and shifting relationships that her daughter only sometimes seemed her priority and might often have felt

- 458 -

like the unwanted floorboards or the rubble to be disposed of. I was clearly not worth spending much time with, and needed to experience that sense of being unable to attract my object's full attention.

Her own fury with her primary objects, experienced as so fleetingly available to her, was projected into me. Being a trainee, I was more than usually susceptible to a feeling of being worthless, ineffective and inadequate, but at times and increasingly I felt enraged at her apparently contemptuous treatment of me. It was a turning point in the treatment when I was able to get more in touch with my anger and therefore acknowledge her contempt. My recovery of my own subjectivity - being able to feel and process the anger - helped me recover the sense of being a worthwhile object who did not deserve to be so tantalized. However, I then had to deal with the invitation to become a persecutory superego, chastising and finding fault in her. This working through was crucial, enabling more effective work to be done.

Claustrophobic Anxiety

As time went by, it became evident that her lateness also had a phobic quality at times, as a way of evading a claustrophobic and - to her - seductive relationship. A month into treatment she came only 7 minutes late, which was by some distance early for her:

She was awkward and was silent for a long time. Then she said she was unsure what to tell me about. Eventually she filled me in about her weekend. She had gone to a tango lesson, but had been uncomfortable with the atmosphere around tango. A man had said she was a flirt.... [Details omitted]

I picked up on how she had started with not knowing what to say here. Maybe she was unsure of the atmosphere, not quite knowing whom she was coming to today.

She said she wasn't so late, so today she wouldn't be talking about her lateness any more.

I said she was anxious about what it meant to come for more of the time. It made her less sure of the nature of our relationship.

She told me more about the man who had asked her to do the tango class. She wants it to be just about dancing but other people may be getting the wrong idea. Dancing is flirting and did the man think it was about something else?

I said she was uneasy with me this morning coming much less late. It had been taking a step towards me, but would I get the wrong idea in some way? It was so dangerous to step towards me.

Given the enmeshed relationship with her mother, it is not surprising that any step towards me in the treatment held within it the threat that we might become unhealthily entangled. The sexual confusion that characterized her early life has added to the difficulty in believing that there can be closeness that isn't going to give someone 'the wrong idea'. Being closer to getting 'in step' with me in the therapy would be 'flirting', so the lateness was a buffer, a concrete barrier to dangerous and sexualized claustrophobic togetherness (Rey, 1994).

- 459 -

There is also reference in this story to her difficulties around her father. The tango is a sexy dance about seduction and aggression, and also plays with rejections, comings and goings. It implies the capacity to integrate sexuality in one's relationships without necessarily becoming fully sexual. This patient's relationship with her father had not enabled her

to develop these capacities, as he had not helped her to separate healthily from her mother. [I am grateful to one of the anonymous reviewers of this paper for elaborating this idea.] She was excited, hurt and appalled by his infidelities but was not enabled to get 'in step' nor to flirt safely with him, so the complexity of the relationships between closeness and sexuality had not been explored effectively. Father had not helped her deal with the 'core complex' (Glasser, 1979) and this had led to her not being able to 'dance' with her object.

Spreading Oneself Thinly and 'Flirting' as a Defence

As mentioned, the time issue with the therapy was linked to ongoing difficulties in relation to her work as she had persuaded her employers to let her share her time between her central and two other applied fields, spreading herself thinly. She was disenchanted with her primary work, with apparently logical reasons, but what became evident was an increasingly phobic reaction to her workplace, which had become contaminated with fierce oedipal jealousies with colleagues and a long-standing grievance over not being given a good enough 'inside' place as symbolized by her assigned room. Her deep fear of rejection was being turned around into her being rejecting towards others and towards her work, and revealing a grave difficulty in committing to any one person or course of action.

