A PHENOMENOLOGICAL INVESTIGATION INTO THE PSYCHOANALYTIC PSYCHOTHERAPIST'S EXPERIENCE OF IDENTIFYING, DIFFERENTIATING AND PROCESSING THE PATIENT'S TRANSFERENCE-BASED AND REALITY-ORIENTED REACTIONS

THESIS

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ABSTRACT

The aim of this study was to describe the psychoanalytically-oriented therapist's experience of identifying, differentiating and processing the patient's transference-based and reality-oriented reactions. In order to investigate the therapist's lived experience of being receptive to the total communication of the patient in the analytic situation, the researcher adopted the empirical phenomenological method. This descriptive and intuitive method grounded the researcher in the concreteness of the everyday life-world of the therapist, and enabled him to explicate the therapist's immediate, pre-theoretical experiences of his patient.

The appropriate central research question, formulated to elicit the experience of this phenomenon, emerged through the process of enquiry during the pilot study. Thirteen experienced, psychoanalytically-oriented psychotherapists were interviewed and the five protocols considered most revelatory of the phenomenon under investigation were analyzed in detail. The remaining eight protocols were used to illuminate central themes and to clarify areas of uncertainty during the phase of formal explication.

The central findings revealed that the oscillating process of the therapist as he shifts from being immersed in the world of his patient to being in a position of observation and self reflection is the fulcrum around which he evaluates the nature of his patient's communications. During this ongoing process of discrimination, living in duality, the therapist comes to experience himself as a patient scrutinized by his own and his patient's confrontations. His journey of disentanglement, the endeavour to differentiate his responses from his patient's actions, is dependent on his ability to engage in honest self-reflection and to access his pre-theoretical and articulated cognitions of his patient. This allows him to acknowledge his own role in what has unfolded interpersonally and to appropriate his previously denied feelings for and attitudes towards his patient, a prerequisite for the accurate and full appraisal of the nature of his patient's communications. Forsaking fixed judgements, the therapist becomes open to the confluence between the reality-oriented responses and transference-based reactions of his patient. This salient discovery, when dialogued with the literature, reinforced the

theories of Greenson and Langs that not all the interactions between the patient and the analyst/therapist are transference-based and that it is therefore imperative that the analyst/therapist reflect on his participation in the analytic situation.

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CHAPTER ONE

1. INTRODUCTION

1.1 Area of Investigation

None of Freud's epochal discoveries has proved to be more heuristically productive or more clinically valuable than his demonstration of the phenomenon of transference, and despite the theoretical pluralism in psychoanalysis today, the analysis of the transference is generally acknowledged to be the central feature of analytic technique.

Although the meaning, the therapeutic use, and even the theoretical explanation of transference and transference phenomena have undergone significant changes over the past ninety-eight years since Freud's first reference (Breuer & Freud, 1895) to the physician in the present treatment situation being "falsely connected" libidinally to the patient's oedipal love objects, the analysis of the transference remains the cornerstone of psychoanalysis.

One of the major areas of debate between the diverse analytic views "is whether transference is everything or almost everything" (Cooper, 1987, p.512). Laplanche and Pontalis (1973) propose that this controversial issue is aided by the lack of consensus concerning the definition of what transference is. They note that "the reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psychoanalyst" (p.456).

A view common among Kleinian (Joseph, 1985; Klein, 1952; Rosenfeld, 1958) as well as the more conservative, classical analysts (Brenner, 1979) is that all the patient's meaningful reactions to the person of the therapist are transference manifestations and the only important interventions are transference interpretations. This view is not shared by a significant number of psychoanalysts who believe that the patient's experience of the analytic relationship is not entirely distorted by unconscious phantasy, and that other dimensions of human relating take place in the course of an analysis (Fairbairn, 1957;

Fenichel, 1941; Freud, 1954; Greenson, 1967; Langs, 1982; Menaker, 1942; Sandler, Dare & Holder, 1973).

Sandler, Holder, Kawenoka, Kennedy & Neurath (1969) reject the notion that all the material of the analytic patient can be regarded as regressed and inappropriate. They emphasize the importance of distinguishing between the various relationship elements (dimensions of transference) which emerge in the psychoanalytic situation, particularly aspects of past relationships which are facilitated in the special analytic setting and thus incorrectly regarded as being a repetition of past relationships to important figures.

According to Greenson (1978), a classical analyst with relational theoretical contributions, the Kleinians' tendency to deny or belittle the nontransference relationship between the patient and therapist undermines the patient's self-esteem and makes him feel he is always wrong, sick or crazy. He urged analysts to recognize the nontransference aspects of the patient's productions as this would facilitate the development of a human experience in the analytic environment, and bring about the resolution of the transference neurosis.

This belief that not all interactions between patient and analyst are transference-based is supported by Robert Langs, an ardent proponent of the interactional approach to psychoanalysis. Langs (1982) emphasized that there is one relationship between the patient and therapist comprised of both realistic and fantasied aspects, i.e. nontransference and transference components. He believes that traditionally therapists have focused on the patient's pathological or transference-based responses to the therapist, paying only lip service to the patient's valid reactions to the therapist, which has led to an imbalanced view of therapeutic work, and consequent neglect or denial of poor therapeutic interventions.

Langs's (1982) dictum that the patient's material must be evaluated in the light of activated intervention contexts reinforced Gill's (1979) belief that it is essential that therapist s reflect on their participation in the "actual analytic situation". This recognition of the imperative function of "horizontal analysis" (Casement, 1985) led Langs (1982) to

the opinion that:

> Taking into account indirect and unconscious capabilities, one is led to conclude that in general - and, of course, with notable exceptions - only a small segment of the patient's communications and reactions fall outside of such essentially valid functioning and into the realm of dysfunction and transference. It is therefore important to realize the pervasiveness of the patient's sound capabilities and to set aside the highly prejudiced view of the patient as entirely or mainly sick, continuously involved in distortions and transferences, and lacking most of the time in sound capacity (Langs, 1982, p.503).

The area of study of the present research concerns this pertinent function of differentiating between transference and nontransference functioning, which is an indispensable ingredient for successful psychoanalytic treatment.

1.2 Need for the research

The Neo-Freudian era has witnessed the attempted transformation of the conservative psychoanalytic identity which was rooted in the metaphors of archaeology and history. Numerous analysts (Shainberg, 1977; Symington, 1986a) with more romantic relational views have focused on self-knowledge and change resulting from the encounter between patient and analyst, the recognition that the omnipotent position of the analyst as "reality perceiver and speaker of the truth" (Barton, 1974, p.30) infantilizes the patient and undermines his self-esteem. This call for analysts/ psychoanalytic therapists to recognize the total therapeutic relationship, which includes the nontransferential dimensions of object-relations between the patient and the therapist, beckons them to address the "human dimension in clinical practice" (Frank, 1977).

Unlike the dogmatic intrapsychic adherents of the past who strayed from grasping the patient's subjective, phenomenal world, modified psychoanalytic translations of the therapeutic relationship have been generated by Fairbairn, Ferenczi, Fromm, Greenson,

Horney, Jung, Klauber, Searles, Winnicott and many others.

Anna Freud (1954) expressed this need to recognize the personal element in the analytic process when she stated:

> So far as the patient has a healthy part of his personality, his real relationship to the analyst is never wholly submerged. With due respect for the necessary strictest handling and interpretation of the transference, I feel still that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other (pp.618-619).

Another major shift that has paralleled this recognition of the human dimension in psychoanalytic practice is the attention that has been given to the dialectical, interpersonal processes operating in the therapeutic relationship. Whereas Freud described the analytic relationship as a unidirectional communication process, emphasizing the cognitive journey to reconstructing one's infantile, oedipal forgotten past, later analysts such as Joseph (1985), Loewald (1986), Sandler et al. (1973), Strachey (1934), Sullivan (1953) and Winnicott (1965) viewed the analytic experience as unfolding in a "bipersonal field" (Langs, 1982) marked by the resonance between the patient's and the analyst's unconscious. Although Freud (1913) recognized the power of the unconscious as an instrument to interpret the utterances of the unconscious in other people, his pejorative view of countertransference reinforced his contention that the analytic relationship should be patient-therapist directed and not interactional.

Ogden (1982) highlights the traditional classical theorists' neglect to take into consideration the complementarity of the transference and countertransference components of the analytic process. He argues that without an understanding of the patient's creation of countertransference, "there are no terms with which to conceptualize a process in which the therapist is pressured to participate in and experience aspects of the patient's internal object world" (p.81). His view that transference is one facet of a two-person transference - countertransference system within which neither component

can be meaningfully understood in isolation from the other, is supported by Stolorow, Brandchaft and Atwood (1987), who describe transference and countertransference as together forming an intersubjective system of reciprocal mutual influence.

Unless the definitions of transference and countertransference are accepted as being interdependent, the analyst's/therapist's participation in the "transference-countertransference matrix" (Marshall & Marshall, 1988) will be undermined and the feedback relationship, that is the influence the countertransference has on the transference, will be denied. This will preclude the development of an intersubjective relationship in the analytic situation as all or most of the patient's responses will be judged as being historically and intrapsychically generated and of a pathological nature. The therapist's judgements of the various interactional sequences comprised of the transference, nontransference, countertransference and noncountertransference components will determine whether his interventions are curative or harmful.

According to Langs (1982), "It must be remembered, however, that transferences can emerge only when the therapist's interventions do not justify the symptomatic or maladaptive response or image from the patient" (p.535). To ascertain whether the patient's responses are appropriate and applicable to the present analytic situation, he urges therapists to fully analyze the conscious and unconscious implications of their interventions. In other words, it is his belief that the therapist's appraisal of the extent of the patient's nontransference functioning is largely dependent upon the therapist's capacity for self-awareness, self-insight and self-analysis.

Langs's (1982, p.523) suggestion that "transferences can only be interpreted in the context of a sound holding environment and a basically corrective interpretive approach by the therapist", invited therapists to become more attuned to their own conscious and unconscious processes during the evolution of the therapeutic relationship, and reinforces Strachey's (1934) statement of surprise "at the relatively small proportion of psychoanalytic literature which has been concerned with the mechanisms by which its therapeutic effects are achieved" (p.362).

This neglect of the description of the therapeutic process itself pertains especially to the emotionally charged analytic relationship which has been exhaustively characterized with sterile physicalist terminology. Whereas the phenomenon of transference has been thoroughly researched with respect to the mechanisms of displacement, projection and introjection, little has been written on the intersubjective experiences of the participants in the analytic situation, especially the phenomenology of the therapist's process of differentiating the patient's transference-based and reality-oriented responses. The present study may be seen as a direct response to Strachey's appeal to rectify this neglect in the field of psychoanalytic research, and to extend the literature referred to by Langs (1982) and Greenson (1967) on the topic of the therapist's appraisal of the total communication of the patient.

1.3 Aims of the present study

This research study has two broad aims: clinical (i.e. the practice of psychoanalytically-oriented psychotherapy) and methodological. With respect to the practice of psychoanalytic therapy, the primary aim is the humanization of the analytic relationship, particularly as it concerns the concept of transference which has been traditionally viewed as that pathological dimension of object relations which pervades the therapeutic relationship. In other words, the main objective is to address the misconception concerning the omnipresence of the phenomenon of transference, by revealing its complementary component, the nontransference dimension of human relating in the analytic relationship.

The methodological aim which corresponds to the dethroning of the omnipresence of the transference phenomenon and addresses the human dimension in clinical practice, entails the utilization of the Empirical-Phenomenological method of research. The clinical and methodological aims will be discussed further under separate sections to highlight their respective goals. The "technical" implications will be explored in conjunction with the clinical aims as the construct of transference refers essentially to a clinical phenomenon.

1.3.1 Clinical aims

The use of the terms transference and nontransference conceal the intersubjective worlds of both the therapist and the patient, and how they merge in mutual dialogue. It is the aim of this study to retrieve the authenticity of the interpersonal realm of psychoanalytic therapy by investigating the experiential process which inspires the therapist to evaluate the patient's responses as either distorted and inappropriate or realistic and applicable in the here-and-now analytic situation. In other words, it is the intention of the researcher to investigate the psychoanalytically-oriented therapist's lived experience of being receptive to the total communication of the patient in the analytic situation. In order to ascertain to what extent psychoanalytic therapists perceive the analytic relationship as a transference-countertransference matrix and what their views are concerning the nature of the clinical concept of transference, it is necessary to explore their first hand, concrete experiences when appraising the responses of the patient. To accomplish this goal, it is imperative to uncover the subjective, lived world of the psychoanalytic therapist as he engages in the experiential process of identifying, differentiating and processing the patient's transference-based and reality-oriented responses.

This aim is a pragmatic one, as the concepts transference and nontransference, artificially dissect the therapeutic relationship which is in essence unified and indivisible. In order to transcend what is assumed in the psychoanalytic literature to be primarily an empirical distinction, the unveiling of the phenomenal experiences of the psychoanalytic therapist in the present analytic situation will possibly reveal issues to do with therapeutic intent. This therapeutic consideration underlies Szasz's (1963) contention "that the concept of transference although a crucial part of the patient's therapeutic experience is also a successful defensive measure to protect the analyst from too intense and real-life involvement with the patient" (p.432).

It is not the intention of the researcher to reify psychoanalytic constructs which are for academic and training purposes artificially identified, but to illuminate to what extent psychoanalytic therapists are aware of the different dimensions of object relations operating in the analytic situation. The motive is not the revisioning of the concept of

transference, but the revealing of the multiple functions and faces of transference, especially as it is reformulated within the context of its kinship with the nontransference dimension of object relations.

Considering that this study investigates the analytic experiences of South African psychoanalytically-oriented therapists and not psychoanalysts per se, the implications pertain primarily to therapists "working in the transference". It must be emphasized that unlike psychoanalysis proper, which has been portrayed as taking place in an artificial setting which fosters regression, dependency and intense emotional cathexes to the analyst, the psychoanalytic therapy consulting room can be characterized as being less neutral and detached and more dialogical. Whereas psychoanalysis is usually associated with the development of the transference neurosis and its resolution, psychoanalytically oriented psychotherapy because of its arrangements (time limited, reduced frequency of sessions) is more focused on adaptation to external reality. This sanctions a more interactional climate, one in which the therapist is reciprocally engaged, and less omnipotent and preoccupied with interpretation. In other words, the domain of this study applies directly to the field of psychoanalytically-oriented psychotherapy which is traditionally less conservative and more humanistically inclined, with therapists nurturing the nontransference or relatively transference-free reactions from the patient. Nevertheless, the implications of this research study will have relevance for those flexible relational analysts like Greenson, Langs and Sandler and the more humanistically insightful followers of Searles, Sullivan and Winnicott who observe the tenet that insight is attained in a holding interpersonal context which facilitates the development of trust, self-knowledge and the re-awakenings of the dormant self.

It is hoped that the insights obtained from this study concerning what Casement (1985) refers to as "internal supervision", will lift to articulation an expanded account of the process of comprehending the patient's unconscious role - responsiveness, and that the therapist's intuitions or pre-verbal inklings will become more accessible for academic scrutiny.

Through becoming aware of the therapist's pre-logical experiences, that domain of pre-

verbal, corporeal knowledge referred to by Bollas (1989) as "the unthought known" we may discover additional non-intellectual criteria to be utilized in the process of differentiating transferential from nontransferential responses of the patient. This may prove to be beneficial in the training of psychoanalytically-oriented therapists, who in their formative years of practice often tend to evaluate most of the patient's reponses as being transference-based. A more balanced view of therapeutic work can be reached by those therapists who acknowledge their poor therapeutic interventions, and recognize the patient's attempts to correct their countertransference acting-out. A post-archaeological model of psychoanalytic therapy demands that we shift our focus from the historical-archival realm and concentrate our attention on the "corporate reality" (Symington, 1986b), embodied by two persons engaged in learning from each other.

To adequately research the therapist's capacity to use countertransferences, his employment of his internal experiences in order to gain an emotional understanding of a patient, a method that is intuitive and reflective, as well as empirical, is of utmost importance.

1.3.2 Methodological aims

The accrual of psychoanalytic knowledge and insight should be carried out by a qualitative research method which respects as its data base experiential accounts of the psychoanalytic process. In order to grasp the unarticulated experiences of the psychoanalytic therapist, particularly as it concerns his receptivity to unconscious resonances in the analytic relationship, it is suggested that the Empirical-Phenomenological method be utilized. This qualitative, descriptive method serves as an alternative or adjunct to the traditional case study method which has been the sole avenue for the accrual of psychoanalytic knowledge and insight. This method, known as the phenomenological method, is suitable for the psychoanalytic researcher who requires an empirical psychological approach which is systematic, communicable and academically accountable. A descriptive method of enquiry will enable the empirical human scientist to explicate in a non-technical way the most original experiences undergone by the therapist during the dialogical process.

This method, which has been developed at Duquesne University, U.S.A., will be adapted for the present investigation as it offers a non-mechanistic/non-reductionistic approach to uncovering and describing the immediate experiences of the psychoanalytic therapist as he grapples with the role evocations of the patient. An understanding of the therapist's "pre-ontological felt sense" (Gendlin, 1988) in the analytic situation cannot be authentically illuminated by a natural-scientific methodology which belittles or denies the value of description and reflection.

The empirical-phenomenological method as described by Giorgi (1975, 1985), Kruger (1986, 1988) and Wertz (1983) will be discussed in more detail in the chapter on method (chapter three). The procedures of analysis of the data employed by the researcher will also be dealt with extensively the chapter three.

CHAPTER TWO

2. LITERATURE REVIEW ON TRANSFERENCE AND NONTRANSFERENCE

2.1 Introduction

This chapter reviews historically the concepts of transference and nontransference and includes a section which deals exclusively with the psychoanalytic therapist's use of his own countertransference analysis in order to differentiate whether the patients' responses are transference-based or reality-oriented (nontransference).

The evolution of the concept nontransference is inseparable from the development of its complementary relational component transference, and for this reason has been discussed together under one section which historically reviews the study of these clinical concepts.

Over the ensuing decades since Freud's identification and clarification of the transference dimension of the patient's relationship to the analyst, various debates among psychoanalysts of competing schools over the nature and definition of transference have taken place, yet the conviction of its central importance in the therapeutic process appears to be a unifying theme maintaining the identity of psychoanalysis. The concept of transference has been considered by many psychoanalysts to be the pivot upon which the entire structure of psychoanalytic treatment rests. Meyers (1986) reinforced this belief in the importance of this central discovery when he noted that the concept of transference has "facilitated the transition from psychotherapy by means of catharsis to psychoanalysis as we currently know it" (p.237).

This fundamental discovery by Freud has stimulated competing theories concerning critical issues such as the crucial importance of the transference neurosis, the ubiquity of the transference phenomenon and the primacy of transference interpretations. It is not possible to scrutinize the varying definitions of transference, nor to critically discuss the multitude of controversial issues that have caused dissension among the various psychoanalytic camps, as this topic is inexhaustible. Instead, it is the aim of this literature

review to focus on a single debate that has perturbed the solidarity of the psychoanalytic school and that still engenders discordant views among its ranks. The debate concerns the question: "Are all of the patient's reactions to the analyst in the analytic situation to be construed as transference or do some partake of the real, non-neurotic relationship or of the working alliance?" (Esman, 1990, p.2).

The implications of this question are far-reaching, as it pertains not only to questions concerning the importance attached to transference interpretations but also to the psychoanalyst's attitude and professional stance towards his patient, his understanding of the nature of the psychoanalytic situation and analytic process.

Szasz (1963) recognized this when he stated that transference "is an inspired and indispensable concept; yet it also harbours the seeds, not only of its own destruction, but of the destruction of psychoanalysis itself. Why? Because it tends to place the person of the analyst beyond the reality testing of patients, colleagues and self. This hazard must be frankly recognized" (p.36).

Although the nontransference dimension has been relatively neglected by psychoanalysts, this area of analytic interaction was not totally avoided by Freud, nor by a minority of classical analysts in the period 1936-1960 when there was a growing concern in some quarters with "interpersonal" functioning. In order to trace the evolution and growth of the transference concept, and the development of the recognition of the nontransference concept and the contingent establishment of the interactional perspectives of the therapeutic relationship, it is useful to arrange more or less chronologically some of the seminal, psychoanalytic papers on this topic. Esman's (1990) delineation of the essential papers on transference into three historical periods (the pioneering period, the middle period and the modern period) provides a "structural guideline" which highlights the major developmental themes under consideration.

It must be noted that Esman's (1990) historical arrangement, although rigorous and comprehensive, has not been rigidly adopted. Certain authors, whose contributions have been monumental and longstanding, have not necessarily been assigned the historical

period allocated by Esman (for example, Winnicott has been placed in the Modern Period). In order to illustrate the appearance and development of certain themes it has been deemed necessary to slightly modify Esman's (1990) historical presentation.

The Pioneering Period (ca. 1909-1936) will focus mainly on the works of Freud and his early followers (Ferenczi, Anna Freud, Glover, Jung, Sterba, Strachey and Bibring-Lehner) who attempted to deal with and understand the powerful phenomenon of transference.

The Middle Period (ca. 1936-1960) includes the early revisionist statements of the Neo-Freudians (Horney, Fromm, Sullivan and Fromm-Reichmann), the discoveries of Klein and her followers, and the critical works of Greenacre, Greenson, Macalpine, Nunberg, Stone and Zetzel. This period highlights the development of clinical terms such as the "working alliance" and the "therapeutic alliance". Both the Kleinian and Classical lineages will be discussed as they both, in their own ways, contributed considerably to the formation of interactional concepts and approaches in the psychoanalytic field.

The Modern Period (ca. 1960-1987) refers to those psychoanalytic perspectives which hold that the analyst is an active participant in, and regulator of, the analytic process. In other words, relational perspectives that emphasize that the personal characteristics of the analyst powerfully influence the content and nature of the transference and that the analyst himself will be changed in the course of the treatment. The views of three classical relational adherents will be outlined (Winnicott, Searles and Sandler). In order to elucidate some of the major differences between the views of the classical relational adherents and their counterparts, the traditional conservative analysts, the perspectives of Arlow & Brenner will also be referred to. This will be followed by a brief presentation of the contemporary perspectives of Gill, Langs, Casement, and Symington.

The historical review will conclude with a synopsis of the major developmental themes considered and will be followed by a separate section (2.6) titled, "The Wisdom of Countertransference Analysis".

2.2 The Pioneering Period

It is noteworthy that since Freud's fundamental delineation of transference in 1912, much of the classical psychoanalytic literature on transference is essentially a restatement and elaboration of his basic ideas. In order to appreciate the works of Klein, Strachey and other Neo-Freudians it is imperative that Freud's revolutionary papers on transference and psychoanalytic technique be referred to as this will enable us to determine to what extent Freud's views have been modified, rejected or maintained without revision.

2.2.1 Freud's Contribution

Freud first referred to the phenomenon of transference in 1895 when he noted that the patient's emotionally charged attitude to the physician during the course of treatment could impede the process of verbal association, often substantially obstructing the treatment. This view, that transference served as a mode of resistance was emphasized by Freud throughout his writings. In "Studies on Hysteria" (1895), Breuer and Freud postulated that feelings, usually of a sexual nature which were rooted in past unconscious infantile wishes emerged in the present treatment situation and were consequently "falsely connected" to the person of the doctor. According to Freud, transference was the displacement of affect from an unconscious idea to a preconscious one. In his masterwork, "The Interpretation of Dreams" Freud wrote:

> An unconscious idea is as such quite incapable of entering the preconscious and...can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity to it and by getting itself "covered" by it (1900, p.562).

The psychological experiences which were revived in the present treatment situation were considered by Freud (1905) to be new editions of impulses and fantasies which were transferred to the person of the physician at the present moment, as if they did not belong to the past. It was during this early period of psychoanalysis that it became clear to Freud that transference was based on unconscious fantasies and memories, which

served as the central distorting factor in the patient's relationship with the analyst. Freud realized that if this source of resistance could be managed and prevented from interfering with the proper business of the analysis, that which he had perceived to be the greatest obstacle of psychoanalysis could become its most powerful ally.

In his seminal paper, "The Dynamics of Transference" Freud (1912) clarified the transference dimension of the patient's relationship to the analyst. The patient's libidinal cathexis to the figure of the analyst was attributed to his instinctual frustration and the search for gratification. Freud believed that neurotic patients suffered from a variety of unresolved conflicts and that they were in a constant state of instinctual dissatisfaction and, as a result, in a state of transference readiness. Freud suggested that the particular characteristics of a patient's transference stem from the specific features of that patient's neurosis and were not to be considered as simply an outcome of the analytic process.

It was in this revolutionary paper that Freud (1912) differentiated the non-sexual, conscious positive transference which he called "rapport", from the erotic transference and from the negative hostile transference, and characterized transference as consistently ambivalent. In other words, Freud's distinction between the friendly or affectionate feelings toward the analyst, of which the patient was aware, formed what he referred to as the unobjectionable part of transference, which was not directly linked to primitive, childhood erotic relationships with oedipal love objects. Herein lies the source of later criticism levied at Freud and the core of the debate concerning the differentiation between the transferential and nontransferential reactions of the patient. By 1912 Freud had clearly entrenched his theory of transference in the realm of the libidinal and had built an archaeological-historical narrative that emphasized oedipal-reductiveness and the mechanisms of displacement and regression. Yet, his mechanistic-drive model which was rooted in the topographical model of the mind left space for the interpersonal element.

The need to establish an "effective transference" before the full work of psychoanalysis could begin was suggested by Freud in 1913. He later (1937) reiterated that the viability of a therapy depends upon a fundamental "confidence transference" which was attributable to a shared "love of truth". The question concerning whether this

unobjectionable part of the transference can be regarded as a component of the treatment alliance engendered much disagreement among Freud's followers, some of whom opposed his strictly intrapsychic drive oriented model by contributing relational concepts to humanize the interpersonal nature of the analytic relationship.

Although Freud included in the transference not only the repetition of repressed elements in the person's "stereotype plate" which are inappropriate to the present, but also its conscious and appropriate elements, he viewed this friendly personal relationship with the patient as separate from the analytic work and not a subject for technique, in contrast to the erotic positive or negative transference (Kelly & Olsen, 1988). This was clearly stated in 1925 when Freud advised his followers that the unobjectionable positive transference did not require analysis, as it was the "vehicle of success in psychoanalysis". Gill (1982) in support of Freud, believes that although the positive transference is consonant with reality, it is still significantly dependent on the past and that it would be a grave error to exclude this conscious component and define it as not belonging to the concept of transference. This belief is reinforced by Sandler et al. (1973) who stated that Freud never designated the notion of treatment alliance as a distinctive concept, but encompassed it within the general concept of transference.

Stein (1981) argues that by 1937 Freud had revised his theory on the unobjectionable positive transference and he no longer insisted on the existence of a relatively simple nonerotic, conscious, positive transference which required no analysis. Freud then emphasized the presence of conflictual elements which were inaccessible to analysis, because they were latent or inactive during the period of treatment.

Although Freud did not totally avoid the nontransference dimension of analytic interaction, his descriptions of these nontransference elements as being relatively sublimated byproducts or derivatives of their erotic, libidinal source de-emphasized their maturational capacity and consequently demoted them to the corporeal, primitive domain.

Statements reducing transference reactions to the level of the oedipal relationship generated criticisms from many Neo-Freudians who opposed the theory that transference is an "autogenous" product of the patient shaped in the regressive sterile environment of the psychoanalytic chamber.

Freud's position on transference emerging as the most powerful resistance to the treatment was expanded in his paper "The Dynamics of Transference" (1912). He saw transference as functioning as an obstacle which impedes remembering of the repressed material. Freud postulated that the analysand's tendency to reproduce and act upon his unconscious impulses served the function of not remembering them. This compulsion to repeat the repressed material as a contemporary experience instead of remembering it as something belonging to the past was addressed extensively in his brilliant paper "Remembering, Repeating and Working-Through" (1914). Freud's consideration that transference was preponderantly a mode of resistance, emphasized his view that repetition is a resistance. According to Racker (1968) this view was contradicted by Freud in 1920 when he pointed out that the transference is what is resisted. In this monograph titled "Beyond the Pleasure Principle" Freud proposed that "the physician places himself on the side of the id and of its tendency towards repetition, and struggles against the resistances of the ego which oppose repetition" (cited in Racker, 1968, p.48).

Freud's 1920 exposition was confusing as he considered repetition as an id-tendency, while resistance was now viewed as springing from the ego which opposed repetition. Racker's (1968, p.47) solution to this contradiction was simply that "the transference is both things, it is a resistance and it is "the resisted", according to which of the two aspects is brought into focus". Racker (1968) believed that these two aspects of the dynamics of the transference, determined an important part of the difference among the diverse techniques practised by analysts with respect to the analysis of the transference. In other words, one of the implications of Freud's contradiction was the splitting of the psychoanalytic tree, with one group of analysts maintaining that transference is predominantly resistance and that the purpose of the analytic process was to fill in the historical gaps and to reconstruct the repressed infancy of the patient. The other branch of analysts focused on the patient's re-experience in the transference itself. For these less

historically oriented analysts, the dynamics of the analytic relationship would reveal the conflicts of the patient as he repeated infantile defences in relation to the analyst. In essence, this was possibly one of the major developmental milestones in the evolution of the different approaches to psychoanalysis.

An earlier invitation for analysts to ground their work in the relational realm was extended by Freud in 1914, when he illuminated the complementary side to the "concealing" transference, the face of the transference which reveals.

> We render the compulsion harmless, and indeed useful, by giving it the right to assert itself in a definite field. We admit it into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient's mind (Freud, 1914, p.154).

In this same revolutionary paper, he wisely added: "The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made" (p.154). The concept of the "intermediate region" was later taken up by Winnicott and his followers who viewed transference as manifested in therapy as a transitional process, "a distillate of past experience without which the person could not change from one state or form to another" (Sanville, 1991, p.83).

It is quite evident that Freud did not only view transference as a form of resistance but described it as an interactional terrain upon which the patient re-enacted his intrapsychic conflicts. Langs (1978, 1981) has come to Freud's defence by arguing that from the outset, he took into account the actual structure of the analytic relationship and setting and the patient's efforts to create actual repetitions of past pathogenic experiences in his relationship with the analyst. Freud's (1920) finding that patients unconsciously evoke reactions in the analyst comparable to those of earlier figures with the hope of having infantile fantasies and instinctual drive wishes gratified, laid the basis for Sandler et al.'s (1973) proposition that transference should not be restricted to the illusory apperception

of another person as it also included the unconscious provocations by the patient. According to Langs (1978), it is here, then, that the interactional dimensions of transference were first specifically recognized.

Freud's clinical concept, the transference neurosis, appears to have served as an essential connection between the intrapsychic world of the patient and the interactional analytic terrain formed by both participants. Freud used the term, transference neurosis, in two ways. Firstly, to designate a group of neuroses (hysterias, phobias and obsessive-compulsions) characterized by the patient's ability to form and maintain a relatively cohesive, multiform and accessible set of transference reactions. In contrast to patients manifesting with narcissistic neuroses, who were perceived as being able to develop only fragmentary and sporadic transference reactions, the transference neuroses were disorders which were considered to be treatable by classical psychoanalysis.

Freud's second use of the term pertained to his description of a specific and organized development of the transference in the process of psychoanalysis. Freud (1914, 1917) explained that the concept referred to an "artificially constructed transference illness" in which the patient's original neurosis was re-created in the analytic situation itself, in relation to the analyst. He emphasized that unless the significant experiences and inner conflicts which led to the neurosis were revised again in the immediacy of the analytic situation, effective self-understanding would not be achieved. According to Reed (1990), psychoanalysis had already moved at this point (1914) in the history of the technique from an intellectual reconstruction of the past to the in vivo experience of the transference. The realm of the transference neurosis was considered by Freud (1905) to be "the latest creation of the disease" (cited in Reed, 1990, p. 428) and which served as that transitional space between illness and real life. Reed's (1990) interpretation of Freud's (1914) theory is that the transference neurosis is a product of the psychoanalytic treatment, which includes transference as a transforming agent.

Loewald (1971) maintains that Freud (1914, p.154) recognized that the function of the analyst was to give "all the symptoms of the illness a new transference meaning", thus replacing the transference neurosis with the work of insight. The old illness loses its

autonomous character through becoming reactivated and comprehensible in an interpersonal terrain. Although Freud emphasized that the transference neurosis was brought about by the libidinal nature of the patient, belonging a priori to the patient, he was fully aware that the transference meaning was created interactionally, in a new context of interpersonal growth. Is this not the beginnings of the synchronic view adopted by Gill (1982), Schafer (1977) and Spence (1982), which contends that the past is collaboratively constructed in the present analytic situation?

Following Freud's last reference to the term in 1926, there has been widespread disagreement about the value and meaning of the transference neurosis as a clinical concept. Whereas Bird (1972) has considered the concept indispensable to clinical analysis, Brenner (1982) and Loewald (1971) have not. On the other hand, Gill (1954) and Rangell (1954) consider the development and resolution of the transference neurosis to be the essential feature that distinguishes psychoanalysis from psychotherapy.

Freud's work has been criticized and challenged for emphasizing the intrapsychic basis of transference to the considerable neglect of contributions from the analyst (Casement, 1985; Gill, 1982; Langs, 1980). The Kleinian school backed by the brilliant works of Gill (1982) and Langs (1978, 1980, 1982) have maintained that the clinical view of transference as propounded by Freud too narrowly involves direct references to the analyst, neglecting to consider the role of unconscious fantasies and the allusions to the transference. The overriding stress on manifest references to the analyst contributed to the disregard of the patient's unconscious perceptions of the analyst which as Langs (1980) points out are often valid. It was left to Freud's followers to counterbalance the initial emphasis on the patient's pathological functioning by extending the focus to include the patient's unconscious perceptiveness and constructive capacities. The growing appreciation of the introjective side of the analysand's experience has also contributed to the growth of the recognition of the interactional aspects of the analytic relationship.

2.2.2 Early fundamental reconstructions of Freud's views

The development of the interactional aspects of the analytic relationship was given a major impetus by the creative work of Ferenczi (1909). He was the first to specifically investigate the identificatory and introjective aspects of transference and, later with Rank in 1923, considered the analytic relationship not only as a means to intellectual reconstruction but also as an interpersonal context for emotional reliving.

Ferenczi advised that analysts introduce human qualities into the analytic relationship which would act as an antidote to the traumatic quality of the transference and reduce the imbalance of the hierarchical, autocratic analytic relationship. His work strongly influenced the attitudes of Klauber and other members of the British Psychoanalytic Society who supported the belief that some spontaneity and openness by the analyst is necessary in the analytic encounter. Ferenczi's denunciation of Freud's notion that the analyst's stance should be neutral and detached was supported by Jung who perceived the therapist as a partner in an interactional and reciprocal relation. Whereas Freud downplayed the value and importance of countertransference, Jung emphasized the inseparable relationship between the transference and countertransference dimensions of the analytic relationship, and held that it was a genuine encounter between two real people (Goodheart, 1984; Gordon, 1968; Jung, 1921, 1946; Lambert, 1981).

Jung (1921), like Ferenczi, stressed the importance of the human relationship between the patient and analyst as the sine qua non of psychotherapy. He concentrated on the goal-seeking and therapeutic function of transference and tended to depathologize the concept of the transference which he viewed as frequently occurring in any human relationship that is at all intimate.

Jung's (1946) descriptions of the phenomenology of the transference attest to his conviction that the interactional union (coniunctio), which takes place in the vessel of analysis, transforms both its participants involving them on both the conscious and unconscious levels.

In his later work Jung (1946)explored the complexed nature of the interpersonal dynamics of the analytic relationship. His recognition of the transference - countertransference matrix and the nontransference dimension of the therapeutic encounter enabled him to humanize and interpersonalize the process of analysis.

During this period Glover (cited in Meyers, 1986) extended the transference concept by emphasizing that the individual's attitude to, and experience of, the analyst cannot be solely reduced to the mere displacement of affects and ideas. He contended that the totality of the patient's mental development must be acknowledged in order to understand how he assimilates the figure of the analyst into his already formed self schemas. This perspective tended to reformulate the concept of transference as an "organizing activity" (Stolorow, Brandchaft & Atwood, 1987). Glover's efforts formed the ground which incited the pioneering works of Anna Freud and James Strachey.

Anna Freud's (1936) distinction between transference of libidinal impulses, transference of defence and acting-in the transference, illuminated the presence of additional dimensions to the "transference relationship" and partially promoted the concept of transference from the intrapsychic to the interpersonal domain.

Freud's (1954) belief that "the analyst and patient are also two real people of equal adult status in a real personal relationship to each other" (pp.618-619) shows evidence of her consideration of the nontransference dimension of the analytic relationship. In addition to this, her use of the term "acting-in the transference" further demonstrates her recognition of the reciprocal, inseparable relationship between the daily life of the patient and the analytic experience. Ms. Freud's investigation of the outward-orientated defences of the ego paved the way for bringing realistic object relations more within the framework of the drive model.

Continuing the tradition started by Ferenczi concerning the humanization and interpersonalization of the analytic process, Bibring-Lehner (1936) shifted her attention to the therapist's role in shaping the emerging transference. Unlike Freud who presumed that impasses in therapy were primarily instigated by the "autogenous" products of the

patient, she suggested that the real person of the analyst, especially the sex of the analyst, or his behaviour might collapse the illusory quality proper to the transference thus interfering with the patient's therapeutic progress.

Although Bibring-Lehner was fully aware of the analyst's participation in the actual analytic situation, she did not differentiate whether the patient's perceptions and responses catalysed by the analyst's behaviour were transferential or not. According to Esman (1990), Bibring-Lehner's belief that a predominantly positive transference, based on confidence, was necessary to overcome the transference neurosis, prefigured the concepts of the "therapeutic alliance" (Zetzel, 1956) and the "working alliance" (Greenson, 1965).

In a similar vein, Sterba's (1934) theory on the capacity of the ego for dissociation significantly contributed to the realization that as long as the analyst was able to ally himself, by means of his interpretations, with the observing ego of the patient it was indubitable that a segment of the patient's perceptions (conscious and unconscious) of the analyst were reality-oriented and sound. In other words, although Sterba (1934) did not make direct reference to the existence of the nontransference dimension of the therapeutic relationship, implicit in his theory of the "dissociated ego of the patient" was the recognition of the patient's capacity to relate to the analyst on an appropriate, adaptive and reality-oriented level.

The exploration and development of the interactional nature of the analytic relationship was greatly advanced by James Strachey. In his (1934) influential paper, "Nature of the Therapeutic Action of Psycho-Analysis", he proposed that what was transferred to the person of the analyst included the internal objects of the patient's infantile past and that the patient in analysis tends to make the analyst into an "auxiliary superego".

According to Langs (1978), Strachey's main thesis was that the introjections of the analyst into the patient's superego were based on the actual traits and behaviours of the analyst. Like Bibring-Lehner (1936), Strachey (1934) called to our attention the importance of the actual object relationship with the analyst. His consideration of the immediate object

relationship and interaction between patient and analyst included not only the surface or manifest qualities of the analytic relationship but also their extensive unconscious implications.

Although Strachey's work stressed the indentificatory and introjective aspects of transference and considered the analytic relationship as a needed interpersonal context for developing the patient's ego strength, his view of the total therapeutic relationship was skewed. His contention that virtually all of the patient's reactions to the analyst are transference reactions undermined the role of the analyst in co-constructing the psychic reality of the patient. His neglect of the existence of the nontransference dimension of the therapeutic relationship and contingent belief that the only therapeutically valid interpretations were transference interpretations instilled many unresolved debates between the classical-relational adherents and their Kleinian counterparts concerning the value of extra-transference interpretations (Haesler, 1991; Leites, 1977). The controversial belief that the whole analytic situation is constituted of transference elements only further separated the relational-classical disciples of Freud from their Kleinian counterparts.

2.3 The Middle Period

The Middle Period (ca 1936-1960) in the evolution of the concept of transference (Esman, 1990) mainly concerned contributions by classical analysts who considered the alliance sector of the therapeutic interaction between the analyst and the patient. Whereas the followers of Klein and Strachey had extensively explored the interactional aspects of the analytic experience by focusing on the mechanisms of introjection, projection and projective identification, classical analysts trace the roots of the concepts "therapeutic alliance" (Zetzel, 1956) and "working alliance" (Greenson, 1965) to Freud's (1912) original distinction between the different components of the positive transference. They maintained that the neutralized or sublimated aspect of transference could be viewed as the basis for the patient's co-operation with the analyst.

Langs (1981) notes that the classical conceptualizations of the analytic situation increasingly encompassed the multiple dimensions of the therapeutic interaction, and that the attention given to the alliance sector enabled them to modify their tendency to isolate the intrapsychic world of the patient from other dimensions of therapeutic experience.

It must be emphasized that many innovative investigations of the therapeutic alliance did not fall into this Middle Period, demarcated by Esman (1990), and that some of these significant classical contributions (for example, Stone's views) to the understanding of the interactional dimension of the therapeutic relationship will be collected under this heading to demonstrate the growth and continuity of psychoanalytic thinking with respect to the alliance concepts and the nontransference relationship.

Esman (1990) has pointed out that the main concerns of the analytic contributors during this period were to relate the phenomenology of the transference to the growing understanding of the ego, to new theories of early development and to exploring the interpersonal domain of psychoanalysis.

It would be naive to believe that the Kleinian analysts did not contribute significantly during this period in the evolution of the transference concept, but their explorations emphasized the importance of early object relations and primitive instinctual fantasy and were less concerned with the role of the ego and the analysis of defence. Their views on the omnipresence of the transference phenomenon, the emphasis attached to mutative transference interpretations and the neglect of the concept of the transference neurosis, invited classical analysts to react to these revolutionary trends by further investigating the interactional landscape beyond transference.

Further influences included the humanistic orientations of the Neo-Freudians who recognized and valued the interpersonal realm of psychoanalysis, and the outcast views of Alexander & French (1946) who advocated that psychoanalysis was primarily a "corrective emotional experience" thus threatening the identity of psychoanalysis proper which prided itself on the analysis of the transference.

2.3.1 The Neo-Freudians

The establishment and elaboration of the major Neo-Freudian Schools by Horney, Fromm and Sullivan during the 1930s and 1940s emerged as an alternative tradition to Freud's drive-structure model.

Horney (1939) believed that Freud's mechanistic-evolutionistic thinking imbalanced his perceptions of the analytic relationship. According to her, Freud's disregard of the analyst's characteristics and behaviour as influencing the patient's reactions in the analytic situation was a grave error. Horney's contention that the analytic relationship is a unique human encounter between two participating persons was supported by Fromm (1980). He urged analysts to refrain from playing the role of the neutral and detached screen and instead to be more real and engaging. His work introduced humanistic principles into the analytic chamber and opposed the artificial, technical procedures of analysis which, he contended, fostered the erroneous belief that the patient's reactions were predominantly regressed, inappropriate and transference-based.

Sullivan's (1953, 1954) views on the concept of transference, although similar to Freud's, were linked to the presence of interpersonal anxiety and were not perceived to be oedipally based, nor taken to be a manifestation of the repetition compulsion. Although Sullivan and Fromm-Reichmann (1939), who applied his principles to her work with schizophrenics, located their constructs in the interpersonal sphere, they tended to emphasize the dynamics and defences of the patient's historical past and consequently neglected the influence of the analyst's present behaviours. Rioch (1943), a follower of Sullivan's, recognized and emphasized the actual behaviours of the analyst as a determinant of the character of the transference illusion, but did not define these reactions of the patient as being nontransferential. This appears to be a major flaw in the therapeutic approach adopted by these analysts who drew on the relational/structure model's (Greenberg & Mitchell, 1983) basic premises. They did not clearly demarcate that the reactions of the patient evoked by the actual pathological behaviours of the analyst were nontransference based.

2.3.2 The Kleinian tradition

An investigation of transference beyond Freud should entail the study of the attention and appreciation the Kleinian writers have given to the interactional aspects of the analytic relationship, and how this line of thought is an extension of the innovative works of Ferenczi (1909) and later Strachey (1934). According to Langs (1978), analysts who have investigated transference on the basis of Freud's key discoveries can be divided into two groups. The first group includes those analysts who elaborated upon the intrapsychic dimensions of transference, attempting to reconstruct the unconscious transference fantasies and memories of their patients. The second group of analysts have stressed the curative potential of projective and introjective identifications, deriving their writings more from Strachey than from Freud and, with notable exceptions, have been followers of Melanie Klein rather than Classicists.

Klein's approach to the transference is "rooted in her conception of the developmental process and the role of early object relations" (Mitchell, 1986, p.201). In 1952 she proposed that the patient dealt with the conflicts and anxieties which were reactivated in the present analytic situation by making use of the same mechanisms and defences as in earlier situations.

Transference was regarded by Klein "as a re-enactment of current phantasy experiences" (Hinshelwood, 1991, p.465). Klein focused on the analytic setting, the environment in which the patient's psychic organization based on his early and habitual ways of functioning, his fantasies, impulses, defences and conflicts were lived out. Klein therefore urged analysts to focus not only on what was said, but on the recurring interactional processes in the analytic situation, the object relationships being acted out in the transference (Joseph, 1985, 1988). Only through conceiving of transference in terms of total situations transferred from the past into the present, could the analyst become aware of how the patient used him to feel things. This perspective of transference not only illuminated the patient's defences but revealed the enormous value of countertransference analysis.

Klein also extended the recognized range of transference beyond direct references to the analyst and readily identifiable displacements, suggesting that every communication from the patient contains unconscious manifestations of the transference. For Klein, the term transference referred to the patient's total relationship with the analyst.

Klein, like Strachey (1934), paid special attention to the transference onto the analyst of internal figures from the patient's inner world. Segal (1981) points out that Klein showed how, in the transference relationship, internal object relations are mobilized by projection onto the analyst and modified through interpretation and experience as they are reintrojected. According to Klein, the analyst's function of processing the patient's projections made it possible for the patient to gain insight into his distorted perceptions of the analyst. In the words of Joseph (1988), one of Klein's greatest followers:

> In fact, transference itself and the process of transference are based on projective identification. Parts of the self, impulses, and internal objects are projected into the analyst, and the patient then behaves toward the analyst as if this were the truth (p.630).

This statement denies the role played by the analyst in evoking the patient's reactions and consequently assumes that the patient's perceptions are inappropriate and distorted. In a similar way, the Kleinian emphasis on the inner life of the patient tends to deny the role played by life experiences in the patient's illness (Greenson, 1978) and leads to the extremist perspective proposed by Isaacs (1948), that the patient's relation to his analyst is almost entirely one of unconscious phantasy.

It is apparent that although Klein illuminated the enormous value of countertransference analysis and extended the field of transference to include the patient's unconscious perceptions of the analyst, she nevertheless tended to neglect the actualities of the analytic experience. They serve not merely as hooks or "day's residues" for the free associations of the patient's material, but also shape his unconscious perceptions and therefore determine whether they are accurate and relevant in the here-and-now.

It is argued that although a primary function of the analyst is to observe the transference as it is lived out dynamically in the analytic environment, it is nevertheless imperative that the therapist monitor his influence upon the mental processes of the patient in order to ascertain whether the patient's unconscious perceptions and commentaries of the therapist's behaviour are accurate or not.

These and other criticisms have been levied at most of the adherents of Klein who have continued to focus on the patient's transferences and pathological projective identifications to the relative exclusion of the analyst's pathological countertransferences and his own pathological projective identifications.

It has been posited by Langs (1978) that although the Kleinians have greatly contributed to the theory of analytic technique, which has lead to the increased recognition of the interactional conceptualization of the nature of the transference-countertransfernce matrix and to the contingent emphasis on the understanding of projective identification, their conception of transference is incomplete. He argues that they have been biased in terms of emphasizing the impact the patient's personality system has on that of the therapist to the point of undermining the powerful influences of external reality. This has precluded the Kleinians from reaching a full appreciation of the analyst's behaviour in the analytic relationship and has resulted in a disregard of the nontransferential dimension of the therapeutic relationship.

The Kleinian approach has tended to incorporate the influence of external reality in terms of the curative function of the analyst's transforming power of interpretation (Malin & Grotstein, 1966; Racker, 1968; Segal, 1981) and his capacity to contain the patient's projective identifications (Bion, 1962; Grinberg, 1962). This has had major positive implications for the treatment of the narcissistic neuroses (Meltzer, 1978; Rosenfeld, 1987; Segal, 1981).

Notwithstanding the major contributions made by Kleinians with respect to the study and treatment of the preoedipal disorders, fundamental conceptual criticisms levied at them cannot be ignored. The Kleinian belief in the omnipresence of the transference has

reinforced the analyst's powerful position as "expert in reality" (Jordan, 1992), partially blinding him to his own errors of judgement. This has consequently led to the devaluation of the patient's perceptions and to his infantilization as a person. It seems therefore that the Kleinian approach has only partially overcome the limitations of the intrapsychic narrative which precludes the adoption of a comprehensive bi-directional definition of the analytic relationship.

2.3.3 The controversial views of Greenacre, Zetzel, Stone and Greenson.

a. Phyllis Greenacre

Greenacre (1954) distinguished between an essentially nonconflictual transference and the transference proper which needed to be analyzed in full. What Freud had referred to as the "effective, positive transference" (Freud, 1912, 1913) and later the "analytic pact" (1937, 1940), Greenacre called the "basic transference". This she believed was derived from the early mother-child relationship, and due to the unevenness between the role of the patient and that of the analyst was induced in the patient (i.e. an attitude of dependency and cooperation toward the analyst). According to Greenacre (1954), the "titled emotional relationship" created a psychic uprooting of the patient's past attitudes and fantasies which were reenacted in relation to the analyst in the present situation. This view was congruent with the theories of Macalpine (1950) and Nunberg (1951) who posited that the infantile setting of analysis acted as a catalyst for the patient's regressed behaviour. In other words, they recognized that the detached position of the analyst in conjunction with the imbalanced setting of analysis invited regressed, transference-based reactions from the patient.

It is quite evident that her differentiation between the basic transference and the analytic transference proper foreshadowed later discussions on the distinction between the therapeutic alliance/working alliance and the transference neurosis.

b. Elizabeth Zetzel

Zetzel's (1956) paper, "Current Concepts of Transference" served as a landmark in the development of the alliance concept and further distinguished between the alliance sector of the therapeutic interaction and the transference neurosis. In this prominent paper she emphasized that the pre-analytic maturity of the ego of the patient was a prerequisite for the traditional psychoanalytic procedure. Zetzel (1956) also proposed that effective analysis was built on the foundation of a sound therapeutic alliance, which preceded analysis proper, and was different and distinct from the transference neurosis.

For Zetzel (1956), the therapeutic alliance was not considered to be part of the nontransference dimension of the therapeutic relationship but related to the nuclear aspect of the transference. The therapeutic alliance was, according to her, a recapitulation of the very early relationship between mother and infant. Zetzel posited that the maternal behaviours of the analyst nurtured the therapeutic alliance and facilitated the patient's identification with the analyst. Like Greenacre (1954) and Macalpine (1950) before her, Zetzel (1956) acknowledged the powerful role of the analyst in managing the imbalanced analytic relationship.

c. Leo Stone

In the tradition of Freud (1937) who had distinguished between the "confidence transference" and the "transference proper", Stone (1961, 1984) referred to the concepts of the "primordial" and the "mature transference". The "primordial transference" concerned the patient's wish to master the crucial separations from the mother-substitute, the analyst. Stone (1984) distinguished this regressive striving to establish symbolic bodily reunion with the analyst mother from the "mature transference" which encompasses the wish to understand and to be understood by a parent substitute. Like Freud's (1925) unobjectionable positive transference, the mature transference is a dynamic and integral part of the therapeutic alliance, and includes the wish for increasingly accurate interpretations, the genuine adult needs for help and the intuitive appraisal of the analyst.

Whereas Stone (1984) views the primordial transference always as a potential source of resistance and thus requiring analysis, the mature transference did not need to be

analyzed. Unlike Bird (1972), who asserts that everything that occurs in the analysis on the part of the patient partakes of transference elements, Stone (1984) has maintained that:

> There is a residual real relationship between persons who have worked together in a prolonged, arduous and intimate relationship which, strictly speaking, is not a transference, but there may be mutual colouration, blending, and some confusion between the two spheres of feeling (p.101).

Stone's (1984) belief that "no reaction to another individual is all transference, just as surely as no relationship is entirely free of it" (p.98) found expression in the majestic works of Ralph Greenson.

d. Ralph Greenson

The relatively neglected dimension of nontransference functioning was extensively studied by Greenson, a classical analyst, who reacted strongly to a tendency among psychoanalysts to view the patient's relationship with them almost exclusively in terms of transference and distortion. Greenson (1971) emphasized that in order to fully understand and handle the vicissitudes of the psychoanalytic situation, the total analytic relationship which incorporated the "nontransference" dimension between the patient and the analyst must be taken into account. Greenson (1967) took issue with the Kleinian and conservative, classical analysts who stated that all the patient's meaningful reactions to the person of the therapist are transference manifestations and the only important interventions are transference interpretations.

Greenson (1967) maintained that:

> All analysands have realistic and objective perceptions and reactions to their analyst alongside of their transference reactions and their working alliance. These three modes of relating to the analyst are interrelated.

> They influence one another, blend into each other, and can cover one another (p.219).

Although he explicitly stated (1971) that all object relationships consist of different admixtures and blendings of real and transference components and that the terms transference, nontransference and the real relationship must be considered as relative and overlapping, his pioneering work in this relatively unchartered field by psychoanalysts has been heavily criticized by Gill (1982, 1985), Langs (1980, 1982) and Stolorow et al. (1987).

Greenson's concept of the real relationship has been opposed by these authors on the basis that it implies that the nature of the patient's analytic experience can be cut up into various kinds of relationships, interfering with the analyst's ability to empathize with the patient's experience. Langs (1982) has denounced Greenson's (1967) conception of the "transference relationship" because it "fosters the mistaken notion that the so-called "real" relationship is relatively free of unconscious influence and exists as some type of autonomous, reality-oriented mode of interacting" (p.576).