She spent many months oscillating between different plans as to where she would work, antagonizing colleagues and superiors. This was carried into the treatment by her toying with the idea of pursuing different therapy. She was in identification with the 'flirt' she saw her father to be, playing with others so they were never sure of their place in her life. She was at one time not only in three different work teams but juggling three different boyfriends. I worked to show how this was a way of protecting herself from being open to potential hurt and intensity. This linked to her lateness with me; some part wanted to work with me, but she always kept one little bit of herself outside by not coming on time, or by thinking of alternatives as a protection. In part this served to allay her claustrophobic anxiety, the fear of being sucked into a toxic, persecuting claustrum (Steiner, 1979) but it also meant that in work, relationships and therapy she created situations where people made her feel wanted, whether or not she wanted them. All insecurity about being wanted was projected, accompanied by a substantial dose of contempt.

Oedipal Issues and Problems with the Couple

As the treatment progressed, serious oedipal anxieties emerged which had a powerful role in her lateness. She frequently came in a manic state of mind, telling excited stories of relationships in her outside life, inviting me to be fascinated by the melee

- 460 -

around her but unable herself to reach any real connection or understanding. This replicated the dynamics of her early years that had bombarded her with a swirl of confused sexuality and shifting pairings far beyond her capacity to comprehend. This linked to her inhibited sexual development and her continuing sexual difficulties. More crucially, it shows how her early external circumstances may have presented her with more than she could metabolize, leaving her unable to negotiate the oedipal configuration and having to use primitive defensive manoeuvres such as massive projection to avoid a much more depressed and anxious state of mind, in which the sexual couple not only left her feeling abandoned but also damaged.

Dreams and other material showed clearly how her internal parents (Feldman, 1989) were ones who hate and damage each other, and how she saw herself as the damaged product of a profoundly disturbed intercourse which had nothing to do with nurturing a baby. As Hanna Segal (1989) says: 'The patient's phantasy concerning the nature of the parental relationship not only affects the quality of his object relationships and the nature of his anxieties and defences but has a profound effect on his thinking' (p. 6). For example, in a dream from two months into treatment:

Her father had killed someone, but in a particularly nasty way - a piece of steel had been thrust through their face into their cheek, deforming their face.

There were many more disturbing dream images of a similar sort, particularly featuring with brutal stabbings. Other dreams had couples on whom she intruded and who became persecutory, furious with her for coming in on them and using knives and spikes to attack.

In external life she found couples amongst her friends difficult to deal with. She was stirred up with envy and jealousy, sometimes felt consciously, but usually acted out or projected. At times she could become quite lost, as if she could find no way of getting herself into a proper place in relation to a couple. She told me once about a time when she had been to visit a couple she knew. She had set off, forgetting to take with her the address or the telephone number. She had ended up wandering around for hours, never making it to their house. She did something similar when visiting her boyfriend, showing how her difficulties relating to a couple can prevent her from herself becoming part of one. At times she was in a similar totally lost state of mind before setting off to get to a session. Her lateness then seemed to be to do with the impossibility of having a place with me if she

imagined me in a couple; she felt completely dropped out of mind and could not hang on to a way of reaching me. She could also not conceive of a successful couple being established between us, and the lateness manifested this, as if a complete session signified full and healthy intercourse.

Destructiveness and Doubts about Reparation

Later, another dynamic emerged in which her lateness was also an expression of despair that reparation was possible. An acquaintance lost a daughter in an accident, and her relationship with this person became intense, but also often phobic. Ms T felt shy, unable to maintain any ordinary relationship with this bereaved mother because

- 461 -

she was so aware she could not make up for the lost child. This could be understood as an understandable response to how disturbing and difficult it is to manage our relationships with those bereaved in such difficult circumstances. However, beyond this there was an intense preoccupation with this woman, with an oscillation between unprecedented involvement and anxious avoidance, both out of proportion with their earlier relationship. This perhaps linked with her early experience in which she might have felt unconsciously that it was up to her not only to restore mother but also to make up for all the lost babies. Because this was beyond her and filled her with guilt, she could not do the *ordinary things* that would maintain the relationship, which then became increasingly persecutory. This was a further way of understanding her lateness with me. Unable to be the perfect healing patient/baby, she became 'shy', avoidant, which had the effect of diminishing or even souring what we could have had.