Greenson (1967, 1971) used the term real to refer to the realistic and genuine relationship between analyst and patient, which is distinguished from transference reactions, which, although genuinely felt by the patient, are considered to be unrealistic and inappropriate by the analyst. Greenson (1971) further elaborated that the "real" relationship, like all object relations, also consists of repetitions from the past, but it differed from transference in being selective and discriminatory in terms of what was repeated. The real relationship, unlike transference reactions, was also viewed as being modifiable by internal and external reality. Unlike many of his predecessors, Greenson acknowledged that objectionable traits in the analyst could produce realistic reactions in the patient which could preclude successful psychoanalytic treatment from taking place.

Notwithstanding his relational contributions which have humanized and interpersonalized the traditional conceptualization of transference, Greenson's (1967) emphasis on the mechanisms of repetition, displacement and regression as operating in the psychic

phenomenon of transference, reveals the traditional metatheoretical context of his work. An extension of this has been Greenson's (1967) claim that the outstanding trait which denotes a transference reaction is "inappropriateness". Stolorow et al. (1987) disapprove of this claim as it implies that judgements about what is appropriate or realistic patient behaviour are the sole discretion of the analyst. This criticism echoes Szasz's (1963) contention that the term transference is not a neutral description, but rather the analyst's judgement of the patient's behaviour.

Greenson's essentially classical model of treatment is based on the proposition that in psychoanalysis another kind of relation to the analyst is necessary besides the more regressive transference reactions. He (1965) posited that the key to understanding therapeutic impasses with many seemingly unanalyzable or interminable patients was to be found in the failure of the patient to develop a reliable working relationship with the analyst. It was on this basis that Greenson (1967) presupposed the importance of separating the patient's reactions to the analyst into two distinct categories, namely the transference neurosis and the working alliance.

In order for the transference neurosis to be analyzed effectively he believed it was imperative that the working alliance be developed, and that this relatively nonneurotic, rational purpose-oriented relationship was created out of the patient's capacity to establish adequate and reality-oriented object ties to the analyst. The analyst's attitude of respect and concern for the patient was also considered essential to nurture this goal-oriented, reality bound relationship. Like Zetzel (1956), he recognized that the alliance which was formed between the patient's reasonable ego and the therapist's analyzing ego was borne out of the partial and temporary identification that the patient made with the analyst's humane attitude and method of work.

Although Greenson (1967) originally stated that the differentiation between transference reactions and the working alliance is not an absolute one, since the working alliance could contain elements of the infantile neurosis which will eventually require analysis, in his later papers (Greenson & Wexler, 1969; Greenson 1971) he attended more to the real relationship and emphasized that this nontransference dimension was the enduring core

of the working alliance. In other words, although the working alliance concept was originally described as being comprised of both rational and irrational components, in his later works Greenson tended to view this concept as referring essentially to a nontransference dimension of human relating.

Greenberg & Mitchell (1983) assert that Greenson, on the one hand posits that the working alliance is a prerequisite for the interpretation of the transference neurosis, yet on other occasions states that the working alliance derives from transference interpretations. They conclude that what for Greenson is supposed to be a prerequisite has become a consequence. It is argued that the working alliance is both a prerequisite for the interpretation of the transference neurosis and, on the other hand, maintained by transference interpretations.

Gill's (1982) dissatisfaction with the various alliance concepts centres on their failure to distinguish clearly between present and past determinants of the patient's attitudes. Although Langs (1980, 1982) acknowledges the valuable work carried out by Greenson with respect to according the alliance sector a more interactional role, he finds fault with Greenson's neglect of the sphere of the unconscious communicative relationship.

Greenson's work has been appraised as being controversial and metatheoretically unsound, yet on the clinical level his plea to analysts to view the analytic relationship with humaneness and flexibility needs to be heard and supported. The essential part of his work also concerns his basic proposition:

> To facilitate the full flowering and ultimate resolution of the patient's transference reactions it is essential in all cases to recognize, acknowledge, clarify, differentiate, and even nurture the nontransference or relatively transference-free reactions between patient and analyst (Greenson & Wexler, 1969, p.361).

In the midst of conservative classical and Kleinian views that transference manifestations are omnipresent, and that abstinence and neutrality is the only analytic stance advocated,

Greenson introduced the dictum that interpretation alone was not sufficient to resolve the transference neurosis and that a productive psychoanalytic atmosphere was built upon human elements which are beyond transference analysis. Greenson permitted the humaneness of the analyst to be awakened and gave psychoanalysis an alternative route to that adopted by the orthodox school.

2.4 The Modern Period

According to Esman (1990), in the latest period (ca. 1960-1987) we notice a balance between reassertion of traditional views and the various revisionist statements of some of the classical positions. Unlike the traditional drive model theorists or what Cooper (1987) refers to as the "historical analytic approaches", the attitude of those classical analysts with "relational contributions" (Greenberg & Mitchell, 1983) has been to acknowledge the multiple dimensions of the therapeutic relationship.

It has therefore been necessary for academic reasons to separate the contributions of the more traditional conservative analysts from their "classical relational" counterparts whose views on analytic attitude and stance are markedly different. The views of Arlow, Bird and Brenner have therefore been grouped together under the umbrella term "Conservative Psychoanalytic Contributions" which sets them apart from the more revisionist statements of Sandler, Searles and Winnicott who espouse theories emphasizing the inherently dyadic nature of the psychoanalytic situation.

2.4.1 Conservative psychoanalytic contributions

A critical discussion of the evolution of the transference concept would be incomplete if the views of Brenner (1976) and Arlow (1985) were omitted, as their notions of what constitutes a transference reaction are so traditionally bound to the intrapsychical field that their views on the alliance concepts contrast significantly with those of Greenacre, Greenson, Stone and Zetzel.

Unlike Greenson (1965, 1967) who advocated the analyst's responsibility to recognize and nurture the nontransference reactions between patient and analyst, Brenner (1976) holds the view that the analyst's priority is to consistently maintain a strict neutral analytic attitude which fosters the success of the analytic use of the transference. For Arlow (1985), Bird (1972) and Brenner (1976, 1979), transference is always present, active and significant in the analytic situation. According to Brenner (1976):

> In addition to being a very real part of every patient's mental life, transference wishes and conflicts are often the most important determinant of a patient's conscious thoughts, emotions and actions, however little he may be conscious that this is the case (p.126).

It is maintained that these analysts relegate the role played by external factors in the actual analytic interaction to the presence of mere stimuli which excite the patient's mental activity. This reductionistic belief maintains the preconceived notion that the material which appears in the patient's consciousness is "predominantly endogenous in origin" (Arlow, 1985, p.114).

Arlow (1985) and Brenner (1976, 1979) naively maintain that the essence of the analyst's participation is merely that of a detached, objective human screen which triggers the effects of the patient's intrapsychic mental set. They rigidly hold that the patient's perceptions of the analyst are fuelled and sustained by their (patient's) persistent unconscious fantasies, irrespective of the process of the actual analytic situation.

For Brenner and Arlow, the interpersonal dimension of the therapeutic interaction only really comes into existence when the analyst is actively included in the patient's neurosis. The "hardest part of the analysis" for Bird (1972) entails the recognition, comprehension and interpretation of the patient's intrapsychic conflict as it is transformed into an interpersonal impasse in the process of analysis. Langs (1981) comments that Bird's (1972) paper shows some acknowledgement of the extent to which the analyst participates in the patient's transference neurosis and attests to a growing awareness

among some conservative classical analysts of the countertransferential dimension of the interactional domain.

With respect to the alliance concepts, Brenner (1979) believes that "it is neither correct nor useful to distinguish between transference and the therapeutic or working alliance" (p.172). Arlow (1985) reinforces this statement and argues that these concepts are "misconceptions and confusions that tend to blur the concept of transference" (p.150). These conservative analysts maintain that the authors and adherents of these concepts use these relational constructs to protect themselves from having to tolerate analytic abstinence and neutrality (Malcolm, 1982). This accusation highlights one of the major differences between these respective schools of psychoanalysis regarding therapeutic considerations and technique. It is evident that what the conservative analysts regard as taboo, their counterparts perceive as being imperative for effective therapeutic management.

2.4.2 Classical relational contributions

The relational/structure models of Loewald (1960, 1971, 1986), Sandler (1976), Searles (1965, 1973, 1975) and Winnicott (1949, 1956, 1971) attempted to bring about a number of major changes concerning the conservative followers' exclusive focus on transference which posed foreseeable dangers to the technique of psychoanalysis. Their reformist views of the concept of transference took into consideration the actualities of the analytic situation, particularly the analyst's pathological contributions to the therapeutic interaction and illuminated the importance of recognizing the curative effects of the therapeutic setting. These analysts focused on the interactional zone of the transference-countertransference matrix, and in their own ways conceptualized that the transference relationship rested on the paradigm of the early mother-child relationship. Their place in the historical evolution of the concept of transference is a special one, as they formed the viaduct between the Middle and the Modern Periods as set out by Esman (1990). Although many of their investigations of the analytic interaction were concentrated primarily in the 1970s, some of their pioneering studies fell within the Middle Period (ca 1936-1960).

a. Donald Winnicott

Winnicott's (1956) paper "On Transference" illuminated the necessity of safeguarding the environment of analysis by nurturing the nontransference dimensions of the analytic relationship. This was postulated to be of particular importance in the management of borderline/schizoid cases. Winnicott (1960) reasoned that because "what happens in the transference especially in certain regressed phases is a form of infant-mother relationship" (p.141), it is imperative that the analysand experience sufficient safety in the therapeutic space to allow for the natural evolution of the transference.

Although Winnicott did not distinguish between the transference neurosis and the working or therapeutic alliance, his contention that the former cannot be analyzed effectively without the provision of a holding analytic environment supports Greenson's (1967) position on the necessity of nurturing the nontransference based dimension of the therapeutic relationship. Both analysts take into consideration the actual setting of analysis, particularly when it refers to the resistance of the patient which is often an indication that the analyst has made a mistake.

Winnicott's conceptualization of the inseparability of the transference and countertransference dimensions of the therapeutic interaction demonstrates his recognition of the bi-directional communication flow between the analyst and the patient, whose roles are defined by the other.

b. Harold Searles

Searles's (1965, 1973) comprehensive interactional approach sensitized him to develop a deep understanding of the reciprocal influence that transference and reality (external factors) have on each other, and how reality elements are unconsciously incorporated in transference manifestations.

Like Fenichel (1941) and Greenson (1967), Searles suggested that there is an element of reality in all the patient's distorted transference-perceptions of the analyst. Searles (1975)

posited that the evolving reality-relatedness made possible the development and resolution of the transference which in its turn furthered the parallel process of the reality dimension. This reinforces Greenson's (1967) theory that both dimensions of the therapeutic relationship are interdependent and overlapping.

Searles's (1975) hypothesis that man has an innate striving to heal his fellow man, uncovered a previously neglected area concerning the unconscious transference fantasies of the patient and revealed what had previously been only partly explored, namely the sound and unsound unconscious communications of schizophrenic and other patients.

c. Joseph Sandler

Sandler et al.'s (1969) intermediate view conceptualizes transference as a multidimensional phenomenon which partakes of as many dimensions to relationship as the study of object relations itself. They hold that it is technically imperative to distinguish between the various dimensions of transference engendered in the psychoanalytic situation because not all aspects of past relationships can be considered as being a repetition or new edition of past object relations. For example, Sandler et al. (1973) subscribe to the usefulness of the alliance concept but believe that a form of transference itself appears to be an essential ingredient of the treatment alliance. It is noticeable that like Freud (1913), Sandler et al. (1973) maintain that the effective, co-operative behaviour of the patient is on some level a derivative of the transference domain.

Sandler et al. (1973) maintain that transference should "not be restricted to the illusory apperception of another person" as it includes the unconscious manoeuvres which induce situations with others. This conceptualization was later expanded when Sandler (1976) linked the unconscious transference fantasies of the patient to the induced interpersonal behaviours of the analyst. Although this theory is a restatement and elaboration of the early ideas of Freud (1920), Sandler's (1976) thesis emphasized the enormous value of countertransference analysis. This increased the understanding of the deep unconscious rapport between patient and analyst and reduced the need to discriminate whether the

patient's conscious perceptions of the analyst were distorted or not. Sandler (1976) clearly advocated that the analyst's discriminations concerning the nature of the patient's reactions needed to incorporate the indirect communications from the patient.

Sandler's (1976) conceptualizations were supported by Loewald (1986) whose remarkable insights on countertransference analysis articulated the space of unconscious fusion between the analyst and the patient.

2.4.3 Contemporary psychoanalytic perspectives

Modified psychoanalytic perspectives of the nature of the therapeutic relationship have been developed in recent decades, bearing witness to the formation of divergent theories concerning the transference in all its aspects. This does not discount the presence of the drive model conceptualization of the analytic process which has continued to be supported by its many orthodox followers, nor does it exclude the existence of the Kleinian tradition which has matured under the guidance of Joseph, Rosenfeld, Segal and others.

The ongoing cultivation of the "interactional" approach which has its foundations in the contributions of Sullivan (1953) and the Interpersonal School, Strachey (1934) and Racker (1968) from the Kleinian tradition and later Langs (1978) and Lipton (1977) from the Freudian lineage, has been nurtured by "relational model" adherents (Greenberg & Mitchell, 1983) during the Modern Period. They advocate the view that the analyst serves as a co-creator of the transference in a psychoanalytic situation which is inherently dyadic.

Although the theorists referred to under the umbrella term "interactional" have all considered the powerful influence of the here-and-now actualities of the analytic situation, their respective theoretical conceptions emphasize different, yet not unrelated, psychoanalytic narratives concerning the nature of man, and consequently the therapeutic relationship.

a. Divergent theoretical conceptions

Whereas Langs (1978, 1980, 1982) has focused on the conscious and unconscious perceptions of the two participants in the analytic situation, appraising their transferential and nontransferential responses and the manifest and latent alliances between them, Gill (1979, 1982, 1985) has adopted a more hermeneutical perspective of the interactional domain of analysis.

Langs (1980) has described transference as the pathological component of the patient's relationship to the therapist, constituted of maladaptive, distorted and inappropriate responses and perceptions of the therapist. This contrasts with Gill's (1985) identification of transference which is not restricted to the traditional conceptualization of transference as distortion. Gill (1985) maintains that:

> What goes on between two people cannot be objectively and unequivocally characterized but is subject to varying interpretations depending on the point of view of the interpreter; that is, the inherent ambiguity of interpersonal relations is such that patient and therapist may have quite different though equally plausible understandings of their transaction (p.90-91).

The views of Casement (1985, 1990), Klauber (1987) and Symington (1986a) introduce a more humanistic element into the study of the analytic encounter which is appreciated not only as a potential space for discriminating "truth" from "illusion", but valued for its experiential quality, out of which is born the power to imagine, to hope and to live more spontaneously, beyond one's neurosis. These analytic masters share the belief that an aspect of their patient's perceptions are true and take into consideration the patient's "unconscious developmental hopes" (Symington, 1986a) which are transferred on to the analyst. Casement (1990) corroborates Symington's (1986a) prospective outlook by maintaining that the patient's so-called primitive and pathological behaviours are typical expressions of unconscious hope and can also be viewed as the unconscious search for new solutions.

Gill (1982), Schwaber (1983), Stolorow et al. (1987) and Symington (1986a) corroborate Barton's (1974) belief that the analyst/therapist is not the primary or sole "reality perceiver and speaker of the truth" (p.30). The notion of transference as distortion is not upheld by these unorthodox analysts who attempt to transcend the traditional archaeological narrative which posits that there is an absolute external reality, which is the prerogative of the analyst.

Symington's (1986a) position that truth in psychoanalysis emerges between the analyst and the patient is underlined and "radically" modified by Schafer (1976, 1983) and Spence (1982, 1987). Their understanding of the therapeutic action of psychoanalysis emphasizes the collaborative construction of multiple evolving interpretations of the patient's biography. The metaphor of analysis for them is not one of historical reconstruction of the past, but the creation of new meanings, couched as psychoanalytic narratives, which illuminate the non-sensical nature of the patient's life. The writings of Schafer and Spence alert us that the therapist's appreciation of the patient's responses cannot "be judged right or wrong on the basis of objective criteria that exist free of theoretical presuppositions and interpretive grasp of context" (Schafer, 1983, p. 39).

b. Therapeutic considerations

A major therapeutic consideration shared by the majority of the contemporary relational analysts concerns the importance attached to "horizontal analysis" (Casement, 1985). In order to facilitate the development of an intersubjective relationship in the analytic situation, they uphold the belief that it is of utmost importance that the analyst reflect on his participation in the actual analytic situation. They maintain that unless the analyst/therapist reflects on his "therapeutic conduct", it is impossible for him to determine whether the patient's behaviour is grounded in fantasy and illusion or if it is reality-oriented and adaptive.

Langs (1978) advocates that one of the therapist's clinical tasks is to monitor the manifest and latent content of the patient's associations for conscious and unconscious allusions related to himself. Learning from the patient's unconscious perceptive responses

concerning the nature of the analytic relationship, can guide the therapist to rectify his erroneous interventions and consequently lead to the recognition of his countertransference expressions.

Langs (1980) believes that this will enable the therapist to "manage" the sequences within the therapeutic interaction more adequately, thus promoting the basis of "truth therapy". He (1978, 1980, 1982) holds that it is imperative for the analyst to maintain the therapeutic framework, to appraise the patient's material in light of the prevailing adaptive contexts and to take into account the indirect and unconscious capabilities of the patient. He argues that it is essential to recognize the nontransference based reactions of the patient and contends that this therapeutic consideration, in addition to the others referred to, augments the patient's capacity for transference functioning which is the essential condition for psychoanalytic work.

In a similar vein, the followers of Winnicott (Casement, 1985, 1990; Kennedy, 1984; Klauber, 1981; Symington, 1986b) posit that a management consideration not to be overlooked concerns the protection of the patient against the impending recurrence in the transference of traumas associated with the past but triggered by similarities in the present.

Casement (1985, 1990) emphasizes that unless the therapist engages in "horizontal analysis", he will unknowingly create an analytic relationship which is too similar to the original relationship experienced by the patient in infancy and this will lead to the unnecessary traumatization of the patient. This echoes the position taken by Kennedy (1984) who maintains that it is the responsibility of the analyst to conserve and safeguard the "dual aspect of the transference" by recognizing the role of the nontransference elements which hold "the patient until the unconscious conflicts behind the transference reactions are understood" (p.473).

Patient resistance for Casement (1985, 1990), Gill (1982), Kennedy (1984), Kohut (1971, 1977), Langs (1980, 1982) and Stolorow et al. (1987) is not confined to the intrapsychic

realm of explanation but understood as co-determined by the actual behaviours of the analyst.

According to these relational therapists, patient resistance is always to some extent prompted by some quality or activity of the analyst that threatens to repeat past childhood traumas in the present analytic situation. This supports Gill's (1982) contention that "rather than regard transference as primarily a distortion of the present by the past, I see transference as always an amalgam of past and present" (p.177).

Langs (1980, 1982), unlike Gill (1982), emphasizes the necessity of identifying whether the patient's resistance is transference-based and founded upon pathological unconscious fantasy-memory constellations and pathological introjects or attributable to the analyst's inappropriate interventions and expressions of pathological countertransference. In the latter case, the patient's resistance is based on sound, essentially valid and perceptive reactions to the therapist's poor interventions and is thus considered to be characteristic of nontransference functioning.

Langs's (1980, 1982) perspective that it is a prerequisite to identify all activated adaptation-evoking contexts before determining whether the patient's reactions to the analyst are transference-based or reality-oriented and sound is strongly advocated.

2.5 Review

Three main historical periods pertaining to the development of the transference concept have been outlined in order to illustrate the growth and diversification of this concept in both the classical and the Kleinian lineages and to outline the emergence of the nontransference concept.

It has been shown that although Freud's drive model emphasized the intrapsychic realm, his (1914) description of transference as an intermediate area and his observations (1920) that patients unconsciously evoke reactions in the analyst, opened up avenues to be

explored by both the Kleinian and classical-relational adherents concerning the interactional dimensions of transference.

A major developmental milestone in the formation of the proliferation of psychoanalytic approaches to conceptualizing the transference phenomenon was the appearance of the post-Freudian contributions of Ferenczi (1909), Klein (1952) and Strachey (1934). They recognized the curative potential of projective and introjective identifications and facilitated the shift of attention from the intrapsychic dimension to the realm of object relations. Although Klein (1952) revealed the value of countertransference analysis, it has been argued that her view of the transference concept is limited and that her appreciation of the total therapeutic relationship too one-sided.

It has been noted that the attention given to the alliance sector by the classical relational analysts during the Middle Period (ca 1936-1960) and the transition phase linking this with the Modern Period (ca 1960-1987), enabled analysts (Greenacre, 1954; Greenson, 1967; Stone, 1961; Zetzel, 1956) to encompass the multiple dimensions of the therapeutic interaction. Their relational contributions which were built on the foundation of the innovations of Anna Freud (1936), Sterba (1934, 1940) and especially Bibring-Lehner (1936) augmented the recognition of the interactional aspects of the analytic experience.

The monumental contributions in the 1960s and 1970s by Greenson (1971, 1972, 1978), Searles (1973, 1975) and Langs (1975, 1976, 1978), who studied the presence of the nontransference dimension, tended to humanize the sterile technical atmosphere of psychoanalysis. In conjunction with the relational/structure models of Loewald (1960), Sandler (1976), and Winnicott (1956, 1971), they explored the fulcrum of the interactional zone, the transference-countertransference matrix, and demonstrated the conjoint interactional nature of the analytic field.

Although there has been a tendency among non-orthodox classical analysts during the Modern Period to view the transference along interactional lines taking into consideration the analyst's actual behaviour and personality characteristics as present determinants which shape the nature of the unfolding therapeutic process, relatively few analysts have

referred to the presence of the nontransference dimension of the therapeutic relationship. The conclusion is drawn that most analysts, whether affiliated to the Kleinian lineage or the reformist offshoot of the classical lineage, view "new" psychoanalytic concepts such as the nontransference or the real relationship as too threatening to be incorporated into their present vocabulary, possibly because it signals the impending demise of traditional psychoanalysis, which is associated with the historical archaeological narrative. This apparent neglect of the nontransference dimension has consequently led to the erroneous belief that the reality-oriented component of the therapeutic relationships is the possession of the psychoanalytic therapy field and not analysis per se.

The views of Greenson (1967, 1971, 1978), Searles (1973), Langs (1978, 1980, 1982) and Sandler et al. (1973) are strongly supported in this thesis, which underlines the view that transference has many functions and appearances, and that to understand its polymorphous nature in both psychoanalysis and psychoanalytic psychotherapy one needs to conceptualize this clinical phenomenon interpersonally. This entails comprehending the interactional complexities of the actual analytic situation, which basically means recognizing that all interpersonal interactions are both intrapsychically structured and shaped by the immediate interpersonal context. This leads to the conclusion that although analytic experiences are jointly created, not all of the patient's responses in the environment of analysis/psychoanalytic therapy are regressed and inappropriate, nor distorted and misdirected, but congruent and applicable to the situation (i.e. nontransference functioning).

2.6 The wisdom of countertransference-analysis

A comprehensive review of the psychoanalytic literature reveals that although many analysts since the 1950s recognize that the analytic relationship occurs in a "bipersonal field" (Langs, 1981, p.218) which is essentially constituted of a "transference-countertransference matrix" (Ogden, 1982; Marshall & Marshall, 1988), there nevertheless persists a tendency among many psychoanalysts to overlook the existence of the nontransference component of the therapeutic relationship. In other words, although the majority of non-orthodox analysts treat transference and countertransference as

inseparable issues acknowledging the interactional nature of the analytic relationship, and the presence of the phenomenon of "interpersonal actualization" (Ogden, 1982, p.210), there remains an archaeological gravitational pull to focus on the pathological component of the patient's relationship to the analyst. It has been pointed out that the few notable exceptions to this readiness to pathologize the reactions of the patient include the neo-classical interactional approaches of Greenson (1967), Langs (1978, 1980, 1982), Searles (1973) and the revisionist approaches of the micro-society of Independent British Psychoanalysts.

One of the "technical" implications of this neglect of the nontransference dimension of the therapeutic relationship, as it pertains to the topic of this thesis, is that few analysts have deemed it necessary to identify whether the patient's responses are transference-based or reality-oriented and valid.

On the one hand, Greenson (1967) has outlined typical characteristics which distinguish whether the patient's reactions are maladjusted and inappropriate. Langs also has formulated a "model of self-analysis" (1982, p.76) and a "listening and validating process" (1978) in order to understand the manifest and latent material from the patient so that his valid unconscious perceptions (of the analyst) can be recognized and his accurate latent commentaries on the analyst's interventions acknowledged. The majority of analysts (Balint, 1968; Bion, 1959; Khan, 1974; Klein, 1946; Little, 1951; Ogden, 1982; Racker, 1968; Sandler, 1976; Searles, 1963; Winnicott, 1949 and others), however, have expanded the concept of transference to include the interaction of the two separate participants in the analytic situation and have emphasized the use of countertransference analysis as a tool to understanding the dynamics of the patient's internal object relationships and their unconscious fantasies.

It is not the intention of this section to historically review the literature on countertransference, nor the phenomenon of projective identification as this academic task has been competently carried out by Gorkin (1987), Thorpe (1989) and others before them. The relevant issue pertaining to this thesis concerns the therapist's experience of coming to know which role he has unconsciously been assigned by the

patient. The pertinent issue which concerns analysts and therapists who recognize that "transference and countertransference together form an intersubjective system of reciprocal mutual influence" (Stolorow et al., 1987, p.42) is to understand the clinical phenomenon of "role-responsiveness" (Sandler, 1976) and how this is induced by the patient's "communication by impact" (Casement, 1985). Countertransference analysis enables the analyst/ therapist to articulate the interactive nature of the analytic exchange, particularly his "subjective experience of interactional and interpersonal pressures from the patient" (Langs, 1982, p.73) and the induced identifications with aspects of the patient's ego.

The view that patients convey aspects of their inner world by arousing feelings in their therapists and that through being receptive to their countertransference feelings, images and visceral sensations, therapists have access to their patient's unspoken, pre-verbal experiences, has been echoed by Heimann (1950), Winnicott (1949), Little (1951, 1957), Racker (1953, 1968), Fromm-Reichmann (1950), Tower (1956) and many other adherents of the "totalistic" view of countertransference. Kernberg (1965) states that the "totalistic" approach views countertransference as the total emotional reaction of the psychoanalyst to the patient in the treatment situation. This approach, according to Kernberg (1965), "uses a broader definition of countertransference" (p.208) and "does justice to the conception of the analytic situation as an interaction process" (p.209). Unlike the classical views of Reich (1951, 1960) which assert that the term countertransference refers to the analyst's transference to the patient, which needs to be "kept in check", the Kleinians (Bion, 1975; Joseph, 1985) and their Independent British counterparts (Casement, 1985; Little, 1951; Symington, 1986b; Winnicott, 1949) have viewed countertransference as an indispensable means for understanding the patient's primitive "form(s) of affective communication" (Casement, 1985) and a sensitive receptive tool which can be turned towards the unconscious of the patient.

Kernberg (1965) and Gorkin (1987) have both comprehensively reviewed the literature comparing the classical and totalistic approaches to countertransference. They have underlined the importance the latter approach has attached to the use of

countertransference analysis as an interpersonal mechanism available to monitor the deeper participations of the analytic members.

The notion that the therapist's/analyst's countertransference reactions originate in response to the patient's psyche and can be constructively employed as an instrument to identify the patient's infantile strivings and the complementary experience of the objects of these strivings, was referred to by Deutsch in 1926 and later focused on by Racker (1968). He distinguished between two types of countertransference reactions of the analyst and referred to the identifications that take place as either concordant or complementary. Under the influence of concordant identification or what Ogden (1982) has described as "the therapist's identification with the patient's unconscious experience of self in the internal object relationship" (p.72), the analyst senses in himself the primary emotional constellation lived by the patient at the moment. These temporary pre-conscious identifications provide the analyst with a rich source of "emotional knowing" (Greenson, 1960) or what is more commonly referred to as empathy.

Complementary identification allows the therapist to identify with the transference objects of the patient, the "object component of the patient's internal object relationship that underlies the transference" (Ogden, 1982, p.72).

The perspective that countertransference analysis facilitates the analyst's sensitivity to the resonance between his own and the patient's unconscious is built on the premise that the analyst/therapist must be available and open to "feeling participation" (Searles, 1963) in the analytic environment. This view is emphasized by Bollas (1987) who compared the dialectical process of psychotherapy to the mutual contaminating process of a situational illness. It is essential during these periods of boundary blurring between patient and analyst, when the analyst's capacity to distinguish himself from his patient is challenged, that he monitor his own mental associations while listening to the patient and refrain from responding to the patient's intense projective identifications with "projective counter-identifications" (Grinberg, 1962).

For the therapist/analyst to "intuitively sense" (Bollas, 1987) and understand from within himself the patient's unarticulated motivations to manipulate interpersonal situations, it has been highlighted by Bion (1967) that the analyst should adopt "an attitude of faith" in order to expose himself to the emergence of the unexpected dimensions of the patient's existence. This act of "refraining from memory and desire" (Bion, 1967) cultivates an analytic stance of free floating attention and "free-floating responsiveness" (Sandler, 1976) which facilitates "participant-listening" (Greenson, 1960). This permits the analyst/therapist to oscillate from being an observer to participating temporarily and partially in the space of the in-between which is constituted of the feelings, images, fantasies and sensations of both analytic partners. Only through generative countertransference regression or what Kris (1950) refers to as "regression in the service of the ego" can the experiencing ego of the analyst partially and temporarily share in the experience of the patient. These controlled states of temporary regression open windows to the patient's inner world of emotional evocative imagery enabling the analyst/therapist the opportunity to engage in intuitive empathy through "trial identifications" (Fliess, 1942; Casement, 1985). Beres & Arlow (1974) have described the affect experienced by the therapist/ analyst as a signal affect, a momentary identification with the patient which leads to an awareness of the patient's unilluminated feelings, fantasies and infantile interpersonal demands.

It is quite evident from the extensive literature devoted to understanding the unconscious fantasies and perceptions of the patient that the process analysts/therapists undergo in order to differentiate whether the patient's responses are transference-based or reality-oriented is not a purely rational activity of cognitively organizing data. Nor is it a primarily conscious endeavour aimed at judging whether the patient's responses are inappropriate, distorted and maladjustive. The "impossible profession" of psychoanalysis (Greenson, 1977) requires of its followers that they participate in the interpersonal healing ritual by applying themselves both cognitively and emotionally. This implicitly demands of the therapist/analyst that he will gather together his inherent resources of intuition, empathy and human responsivity with the intention of making sense of the dynamics of the transference-countertransference encounter. The soul of the human

practice of psychoanalysis and psychoanalytic psychotherapy requires this of every therapist.

CHAPTER THREE

3. METHOD

3.1 Introduction

The aim of the present research study is to come to an understanding of what the psychoanalytically-oriented therapist experiences in the analytic relationship which enables him to identify the patient's reactions as either transference-based or reality-oriented. In order to obtain a deeply reflective understanding of the therapist's experience of differentiating and processing the patient's transference-based and reality-oriented responses, the method of choice was the empirical phenomenological method as described by Brooke (1983), Giorgi (1975, 1985), Kruger (1986), Todres (1990) and Wertz (1983).

Greenson's (1967) belief that all human relations consist of different admixtures and blendings of real and transference components indicates that these are technical, psychoanalytic concepts which artificially disentangle the strands of the total analytic relationship, obscuring the therapist's original lived experiences of the process of therapy. Hence the necessity of utilizing the phenomenological method to gain insight into the therapist's first hand experiences of making sense of the interactional dynamics operating in the analytic environment.

Considering that our present research procedures do not capture enough of the lived experience of therapy because so much is lost during the translation process to our conceptual understanding of psychotherapy (Fessler, 1983), it is argued that the phenomenological method which describes the essence of phenomena appearing in the life-world needed to be used in the present study to explicate the phenomenon in question. This descriptive and intuitive method grounded the researcher in the life world of the psychoanalytically-oriented therapist whose experiential presence in the analytic situation was investigated, particularly his receptivity to the total communication of the patient in the analytic environment.

3.1.1 Psychoanalytic considerations

The analysis of the transference is generally acknowledged to be the central feature of analytic technique, and, starting with Freud, the traditional case study method provided an extraordinary range of insights into comprehending the complexities of this technique. It was Wallerstein's (1986) contention that the accrual of psychoanalytic knowledge should not have to rely on the traditional clinical case study method, which has been the road to explanation for over one hundred years. It would seem that the aim of psychoanalytic research is not the construction of alternative methods of revealing the mystique of the analytic experience, but to continue to research human phenomena with qualitative methods that are descriptive, rigorous and formal.

This supports Wallerstein's (1986) argument that psychoanalytic research must be supplemented by more systematic, organized and formal research. The empirical phenomenological method satisfies these criteria by "having an identifiable, teachable method, by which it is possible to replicate studies, by seeking valid results, and by embedding itself within science's social enterprise" (Brooke, 1983 p.75). This is a human scientific approach that will allow psychoanalytic researchers to attempt to reproduce what transpires in the dwelling place of psychotherapy itself. Psychoanalytic enquiry, being inherently descriptive and hermeneutic, should continue to focus on quality rather than quantity, meaning rather than measurement and guided by empirical phenomenology should explicate what actually takes place in the analytic situation. This would entail describing the immediate experiences of the analyst/psychoanalytic therapist and not necessarily presenting smoothed-over versions of what was recollected. Psychoanalytic research should illuminate the psychoanalytic process as it unfolds and is lived out in a human relationship, where all the patient's reactions are considered to be meaningful and the analyst's participation in the actual analytic situation is acknowledged.

It was possible during this research endeavour for some aspects of the case study method to be integrated into the phenomenological methodology, as experienced therapists participated in the study. This corroborated Thorpe's (1989) method of researching the phenomenon of projective identification.

An issue that is crucial to many psychoanalysts/psychoanalytic therapists engaged in researching the interpersonal processes operating in the analytic relationship is the upholding of the sanctity of the analytic environment. This precludes the use of audio-taping specific sessions which would interfere with the therapeutic frame. The alternative chosen by the majority of psychoanalytic researchers is to review the retrospective accounts of the specific analytic sessions selected for analysis. This raises the issue whether research questions formulated to elicit retrospective accounts of psychotherapy situations explore and raise to an articulate level of intelligibility the therapist's/analyst's pre-reflective experiences in the analytic situation.

Fessler (1983) argues that the recollections of psychotherapists about their own work are of limited value because they portray the therapist's experience only and are smoothed over versions of what actually took place. Todres (1990) counters this argument by stating:

> Although a retrospective account of an experience by the subject is a transformation of lived experience, it is nevertheless grounded in an experience that has been undergone. There is no such thing as a 'pure' lived experience, as the meaning of an experience is always constituted by its ongoing history (p.70).

Phenomenological psychology does not view the interview as a source of distortion, but rather understands that through dialogue the meaning of an experience is more likely to be illuminated. We are not ahistorical beings dislocated from past experiences, but have the potential to reflect on our existence and within a growing historical context the meaning of our past experiences becomes clearer. The concrete lived occurrences of the psychoanalytic therapist in the analytic situation should not be viewed outside the context of history, as every moment in the analytic situation is constituted intersubjectively by both participants within the dimension of their ongoing historical relationship.

3.2 Research question

Although it was originally intended that the research question would be formulated in terms of the lived experiences of the therapist during the process of psychoanalytic therapy using as few theoretical terms as possible, the pilot study revealed that this generated descriptions obtained from the subjects that were not revelatory of the phenomenon being investigated. Unless specific theoretical terms familiar to all the psychoanalytic therapists were included in the formulation of the central research question, the phenomenon in question was not given enough attention.

The use of specific theoretical terms in the formulation of a research question enhances the subject's understanding of the exact nature and purpose of the research study and consequently generates articulate expositions with insightful descriptions of the phenomenon under investigation. This reinforced Samuels's (1985a) views when researching the phenomenon of countertransference.

To enable the therapists to focus on their concrete lived experiences in the analytic situation, it was believed that it was essential to emphasize to them that the aim of the study was not to ascertain their academic knowledge. It was hoped that this clarification would facilitate that the therapists interviewed temporally suspend their theoretical judgement and "bracket" their scientific foreknowledge in order to respond "concretely" to the central research question.

One hundred years of continuous attention to the analysis of the transference presupposes that all psychoanalytic therapists share an implicit understanding of the term transference. It was also assumed that, irrespective of the therapist's theoretical or academic background, the majority of the therapists who considered participating in the study viewed the analytic process as including the existence of reality-adapted behaviour. This therefore made it possible for the researcher to include terms such as "reality-oriented" in the formulation of the central research question.

3.2.1 Pilot study: The emergence of the central research question

Part of the methodological challenge in this study was to formulate questions that would elicit the experiential world of the therapist without being overloaded with theory. Through five individual pilot interviews the questions were modified in order to arrive at the most suitable way in which to elicit descriptions revelatory of the process under investigation. The research question emerged with increasing clarity out of the dialogues with the respective five subjects. The following section shows how the appropriate central research question emerged through the process of enquiry during the pilot study as the questions and the phenomena reciprocally informed each other.

A short rationale for the modification of each of these questions formulated during the pilot study is given below.

Question 1: "Can you recall a situation in psychotherapy which furthered your understanding of the therapeutic relationship, and thus of your client?"

The descriptions obtained did not give access to the therapist's pre-reflective experience of differentiating the patient's reactions. In other words, the concrete situations described by the therapists, although pregnant with relational meanings, were not revelatory of the primary phenomenon investigated. This question elicited articulate texts which disclosed the experience of identifying situations characterized by transference manifestations.

Question 2: "Can you recall a situation or phase in therapy when you experienced some difficulty determining whether the patient's reactions were transferential or reality-oriented? If so, please describe your experience of the situation as accurately and in as much detail as possible."

The intention of this question was to locate the therapist in the experience of grappling with a situation that was not obviously transferential. This question was unfortunately too heavily loaded on the cognitive plane and tended to generate texts which served as a

point of departure for rational exposes of the phenomenon under investigation. The researcher found it necessary during these interviews to prompt the therapists in the direction of describing the experiential process whereby they became aware that the patient's reactions were either transferential or reality-oriented. To augment these one-sided mental descriptions, the researcher asked the therapists to focus on how this situation was experienced as being different from other situations in the journey of therapy. The therapists concerned also tended to recall situations characteristic of severe psychopathology, as if the phrase "experienced some difficulty" implied reporting the experience of being with difficult patients.

Question 3: "Can you describe the process which led you to differentiate whether a situation in psychotherapy was transferential or reality-oriented? If so, please describe your experience of the situation as accurately and in as much detail as possible."

This question was followed by: "In what way did you experience this situation as being different from other situations in the process of therapy?"

Although the therapists interviewed gave articulate descriptions of the relevant process, questions posed by some of them concerning the distinction between the terms transferential and reality-oriented compelled the researcher to clarify the situation under investigation by referring to the distinction between transference distortions and correct perceptions of the therapist. Theoretically this clarification highlighted the distinction referred to by Greenson (1967) and later focused on by Langs (1980) in his definitive work on distinguishing the concepts transference and nontransference. It was also realized that therapists schooled in the Kleinian fold understood the concept of transference to apply not only to direct references to the analyst but also to reports about the patient's everyday life (Joseph, 1985). This supported the inclusion of the distinction between transference distortions and correct perceptions of the therapist, and provided Kleinian trained therapists with the opportunity to explore when the patient was alluding to the transference by presenting material which referred to the therapist in a displaced form. It was hoped that the use of the term "distortion", although a derogatory and judgemental designation of the patient's behaviour, would call therapists to attend to the

patient's deeper or latent meanings of aspects of their material, i.e. the patient's unconscious perceptions of the therapist.

The following request to subjects thus formed the central research question:

"Can you describe the process which led you to differentiate whether a situation in psychotherapy was transferential or reality-oriented? If so, please describe your experience of the situation as accurately and in as much detail as possible. In other words, can you describe the process in psychotherapy which led you to distinguish between the patient's transference distortions of you and their correct perceptions of you?"

3.3 Subjects

It should be noted that the emphasis in qualitative research is less on the number of subjects interviewed than on the articulate exposition and insightful descriptions of the subjects. Considering that not all subjects who are interviewed give an insightful description of their experience, and not all aspects of the experience being investigated are articulately presented, it is therefore essential to interview a number of subjects to elicit a comprehensive account of the researched phenomenon. To ensure that the concrete descriptions generated in the present study reflected a wide variation of the essential parts of the phenomenon being investigated, eighteen psychoanalytically-oriented therapists were interviewed in total (including pilot study). They were all experienced therapists schooled mainly in the fields of British or American Object Relations. Irrespective of their academic training or supervision experience, they all considered themselves to be long-term therapists who "worked in the transference". The majority of these therapists had at least five years registered experience and were well socialized in the principles and techniques of psychoanalytic therapy/Object Relations, having been supervised and "analyzed" by therapists of the same analytic cloth.

The present study necessitated that all therapists considered to be subjects upheld the belief "that humans regularly and inevitably repeat with the analyst and with other

important figures in their current lives patterns of relationship, of fantasy, and of conflict with the crucial figures in their childhood primarily their parents" (Esman, 1990, p.1).

Although therapists from diverse orientations may label these repetitive infantile interactions as "transactional games" (Berne, 1964) or "dysfunctional strategies" (Haley, 1963), they do not view the here-and-now relationship with the therapist as a re-enactment of relationships in infancy or early childhood, and thus are not motivated to unearth the latent or deeper meanings and associations which these behaviours conceal. Therapists who did not share in the belief that the basis of psychotherapy is the restorying of the past in the light of the constructed experience between the therapist and patient were not suitable for the study.

It is assumed that the psychoanalytic therapists contacted who were willing to participate in the study also shared the notion proposed by Anna Freud (1954) that the analyst and patient are two real people, of equal adult status, in a real personal relationship to each other. It was essential that all the therapists interviewed corroborated the belief that the patient's experience of the analytic relationship is not entirely an "illusion" (Klauber, 1987) and that other dimensions of human relating take place in the course of an analysis/psychotherapy. The psychoanalytic therapists who were contacted that contended that all the patient's meaningful reactions to the person of the therapist are transference manifestations, were excluded from the study as they denied having experiences relating to the phenomenon to be researched.

3.4 The interview situation

After having interviewed five psychoanalytic therapists during the pilot study, an additional twenty therapists, all psychoanalytically-oriented, were contacted telephonically and briefly informed as to the goals and rationale of the doctoral research study. Most of these subjects had already been told about the intended research as they were members of a psychoanalytic study group. Some of these therapists were reluctant to participate in the study and expressed anxiety concerning the complete anonymity of both themselves

and their patients. Another reason that some of the therapists resisted participating in the study was that they feared portraying themselves as inadequately trained therapists.

The central research question was read to the fourteen therapists who agreed to act as subjects in the research study, and an interview was set up with all of these therapists at their consulting rooms approximately two weeks later. They were also sent a letter endorsed by the psychology department at Rhodes University informing them of the goals and rationale of the study and the research questions to be deliberated over. This letter (Appendix A) also emphasized that the intention of the research was not to examine their academic knowledge. The complete anonymity of both the therapists and their respective patients was also ensured.

Only one of the therapists who was initially contacted and consented to be interviewed later declined to take part in the research. Nevertheless, this therapist agreed to meet with the researcher to discuss the topic concerned. Being of Kleinian orientation, the therapist contended that the issue to be addressed concerned not the differentiation between the patient's transferential and reality-oriented responses, but the therapist's attempt to distinguish what was transference and what was countertransference. This critique of the research echoed the difficulty and theoretical confusion that some of the other Kleinian therapists had expressed during the pilot study, when the central research question was being formulated.

It was not necessary, unless requested by a subject, for the researcher to repeat the central research question at the start of the interview as most of the subjects were well acquainted with it and had prepared themselves adequately for the interview.

The interview was conducted in a facilitative atmosphere, in which the subject was allowed to speak as uninterruptedly as possible. The researcher's stance was to encourage the subject to ground his account in lived experience, thus remaining faithful to the phenomenon being explored.

> In a focused interview what matters is thus to lead the interviewee towards certain themes in his life world but to avoid leading him in the direction of experiencing specific meanings about these themes (Kvale, 1983, p.190).

The qualitative research interview should be experienced as a collaborative dialogue in which the meaning of the subject's experience is thematized and the phenomenon in question brought to articulation in an atmosphere of respect, understanding and trust.

In order to allow that the therapists interviewed generated descriptive texts which revealed the central themes in the life world of the analytic situation and that many of the descriptions which were obtained were presuppositionless, it was considered necessary to adopt what Bion (1967) refers to as an attitude of "faith". In the analytic situation this calls for the analyst's suspension of both memory and desire and facilitates the immediate experiencing of the patient and the search for the unknown. Similarly, the qualitative research interview demands of the researcher that he temporally suspend his memory of scientific knowledge and curtail his desire to direct the subject to specific meanings associated with specific themes.

In order to ensure that the subject had comprehensively given a retrospective account of the relevant process under investigation, those subjects who had disclosed a text which was not faithful to the way the situation was lived concretely were asked either one or both of the following questions:

A: "In what way did you experience this situation as being different from other situations in the process of therapy?"

B: "Describe your experience of differentiating whether the latent meanings of an aspect of the patient's associations reflected a transference based distortion or a valid perception of the therapist."

After having interviewed thirteen therapists during the central study, enough protocols had been generated to achieve consistently unifying themes which defined the phenomenon in such a way that the place of the variations could be indicated. According to Todres (1990), "the decision to stop recruiting new subjects is based on a tension between seeking new variations and concentrating one's hermeneutic efforts on the internal coherence of a few, revealing protocols" (p.76).

3.5 Procedure for the analysis of the protocols

3.5.1 Goals of procedure

Ten of the thirteen interviews audio-taped were selected for transcription and the five protocols considered most revelatory of the phenomenon under investigation were chosen for the phase of formal explication.

The selection criteria were as follows:

1) The situation described illuminated the phenomenon investigated i.e. Only protocols describing the experiential process of differentiating the patient's responses were considered for the formal phase of explication.
2) Four of the five protocols selected described very recent experiences in the analytic situation, thus enhancing the subject's power of recollection.
3) Although the great majority of therapists interviewed recalled situations designated as transferential, it was considered essential to select at least two protocols which described a reality-oriented situation in psychotherapy.

3.5.2 Steps of procedure

Procedures for analysing the interview protocols comprise several steps concerned with extracting the essential themes in their varying manifestations in order to construct a general structure of the phenomenon investigated. The disciplined procedure of analysis

of the transcribed protocols required that the researcher transform the concrete descriptions through engaging with the material in a reflective, interpretive manner in order to arrive at its structural meaning. The formal procedures adopted to explicate the five selected protocols have been described by Giorgi (1975, 1985), and include the following steps:

Stage 1: **Initial reading of the protocol**

Giorgi (1985) refers to the first step as that involving multiple readings of the entire text in order to get a general sense of the whole statement. It is essential that before the next step can be taken, that the reader obtain "an intuitive and holistic grasp of the whole description" (Stones, 1985,p.69). Listening to the tape recordings provided subtle nuances of meaning, hidden when read perfunctorily. The researcher needed to adopt a phenomenological attitude when reading the whole text, in order to immerse himself in the lived reality to which the description referred. Only by having an attitude of openness can the researcher truly understand the phenomenon's "gestaltness".

Stage 2: **Discrimination of meaning units**

The specific aim during this stage was to read through the whole text with the purpose of breaking it down into manageable units, called *meaning units*. On the basis of psychological criteria, the researcher discriminated changes of meaning in the situation described by the subject. It must be emphasized that the meaning units emerge and exist only in relation to the psychological attitude adopted by the researcher who interprets the lived world of the subject. The meaning units that are constituted by this procedure exist in the context of the other interrelated meanings of the protocol (Stones, 1985).

Considering that the material presented for explication was of a complexed nature, and occasionally embedded in the language of psychoanalysis, the researcher followed Thorpe's (1989) recommendation to work directly from the unaltered articulation of the subject's experience and not to alter the meaning units to a form in which they were expressed in the third person.

The meaning units resulting from this step appear in the left hand columns of the five examples of qualitative analyses, which appear in the Results chapter (chapter four).

Stage 3: **Re-articulation of meaning units from a psychological perspective**

The researcher then reflected on the meaning units and transformed the intention of each unit from the concrete language of the subject into language which elucidated the psychological aspects originally unarticulated. According to Giorgi (1985) the transformations take place basically through a process of reflection and imaginative variation.

Imaginative variation (Stones, 1988) is the process whereby the researcher reflects on the imagined possibilities inherent in each central theme and discards those that do not withstand criticism. This process of enquiry entails that the researcher engage with the text with the intention of discovering what constituents are truly essential, psychologically speaking, to the structure of the whole phenomenon. During this stage of analysis, the researcher eliminates redundancies in order to clarify how the constituted meaning units relate to each other and to the sense of the whole. Brooke (1983) points out that the transformation process "is a crucial hermeneutic step as the new formulation which reduces the subject's particular experience to a general statement of the structure of that experience should remain with the actual phenomena" (p.86).

The transformed meaning units arising from this step appear in the right hand columns of the five examples of qualitative analyses, which appear in the results chapter.

Stage 4: **Situated structure**

In this phase, the researcher synthesized and integrated the psychological themes of the transformed meaning units in order to arrive at a description of the situated structure of differentiating patient's transference-based and reality-oriented responses for each particular subject. The researcher needed to connect and make coherent the intertwining

meanings of the transformed meaning units in such a way as to reveal the unity of the experience as well as the specific, contextual factors which form such an experience.

Todres (1990) highlights that the researcher's task during this phase is to attempt to capture and express descriptively the essential structure of each subject's respective experience by reflecting not only on the explicit dimensions of what has been described but on implicit dimensions as well.

Remaining faithful to the psychoanalytic tradition of contextualizing clinical material as individual case studies, it was possible to view each subject's description of a recent experience with a particular patient as fabric for a specific case study. This supports Thorpe's (1989) designation of the case studies as individual *clinical situated structures.*

The situated structures in the present study could thus be seen as five case studies in "the differentiation of patient's transference-based and reality-oriented responses" and are therefore correctly referred to by Thorpe (1989) as clinical situated structures.

The validity of the five clinical situated structures was judged intersubjectively by another reader who was familiar with the empirical phenomenological method, who evaluated the descriptions as being insightful and specific to the phenomenon under investigation. Giorgi (1975) states:

> The key criterion for qualitative research is whether a reader, adopting the same viewpoint as articulated by the researcher, can also see what the researcher saw, whether or not he agrees with it (Giorgi, 1975, p.96).

The situated structure for each subject is presented in the results chapter.

Stage 5: **Obtaining the general structure**

During this stage of the analysis, the researcher aimed to discover that which was essential to the experience of "differentiating the patient's transference-based and reality-

oriented responses", those themes that were typical of the phenomenon. In order to determine this, the researcher needed to read the five individual "clinical situated structures" with the intention of identifying those constituent themes that were common to each subject's experience of the phenomenon. Through engaging in a deeply reflective process which involved identifying those features that were essentially invariant across individual cases, the researcher was able to move from the individuality of each specific situated structure to the level of generality, capturing the general themes and structure of the phenomenon investigated. Once the essential invariant features from the five respective clinical situated structures had been identified, they were retained for the phenomenological reductive process of imaginative variation. Basically this meant asking the following question: "If this particular aspect was changed or deleted would this alter the meaning of the experience?" If it did alter the meaning of the experience, it was noted for inclusion and a further re-examination was carried out to highlight its meaning and significance in the structure of the phenomenon. If not, it was considered for exclusion and not retained as an essential aspect of the structure. When essential variations or possibilities were found they were included in the general structure.

Enquiring as to the significance of each constituent theme and reviewing the interrelationship between these commonly identified themes made possible the construction of the general structure. Giorgi (1978) expressed this as follows:

> It is the intent of the method, however, to arrive at the general by going through the concrete and not by abstraction or formalization (Cited in Stones, 1985, p.71).

CHAPTER FOUR

4. RESULTS

In this chapter the five protocols considered most revelatory of the phenomenon under investigation are presented in turn with the aim of demonstrating the qualitative analysis of each. The selected protocols are numbered one to five. The qualitative analysis of each protocol, illustrated in tabular form, is followed by the presentation of each protocol's respective clinical situated structure. Thereafter, the Extended Description of the general structure of the phenomenon under investigation is given. This is followed by the enumeration of the primary nodal themes illuminated in the extended description. Finally, a summary of the extended description of the therapist's experience of identifying, differentiating and processing the patient's transference-based and reality-oriented reactions is given. This linear format of the formal procedures adopted to explicate the five selected protocols provides the reader with an ordered and comprehensive view of the process followed in reaching the essential description of the analytic phenomenon researched.

The original interview in each case may be read by taking the meaning units of each respective protocol. Each protocol has been minimally edited in order to assist the reader in obtaining a lucid understanding of the original interview. Redundant statements have been removed and the unessential exclamations of the interviewee edited out.

Presenting all thirteen protocols would unnecessarily have expanded this thesis. If required, the eight protocols not included in the results chapter can be obtained from the researcher for academic reasons.

4.1 Protocol one

4.1.1 Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of the process of identifying, differentiating and processing patient's transference-based and reality-oriented responses.	*Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of identifying, differentiating and processing patient's transference-based and reality-oriented responses.*
(1) T: So this young girl of twenty, a student, was referred to me by a therapist whom I don't know. The therapist is leaving town.	(1) P was a twenty year old female student who was referred to T by an unknown colleague who was leaving town.
(2) She comes in and I'm very aware of how people are when they come in. She seems very, very cautious and she sits on the edge of the couch. I immediately wonder about this; why she's on the edge of the couch. Quite rigid etc.	(2) T being sensitive to how people present themselves when entering therapy wondered why P sat rigidly on the edge of the couch.
(3) I begin to ask her why she's here and I am immediately feeling uncomfortable. I'm feeling quite pressurized from the beginning and I perceive part of this is because she's sitting on the edge of the seat. My experience is that she, if she could, she would like to sit on my lap.	(3) T felt uncomfortable and pressurized from the very beginning. T sensed P's unspoken need to sit on his lap.
(4) She starts to tell me about her problem and I can't relate to what she's saying. I perceive she looks like she's depressed. She looks quite close to tears at times but when I ask her what her problem is, she says basically, "I think I have a problem with approach to lifestyles" and I'm stunned by that response. Because I perceive somebody who is feeling many things and she uses language which I don't relate to. I don't know what she means.	(4) T could not grasp P's ambiguous description of her problem. T was confused by the incongruity between P's verbal and affective responses.
(5) I start to become irritable with her. I feel irritated inside and I immediately think of my patients who are not students. They haven't got university degrees. They don't come from professional families and at least they can jolly well say, "I'm unhappy" or "I'm depressed" or "I'm sad" or "I can't stop crying" which is far more honest.	(5) T's subsequent irritation emerged cognitively as a comparison between P and non-academic patients who are capable of disclosing honestly what they are feeling.