Hostility to Receiving: The Anorexic Dynamic: Greed and Guilt

Alongside these more depressive anxieties there existed a more primitive conflict over *receiving* from another - indeed being offered something often provoked a hostile, envious and destructive response (**Klein, 1957**). A patient like Ms T feels needy, greedy and deprived. She becomes envious of the object that can provide, rejecting and spoiling what is on offer, only then to feel even more needy and deprived. She once brought a story from her teens when, to her fury, her mother kept buying fresh bread, even though there was still some left from before. She used to throw the bread out of the window.

She responded regularly to any generosity on my part with exaggerated lateness. For example, some 15 months into the therapy she could not make a session and I offered her an alternative time. She was touched by this and in that session responded much more directly, noticeably holding particular words or phrases of mine in mind and returning to them, listening in a much more connected way. This was commented on. The following session she was 30 minutes late. This seemed to be a re-enactment of the anorexic dynamic. My 'generosity' awoke a desire for more that was very threatening, and so her appetite had to be throttled. She could feel hatred and envy towards me if I can give her something good, and hated herself for needing me. My noticing that things were better between us had been seen by her as my being pleased with myself for giving her something, and aroused her hatred and a desire to crush any sense I might have had of being creative. I was at this moment the mother flaunting her abundant 'fresh bread' and it had to be thrown out of the window.

One could think about the anorexic dynamic as being to do with 'no entry defences' (**Williams, 1997**). This patient's early life had apparently been characterized by parents who failed considerably in containment, projecting powerfully into her, surrounding her with a confused, sexualized environment which provoked her and aroused her jealousy and sense of exclusion. She may have rejected food as a way of gaining control over these intrusive projections, but then became unable to take in other good things.

- 462 -

A contrasting view (**Lawrence [2002]**) emphasizes the patient's own intrusive phantasies which are in turn projected into the parent. Intrusive curiosity certainly had a place for this patient and she had told me of an episode of 'stalking' a boyfriend. On one occasion she saw me with someone else outside the therapy room and in the subsequent session she was extra late. This could have been jealous anger, but seemed more to be a reaction-formation (**Freud, 1908**) against her intense wish to find out more by coming early. Her lateness was intensely linked to the need to control intake, to be in charge of who was starving whom, whether of information and familiarity as well as sustenance. The 'generosity of acceptance' (**Williams, 2004**) was intensely challenging.

Guilt and Defiance

Of course her persistent lateness gave her an ongoing burden of guilt that had to be borne or manically avoided. If she were to start caring for her object then it would be so

hard to face the guilt at what she had been doing all this time, so when she came close to it she often shied away in some manic gesture.

In a session just after we had been discussing whether she would take up a fourth session, she was 12 minutes late. She looked wet and bedraggled, and at first told me at length of her exhausting efforts to clean up the mess on the staircase caused by her bike. This has been upsetting her neighbour so she was determined to do something about it. She then went on to tell me defiantly that she had decided to claim unwarranted expenses for a work trip and could not be bothered to prepare for a presentation. I took up her oscillation between trying so hard to make things better, feeling it was too much and then opting for defiance and triumph, the struggle between the guilty wish to repair, despair that things ever could be repaired and fury that she had to work so hard to put things right.

It is interesting that this session followed our thinking of intensifying our work, as it represented both her wish to put in the effort and her tendency to resort to secret triumph over those who thought she was doing well. The burden of putting things right was often felt to be too much, leading to defiant and self-destructive acts.