(6) After a while, she's still now sitting at the edge of her seat. And she's hardly explained her problem, what brought her here and she says, "What do you think, what do you think?" I remember my feeling that I'm under some kind of pressure with her from the beginning. I don't answer her question. I say, "I'm listening to you, trying to get a good idea of what is troubling you, so I'm listening to you." And she said, "Yes, but I'm also here to see what you're like, to check you out." Which I sort of accept.	(6) P, still anxiously perched, did not expand adequately on her problem and T's sense of being pressurized was reinforced by her appeals for interpretation. T's response that he needed to listen carefully to understand the problem, was countered by P's comment that she was there to assess his style/compatibility before she revealed too much, a motivation T partially accepted.
(7) And as the interview progresses I'm still finding it immensely difficult. I'm aware just of feeling, "I'm not relating, we're not connecting." I'm irritable, I'm under some pressure, I feel there's all sorts of demands, intense demands being made.	(7) As the interview progressed, T found resentfully that the distance between himself and P remained owing to the pressure exerted on him by P's intense but unspoken demands.
(8) And then I begin to feel ... I begin to look at my own response. I say, "What's going on?" I can understand her problem in a theoretical way and I can understand why she's sitting at the edge of her seat and why I'm experiencing that she wants to sit on my lap. Because she tells me that her real problem is that she's bulimic, and she's been bulimic for years and she hasn't told anybody. It's a secret etc. and she had problems with her mother and her parents etc. and so I began to identify that part of this girl's problem; and why she's sitting and why she's demanding so much from me is because she can't tolerate the space. There's no ... there's very little separation in her self, so I know these things. And then I also begin to reflect on myself. I know my style, I'm not very active. I only talk really when I've got something really to say. Really that is my style.	(8) T proceeded to analyze his own responses objectively within the context of P's admission of her bulimia and interpersonal and familial difficulties; and his theoretical understanding of P's interaction in therapy, this being a manifestation of her inability to tolerate both interpersonal and intrapersonal space. T assessed his non-directive style as being partially responsible for the problem.
(9) So I try to ... I perceive now that maybe I should help this girl. She's been quite under, but I must try and perhaps meet her halfway. So I try and respond, and I try and nod more or will comment more, whatever. And what happens is she sits back in her chair but that doesn't help the quality of the communicating. I still perceive that we're going apart, we're actually going apart. In my mind I'm thinking, "Should I refer this girl? Clearly something's happening here where she's uncomfortable "	(9) T perceived P's need to be accommodated therapeutically and attempted to engage her more actively. Nevertheless, T felt increasingly detached from P and considered referring her.

(10) She begins to become tearful and I say to her, "You're very upset about something" and she nods and she says something and I mishear it and I say, "Are you upset about being here? It's not nice to be here?" Because this is what I think is what she's experiencing and she says, no, it's because she hates herself because she's bulimic. She hates being bulimic. So, although she says that, it doesn't help me much. I still don't feel I'm containing or in touch with this girl. I tried to alter my stance, to be more accommodating for her but it hasn't actually helped the situation as far as I'm concerned.	(10) T's failed attempts to understand and contain P's present experiences reinforced his feelings of helplessness in trying to reach P.
(11) And I'm wondering now, "How should I bring the interview to an end?" because now time is running out. I ask her what did she have in mind in terms of intervention or psychotherapy because, remember, she's had some psychotherapy already but it has been more of a counselling type. She says she'd like to see me. No, she says, she doesn't really know. And then I tell her what my recommendations are for her. I say to her, now this is in the whole context of feeling that she's hating me, she hates being here, she doesn't want to be here. If she could run out of the door, she would run out of the door. Something is terribly disturbing for her here and that disturbed me.	(11) Before ending the interview T decided to ask P about her therapeutic intentions. P's indecision led to T making recommendations with his own feelings as the context that she is clearly uneasy in therapy and he is disturbed by her experience of their session together.
(12) At the same time I'm aware now, hearing a little about her symptoms and seeing her physical behaviour here and her non-verbal responses. And I say to her, "Look, let me just tell you how I generally work." I reinforce her idea. "It seems that you are very unhappy." Although she hasn't used that word, I use it. I said, "It seems you're very unhappy. I very much support your desire or drive to get help. I think it would be very good for you to see somebody quite frequently and for a long time." And I tell her why and then I ask her what she feels, what her response is to what I've said. And she says, no, she doesn't want to see anybody twice a week and she doesn't want to see anybody for longer than five months. She thought she'd like to see somebody for a short period and once a week.	(12) Being aware of P's symptomatology and behaviour in therapy, T conveyed to P his therapeutic approach, reflected her unhappiness, reinforced her desire to be helped and recommended intensive long-term psychotherapy. P's response indicated that she sought weekly, brief therapy.

(13) Now I'm thinking, "Maybe she's using this as a way out of the situation here or it might be quite genuine." I said to her what I feel my assessment of the situation is and what I recommended. So I've been consistent all along. I suggest to her when she says that she can't see me or she doesn't want to see me, that perhaps she could try somebody X, Y or Z, to refer her on. And I said I will think of somebody who might be willing to see her once a week and who might work that way. Because at the same time perceiving obviously something is not jelling between her and I. Clearly, that is the experience. And I think of somebody whose lap she could sit on, metaphorically, and who might like her being there. Because in my mind I have this image that any space is difficult for her. She wants somebody who can respond all the time. I can't do that. So, in my mind, I'm thinking of somebody I know whom she might fit in with.	(13) T questioned whether P's therapeutic intentions were genuine or expressed a need to avoid the present situation or whether it was a genuine response to his assessment. T felt confident in his decision because he believed that his therapeutic approach had been consistent throughout. Acknowledging that the needs of P and his style of working were incompatible, T suggested that he would refer her to someone who might be more engaging and accommodating of her needs.
Researcher: Who is more directive? (14) Who's more directive. I suggest to her that perhaps she phones me on Monday evening and then I will be able to tell her to try X, Y or Z; these are the names she could try. And she leaves.	(14) T suggested to P to phone him in order to be referred to a more directive therapist.
(15) I sit down and I think what was going on here and I go over the session in my mind. And it seems to me that there are two things happening. The one is that she's coming in with a need for somebody to fill the space - she can't be alone and that's her need. And that's the neediness that I was experiencing all along.	(15) Having reviewed the session, two things became apparent to T. First, P's incapacity to be alone. T had been in touch with P's need for someone to fill that space. This need of P had created the tension between them.
(16) Because remember also, it's clear that she can't give up her symptom. She says this clearly and I remember asking her at one stage, "Tell me a little bit more about yourself?" After she described this bulimic activity, I said, "Please tell me a little bit more about yourself. What kind of a person are you. What do you like to do?" She looked at me as if she didn't know how to respond. She had almost become the symptom. This is why I think she's really in a very fragile position still, because she is now this symptom, she's nothing else.	(16) T noted that P's fragile position precluded her giving up her symptoms. P had become the symptom and could not identify with any other aspect of her life.

(17) And that's where I thought, "I don't know about more directive psychotherapy with her," because, until she develops internal feelings in relation to somebody else, she can't give up the symptoms - because there's nothing to replace. If she stopped being those symptoms she'd be empty or nothing. So that's why I thought, "Well, there's no way short term therapy could be of any help to this young girl," because I perceive that beneath the bulimia is a lot of identity and separation issues. So I perceive that's her need.	(17) (For this reason) T doubted the efficacy of short-term, directive therapy as P needed symptoms to replace her emptiness. Because of identity and separation issues underlying the bulimia she would have to develop inner feelings in relation to someone else to relinquish them.
(18) At the same time I perceive that my style is totally incompatible with where she's at. I tried to be more active, but I felt insincere and I couldn't be that, and that's why I was prepared basically to refer her on. And I think, "In a way there is a reality principle operating. She perceives my style correctly which is not passive, but it's not directive and she's correct." So there's like a two-way thing happening. She and I perceive the reality which is that we're very different.	(18) While T perceived his style to be incompatible with P's needs, P correctly perceived T's style to be less engaging. The reality principle operating was a mutual recognition of their differences.
Researcher: That she cannot tolerate you frustrating her by not being directive? (19) She didn't make it so clear but she said she wants to be able to discuss. "I want to be able to discuss with the other person." That's what she's wanting - and I'm afraid my images were a lot of intellectualizing and talking about the symptoms but getting nowhere. Because, you see, this is what she's had. And I asked her, "What has helped? Have you moved?" I'm not so blatant. She says, "No, but I understand it more." Then that's been a waste of time as far as I'm concerned.	(19) P verbalized her need to be able to discuss issues with T. T perceived that intellectualizing was the style P was accustomed to and that her intellectual understanding was meaningless as P admitted to no change.
Researcher: What was transferential for you? (20) The transferential was her frustration, her irritation, her rage, her neediness. That I thought was transferential. What I was feeling basically and what I was responding to was the neediness, her irritation - that I perceived as transference. And her asking me to respond, to discuss. "I feel you're not giving me anything, I feel you're not telling me anything."	(20) T perceived transference as being the P's feelings of neediness and frustration that he was called upon by P to respond to.

(21) And what I was feeling was countertransference. I don't know what the difference between projective identification and transference and countertransference really is.	(21) T described what he was feeling as countertransference. T stated his uncertainty as to the difference between projective identification, transference and countertransference.
Researcher: How would you describe a transferential response from a client? (22) Transference for me is when a patient has experienced something which doesn't seem real to the situation, to what I'm feeling - that there's a dissonance in what she's feeling and where I'm at. And where I become aware of feelings that I didn't have and I don't normally have in other sessions.	(22) For T transference occurred when there was a dissonance between P's and T's experience of the reality of the present situation. T also became aware of feelings that were absent in other sessions.
Researcher: Feelings within yourself? (23) In myself and in response to something. So the transference can be conveyed through body or through behaviour or through words or whatever.	(23) T located these induced feelings within himself and perceived that they (transference) can be evoked verbally or bodily by P.
Researcher: And how do you become aware of it generally? (24) In what I feel, I observe, I see, or I hear or I sense, but mainly I feel. I begin to feel things that I didn't expect or things that I don't usually feel. Ja. I begin to respond to something which isn't appropriate to the content of what is spoken. If you cut out everything and took the words, my responses have nothing to do with the words. It's got to do with all sorts of other things.	(24) T described that he became aware of the transference communication by being perceptive but mainly through feeling things that were unexpected or unusual and inappropriate to the content of what was spoken.
Researcher: With this client, what were you feeling that made you aware that this was inappropriate? (25) I began to feel tense. I must also sit on my seat now and give and give and perform. It was a performance anxiety which I feel to some extent with every patient who comes in 'cause I want to try and encapsulate something for them. It's not a performance anxiety but there's a raised anxiety. But this was with her a performance anxiety - that I wasn't squeezing enough out, that I wasn't giving enough. I was confused, I remained confused throughout the session. I was frustrated. I felt lonely. I felt, "I want to reach this girl and help her," but I couldn't. I wasn't getting there, so I was feeling helpless, I was feeling frozen out.	(25) T recounted feeling tense and anxious about satisfying P and contrasted this pressure to perform with other patients who were less demanding. T recollected feeling confused, helpless and alienated throughout the session.

Researcher: When did the confusion clear up and how? (26) The confusion cleared up when I began to reflect on why I was feeling like this; and when I could understand her symptoms and the origin of her symptoms. So once I could kind of understand why she was so needy or why the space was so difficult for her, then I could relax.	(26) T's confusion cleared up once he had reflected on and understood his own feeling state and grasped P's existential predicament.
Researcher: The confusion cleared up once you had more control cognitively, once the link had been made between the cognitive and let's say the bodily within yourself? (27) Ja, because I was just feeling all sorts of things and, obviously, the more I was feeling things, the more I wasn't necessarily listening to new information. I was beginning to, not panic, but I was beginning to feel, "I've got to somehow make things understandable for her or contain things for her." Because my experience was that she was having great difficulty and hence my question when she became tearful, "Are you feeling maybe its because of the situation?" So once I understood why I was responding ... It was definitely a kind of a triangle - she, me and the something. And then once that was complete, then I could relax.	(27) While T felt compelled to contain and make comprehensible P's world, he was not receptive to new information. Once T understood what his responses were born of he could then relax. T felt "liberated" when the triangle of understanding was complete.
Researcher: You say a triangle. Maybe your experiencing-ego, her and your observing-ego? (28) Absolutely, ja. When the experiencing-ego and observing-ego are ... when they are consistent then I could relate to her. Then I could deal effectively with her. Because I was lost. I was feeling all these things and I was lost. I thought, "What's going on here?" Really, it was a very difficult session. I didn't know what was going on. And once I wasn't lost any more and it wasn't as if it was "intellectics", I really felt then at one.	(28) T could relate to P fully and effectively when there was "harmony" between his experiencing and observing egos. Until then T had felt lost, confused and unintegrated.
(29) I felt I understood her difficulty and this is the terribly important thing. This is why I'm using her as an example. I also knew my style and I could reflect on myself and say, "Yes, of course that's why it's so difficult for her." My style is so far away from where she is. Then it was easier to deal with the situation insofar as I wasn't lost any more.	(29) T emphasized the importance of understanding P's difficulty and of recognizing how his style of working accorded with P's mode of being which had enabled T to locate himself in the situation.

4.1.2 PROTOCOL ONE: CLINICAL SITUATED STRUCTURE

The patient's previous therapist referred her as he was leaving town. The patient was a female student from a professional family.

The therapist wondered why this patient appeared so cautious when entering therapy and sat rigidly on the edge of the couch. He felt uncomfortable and pressurized from the very beginning and attributed his uneasiness to her apprehension, which he conceptualized imaginatively as a need to sit on his lap.

When the patient began to disclose her problem, the therapist could not grasp her ambiguous, intellectual description. He was confused by the incongruity between her verbal and affective responses.

The therapist's subsequent irritation emerged when he compared the patient to his less fortunate, non-academic patients whom he perceived in a positive light, as they were capable of revealing their feelings honestly. The therapist's experience of discontent persisted while the patient remained in a nervous posture and did not expand adequately on her problem. His sense of being pressurized was reinforced by her appeals for interpretation concerning her problem. The patient's comment that she needed to assess his therapeutic style and human presence before revealing her narrative, although partially accepted by the therapist, amplified his discomfort.

The therapist continued to feel irritated with and resentful towards the patient as the interview progressed and recognized that the distance between them remained. He ascribed this to the pressure exerted on him by the patient's intense but unspoken demands.

The therapist attempted to be conceptually insightful with regard to the analytical process, and examined his own feelings and analyzed his own responses with detachment, the context being his theoretical understandings of the patient's bulimia and her interaction in therapy. The therapist discerned that part of the patient's problem was her

inability to tolerate both interpersonal and personal psychological space and that his non-directive style was partially responsible for the developing therapeutic ordeal. He believed that her expectations for more active guidance in therapy were frustrated by his therapeutic style.

The therapist's attention to the analytic process enabled him to perceive the patient's need to be accommodated therapeutically. He attempted to engage the patient more actively but still felt increasingly detached from her. His failed attempts to understand and contain her present experiences reinforced his feelings of helplessness in trying to reach her. He felt insincere altering his stance and refused to continue to sacrifice his authenticity and consequently considered referring her.

The therapist decided to ask the patient about her therapeutic intentions before ending the interview. The patient's indecision led to his reflecting her unhappiness, reinforcing her desire to be helped and making recommendations for intensive, long-term psychotherapy. These recommendations were based on his awareness of her symptomatology, his perceptions that she was clearly uneasy in therapy and his disturbed feelings about her experience of the session. Her response to his professional advice indicated that she rejected his suggestion and that she sought weekly, brief therapy instead.

The therapist reacted by covertly questioning whether her therapeutic motives were genuine or expressed a desire to avoid the present situation. He felt confident that his decision to refer her on was grounded in a consistent therapeutic approach, and accepted that her needs and his style of working were incompatible. For this reason, he assented to referring her to a more directive therapist, who would be more engaging and accommodating of her needs.

When the therapist reviewed the session, two things were thematized for him, namely; the patient's incapacity to be alone and the incompatibility between his therapeutic style and the patient's needs.

The therapist had been in touch with the patient's need for someone to fill the space, occupied by her symptoms. He noted that her fragile position precluded her giving up the symptoms which governed her life.

The therapist retrospectively realized that her need for him to replace her emptiness had created the tension between them. The patient would need to develop inner feelings in relation to the therapist before she could relinquish the symptoms and develop the capacity of being alone in his presence. Only when she could trust that he had created a holding environment, with potential space for working through and understanding the identity and separation issues underlying her bulimia would she be able to live autonomously.

The therapist, though cautious and diffident about his ability to distinguish conceptually between the psychoanalytic concepts transference, countertransference and projective identification, explained that he perceived transference as being her feelings of neediness and frustration that he was called upon to respond to. He had responded to her infantile demands to be nurtured and contained by a good-enough therapist who would not deprive, nor frustrate her basic needs. He located these induced feelings within himself and perceived that they could be evoked verbally or bodily by the patient.

The transference communication was illuminated for him when there was a dissonance between their experience of the reality of the present situation. He felt that his attempts to reach her therapeutically and engage her in a verbally-holding manner were rejected by her as being depriving and threatening. Her ambivalent attitude in the analytic situation was rooted in her infantile development and presently sabotaged his attempts to be a gratifying object. He had also become aware of her transference-based responses by being perceptive and mainly through feeling things that were either absent in sessions with other patients or unexpected, unusual and inappropriate to the content of what was spoken. For example, he recounted feeling tense and anxious about satisfying her and contrasted this pressure to perform with other patients whom he perceived as less demanding and with a greater propensity to experience the analytic environment as being good-enough.

Although he perceived that her need to be able to discuss issues with him characterized the intellectualizing style she was accustomed to, which he believed was meaningless as she admitted to no change, he nevertheless acknowledged that she had correctly perceived his style to be less engaging. For this reason, it was apparent to him that the mutual recognition of their differences was reality-based, and that the doubts that he had concerning the efficacy of short-term, directive therapy needed to be viewed within the context that his style was incompatible with her needs.

The therapist thought that although the patient correctly perceived the current therapeutic environment as being frustrating and unsatisfying, her inherent struggle to occupy the transitional space of therapy was rooted in unresolved infantile experiences concerning her cautiousness to use the object and perceive it to be good-enough and growth promoting. In short, her reality-oriented perceptions and her transference-based attitude were inextricable.

The therapist's countertransferential feelings of confusion, helplessness and alienation, which he had experienced throughout the session, cleared up once he had reflected on and understood his own feeling state and what his responses were born of and had grasped the patient's existential predicament. He could then relax and be receptive to new information from the patient, unlike when he felt compelled to contain and make comprehensible her world. The therapist felt "liberated" to relate fully and effectively to the patient when there was harmony between his experiencing and observing egos, and his understanding of the interaction was deepened. He emphasized that to be able to locate himself in the analytic situation he had needed to understand how his style of working accorded with the patient's mode of being.

4.2 Protocol two

4.2.1 Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of the process of identifying, differentiating and processing patient's transference-based and reality-oriented responses.	*Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of identifying, differentiating and processing patient's transference-based and reality-oriented responses.*
(1) The patient's a young woman, that I've seen for a very long time who is a real borderline personality. She was traumatized as a child; she comes from a borderline mother who's extremely abusive and she herself came into therapy because she suddenly realized that her rage was out of all proportion to everything that's going on in her life. She was finding herself abusive to her kids, not physically but emotionally abusive and that she couldn't relate to other people.	(1) T's long-term patient, a young woman traumatized as a child by her abusive (borderline) mother and herself a borderline personality, entered therapy because she was emotionally abusive to her children, could not relate to other people and realized that her rage was inappropriate.
(2) I have seen her for about five years during which time the first four years she made good progress and in the last two years she's really remained static and even in some instances gone downhill.	(2) The last two years of P's five year therapy had been static and at times even regressive.
(3) And she has M.E. And of course you know the big question is, is it depression or is it a physically disabling disease and I waver. On the one hand I really do think she has physical characteristics, and on the other hand I think that she is extremely depressed.	(3) T was indecisive as to whether P's M.E. was a physically disabling disease or depression as she displayed characteristics of both.
(4) She's on anti-depressant medication which doesn't do much but I think it's the abandonment depression that she's in, if one looks at it in those terms. She projected an enormous amount onto me. She wants instant gratification, she wants constant gratification, she wants me to be available to her when she wants me to be available, and we've weathered these kind of storms over the years.	(4) T thought that P's anti-depressant medication was of little benefit as P was (re-) experiencing the abandonment depression. The therapeutic relationship had survived despite P's demanding unconditional availability and gratification from T, the screen for her projections.

(5) What led up to this incident is that I have found her increasingly unresponsive to therapy and I was really getting quite sick of the whole thing.	(5) The background to the present incident was P's increasing unresponsiveness to therapy, which upset T.
Researcher: In what way unresponsive? (6) That she's not using the therapy which she used to do; she used to use the therapy really well. She comes in and she just relates the menu of the week, I can't get into anything with her. She's also being doing an enormous amount of reading, reading on M.E., reading on children of alcoholic parents, anything to do with shame and guilt, abuse, and she will go to the ends of the earth to find anything.	(6) Unlike the previous productive years in therapy, P did not utilize her therapy but related the incidents of the week and read compulsively about her illness and its origins.
(7) And she comes here with a pile of books and she sits down. She puts the books next to her and she'll make a whole lot of excuses that she's got to hang onto these books because she doesn't want them to get stolen out of the car and I've interpreted that it's her link to reality and so on and so forth.	(7) T interpreted P's need to bring books to therapy as her link to reality.
(8) Anyway what happened is that she saw on my desk a book that somebody lent me on co-dependents and she asked me if she could borrow it, and I said it wasn't mine and that I had to return it. She phoned me two days later and in a very demanding voice said would I please phone her back, she wanted the name, the publisher, the author, ... she wants to order the book; will I please leave a message on her machine.	(8) P asked if she could borrow a book on T's desk. T explained that the book was not hers. P then phoned from home and urgently requested that T return her call with the full particulars of the book.
(9) It happened to be a week when I was terribly busy and I didn't phone her back. I also thought a lot about it and I thought I'm not going to phone her back because this is evidence of her inability to wait. No great necessity for me to phone her back with a book name. So I left it.	(9) T did not comply as she was busy. P's request was merely indicative of her inability to wait.

(10) Two days later I got another very angry phone call that I hadn't phoned her back and she was waiting. So I thought about it a bit, by that stage it was Thursday. I phoned her back on the Friday and I just said that I realized she was very anxious to get the name of the book and that I thought we needed to talk about it and why she was so anxious to have the name of the book and I would give it to her but we would talk about it on Monday.	(10) T responded to P's subsequent angry response by acknowledging P's anxiety to obtain the book and proposing that they talk about it at the next session.
(11) So she came in on Monday and I could already feel that I was pissed off with her is not a word to describe it, I was so annoyed with her. I just felt that I was being sucked dry by her, that no matter what we did in therapy it was never enough. That she was like a bottomless pit, an insatiable person and I couldn't get to what was irritating me about this whole book business.	(11) At the session T felt very annoyed with P whom she experienced as an insatiable person who ungratefully exploited her emotionally. T was lost to explain her irritation over the book incident.
(12) Anyway she walked in and we sat down and she didn't say anything and I didn't say anything and then after a while I said, "look, I think we really need to talk about the phone calls," and that I had felt very angry, that I had felt intruded upon, that I wondered why she couldn't wait, that she knows that if there's ever been a crisis in her life I will always phone her back, but I did not consider the title of a book to be a crisis unless it was hiding something else and we need to talk about that, but I felt that it was really quite intrusive of her to demand the title of a book and not be able to wait for her session.	(12) A while after the session commenced T confronted P concerning her demands which did not necessitate an immediate response from T who had felt intruded upon and very angry. T reminded P that in a real crisis she could always rely on T to contact her, but that her demanding behaviour demonstrated an inability to wait and an underlying problem.
(13) She didn't say anything, she made millions of excuses and I kept on at her and I could feel that I was absolutely fuming with her. Anyway she left and we didn't really resolve anything and I felt that I'd handled the interview very badly.	(13) P made many excuses as T pressed on at her feeling intensely angry. When P left T felt she had conducted the interview untherapeutically and that little had been resolved.
(14) The following day there was a message on my machine to say that she was phoning the Medical and Dental Council to get another therapist, that she feels that she can't work with me any longer and that she is so angry with me that she could actually kill me and that she'd see me for her session on Monday.	(14) The following day P telephonically announced her intention of contacting the S.A.M.D.C. to get another therapist. P felt hostility towards T whom she could no longer work with. P would nevertheless see T at the next session.

(15) So I didn't phone her back. She came in on the following Monday and she really let me have it. How dare I talk to her like that and why was I so angry and she felt that my anger was skew and that what did she do that was so terrible and so on and so forth.	(15) T did not return P's call. At the following session P showed her discontent by confronting T concerning her aggressive manner which P believed was unfounded and skewed.
(16) And I actually realized then that she was right, that it wasn't a transference. In that instance I wasn't her withdrawing, withholding abusive mother I was just me because I had been really angry with her and I hadn't really dealt with it.	(16) T realized then that P's perception of T was correct and that T did not represent P's withholding abusive mother but was herself, a really angry person who had not appropriated her own feelings of hostility.
(17) And we dealt with it a lot,with just the reality, yes I was very angry with her. I did feel intruded upon. I felt she was asking me for more than I was able to give her right at this moment and that I was probably angry, also that the therapy seemed to be so bogged down and flat and that she wasn't really using the therapy and she felt that I hadn't been working with her and that she felt very angry with me; and part of all her reading was to try and find some answers to some of the questions that were plaguing her and that I hadn't really picked that up.	(17) They dealt extensively with the reality of the situation particularly T's anger at P's intrusiveness and her failure to use her therapy. P revealed her own anger at T's failure to meet her needs in therapy, for which she compensated by consulting books.
Researcher: So both of you were dissatisfied with each other. (18) Ja, and I felt it was a reality. I really did. Now what confirmed it for me was I have been working with another patient whom I see on a Tuesday morning, whom I really have been working very nicely with and she's worked well and I really like her, and seen her for about eighteen months. And she came in on the Tuesday after the session where I attacked my patient, and then she came in the following Tuesday where we had been talking about how angry we were with each other about the therapy, and she said to me "was there anything wrong with you last week?" And I said what did she mean? She felt that I was very irritated and very distant and was I angry with her?	(18) The reality of the situation was confirmed for T when another P enquired whether T had been angry with her the previous week when T had seemed irritable and distant.

(19) Obviously there was something going on with me at that point because two patients picked it up and I think I was harassed; I think I was busy and maybe I was just in one of those weeks when I just didn't feel like working. So obviously two patients picked it up. I can't say this is transference. It is reality-based.	(19) The response of two patients confirmed for T that she herself had been overworked, harassed and unmotivated as a therapist.
Researcher: That reinforced it for you? (20) That reinforced it for me, that it wasn't just my borderline patient who was fuming with me that I hadn't gratified her in some way. But there was a part of her that was real, it was quite true - that I had been terribly angry with her and had attacked her.	(20) T recognized the reality of P's experience and accepted her own part responsibility in the process.
(21) And funnily enough they both come at the same time. They both come at half past eight in the morning so I mean it wasn't that I was tired or anything. Although with my second patient I really dealt with it I think much more therapeutically and more analytically and that when I'm not available to her what does she think about herself, and it was reality-based but there was some transference in it as well.	(21) Both patients came at the same early hour when T could not have been tired. T dealt more analytically and therapeutically with her second patient, considering her experience to be both reality-based and transferential.
(22) But with the first patient, the patient I'm really telling you about, although I have had tremendous projections from her and a lot of projective identification in the therapy, in this instance I think I was just so pissed off with her I just let her have it.	(22) Although T had served often as the recipient of P's projections and projective identifications, in this situation T acknowledged her angry outburst.
Researcher: Of her nagging you? (23) Nagging and bitching and whining for six years and where the hell is she going and can't she move. And I was terribly angry about all the reading and the books.	(23) T had been angered by P's infantile attitude/conduct and unresponsiveness in the therapy.

Researcher: What was that making you experience in relation to her and in relation to yourself? The books and the telephone calls. (24) It was making me feel that I was an object to be used in her life as long as I could gratify her. That she was actually doing to me which she probably does to everybody else, so there is an element of transference in it in that instance I suppose, in that she gobbles up her object without really clearly seeing that there's definition between herself and her object, there's no separateness, there's no real boundary. She doesn't see me for who I am or whoever she's relating to or who she is, but as long as there is a merging she can cope with that. But when she has to really see the other person as separate from herself, she can't even deal with that, she can't even conceive of that and she then gobbles them up.	(24) P's discontent had made T feel that she was an object to be used to gratify P, just as P devoured other persons who also served as gratifiers and were misperceived as being inseparable from P. P's infantile mode of being and inability to perceive the individuality of others suggested the presence of an element of transference as well.
Researcher: How were you experiencing that and what was the first indicator for you that this was real, that this was not distorted? (25) I knew that I had been angry with her and she picked it up. She said you were furious with me and it was dead true, I was angry with her. I wasn't angry with her because she represented anything else to me and I don't think she was angry with me because at that moment I was representing anything else to her. I was just her therapist who was dumping on her and I was dumping on her.	(25) P had intuited how truly angry T had been with her. When T realized that she and P were angry with each other rather than with whom each represented to the other, she could appropriate her own anger.
(26) I just felt so taken over by her and intruded upon and I felt it was trivial, that's really what I felt. I mean to have to phone a patient back with a name of a book, it's not life and death. I just felt so - I give her my time, she pays me for my time and she keeps wanting more and extra. Overwhelmed and sucked dry. Sucked dry and not appreciated really. I suppose there is the element of having worked my guts out for her and not being appreciated. There is that too. I have to admit it.	(26) T had felt resentful and hurt at being criticized for such a trivial matter. T felt overwhelmed, unappreciated and drained by P. Repetition of theme '11'

Researcher: And I suppose the feeling of not being appreciated also goes with not feeling satisfied yourself with the therapy? (27) Sure. Ja, absolutely. But I don't think there was a countertransference in it. I don't think I was responding to something in her in a countertransferential way. I think that if anything I was responding to her not as a therapist but just as another person who was "gatvol". Because if I had sat and really thought about it I could have taken it up in a much more therapeutic way but I didn't, I just said I'm actually furious with you.	(27) T had responded to P not as a therapist but as another person who was extremely angry. T responded angrily to the real person of P and the transaction was not counter-transferential.
Researcher: You dealt with it in a very reality orientated way? (28) Ja. I said to her what is this bloody business of reading every book you can lay your hands on. But it's in a kind of an acquisitive way. It's not like going to a library and reading. She'll nag and whine and bitch at people and absorb all this stuff and it doesn't do anything for her. It doesn't change anything for her.	(28) T confronted P concerning her acquisitive way of devouring the literature. P's manner of living did not satisfy, nor change anything for her.
Researcher: Try and recall another situation with this client that would distinguish this reality-oriented situation from a transferential situation? In what way was this different from other moments? (29) Once she arrives she looks unbelievably anxious. Now after six years you expect a patient not to look so anxious when they come into your room. But she is anxious all the time when she walks in. She's always anxious as though she's about to be attacked, about to be punished in some way.	(29) T would not have expected P after six years of therapy to look so anxious when entering each session as though she anticipated being persecuted in some way.
(30) And I've taken that up with her often, how it feels to come into this room and she says she always has to look at my face when she comes in to assess what mood I'm in.	(30) When T had broached the matter P had expressed her need to ascertain from T's face what mood T was in.

(31) Now I know for the most part that I'm pretty even. I'm not either madly up or madly down and most of my patients have commented on the consistency. The consistency in which I greet them, the consistency in which I'm here, the consistency in the way I look - so for her that was a transference.	(31) Feedback received from many of T's patients concerning her therapeutic presence and practice reinforced T's belief that P's anxiety was distorted (transferential).
(32) And I interpreted it for her that somehow as a child she could never be sure how her mother was going to be. She had a mad mother - she never knew if she would be sweet and accepting one minute or screaming the next. Her father had been beaten up by her mother, so her mother is extremely abusive. The kids have all been beaten up. And so when she comes in here, she's always a bit nervous and she has to check me to see what mood I'm in so that she knows how to be - whether to run away and hide or whether to be here fully. And I've interpreted that for her. That somehow she expects me to be her mother, that I'm erratic and that I'm not predictable. She still lives it out in relation to me every time.	(32) Despite T's interpretation that P expected T's mood to be as erratic as P's abusive mother whom she could never anticipate, P still needed to determine T's mood as a guide to behaviour.
Researcher: How do you experience the same situation every morning with her arriving and being so vulnerable? (33) I feel vulnerable. I think it probably contributed to some of my irritation, probably I erupted over many things not just the phone call and the book. Maybe I've just felt I'm not getting anywhere with her. I interpret the same thing over and over again and it doesn't really make an impact on her.	(33) T's vulnerability in relation to P's unresponsiveness in therapy served as another source of T's frustration and anger and led up to the present confrontation.

Researcher: I sense with the other situation that you described, that perhaps with her coming into each session feeling quite fragile and her expectations of you being quite distorted, that you experienced some stuckness. (34) It isn't only over those incidents, it's over the shift in her. She did really well, she began to confront her mother, she began to see that she doesn't have to respond to everybody in her external world as though they are going to be the punitive mother. She began to see her husband in a much more realistic light. She had transferred all her anger and rage on to her husband's mother who is a difficult woman. But she couldn't deal with it in her own mother and so she had deflected it away, put it into his mother and when she came to therapy she had a very bad relationship with his mother. And they'd worked on it a lot and she'd seen her distortions and she was beginning to see that she doesn't have to dump on her mother-in-law. And that she is a lonely old lady and she is difficult but she's not her own mother. She has been much more realistic towards her husband and her children and she really did well. I mean considering that she was so damaged when she came. She was functioning quite well.	(34) T felt blocked because P who was originally so damaged and had begun to function more realistically with family members was now regressing behaviourally.
(35) What makes me think that this illness is a real thing, is her slide into physical incapacity. I mean it happened in front of my eyes. I think what irritates me more than anything else is that she uses the illness as an excuse for anything in her life that she doesn't want to do. She relates to the world as an ME patient. She'll tell everybody that she has it and she will go on at length about how terrible it is and it's her sole view of the world at the moment. She views herself in the world through the eyes of this illness. And she'll come in here and she'll go on for ten minutes about how tired she is and how her bones ache and how she has to sleep all the time, and you know what it's like when you're chronically ill - she'll say that to me.	(35) Not-withstanding T's realization that P's illness was real and physically incapacitating, T was annoyed most by P's restricted approach to living as a M.E. patient using her illness to avoid engagement with the world.

(36) And I suppose I have a sense that she should get out of it. Now I know this is a response that people have to M.E. patients. I suppose I have some ambivalence on the one hand seeing that she is really physically distressed and on the other hand feeling enough is enough, but you've got to get on with your life. And so I suppose in some way I'm terribly irritated with that, and that she's slid backwards after all the work.	(36) Although T recognized that her negative attitude to P's illness was typical of how people relate to M.E. patients and despite P's physical distress she still felt ambivalent seeing P withdraw from life.
(37) Now whether she couldn't confront what was the next step, which was really the death of her relationship with her husband which is severely curtailed and debilitated by her disease and by her psyche, and she had to get sick in order to avoid it, I don't know.	(37) T wondered whether P could not confront the death of her marriage and used her illness to avoid doing so.
Researcher: You were saying that the situation with the telephone calls and how you experienced it - that was a nontransferential situation. Yet you said that some aspect of this was also transferential. Can you explain? (38) The fact that when I became angry in that instant I must have become the punitive mother to her. There were two levels I suppose. The one was a really angry therapist (which was reality) and the other was that a very angry therapist must inevitably be her very angry abusive mother, as well. So it must have been at two levels for her.	(38) T believed that P related to her on two levels, namely as the really angry therapist (reality level) and as the very angry abusive mother (transference level).
(39) I don't think she was inviting me to play a role. I think it was an inadvertent thing that just kind of blew up in our faces. I know I was damn angry with her over the phone call. I felt intruded upon. I felt she was taking up some of my time that did not belong to her and my extrapolation from her was that it's about nonsense. I just felt that she was gobbling me up.	(39) T did not think that P was inviting her to play a role but that it was an unintentional explosive situation. Repetition of Theme '11', '17' and '26'

(40) Talking to you now I wonder if in some way it was perhaps a projective identification. I don't know if that's what her mother felt with this demanding insatiable baby, and somewhere her mother's response to that was screaming rage and rejection. That only talking to you now that I think about it so it may be a sort of analysis after the fact. Because how does a baby get like that? A baby gets like that because the mother can't respond to it.	(40) Talking to the interviewer T reviewed the situation and wondered whether it was in some way a projective identification, something that P's mother may have experienced in relation to her demanding, insatiable baby.
Researcher: I'm also wondering about what was happening in the therapy at the time that allowed her to act out the way she did? **Therapist:** Do you think she was acting out phoning for the book or do you think she was acting out being very angry with me? Which are you referring to? **Researcher:** From the telephone calls. (41) Yes, you're right. I didn't see it like that. I think that probably the book was just an excuse in a way of saying you're not giving me enough and I need more from you. I think you're right and I didn't take it up. I took it up at a reality level that she wanted the name of a book. But in actual fact she was probably saying you're distant from me, you're not working with me, I'm feeling abandoned. Ja. I think that's true.	(41) T realized from the interview with P that she had interpreted P's need for the book too literally and that P's request instead expressed her desire for more engagement from a distant therapist.

4.2.2 PROTOCOL TWO: CLINICAL SITUATED STRUCTURE

The patient entered therapy because she was emotionally abusive to her children. She was a young woman who had been traumatized as a child by her abusive (borderline) mother. She also suffered from M.E. (Myalgic Encephalomyelitis) and displayed both physically disabling and depressive symptoms.

The process of the therapy in the last few years had been static and at times even regressive. The therapist believed that the patient did not utilize her therapy but related the incidents of the week and read compulsively about her illness. Despite the patient's

demands for unconditional availability and gratification from the therapist, who had also served as the screen for her projections, the therapeutic relationship had survived. The patient's increasing unresponsiveness to therapy, her regressive behaviour interpersonally coupled with her restricted approach to living in-the-world as a M.E. patient had upset the therapist who felt blocked, annoyed and vulnerable to exploitation. This frustration and anger formed the experiential milieu in which the present confrontation took place.

The incident occurred when the patient's request to borrow a book from the therapist was turned down. The patient's further demand that she be furnished with full particulars of the book was rejected by the therapist who was busy that week and perceived her behaviour to be infantile and impulsive.

The therapist felt very annoyed with the patient at the following session, and experienced her as an insatiable and ungrateful person who had exploited her emotionally and intruded upon her privacy. The therapist reacted by confronting the patient's inappropriate demands, and reminding her that in a real crisis, she knew she could always rely on the therapist. The patient's many excuses were remorselessly attacked by the furious therapist. During the session the therapist had been unable to articulate why she had been so irritated over such a trivial incident.

When the therapist reflected on the explosive session, she felt she had conducted the interview untherapeutically and that little had been resolved. This retrospective comprehension was strengthened at the next session when the therapist corroborated the patient's accusations that her (therapist's) aggressive manner in that situation had been unwarranted. The therapist came to realize that she and the patient were angry with each other, rather than with whom each represented to the other; and recognized that she had not appropriated her own feelings of hostility, nor had she been aware at the time that she had acted-out untherapeutically. The therapist also recognized that although she had often served as the recipient of the patient's projections and projective identifications, in this situation she needed to accept her own part responsibility in the process, and acknowledge the patient's perception of the experience.

Once the therapist had enlarged her own vision of the patient's experience of therapy and had accepted that the explosive situation could not be (totally) reduced to the patient's unconscious distorted perceptions of her being the withholding abusive mother, the gate was opened for the exploration of the actual situation. The reality of the situation had invited both participants to reappraise their anger. Whereas the therapist had felt resentful and hurt at being criticized for such a trivial matter, the patient's anger came to be understood by the therapist as expressing dissatisfaction with her for failing to meet her needs.

The reality of the situation was confirmed for the therapist when another patient, one she had approved of, enquired whether the therapist had been angry with her the previous week. The similar response of the two patients reinforced the therapist's belief that this was not solely a transference situation, and that she actually had been overworked, harassed and unmotivated as a therapist.

Although the therapist acknowledged that she had acted angrily, she did not at the time consider her outburst directed at the real person of the patient to be induced by the patient's unconscious script. Nevertheless, the therapist could not deny that she had been angered by the patient's infantile attitude and conduct in therapy, and had felt overwhelmed, unappreciated and drained by her in previous therapy sessions. This cumulative sense of being treated disrespectfully, without regard for her individuality made the therapist feel that she was an object to be used to gratify the patient. The therapist's cumulative experience of the patient's infantile way of behaving in relation to others and herself made her consider the possibility that there was an element of transference present as well.

This was born out when she compared the patient's persistent and pervading infantile characteristics in the past few sessions to her habitually anxious way of having entered sessions since starting therapy. The patient's need to ascertain from the therapist's face what mood the therapist was in as a guide to her behaviour in therapy had continued, despite the repetitive transference interpretations. For this reason, the therapist perceived the patient's cautious behaviour to be ingrained in childhood experiences which

were therefore a source of persistent infantile attitudes irrespective of the behaviour of the therapist.

The therapist's conclusion that the patient had related to her on two levels, namely as the really angry therapist (the reality level) and as the very angry, abusive mother (the transference level) was supported when she re-evaluated the past situation with the researcher and considered her own reaction to have been evoked by the patient. This retrospective review during the interview with the researcher crystallized for the therapist that her rage was induced by the patient through the phenomenon of projective identification, something that the patient's mother may have experienced in relation to her demanding, insatiable baby, a possibility that she had not considered at the time. Although the therapist accepted her own acting-out in the analytic interaction, she could not deny that the patient's infantile attitude towards and behaviour in therapy had its antecedents in the genetic past.

4.3 Protocol three

4.3.1 Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of the process of identifying, differentiating and processing patient's transference-based and reality-oriented responses.	*Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of identifying, differentiating and processing patient's transference-based and reality-oriented responses.*
1. I saw an adolescent schoolboy.	1. P was an adolescent schoolboy.
2. He was telling me some dreams at a session on Monday. These were very important dreams in which he was talking about me, what we call a transference dream. He's telling me about coming to my house on the weekend, out of hours for some sort of a consultation. I was quite excited about this because he's been quite a resistant patient to any kind of in the room feelings at all. The feel of it was really that he wants to be my son, that he would like to be relating to me much more closely than a patient would and the whole theme of the dream was about that.	2. T was excited because P, who had until then resisted disclosing his feelings in therapy, now revealed transference dreams concerning his relationship with T, particularly a need to relate to T in a more filial way.
3. He was a bit anxious about telling me these dreams, although he's quite a well controlled sort of person. But he then spoke quite anxiously about intrusion - that's his word. When he was talking about his associations with the dream he said something about intrusiveness or intrusion and I thought, "Ja, that's exactly what he's worried about."	3. The restrained P was hesitant to report these dreams and when giving his associations spoke anxiously about intrusion which signalled to T that this was of great concern to P.
4. I was thinking, "He's going to be telling me today or on Wednesday (that's when our sessions are), how this kind of dream affects him because he's a bit embarrassed and worried about showing me any sort of need." I could see the dream's about me. It was not disguised at all.	4. T thought P would tell him that day how the undisguised dream about T affected him, since P was cautious to reveal any sort of need to T.

5. Anyway, after he told me the dream to try and explicate it (or interpret) - I was looking very intently at him, sort of piercing you know, and I was looking very seriously and trying to talk to him about something I thought the dream was about. I don't remember what I was saying to him and he looks at me and this really hit me like a hot ton of bricks. He says to me suddenly quite aggressively, which he often does to me when he's projecting something into me, "You're looking really very worried." I said, "What do you mean worried?" He said: "As though something's been taken away from you or you're being emptied out." I didn't know where on earth this was coming from; I had no contextual reference. I thought to myself, "What's he talking about?"	5. After P presented the dream for T to explicate, T was looking seriously at P intent on interpreting the dream's contents when P suddenly and aggressively remarked that T appeared worried as if something had been taken away from him or he had been emptied out. T was unprepared for and astounded by P's erroneous comment, which was ungrounded.
6. My internal self-experiencing is the basis of how I start to differentiate these two things. I look inside. What I did (using this as an example) - I thought, "No this is mad. I'm feeling nothing like that," and I was quite in a sense outraged because it was so far from my internal truth. But what's happening with this guy? I immediately started to focus back on him and the old brains started ticking over 'cause I didn't even have to think, "Am I feeling like that?"	6. T's process of differentiating between transferential and reality-oriented responses is based on his internal self-experiencing. Inward focusing revealed the discrepancy between T's internal affective truth and P's comment. Controlling a sense of outrage, T shifted his attention to understanding the motivation for P's absurd comment.
7. I thought the reason I was outraged was that I was trying very hard to say something to him that was meaningful about this dream, and he is in a sense saying to me that I'm terrified of something, of being emptied out or losing something. I'm trying very hard to make sense of that in the first place, so what's he on about?	7. T thought the reason that he felt outraged by P's comment was that it was so incongruous with his attempt at that moment to attribute meaning to P's dream.
8. I sort of clicked. It's fairly obvious to me that he's terrified about telling me about these dreams and what they imply regarding intrusion and what we later call colonization of me, he's terrified of that.	8. T understood P's nonsensical comment when he grasped how anxious P was of exposing his dreams regarding intrusion and colonization of T.
9. He's quite a manipulative and powerful chap incidentally, very brilliant, very bright.	9. P was viewed as being a very brilliant, manipulative and powerful fellow.

10. So I asked him a few questions about what he meant by that and we explored it a bit. I realized immediately that this is a transference distortion of what he saw on my face. He really saw it very really, "That's how you're actually looking to me." Then later he tried to modify what he had said, "Maybe you were just looking very concerned and involved." But his original feeling was there's really something wrong with me. I was suffering under the onslaught of his dreams.	10. Therapeutic exploration revealed that P's actual perception of T's facial expression had been a distortion. Although P later tried to modify what he had said, he initially experienced T as suffering under the onslaught of his dreams.
11. What I did was, I thought, "I know how I'm feeling, I'm quite activated by these dreams." That was my self-experiencing. I couldn't see myself in the mirror but I could imagine how I looked, probably a slight frown you know. So I tried to visualize how I would look in a mirror and I saw a different face to what he was seeing - so I realized he's putting something into me or apperceiving something in me if you like or projecting something into me.	11. T's self-experiencing informed him that he was activated by P's dreams. T's pre-reflective knowledge that P was projecting something into him was confirmed when he imagined how he would appear in a mirror and saw a different face to what P had perceived.
12. Later we were able to talk about the fact that these dreams were quite worrying and what am I going to make of them. He said it was an anxiety telling me about the dreams. (The first two dreams he had brought to therapy in about nine months.) We were actually able to make sense later - after I knew it was a projection, I was able to talk with him about why he's so worried that this will empty me out, or take something from me.	12. Later P & T were able to talk about how anxiety-provoking it was for P to disclose dreams to T and not know how they were to be received and evaluated. Once T had come to know that it was a projection, P's experiential (lived) reality was explored and understood.
13. But actually it's not so simple that he just wants to be my son in a nice warm sort of way. This is quite a controller this fellow and the only kind of fathering relationship he knows about is either you control me or I control you. That's kind of what I think went on with his father who was divorced from his mother when he was about four and to this very day there are all kinds of power issues with his father.	13. T believed that it would be simplistic to understand P's need to relate to T as a son without reference to P's personal history and his dynamics of control.

14. Also, what I wanted to mention, first I look at my internal self-experiencing in the moment. If it fits, it fits, if it doesn't fit, it doesn't. People say to me, "You are feeling very ill today," (I've had bad flu), and I think, "Ja, sure I am." They are in touch with me, they're perceiving something else. I know something of myself, a lot of therapy, a lot of supervision and reasonably in touch with what's happening for me in the room. I wrote here I take in a percept or perception that the chap has of me. I sort of compare it quite quickly with my self-image and I either accept or reject the reality of it. For example: Yes I have got 'flu, or no I'm not horrified about the dreams. Based on that I examine the nature of the transference. Previous knowledge of the patient. When I've done that quick comparison I then sort of move to my overall understanding of the patient. I know reasonably well how his dynamics are functioning after nine months. He's into power, he's into manipulation.	14. His own therapy and extensive supervision have given T the confidence to distinguish quickly between transference/projection and reality-based observations. T then determined the nature of the transference in terms of his overall understanding of P, who in this instance, is into power and manipulation.
15. He wants to become a psychiatrist. But there's all sorts of anxiety about this and I say, "How does that affect us?" aside from maybe having to leave therapy which is really troubling him. And we came down to the point that psychiatrists have more power than psychologists. He is under the impression that they have more power and more freedom. That happened about three sessions ago and I think these dreams also should be seen in that context. This chap has given me lots of these kinds of statements. He tells me that I'm a Mafia gangster who's not really interested in doing therapy with people at all, I actually run another business on the side. Actually my real business has something to do with some sort of gangsterism and I run the therapy as a front. Very wonderful paranoid thought.	15. T referred to two situations in therapy which exemplified the dynamics of the P and reinforce his belief that P's perceptions are distorted. 1. P's desire to become a psychiatrist was interpreted by T as indicating a need to be more powerful than T. 2. P's perception that T is a Mafia gangster who does therapy as a front was viewed by T as evidence of paranoid thought.

16. Ja, so I then start (not consciously) to marshal a bit of history, what I really know about this guy - essential information, e.g. this guy's into control. It's an anchor point for me regarding this boy. Control, power, competitiveness - this is a crucial issue. I've enough evidence gleaned from nine months of this to start to formulate quite a deductive hypothesis about the guy. I don't do it intellectually by the way. I just know about H.	16. Repetition of Theme "14" After T has compared P's perception of him with his own self-image to determine if they fit or not, T marshals some history about P and formulates intuitively quite a deductive hypothesis about P.

17. He has tremendous problems about penetration in the sexual sense. He's only an adolescent but he's been having a sexual affair with a woman and I happen to know he's got big problems about his masculinity, and a tremendous air of competitiveness with me and other young boys at school and with his father. So I'm thinking why's he so worried about wanting to be my son. In today's session he came up with the theme of a burnt out oil rig in the sea. Fascinating. It has been used to pump oil from the earth as he put it and we got a few associations - oil's like blood, it's like energy, it gets sucked from the earth. He says that's a mother image isn't it? He's full of this language so we made a correlation oil or milk, or mother, he does all the work for himself. It's quite daunting actually. Anyway the point is that he then compared me to the burnt out oil rig which is playing beautifully into the interpretation that he's going to suck me dry, and when he's used me to get some kind of something, I'm going to be a ruined oil rig. He said you know people that plunder the riches of the earth they just leave these bloody oil rigs rotting in the sea. This is what he's afraid (my interpretation) he's going to do to me. I don't say he is, but he doesn't know how to really be loved in a vulnerable dependent fashion. He's a very independent intellectualizing boy, very bright. This reinforced my idea that this chap is going to find it very difficult to actually be helped by me because he's so into competitiveness and defensiveness that the only way he can use me is to suck something out of me and the problem with that is that he's left with quite paranoid fears about me. That's clearly transference, he doesn't know that I'm going to be scared of him, he doesn't know that I'm scared of being sucked dry. He imagines that I'm afraid of being sucked dry. I personally know that it's a distortion of me because I'm not scared of him at all. Actually I rather like this boy, in spite of the fact that he's a bit daunting intellectually. I don't believe he is going to suck me dry. I'm quite able to place the fear back into him and I think that's nothing to do with me.	17. T referred to two additional situations which demonstrated P's dynamics of power and control. 1. P's sexual penetration problems and his liaison with an older woman were viewed by T as a sign of his competitiveness with other men. 2. P's use of the image of a burnt out oil rig in the sea was interpreted as P's need to suck T dry. P's belief that T was afraid of being sucked dry did not fit with T's personal experience and was therefore viewed as transference.