As the work progressed, her lateness in therapy abated, but it was still a feature. It served as a reminder to both of us that however much she apparently worked hard in sessions some part of her refused to be part of the process, retaining the right to be outside in a dismissive and mocking way. It stood for her continued perception of herself as being unable to be fully a rewarding patient/child getting a full portion from an attentive parent. As she herself said: 'By the time I am able to come on time I will probably be ready to finish'. Being able to 'dance' in step with me would mean that she had managed to overcome so many of the key obstacles to relating.

For this patient the frame of the therapy was in continual use as a means of bringing to our attention multiple ways in which she defended herself against internal and interpersonal catastrophe. As the treatment progressed there was a close correlation between her improved time-keeping and better relationships with others and at work, leading to a longer-term partnership and more settled employment.

- 463 -

Concluding Remarks

The psychoanalytic frame provides a canvas on which our patients paint their inner worlds. The time boundary is always provocative and the way in which patients deal with it is a powerfully instructive indication of their capacity to relate. Bringing their time into relationship with ours is one of the key tasks of therapy. Each patient who is habitually late will be expressing a personally nuanced set of meanings which will also change over time. Working with these meanings can be a most fruitful way of tackling the intra-and interpersonal difficulties that characterize the patient's world. The specific countertransference experiences created within the dyad and the resultant technical challenges are difficult to manage, but doing so can bring the patient into a more effective pairing and enable the 'two to tango' in rhythm with one another.

References

- Arlow, J. (1986) Psychoanalysis and time. *Journal of the American Psychoanalytic Association* 34: 507-28. [\[↔\]](#)
- Bird, B. (1957) A specific peculiarity of acting out. *Journal of the American Psychoanalytic Association* 5: 630-47. [\[↔\]](#)
- Bleger, J. (1967) Psycho-analysis of the psycho-analytic frame. *International Journal of Psychoanalysis* 48: 511-19. [\[↔\]](#)
- Campbell, D. (2006) A pre-suicide state in an adolescent female. *Journal of Child Psychotherapy* 32: 260-72. [\[↔\]](#)
- Feldman, M. (1989) The Oedipus complex: Manifestations in the inner world and the therapeutic situation In: Britton, R., Feldman, M. and O'Shaughnessy, E. (eds), *The Oedipus Complex Today: Clinical Implications*, pp. 103-28. London: Karnac. [\[↔\]](#)
- Fenichel, O. (1945) *The Psychoanalytic Theory of Neurosis*. New York, NY: Norton.
- Freud, A. (1965) *Normality and Pathology in Childhood*. London: Hogarth.
- Freud, S. (1908) Character and anal erotism. *SE* 9, pp. 169-75. London: Hogarth. [\[↔\]](#)
- Freud, S. (1911) Formulations on the two principles of mental functioning. *SE* 12, pp. 213-26. London: Hogarth. [\[↔\]](#)
- Freud, S. (1932) New Introductory Lectures on Psychoanalysis. *SE* 22, pp. 7-182. London: Hogarth. [\[↔\]](#)
- Glasser, M. (1979) Some aspects of the role of aggression in the perversions. In: Rosen, I. (ed.), *Sexual Deviation*, pp. 278-84. Oxford: Oxford University Press. [\[Related→\]](#) [?](#)
- Hartocollis, P. (1983) *Time and Timelessness or the Varieties of Temporal Experience: A Psychoanalytic Inquiry*. New York, NY: International Universities Press.
- Kegerreis, S. (2010) *Psychodynamic Counselling with Children and Adolescents: An Introduction* Basingstoke: Palgrave Macmillan.
- Klein, M. (1940) Mourning and its relation to manic-depressive states. In: *The Writings of Melanie Klein, vol. 1. Love, Guilt and Reparation*, pp. 344-69. London: Hogarth, 1975.