Researcher: You seem to be following up different situations in the recent past that reinforce your perception that his description of the dream is a transferential dream, a transferential response. 18. Right. The whole dream is to do with his wish for something from me. He's casting me in a certain light I would guess. Father/older brother maybe. You see this word transference is tricky. You mean a distortion of me right? In the dream, he's merely dreaming about me in a particular way. When I say transference dream I mean that it's a dream about our relationship, he wants more from me. I'm using the word transference I suppose in two different ways.	18. P's dream concerns his wish for something more from T. P is casting T in a certain light, possibly father or older brother. T uses the term transference in two different ways, namely the relationship with T and the distortion implicit in the role evocation.
Researcher: You seem to be focusing on his beliefs about you. His experiences and perceptions of you which are distorted and how you have become aware of that, through your reflecting on your own experiencing of him. 19. He said some amazing things to me. The first thing he said to me at the second session we ever met was quite radical. But with adolescent work you find this. He said: "I'm very afraid of you." "What are you afraid of H?" (therapist) - I hardly knew him at this time, we'd just finished the history. "How did you feel about today's session" I said to him. He said to me: (I've never forgotten this) "You're going to take me to a cold, you're going to take me to a wet, dark place and kill me." "Sick patient," I thought. My supervisor's helped me to see that adolescents come up with this stuff, very different to adult patients you know. So right from our second session I'm thinking, "My God, this guy's pretty paranoid - why does he think of me taking him to a cold dark place and killing him?"	19. T referred to paranoid statements made by P at the second session as further evidence of his level of pathology; P's radical remark about T's taking him to a cold, wet and dark place to kill him was a typically adolescent comment. Continuation of Themes "15" and "17"

20. And so from session two I was into that kind of way of relating to this guy, internally, with the internal H. I'm thinking this guy's very scared of something, I don't believe it's me. It's some sort of internal object. Do you mind me speaking this object language? Who is really going to take him to a cold dark place and kill him? Well you know his father, his mother, I don't know something like that. I have various theories about that because we talk a lot about his mother but lately we've been talking about his father a bit more and me in relationship to his father.	20. From the second session T believed that P's experience and perception of a persecutory T referred to his relationship with internal parental objects, as T did not believe that P was really/actually scared of him.
21. Then about two sessions later at the fourth session came the Mafia dream that I'm doing serious business in my rooms with guys and there's a chap parked outside in a car (quite paranoid stuff), who's going to be sent out by me to kill somebody else. And I don't really have any time for him because actually the therapy is only a front and my real business is sort of heavy gangster money business. So what he was trying to tell me was I don't really care about him and I'm just seeing him as a pretence.	21. Repetition of Theme "15" P revealed his lack of trust in T's intentions.
22. So you know I had quite a lot of evidence right from the beginning that this chap has some huge trust problems. Even from the first phone call the referring psychologist said to me I want to refer this rather difficult young man who wants to become a psychologist. Therefore my cognitive set was quite contaminated from the beginning, all sorts of messing around in my own countertransference. ..... Should I put him on the road to psychology and all that. So I felt quite fatherly before I even met him. It's a problem.	22. T had accumulated evidence from the very beginning that P had trust problems. The referring psychologist alerted T of P's desire to become a psychologist and shaped T's attitude towards P. T considered his pre-therapy paternal stance towards P to be problematic.

Researcher: He's kind of identifying with you and being rivalrous. 23. That's his problem, he wants desperately to identify with me, his father's not a wonderful reference figure. You're quite right, the identification and the competitiveness are ambivalently poised and that's his whole problem with me. He would love to fall in love with me. My supervisor thinks there's a latent homosexual transference. He's a very pretty boy. He's really cute. The girls are mad about him. He's got a very soft coy gay way of relating - beautific smile like a saint and yet he's far from a saint. He wants to grab things from people, he can't let you give to him. This is something I've known for a long time and comes out rather beautifully in the dreams. He's finding it very difficult for me to give to him. Ironically he feels he has to force something out of me - he's very destructive towards me at times.	23. T recognized that the essence of P's problem was that his identificatory and competitive attitudes towards T were ambivalently poised. Through supervision T came to understand P's desires for an intimate relationship with him to be suggestive of a latent homosexual transference. T described P as a cute and pretty boy who could be experienced by others as soft and shy or forceful, destructive and mistrustful in his need to take from others.
24. He tells me at the fifth or sixth session that the only reason I became a psychotherapist was for my own sick reasons. "What do you mean sick H.?" (Therapist)... "You've got some kind of sick pathological weak need in you and that's why you do this work with people." (H)... When he spelled it out a bit we got to the fact that he didn't feel so great about himself. By about the eighth session he was already admitting to me he doesn't feel so great about himself you know. It's all projection, it's all in the transference.	24. P's perception at the fifth or sixth session that T became a psychologist because of his own sick reasons and pathological need to work with people, was refuted by T on the grounds that it was a projection of P's own inadequacies. This confirmed his belief that it was a transferential response. Repetition of Themes "15", "17" and "19"
25. He's tried his very best to sort of suspend his technical language. I don't know if he picked up a covert message from me or if he's really trying just to get in touch with more experience you know. I try my very best not to speak a technical language back to him but I get hooked in sometimes.	25. T wondered whether P's attempt to suspend his technical language was a compliant response to a covert message from T or an actual endeavour to be more experientially aware. Although T tried to converse less technically with P he was sometimes seduced into competing.

Researcher: Perhaps he pulls from you that you feel you need to be impressive? 26. Yes, it's almost irresistible, I get into competition with him. I don't feel threatened by it but occasionally I feel I wish to exert my fatherly superiority. "Fuck you, you upstart, I'll give you a whack with some very big words." (Therapist)He's so obviously a kid with a brain far too big for his shoulders. But you're right he zaps me into competition sometimes.	26. At times T could not resist P's challenge to compete with him and therefore exerted his fatherly superiority by using big words.
27. Let me give you another example. He accused me once of being competitive with him and I had to admit internally - I tried not to say anything about it - but I had to admit he was actually pulling me into something there. So it was not really such a distortion. You see here I come to a projective identification. Was I really competing with him? I'm making a false split here you know - was I really wanting to compete with him, me Mr X or was the professional Mr X entering into his pre-identification which I try to do with patients. I mean you have to kind of tune in there.	27. P had once correctly accused T of being competitive when T had inadvertently been seduced into competition with P. T felt his competitiveness could be interpreted in two ways. Either he as himself was competing or he, the therapist, had entered into P's pre-identification to empathize with him.
28. He picked up that I was being competitive but where do we draw the line between transference? Was I really being competitive or was I in a sense responding to a therapeutic discourse, playing my part in the drama if you like? I can tell the difference, I can tell when I really am competing with him or when I'm really angry and at other times it feels as if I'm just responding to the patient who is wanting me to be angry. So I can sort of make a distinction there.	28. P's perception of T's competitiveness had been correct but T questioned whether his competitiveness had been self-initiated or scripted by P. T claimed that he could make the distinction between really feeling angry or being summoned by other Ps to respond angrily.

29. My global understanding of the patient - I make an informed bet. It seems to me probable that based on what this patient usually does to me and others you know (the history), its likely that .... I can't prove it to myself. The anger sometimes feels as though it doesn't know where it's coming from and then I use that as a very important indicator that this is a projective identification. I'm surprised to find myself angry and then I search, I do a little internal therapy, I think that I'm not usually threatened by that kind of thing. Then I think, "Ah it's him, her whatever." On the other hand there are patients who get to a very real part of me not so much anger but insecurity, threatened, anxiety. I've got my own anxieties about certain things in life that a patient will sometimes just put their finger on and then I know Ja they really are picking up on something that is in my real life, bit of a problem for me if you like.	29. Based on a global understanding of the P's interpersonal-history and behaviour in therapy, T makes a rational well-founded prediction as to whether his (T's) response is transferential or not. When T is surprised at being angry and when internal self-examination suggests the anger does not originate with him but with the P, he identifies it as projective identification. Nevertheless, T recognizes that there are Ps who are sensitive to his vulnerabilities and get to a very real part of him.

Researcher: So you're kind of confronted with yourself all the time? 30. Hopefully yes. I would say I'm pretty much always faced with thinking where am I in all this and what are they doing to me. I'm always looking what they're doing to me, what I'm doing to them (both ways hopefully), are they arranging me into something? Reality and transference are not necessarily exclusive concepts, there may be a confluence. I may be angry but he also projects this into me. In other words the whole idea of putting things into me and me feeling actually angry. But there's another sub-variant of that, I may actually be angry but hiding it very well and he might be for his own reasons independent of me thinking "Therapist is angry without actually in any realistic behavioural sense checking that I'm angry." It's possible for him to be in the transference thinking that I'm angry and I might actually be angry but there's like a screen - could be two things going on in the room at the same time and I think I can even distinguish that. I think I know when I'm betraying a feeling. Betraying myself to the patient. I'm sure I don't always know. There are times when I think I'm containing the feeling very well and the patient is still claiming that I'm sad or angry or something. I tend to think that something very complex is going on there but I am hiding it; but they are simultaneously projecting into me their own thing. We are two separate entities at that point.	30. T is continuously cognizant of his position and participation in the therapeutic relationship and how the P sets him up. T believes that reality and transference are not exclusive concepts but may merge in certain therapeutic situations. For example: 1. When P puts feelings into T that already exist (within T) of his own accord. 2. When P perceives the angry feelings that T believes he has successfully concealed from P. T believes he can distinguish between P's unconsciously determined perceptions of T's anger and his own self-generated anger which is screened off from P. 3. T contends that he frequently knows when he is betraying a feeling to a P and that when the P senses these concealed feelings, it is due to his simultaneously projecting into T his personal preoccupations. At that point T and P are understood to be two separate independent persons.

Researcher: Are there any other ways that you distinguish for yourself that this is definitely inappropriate? - that it's transferential? 31. After I've been through the process I objectify it. It's an absolute fact and I'll probably be quite rigid about that in the future. ... So I'm quite quick to sort of objectify or consolidate it. "Ja, that's their own thing they were doing to me there or thinking about me." I think we should work on it, and I make a mental note, store it away, ask myself why did they do that, let's try and work on that. It gives me a clue as to what's going on inside the patient. Usually I decide that almost in an instant.	31. After T has experientially and rationally differentiated his own perceptions and feelings from the P's, he objectifies his usually quick decision by rigidly treating it as a fact and thus consolidates the process (of discriminating what are transferential from what are reality-orientated patient responses). This concluding phase of the process reveals to T a field for further enquiry.
32. I mean the first thing I told you my internal self-experiencing is the basis, that's number one. Number two, put it together with the sum total of everything you know about that patient for the last nine months or three years. The habitual way in which they relate to you. There's a sort of accretion of knowledge about that patient, about every patient really and quite intuitive, not an intellectual process. And on the balance of that I come up with a balance of probabilities e.g. that actually it didn't feel like I was angry there. I give a quick mini-explanation, that helps me to think why they might be thinking I'm angry based on anxieties of their own so I've made quite a neat little like hypothesis for myself I suppose you could say.	32. Repetition of Themes "14" and "29" T's final decision is based on probabilities which he rationalizes into a hypothesis.

Researcher: Please explain what you mean by a mini-explanation. 33. It's in an instant. I pose the question to myself, "Why would he be seeing me as angry now?" or in the case of H, "Why would he be seeing me as miserable and sucked dry?" Seems absolutely incomprehensible and crazy when it first happens but quite quickly I can start to come up if you like with some ideas, hypotheses which seem to me a reasonable explanation. It's because he's wanting to intrude into me and he's afraid that I'm going to expel him rather forcibly, of course. I'm going to be angry with him, hate him, kick him out like his father sometimes does when he tries to get something from his father, you know. All this stuff's running through me rather quickly you know - I think "Ah," it's a working hypothesis if you like why he should be doing this projection into me. He can't own the fact that he's very scared of intrusion into me so he just says that it's all happening inside me.	33. After the initial incomprehension, the condensed explanation of behaviour on which T bases his hypothesis of projection comes to him very quickly within the context of his intuitive, pre-reflective grasp of the P's effect on him, his self-awareness and his knowledge of the P's dynamics.
34. At times he experiences me as caring and helpful. He sometimes sees me as kind of - it might be just a distortion - he sometimes sees me as very wise, but I would claim from my theoretical point of view it's the inverse of the devaluation which is the idealization. So he does tend to idealize me sometimes but that would also be a distortion come to think of it. How often he experiences me as real I'm not sure, but he sometimes seems to use body language, he's sometimes a lot more relaxed, that's something I'd be looking for. He's going to be a lot more contorted and tense when he's doing this other stuff with me. Although he always pretends to look relaxed but he's not really.	34. When P perceived T to be either caring, helpful or wise, it was interpreted by T on the basis of his theoretical knowledge to be an idealized distortion of how T really is. T realized through attending to the body posture of P that he was more relaxed when relating to T in a reality based way as compared to the tense contorted bodiliness he portrayed when devaluing or idealizing T.

35. There's a contamination here - he lives just up the road. He actually knows a bit more than other patients know about me. He's got a realistic store of knowledge about me. A few weeks ago he reported to me in therapy, that he'd seen me walking past his house and had observed me very closely from his upstairs window and I had looked funny to him. I didn't feel particularly funny as I was walking past his house. I didn't know it was his house at the time so I wasn't hung up about it. He said something about me, something realistic. He observed some physical things about me which I thought were acceptable. So this chap's being doing quite a lot of observation of me in reality. He did pick up that I was a little bit threatened, a bit hurt when he decided to do psychiatry. I must have said something - I think he actually picked up something quite accurately there. It might have been something slightly diminishing or cynical in my tone. He said to me you're very hurt or disappointed that I've chosen to do psychiatry and I did a bit of the internal work and I thought, "Ja, he's got something." I was very embarrassed. That's a clue by the way. If somebody picks up something correct about me which I shouldn't be feeling as a therapist - a therapist shouldn't feel angry you know (Therapist smiles) - I'll admit that to myself and I feel quite embarrassed. The patient probably picks up the embarrassment you know. I hope I hide it but I probably don't.	35. Fortuitously P had a realistic store of knowledge about T whom he had on some occasions observed outside therapy. When P subsequently reported having observed some physical things about T, these observations were verified by T. P sensed accurately from T's tone of voice that he was upset to hear that P had decided to do psychiatry. When P confronted T as to his apparent disappointment, T focused inwardly and his experience of embarrassment revealed to him that P's assessment was correct.
Researcher: But he knows where to touch you, he knows where to needle you? 36. You're right. He picked up something accurate and used it very hurtfully against me. I probably was a bit disappointed that he didn't register for psychology. He used it to become very superior, saying, "You're feeling a bit hurt that ...." He could be delusional, you know. Did he actually pick up something behaviourally (something in the tone of my voice), that I was hurt that he's chosen not to follow in his "daddy's" footsteps?	36. T felt vulnerable when P accurately sensed his disappointment. T believed that P had used his accurate sensing of T's feeling state (disappointment) to hurt and weaken him. T wondered what was the basis of P's evaluation of his disappointment, pure subjectivity or behavioural observation.

Researcher: I was just about to say that you appear to be quite fatherly - or is this what he's eliciting from you, the disappointed father?	
37. Yes, I do feel fatherly towards this fellow. It's quite clear that I have a problem like this with some of my younger patients especially. There's a very strong identification with him. Frankly, I've done my own share of projecting into this young boy. That's why I take this to supervision quite often - it's a problem case. When I was his age I used similar defences. I had an intellectualizing mode, very superioristic, a talking head. He's different from me in that way. You see now I'm starting to say we're too similar but actually we're not that similar.	37. T admitted that he experienced difficulties working with younger patients, and acknowledged feeling paternal towards P with whom he had identified because of their similar use of intellectualizing defences as young adults. T sought supervision to assist him in disentangling himself from P whom he accepted as being a problem case. T's assertion of similarity between himself and P was seen by him as evidence of countertransference.

Researcher: What I'm most aware of at the moment is that he gives you the opportunity to confront yourself in how you're similar to him and also how you are separate and different from him. And many of these images and dreams about ingestion and expulsion fit in with what you're talking about at the moment. 38. I suppose you're right. It's very interesting what you saying actually. I feel very separate from him, I feel okay on that level. The other patients I get much more enmeshed with. H makes me very angry, he's really manipulative, the little bitch. You know, this chap is not quite on the same level. As I said to you we're only similar in the one way in that we tended to use intellectualizing defences, certainly when I was younger but I was a bit more of a talking head. I'm not worried about blurring my boundaries with his. I feel he's very different from me. He's Afrikaans-speaking. We're from really different cultures. What I'm trying to tell you, it's okay if he wants to sort of suck me in a bit and I feel I can work with it. The other patients I'm not quite so safe with. Actually I make I would say, false boundaries, I'm a bit distant. I don't feel I need to be particularly distant with this fellow - which is interesting. He I think is very worried about preserving the boundaries. One of the reasons he acts like this intellectualizing, super clever being who needs nothing from anybody and he's pseudo self-sufficient. I start to think to myself right at the beginning of therapy, "Why is he telling me he's so self-sufficient?" He must have terrible problems that if he ever starts to experience a need he fears he'll become fused with the other object, that he won't have any identity left (which a lot of my more disturbed	38. Compared to other patients with whom T is more involved and with whom he may even feel unsafe, T feels quite separate from P who is perceived as being pseudo self-sufficient as a defence against blurring his boundaries and losing his identity. T believes that he is only similar to P in their use of intellectualizing defences and because of their differences, is comfortable working with P.

patients tell me about). Yes, I identify with the "wunderkindt" element in him but it's a very sectoral identification, I don't actually feel that we're that similar in other ways. For the moment I think he's terribly worried about what it means to tell me that he needs something from me. I don't feel threatened by his needs. I seldom feel threatened by my patients' needs, actually threatened in the sense of being sucked dry, won't be able to cope with it etc.	

4.3.2 PROTOCOL THREE: CLINICAL SITUATED STRUCTURE

The patient who had been seen in intensive psychotherapy was an adolescent schoolboy. His parents had been divorced when he was a child. He tended to experience power issues with his father, who was not a good reference figure. In addition to this the patient also had problems with masculinity, displaying competitive behaviour with boys at school.

The therapist's experience of the therapeutic dialogue during a recent session was one of excitement, because the patient who had until then resisted disclosing his feelings in therapy, revealed "transference dreams". These dreams concerned the patient's relationship with the therapist, particularly his need to relate to the therapist in a more filial way. It was within this context of hesitant disclosure that the therapist realized that the patient's associations to these dreams signalled how anxious he was about intrusion.

While the therapist was anticipating that the patient would express that day how the undisguised transference dream affected him (the patient), the continuity of his thoughts was abruptly ruptured by the patient's sudden and aggressive remark that the therapist appeared "worried as though something had been taken away from him or he had been emptied out". The therapist, who had been looking seriously at the patient, intent on interpreting his dream contents found himself unprepared for and astounded by the patient's erroneous comment, which he felt was ungrounded. The disjunction in the temporal flow and continuity of the therapeutic dialogue left the therapist wondering,

"What's he talking about?" In the midst of this experience of surprise, the therapist focused inwardly in order to ascertain whether the patient's perception of him corroborated the image he had of himself. Upon listening to his internal affective truth, the therapist immediately knew that the "madness" of the comment did not fit with what he had experienced. His internal self-experiencing in the moment allowed him to reject the reality of the patient's perception and revealed to him the discrepancy between his internal truth and the patient's psychic reality.

Although the therapist believed that he knew how he was feeling, his visualizing how he would appear in a mirror revealed to him that the patient had seen a different face from what he had imagined. This confirmed his pre-reflective knowledge that the patient was projecting something into him.

In the face of this experience of confusion, the therapist felt outraged because the patient's comment was so incongruous with his attempt at that moment to interpret the patient's dream. The therapist came out of this unexpected situation, controlling his sense of outrage and needing to shift his attention away from himself in the direction of attempting to understand the motivation behind the patient's absurd comment. The therapist attempted to gain an overall understanding of the patient. His previous knowledge of the patient's dynamics and several past analytic experiences spontaneously became available to him and provided a context for examining the nature of their relationship.

While being interviewed by the researcher, the therapist reviewed some of the past situations in therapy which served as a reservoir of lived experiences with the patient, from which he drew both consciously and pre-reflectively in order to formulate intuitively a comprehensive interpretation about the patient.

Along with the recollection of past situations in therapy, the therapist was re-awakened to the awareness of evidence from the very beginning that the patient had problems with trust. During the second session, the therapist had reacted with amazement when the patient remarked, "You're going to take me to a cold, wet and dark place and kill me."

Radical statements like these, although later understood to be typical of adolescent patients, were interpreted as further demonstrations of the level of his pathology. The impact of this paranoid statement, so early in the development of the analytic relationship, convinced the therapist that the patient's experience and perception of him as a persecutory figure was "unreal" and did not actually belong to him, but referred to his relationship with internal parental objects.

The patient's statements that the therapist was a "Mafia gangster who is not really interested in doing therapy with people at all" illuminated the depth of his mistrust of the therapist's motives. The therapist's inability and unwillingness to own these feelings, which were so incongruous with his conscious intentions as a professional, enabled him to perceive these attributions as projections from the patient himself. Denigrating accusations levied at the therapist throughout the evolution of their relationship fuelled the therapist's sense of growing invalidation and served as a foundation for his belief that many of the patient's responses were transferentially-based.

Anchoring himself in their intersubjective experience that very day, when the therapist had felt daunted by the patient's presentation of an image of a burnt out oil rig, the therapist acknowledged being fascinated by this theme but rejected the patient's latent belief that he was afraid of being sucked dry. This unarticulated comparison of the therapist and the depleted, ruined oil rig, did not fit with the therapist's personal experience and was consequently viewed as a distortion.

Based on a global understanding of the patient's interpersonal history and behaviour in therapy, the therapist's substratum of cumulative knowledge informed him intuitively that the patient's inappropriate response that the therapist appeared anxious about being "emptied out", represented a projection. The therapist's "rational well-founded prediction" that his outrage was evoked by the patient, and was therefore not countertransferential, was born out of his intuitive, pre-reflective grasp of the patient's effect on him and his self-awareness acquired through extensive supervision and his own therapy. He believed that because he had attempted to be continuously cognizant of his position and participation in the therapeutic relationship and how patients frequently set

him up, he could often make the distinction between really feeling angry or being summoned by patients to respond angrily. Although the therapist recognized that the patient was sensitive to his vulnerabilities and able to get to a very real part of him, his own search internally had made it clear to him that he was not threatened by this erroneous remark, but shocked. His instantaneously formed explanation helped him to comprehend the source of the patient's distorted perception. The therapist reasoned that, because the patient could not own his anxiety of intruding into the therapist, he consequently located this anxiety in the therapist.

The therapist's final stage of this process of differentiating his own feelings from those of the patient entailed accepting that the patient's response was a projection and working with this judgement unquestioningly in the future. Once the process had been consolidated for him, a field for further enquiry was opened up. Having got beyond this emotionally and rationally informed process, the therapist enquired as to what the patient had meant. Therapeutic exploration revealed to the therapist that the patient's actual perception of his facial expression at that critical moment was distorted. This was confirmed for the therapist when the patient later attempted to modify what he had originally said. Once the therapist had come to know that the patient's response was transferentially-based, he was then able to uncover with the patient the roots of the "illusion".

Drawn back to the analytic experience through presenting a retrospective account of the therapeutic dialogue in the company of the researcher, the therapist found himself needing to distinguish between certain psychoanalytic concepts.

The therapist realized retrospectively that he used the term transference in two different ways, namely the relationship with the patient as a whole, and the phenomenon of distortion implicit in the role evocation, where the patient tended to cast the therapist in a certain light. The therapist acknowledged that his attitude towards the patient had been partially shaped by the referring psychologist's observations, and that he considered his pre-therapy paternal stance towards the patient to be problematic. Although he had come to understand through supervision that he experienced difficulties working with

younger patients towards whom he felt paternal, he acknowledged needing assistance in disentangling himself from this patient with whose intellectualizing defences he had identified. He came to recognize that the patient's desires for an intimate filial relationship with him suggested a latent homosexual transference and that the essence of the patient's problem was that his identificatory and competitive attitudes towards him were ambivalently poised.

Having been unable at times to resist the patient's challenge to compete with him, the therapist observed that he had been seduced into conversing technically with the patient in order to exert his fatherly superiority. Although he had realized retrospectively that he had acted out and that the patient's accusations of his being competitive were sometimes accurate, he viewed his competitive behaviour as either countertransferential or a stance deliberately taken up for evaluative reasons. He claimed that he could make the distinction between his self-initiated competitive behaviour and a response actualized as a result of an unconscious interpersonal drama, arranged by and originating with the patient. The therapist's experience of distinguishing pathological countertransference from "role evocations" scripted by the patient was based on the processing of his internal self-examination. When he found himself surprised at being angry and internal searching revealed to him that the anger did not originate with him but with the patient, he identified this as illustrating an instance of projective identification.

The therapist, who had experienced a need throughout therapy to confront himself for the purpose of identifying how he was similar to and different from the patient, found himself attending to the contorted body posture of his patient as a guide to interpreting the patient's responsiveness as transferential.

Besides focusing externally on the patient's bodiliness as a useful indicator to differentiate whether it was the patient's response or his own reaction which was transferential, the therapist's focusing on his own responsiveness often illuminated that his experience of embarrassment indicated that the patient's assessment of the situation was correct and therefore reality-orientated.

It was within this context of self-confrontation, both during the process of psychotherapy and in supervision, that it was often thematized for the therapist that he had unintentionally colluded with the patient by playing a part in his infantile dramas and thus satisfying the patient's primitive needs and desires. The therapist's experience of vulnerability in relation to the patient's accurate sensing of his feelings generated a need to maintain a process of internal supervision in order to ascertain when he had incarnated the patient's projections.

The therapist's closing consideration when reviewing this analytic experience was that the psychoanalytic concept of transference should not be viewed as a single exclusive phenomenon as there may be a confluence between reality-oriented and transference-based responses expressed by both patient and therapist.

The therapist came out of his experience of being interviewed realizing that, although he was similar to the patient in their use of intellectualizing defences, he nevertheless felt quite separate from him and, because of their differences, was comfortable working with him.

4.4 Protocol four:

4.4.1 Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of the process of identifying, differentiating and processing patient's transference-based and reality-oriented responses.	*Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of identifying, differentiating and processing patient's transference-based and reality-oriented responses.*
(1) I've decided to speak about this one client I've been seeing since June 91. In the assessment I see her as having a lot of narcissistic and borderline traits. I wouldn't say a personality disorder full-blown but quite a few of the criteria.	(1) P who had been seen since June 1991, displayed numerous narcissistic and borderline traits, but was not assessed as being a full-blown personality disorder.
(2) Initially I was quite confused because I didn't have a good enough feel for her background and a lot of the material that I thought was happening in the beginning of our therapy I took for a lot more reality-orientated than in retrospect I think it really was.	(2) T initially felt uncertain because she did not understand P's background and therefore retrospectively questioned whether her designation of P's material as reality-orientated in the beginning of therapy was correct.
(3) It actually started very early on after probably about six sessions. She presented very early as extremely angry and attacking and in response to that I used to feel a lot of anxiety and inadequacy. She would come with a whole barrage of angry kind of critical responses to the world in general and to me as well. I would feel quite paralyzed in that.	(3) After approximately six sessions, P verbally bombarded T with critical responses. T felt quite paralyzed by P's angry attacks and her feelings of anxiety and inadequacy were considerable.
(4) The one time she came along with a barrage just as I have explained and I felt lost for words as if I didn't even know what to interpret, I felt quite paralyzed and her response was that there was no point in coming and that she'd might as well stay at home and talk to the wall and that I was an inferior therapist. And that kind of fed right into my own feelings of inadequacy at the time. I regarded that as being reality-orientated as I think there was an element of that.	(4) T recalled a particular situation when she felt quite paralyzed by P's verbal attack, lost for words and unable to interpret P's material. In reaction to P's derision of her being an inferior therapist, she felt inadequate and regarded P's criticism as valid because she believed that an element of that existed.