[\[→\]](#)

- Klein, M. (1957) Envy and gratitude. In: *The Writings of Melanie Klein, vol. 3, Envy and Gratitude and Other Works*, pp. 176-235. London: Hogarth, 1975. [\[→\]](#)
- Langs, R.J. (1978) Validation and the framework of the therapeutic situation: Thoughts prompted by Hans H. Strupp's 'Suffering and Psychotherapy'. *Contemporary Psychoanalysis* 14: 98-124. [\[→\]](#)

- 464 -

- Lawrence, M. (2002) Body, mother, mind: Anorexia, femininity and the intrusive object. *International Journal of Psychoanalysis* 83: 837-50, August 2002. [\[→\]](#)
- Lawrence, M. (2008) *The Anorexic Mind*. London: Karnac.
- Lewin, B.D. (1950) *The Psychoanalysis of Elation*. New York, NY: Norton.
- Lombardi, R. (2003a) Knowledge and experience of time in primitive mental states. *International Journal of Psychoanalysis* 84: 1531-49. [\[→\]](#)
- Lombardi, R. (2003b) Mental models and language registers in the psychoanalysis of psychosis. An overview of a thirteen-year analysis. *International Journal of Psychoanalysis* 84: 843-63. [\[→\]](#)
- Mattinson, J. (1975) *The Reflection Process in Casework Supervision*. London: Tavistock.
- Meerloo, A.M. (1948) Father time. *Psychiatric Quarterly* 22(4): 587-608.
- Meissner, W.W. (2006) Time on my hands: The dilemma of the chronically late patient. *Psychoanalytic Psychology* 23: 619-43. [\[→\]](#)
- Money-Kyrle, R. (1968) Cognitive development. *International Journal of Psychoanalysis* 49: 691-8. [(1978) In: *The Collected Papers of Roger Money-Kyrle*, pp. 442-9. Strath Tay: Clunie Press.] [\[→\]](#)
- Morris, J.L. (1983) Time experience and transference. *Journal of the American Psychoanalytic Association* 31: 651-75. [\[→\]](#)
- Oberndorf, W. (1941) Time, its relation to reality and purpose. *Psychoanalytic Review* 28: 39-155. [\[→\]](#)
- Piovano, B. (2008) The function of the analyst's boundaries in the psychoanalytic relationship. *Intenational Forum of Psychoanalysis* 17: 91-102. [\[→\]](#)
- Rey, H. (1994) *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States*. London: Free Association Books.
- Segal, H. (1989) Introduction. In: Britton, R, Feldman, M. and O'Shaughnessy, E. (eds), *The Oedipus Complex Today*, p. 6. London: Karnac.
- Sinason, V. (1992) *Mental Handicap and the Human Condition*. London: Free Association Books. [\[→\]](#)
- Steiner, J. (1979) The border between the paranoid schizoid and the depressive position in the borderline patient. *British Journal of Medical Psychology* 52: 385-91. [\[→\]](#)
- Stern, D. (1985) *The Interpersonal World of the Infant*. New York, NY: Basic Books. [\[→\]](#)
- Waugamann, R.M. (1992) Analytic time. *Journal of American Academy of Psychoanalysis* 20: 29-47. [\[→\]](#)
- Williams, G. (1997) The no-entry system of defences: Reflections on the assessment of adolescents suffering from eating disorders. In: *Internal Landscapes and Foreign Bodies*, pp. 115-22. London: Duckworth.
- Williams, G. (Ed.) (2004) *The Generosity Of Acceptance: Exploring Feeding Difficulties Inchildren*. London: Karnac.
- Winnicott, D.W. (1945) Primitive emotional development. In: *Collected Papers: Through Paediatrics to Psychoanalysis*, pp. 145-56. London: Hogarth. [\[→\]](#)
- Winnicott, D.W. (1947) Hate in the countertransference. In: *Collected Papers: Through Paediatrics to Psycho-Analysis*, pp. 194-203. London: Hogarth. [\[→\]](#)

- 465 -

Article Citation

Kegerreis, S. (2013). 'When I Can Come on Time I'll Be Ready to Finish': Meanings of Lateness in Psychoanalytic Psychotherapy. *Brit. J. Psychother.*, 29(4):449-465