(5) It had quite a negative effect on me in the therapy subsequently where I became extremely self-critical and self-aware and even more anxious and I think again she would tune into that. I wasn't able at that time to link it with how she tends to spoil and denigrate other people most especially her mother and her sister because of the very strong element of competitiveness and envy and that's her way of feeling okay about herself.	(5) In subsequent sessions, T reacted negatively becoming more anxious and excessively self-conscious and self-critical. T believed that P was also sensitive to her reactions. At the time T was not able to connect her experiences in therapy with P's denigration of others or with her (P's) defences and characteristic ways of relating.
(6) So I suppose in my assessment of that kind of situation which recurred quite often in therapy I would regard it as almost being a fifty-fifty percent mixture between transference and reality-orientation.	(6) T viewed those situations which recurred frequently in therapy to be comprised of an equal mixture of transference and reality-orientated responses.
(7) I think I've changed in my responses in the therapy and I don't feel so kind of persecuted or feeling so inadequate as a therapist with her. But I think what's helped that is being able to understand more of the transferential kind of communication in therapy and not taking it so personally.	(7) T believed that she felt less threatened and inadequate as a therapist when her understanding of P's transference communication increased and she did not take P's persecutory remarks so personally.
(8) What happens a lot is that I become seen as either the sister or the mother or a combination of both and I'm aware when it's going to happen I think because of non-verbal communications from her. It's almost as if she becomes, she has a change of expression as if she's getting in touch with some very, very intense old feelings from somewhere else. And then she almost has a kind of mischievous smile and out comes this whole critical barrage.	(8) P's non-verbal communication alerted T to when she would be viewed and related to as P's mother or sister, as if P was receptive to intense feelings belonging to her distant past.
(9) Look, some of the issues with her have been a marked identification with a victim kind of position and she's identified a lot with Black people in this country.	(9) The issues P brought to therapy were connected to her identification with Black people's victimized position in South Africa.
(10) I think the turning point in this stage of therapy which has been going on since about the latter quarter of last year was a letter she wrote to me. In her letter to me she said that I thought she had no independence and merely aped her sister whom she gathered I knew.	(10) The turning point in this stage of therapy was marked by an accusatory letter in which P stated that T believed she had no independence and merely aped her sister who was an acquaintance of T's.

(11) Now that sort of came like a bolt of lightning to me because I wasn't at all aware of feeling anything like that in the previous sessions where she had spoken about her relationships. I certainly hadn't felt that she didn't have any independence and that she was aping her sister. I've never met her sister, I wouldn't know her if I bumped into her in the street. That clarified something for me - it was the very unreality of that kind of statement which happened a lot subsequently that started to alert me to what was happening on a more transference kind of level. Of seeing me as allied with her sister, preferring her sister which was very much a dynamic in her family at home. She describes her father as always favouring her sister. So comments like that I think started to clarify for me when a transferential situation was arising. Also, that was so blatantly different to any of my own feelings that I couldn't own it as being reality-based at all. And I felt throughout the therapy that has become my basis of assessing what's happening in our interaction. I've become more able to stand back a bit I think and assess my own feelings and what she seems to think I'm feeling at the time, and I think that's helped to contain my own anxieties.	(11) P's accusation jolted T who was unaware of bearing those feelings in the previous sessions and denied knowing P's sister. The unreality of P's statement alerted T to when a transference situation was arising and how P's perception of T was linked to her family dynamics. The basis of T's assessment of the analytic interaction was her unwillingness to appropriate feelings that were blatantly different from her own. This allowed T to be more objective in evaluating her own feelings and P's beliefs concerning T's experiences and consequently helped T contain her anxieties.
(12) This has been sort of ongoing but recently there has been quite an increase in the kind of transferential things that have been happening in therapy. This particular patient communicates quite a lot when she's angry about pretty poisonous letters that she writes to various people, and a couple of weeks ago I was on the receiving end of another one of these where periodically, within the therapy the issue of whether she comes to see me twice a week or once a week, keeps coming up.	(12) T stated that she had perceived in the recent past that there had been an increase in P's transferential responses, and she referred to destructive letters that P had written to others and herself, particularly a letter questioning her attendance in therapy.

(13) My sense is that she needs to have at least three therapy sessions a week because she needs quite a lot of containment and I would get phone calls out of sessions and she would become more depressed. All signs that I think she needs more containment. She becomes extremely angry, cancels sessions, says that she needs to take control of her life and that she sees me as using a lot of power in trying to enforce that she comes to see me twice a week.	(13) T believed that P needed a minimum of three sessions a week to curtail her acting out and to contain her angry and depressed feelings. P accused T of being too powerful in attempting to enforce that she attend therapy twice a week.
(14) And within this particular letter and the therapy around this time which was at the beginning of May there were a lot of accusations of me being very controlling, very powerful in determining how much she pays for the sessions, how often she must come. She feels that I'm using her for my own needs, financial and ego needs, and that this is a repetition of what always happens to her in the sense of being used for other people's gain.	(14) P accused T at that stage in the therapy of being too controlling and autocratic in determining the therapeutic arrangements, and of using her for T's financial and ego needs which was a repetition and extension of what others had done.
(15) I can't identify with any of those feelings and I think that helps me to see it more in the context of perceiving me as a replacement for her mother and her sister. While she throws these kinds of accusations at me, it's usually quite a shock and it almost feels like I need to recoil a bit from the blow of it and sit back and assess my own reactions and feelings. It shocks because of the venom with which she puts this sort of accusation forward. For instance, that I'm using her for my own ego needs to be a good therapist and to try and help her so that I'll feel good about myself.	(15) T's inability and unwillingness to own those feelings, allowed her to perceive the accusations as being misdirected at her whereas they should have been targeted for P's mother or sister. P's venomous accusations surprised T who needed to react by evaluating her experience of the threatening situation.

(16) I suppose she tunes into some of my own shadow material on a reality base and I sit back then and question her accusations, asking myself "am I doing that," "do I need to keep her in order to have a success story or hope to have one", and I suppose there's quite a challenge in seeing her. So in a small way that might be slightly true but for me the kind of challenge or satisfaction would be more in at the end of therapy seeing her as being more able to cope and more kind of able to interact with the world. So I don't feel that I need to own that kind of using her for my own ego needs in the way that she puts it across. So maybe there's a small percentage of wanting to be a good therapist but I see it far more as her own kind of suspiciousness and sense of persecution at everybody using her, including myself.	(16) T acknowledged that P was able to detect some of her inappropriate, shadowy material. P's accusations invited T to face her own unarticulated intentions and needs concerning P's presence in therapy. P's reproaches challenged T to confront not only her functions as an aspiring therapist but also the integrity of the self. Having been called upon by P to sit in judgement of her self, T assented in part that P's challenge was correct but strongly denied the allegations of narcissistic desires and attributed the condemnatory statements to P's own paranoid pathology.
(17) In fact, very often I really struggle with her as a client and it would be quite a relief actually not to be seeing her. So I think that what she's picking up on is more her experience of me that I don't think is really accurate. Although I think because a pattern of hers has been to very accurately pick up on some of my own material especially shadow material. I think that's the shock in these kind of accusations that are kind of levelled quite often.	(17) T disclosed that because she had often struggled with P, it would have been a relief not to have been P's therapist. This also confirmed for T that P's experience of her was distorted.
(18) On a feeling level it's sort of needing to do a double-take, check out as to whether she is seeing something that I'm trying to deny. So I think what actually happens a lot is kind of a self-analysis going on at the same time as being there with her.	(18) T needed to monitor and evaluate simultaneously both her intrapersonal experiences and the interactional process in order to verify P's perceptions of her behaviour. T believed that she needed to participate both experientially and analytically in the therapeutic relationship, a dual presence.

(19) And I think the power of her own insights is quite threatening in that respect. I suppose through a process of being in therapy myself and being self-reflective and introspective I have an idea of what my complexes are. And when she tunes into one of those with a criticism, I suppose I become quite ... it's a feeling of vulnerability, a feeling of needing to take a step back a bit and assess, but try and hold the balance between doing that and not being sucked into acting out her own material of which mine is just a small part. And I don't always get it right. Often I don't have the ability at this stage to know exactly what's happening. And sometimes only in reflecting back on something that's happened in therapy will I realize that what's happened has been an acting on both of our parts, of colluding in a very unconscious way.	(19) P's ability to be so insightful as to T's complexes threatened T who felt vulnerable having been a patient herself and hence partially aware of her concealed conflicts. T needed to respond to P's threatening criticisms by distancing herself from the feelings of vulnerability and assessing both herself and their relationship to prevent colluding with P's desires and acting out. T who had felt inexperienced at times, acknowledged that she had sometimes failed to hold the balance between experiencing and observing within the analytic relationship, and had consequently colluded with P only to realize this retrospectively.
Researcher: Do you remember a situation like that when you became aware with reflection that it was acting out? (20) Earlier on in the therapy in connection with the accusations of me being an inadequate therapist I became very aware of colluding with people that she would speak about in therapy, whom she had been attacking towards, and I would almost take their part and try and feed back to her reflections of how they might have experienced what she was doing. And I feel I was doing it in a defensive, self-protective way. My justification for it at the time was in a sense to try and get her to reflect on the affect she had on other people but I think indirectly what I was saying through the communication was, "Why don't you be more gentle with people and also with me?" It caused quite a problem in therapy because she saw me as being very unsupportive and siding with these various friends who'd rejected her, which again was a replay of how her mother and her sister and various people in the family had been. I think I only realized it a few weeks down the track when she came back with a lot of anger and a sense of rejection in the therapy.	(20) Continuation of Theme `19' T referred to a situation in therapy which illustrated how she became retrospectively aware of having acted out in the analytic relationship. T had identified with persons in P's life who had also experienced P as threatening, and only with reflection realized that P's feelings of anger and rejection were a reaction to T's taking the side of others. This was a repetition of P's relationship with her family members.

(21) In terms of other things that I use in the here and now; occasionally when she has a dream where I would directly feature or as her association to the dream would be some symbol representing me. Especially recently in the therapy maybe because of the time that's gone by, the dreams reflect me in a way that doesn't feel like me in reality. And I suppose I use that quite a lot as a confirmation of what's happening on a conscious and unconscious level in terms of her experience of me.	(21) P's dream contents either directly or through symbols representing T facilitated that T in the present situation uncover P's latent experiences and perceptions, thus enabling T to confirm her conscious evaluations of P's perceptions. P's recent dreams portrayed T in a way that did not confirm T's experience of herself in reality and thus reinforced T's evaluations that P's unconscious perceptions of her were distorted.
(22) And currently the dream material where I do feature directly or symbolically seems to be showing me in a light that's connected with kind of envy and competitiveness that's going on in therapy. And I suppose I use that more as a kind of gauge of whether my conscious awareness of what's going on is actually in tune with what's going on with her on a more unconscious level.	(22) P's current dream material revealed to T that she was associated with envy and competitiveness. This enabled T to guage whether her conscious knowledge of P corroborated the insights obtained from the dream material.
(23) My responses to that kind of material on a feeling level vary from sometimes feeling quite indignant (because it feels very unreal in terms of my experience of myself) to sometimes also feeling quite defensive because of that. And I suppose it becomes a struggle for me on an internal level not to express that defensiveness.	(23) As a reaction to what P's dream material had revealed, T felt angry and threatened because P's experiences and perceptions of T did not reinforce the views she had of herself. T struggled to contain her angry feelings which expressed a need to defend herself.
(24) I think in that context quite often my experience in the therapy is almost as if I am the person who's being analyzed in a sense and again that makes me quite hyper-aware of needing to assess how much is reality-orientated in my experience of myself, how much might be reality-orientated that I am unconscious of in myself, and how much is actually transference. And for me that becomes quite a confusing kind of issue of how to separate without creating false boundaries.	(24) In the context of understanding P's dreams, T often felt scrutinized as if she was being analyzed by the P and consequently needed to asses to what extent she was intra-psychically aware and how much that was manifest to P was hidden from herself. T felt confused trying to artificially disentangle the threads of their interwoven relationship.

(25) And I think another thing that often happens is, within a session I might be very aware of perhaps using too much of the intellect to try and sift out exactly what's happening. But after the session ending up feeling as if I'm carrying a tremendous amount of material that feels very burdensome and kind of doesn't feel like it fits but I can't quite get rid of. And again that's not really such a here and now experience but on reflection it helps me to be able to assess afterwards what was transferential and what was mine and what wasn't.	(25) T often became aware of being too intellectually discriminating during a session, and after the session felt burdened carrying an extensive amount of incoherent material that she desired expelling but was stuck with. With reflection these experiences helped T assess retrospectively what was P's distorted material - what belonged to and was determined by T.
(26) I think maybe at this stage with her I really do struggle to know in the here and now exactly what's happening and a lot of it for me falls into place afterwards.	(26) T acknowledged that at that stage in the therapy she experienced great difficulty determining in the immediacy of the sessions what was occurring in the analytic process and that only with hindsight did she grasp the complexity of what had transpired between them.
Researcher: How do you come to realize what is taking place in the therapy? (27) It's almost like a sort of subliminal process that happens of sifting through and not sitting down intensively and just reflecting on the therapy but it keeps coming back to me during the course of the day or the next few hours and it almost feels as if certain feelings and reactions fall into place, those which are reality-orientated and the ones that aren't, it's almost as if I can compartmentalize them and get rid of them in a sense from an internal level. Being aware next time I see her of when that comes up and how to be more aware of the feelings I had before when they happen again and maybe what it's really about, how to connect it and interpret it back.	(27) T's process of grasping and integrating P's dynamics materialized between sessions, both on an intentional rational level and on an unconscious, deeper level. Through having uncovered, encountered and differentiated P's material on an internal-latent level, T felt unburdened and relieved entering the following sessions feeling more prepared, informed and resourceful.

(28) But I find with her quite often that I can only do that a few sessions later. For me it has to do with the process of self-reflection that seems to be stimulated by the accusations in needing to be aware of when those issues like say power for instance or my own ego needs are coming out in other therapies or personally. I don't find it an easy process at all. I think it causes quite a lot of internal turmoil and quite a lot of pain as well. And I think perhaps with this particular client one needs to be separate in order to sort out the material. It has a lot to do with boundary issues which I think is for her part of her problem of never feeling separate really from her sister or her mother. In this need to have her identity confirmed and approved of through their identity and their approval which has never really happened and it's an ongoing struggle.	(28) P's accusations stimulated T to turn towards herself and painfully become aware of when her own issues and needs were acted out in interpersonal relationships. T needed to be disconnected from P to disentangle the material more objectively because part of P's problem concerned boundary issues which had incorporated persons who were needed to confirm her identity.
Researcher: It seems that you're experiencing like the sister and like the mother, that at times it becomes difficult to differentiate what is your feelings and what's the client's feelings. You kind of fused with your client in the same way that her sister and her mother were. When you're distant and separate, your observing ego is much stronger and enables you to realize that your client's perceptions/experiences are inaccurate/ inappropriate. (29) It is often like that especially at the more intense times of the negative transference. Somehow while I was in a positive transference it isn't quite so difficult to be separate. Somehow when she's attacking me in a very negative way I have a sense of almost losing my own boundaries and my own perspective on what's mine and what isn't. It's a feeling of a kind of dissolving inside, a collapsing, and I think it has to do with the way that she's able to tune into that material of mine and a sense on my part of needing to try and keep it separate and contained.	(29) When T felt attacked by P during intense stages of negative transference situations, she experienced boundary confusion and identity dissociation. T thought it occurred because P was able to detect her concealed, shadowy material which she attempted to keep separated and contained (from P).

30) I think also a lot of projective identification is happening where I feel overwhelmed by holding and containing my own shadow stuff as well as receiving, experiencing hers and knowing how to package it and interpret it back in a way that's therapeutic. I think it happens a lot outside as well, most particularly in her interactions with her sister and her mother, where they, I think, become extremely rejecting and attacking when this starts happening. So I'm very aware of needing not to do that.	(30) Unlike P's sister or mother who could not hold, nor interpret P's projections and became attacking and rejecting, T was aware that she needed at times to contain both her own and P's unappropriated material and still be able to differentiate and process the material for P without acting out.
(31) Whereas on the positive side - it's less threatening and also while its very encouraging and reassuring when there is a positive interaction - somehow I don't feel that I need to own that so much as if I can attribute that to the process of therapy and the kind of ego resources that are developing within her, and sure I can sort of acknowledge that somehow the interaction between us is facilitating that, but I don't feel like I have to take responsibility for it like I have to take responsibility for the negative transference in a way.	(31) (Compared to T's experiences of negative transference stages) T felt less threatened and more separate when in a positive transference and believed that she was less responsible in creating the postive interaction which was greatly attributable to the process of therapy and P's developing ego resources.
Researcher: It's as if you're saying that maybe you become more parental when there's a negative transference from your client. You need to process and feedback correctly - that there's more responsibility when your client is infantile and attacking you. (32) Ja, I suppose it is that. And yet the paradox is that her experience has been precisely that that parental attitude has been very lacking in her life. And I think I find myself caught between in my head understanding that and feeling like I want to contain it on an emotional level and I suppose be parental but also wanting to not be involved.	(32) Although T realized that P had required a containing parent, she experienced ambivalence trying to remain emotionally detached, not satisfying P's desires nor compensating for P's parent's deficits.

Researcher: Can you tell me more about the positive transference, what that does to you and in what way it's less confusing? (33) Well I suppose in the positive transference I see this particular client as having activated a lot more of her ego resources and having a greater sense of herself as a whole and less fragmented. And I suppose in that way the projective identification isn't threatening. I'm also left in the therapy feeling a lot more whole and a lot more directed and focused and less fragmented. That feeling of disillusion isn't there, whereas it is there in the strong negative transference. I suppose really I'm tuning into how she's feeling more able to cope generally with her life and I feel that in response in a way. So it's obviously much easier to deal with the therapy when that's happening.	(33) T felt more intact and less threatened by P's projections when in a positive transference phase of therapy and attributed her more adjusted feeling state to P's greater sense of self-integration and ego resourcefulness which facilitated the development of a working/therapeutic alliance.
(34) It doesn't last for long though, because I think one of the issues is a tremendous feel of closeness in any sort of trusting or intimate interaction and I have started to be aware of becoming more engaged, when I feel from my side that that's happening in the therapy because I know shortly thereafter the negative is going to be constellated.	(34) T experienced the positive transference phases of therapy to be of short duration and thought that she had started to become more engaged in the relationship anticipating the unwelcomed return of the negative phases of the transference.
(35) What triggers a lot of self-analysis is a sense of fear of her tuning into something that's unconscious in me and something that could be destructive. Somehow it isn't really threatening if she tunes into something more positive or more nurturent, because it's almost as if I feel like I don't have to contain that or modify it or check that it doesn't get out of control, because it's going to be less harmful than more shadow material that she seems to tune into in the negative transference.	(35) P's tendency during negative transference phases of therapy to detect intuitively T's concealed latent material threatened T who initiated a process of self-analysis to monitor her destructive impulses.

(36) Also, there isn't a tremendous amount of acknowledgment of positive things that she gets in therapy or positive experiences of me in whatever way she perceives me. And I suppose I may be colluding with that sense of denying that there's a tremendous amount of positive. Almost as if that's only a minor issue, it doesn't need so much of my attention. I need to be much more vigilant about all the negatives that there seem to be. In fact in speaking I think I find myself unconsciously colluding with a lot of the imbalance and split and focus on the negative which I think is a large part of her as a person, and maybe in that sense I'm not aware enough of needing to be self-reflective about the positive things. Sort of needing to actually acknowledge that some positive transference is happening in the therapy and that we are actually getting somewhere with the material.	(36) T realized that she had unintentionally colluded with P's invitation to form and participate in a critical, non-rewarding analytic relationship which negated the positive interactional qualities and progress in therapy. T acknowledged that she needed to be unbiased when self-reflecting in order to equally attend to positive aspects within herself, P and their relationship.

4.4.2 PROTOCOL FOUR: CLINICAL SITUATED STRUCTURE

The patient was a young woman who, apart from displaying numerous borderline and narcissistic traits, identified with the position of victim. A part of her problem concerned boundary issues, which manifested in a need to incorporate persons to confirm her identity.

In the beginning of therapy, the therapist felt confused not having a thorough understanding of the patient's background and she later questioned whether her initial designation of the patient's material as reality-orientated was correct. She would feel quite paralyzed when the patient verbally bombarded her with angry attacks and critical responses directed at the world. In the midst of these verbal barrages, she experienced intensified feelings of anxiety and inadequacy, and on a particular occasion felt "lost for words" and unable to interpret the patient's material. In reaction to the patient's designation of her as an inferior therapist, she felt deficient and regarded the criticism as reality-based, because she believed that an element of that existed.

In subsequent sessions, the therapist continued to react negatively to the verbal barrages and became more anxious, excessively self-conscious and self-critical. Besides these feelings of being victimized, she felt trapped by the patient's sensitivity to her reactions and was not able at the time to connect her experiences in therapy with the patient's denigration of others. Upon developing a greater understanding of the patient's characteristic ways of relating and transferential communication, she felt less threatened and incompetent as a therapist and did not take the patient's persecutory remarks so personally. The therapist viewed these frequently recurring situations to be comprised of an equal mixture of transference and reality-orientated responses.

The turning point in this stage of therapy occurred when the therapist found herself being accused by the patient in a letter of having perceived her as lacking independence and having aped her sister, with whom the patient believed the therapist was acquainted. The therapist was jolted by the unreality of the patient's statement, and her unwillingness to appropriate feelings that were blatantly different from her own alerted her to when a transference situation was developing. This formed the basis of her differentiation between transference-based and reality-oriented responses, and consequently helped her contain her own anxieties.

Beyond this experience, at a later stage in the therapy, the therapist perceived an increase in the patient's transferential responses, often in the form of destructive letters written to others and herself. In her letters, the patient angrily accused the therapist of exploiting her position of power in determining therapeutic arrangements, and of using her for the therapist's financial and ego needs. Although the therapist acknowledged that the patient was sometimes able to detect some of her (therapist's) repressed material, on those occasions when she found herself unable or unwilling to own those feelings, she then perceived the accusations as being misdirected at her when they should have been aimed at the patient's mother or sister.

The therapist's experience of being accused led her to protect herself by recoiling from the patient's venomous allegations, in order to distance herself enough to be able to evaluate her own motives and experience of the threatening situations. Having been a

patient herself and hence partially aware of her own concealed conflicts, the patient's insightful ability threatened her and made her feel very vulnerable. It was within this context of judgement that the therapist was invited to turn towards herself and face her own unarticulated intentions and needs concerning the patient's presence in therapy. The patient's reproaches challenged her to confront not only her functions as an aspiring therapist but also the necessity of becoming aware of when her own issues and needs were acted out in the analytic relationship. Having been called upon by the patient to sit in judgement on herself, the therapist agreed that the patient's challenge was in part correct, but strongly denied the allegations of narcissistic desires which she attributed to the patient's own paranoid pathology.

The therapist's experience of having struggled with the patient, and her recognition that it would have been a relief if the patient had terminated therapy, confirmed for her that the patient's claims that she was narcissistically motivated were unfounded and therefore a distortion. The lack of correspondence between her lived experiences in the analytic relationship and the patient's perceptions of her reinforced her assessment that the patient's responses were transferential.

The experience of being scrutinized as if she were being analyzed by the patient also occurred when the therapist was in the process of understanding and learning from the patient's dreams. It was within this therapeutic context that the therapist was awakened to the realization that the patient's dream material revealed that she was associated with envy and competitiveness. This did not confirm the therapist's experience of herself in reality and she reacted by feeling angry and threatened, and struggled to contain these feelings of indignation which expressed a need to defend herself. Discovering that the patient's dream contents did not corroborate the therapist's conscious knowledge of herself reinforced her evaluation that the patient's unconscious perceptions were distorted and therefore transferential.

Uncovering the patient's latent experiences and perceptions of the therapist, through being receptive to those dream symbols representing her, enabled the therapist to determine not only whether the patient's unconscious perceptions of her were distorted,

but also to assess to what extent she (the therapist) was self-aware and whether she had comprehended the complexity of the interpersonal zone.

The therapist believed that it had been necessary to participate both experientially and analytically in the analytic relationship, and had attempted to maintain a secure and containing therapeutic environment, but acknowledged that she had sometimes failed to hold the balance between experiencing and observing and had consequently acted out. The therapist often experienced great difficulty determining in the immediacy of the sessions what had transpired between them and only with reflection had she realized that she had colluded with the patient's desires. Only through distancing herself from the situation in therapy, and being detached from the patient whose problem concerned boundary issues, had she realized retrospectively that her participation in the analytic environment mirrored and repeated interactional scenarios associated with the patient's family members.

At that stage in the therapy the therapist often became aware of having been too intellectually discriminating during a session, and afterwards feeling burdened, carrying an extensive amount of incoherent material that she desired to expel but was stuck with. The process of grasping and integrating the patient's dynamics crystallized between the sessions and was located both on a rational level and on an intuitive level. The therapist came out of her experience of reflection, feeling unburdened and relieved. Along with the process of uncovering, encountering and differentiating the patient's material on an intuitive level, the therapist felt more prepared, resourceful and retrospectively informed.

Following the therapy phase in question, the therapist in the context of being interviewed by the researcher, reflected on her experience of having been in both a positive and a negative transference situation.

The therapist often experienced becoming aware of when the patient was in touch with and giving vent to "very intense old feelings from somewhere else". The non-verbal communication of the patient frequently alerted the therapist to when she would be the recipient of archaic feelings and the displaced target of the patient's critical barrages. In

the face of these attacks by the patient, the therapist would often "feel a kind of dissolving inside, a collapsing". She attributed her experiences of boundary confusion and identity fragmentation to the patient's ability to intuitively detect her concealed, repressed material which she attempted to keep separate and contained. The threat of being fully transparent to the patient initiated a process of self-analysis to monitor her destructive impulses. Unlike the patient's mother or sister who could not hold, nor interpret the patient's projective identifications and became attacking and rejecting, she was aware that she needed at times to contain both her own and the patient's unappropriated material and still be able to differentiate and process the material for the patient. Although she realized that the patient required a containing parent, she experienced ambivalence in her recognition of the patient's needs and her own wish to remain detached from a corrective-emotional, parental role.

In contrast to her experiences of vulnerability, in the midst of negative transference situations, the therapist felt more intact and less threatened by the patient's projective identifications when in a positive transference phase of therapy. She believed that she was less responsible in creating the positive interaction which she greatly attributed to the patient's developing ego resources and sense of self-integration which facilitated the development of the working alliance.

Drawn back to those experiences of "feeling a lot more whole", she recalled that the experience of dissolution was absent and, being less fragmented, it was easier for her to deal with the therapy. The therapist realized retrospectively that she had experienced the positive transference phases of therapy to be of short duration and had become more engaged during those periods in anticipation of the inevitable and unwelcome return of the negative phases of the transference.

Her closing realization of the analytic experience was that she had unintentionally colluded with the patient's invitation to form and participate in a critical, non-rewarding relationship which negated the positive interactional qualities and the progress in the therapy. The therapist acknowledged that she needed to be unbiased when self-reflecting

in order to attend equally to positive aspects within herself, the patient and their relationship.

4.5 Protocol five

4.5.1 Qualitative analysis

Discriminated meaning units based upon the perspective that the description was an example of the process of identifying, differentiating and processing the patient's transference-based and reality-oriented responses.	*Discriminated meaning units expressed more directly in psychological language and with respect to relevancy for the phenomenon of identifying, differentiating and processing the patient's transference-based and reality-oriented responses.*
(1) It was right at the end of the session and this client offhandedly said she won't be there the following session. And I looked at her and she looked back and seemed to become uncomfortable and then said, "My children are going overseas and I want to be with them" and we left it at that.	(1) When P. casually announced at the end of the session that she would miss the following session because she wanted to be with her children who were going overseas, she appeared to become uncomfortable.
(2) When she came back the next session ... No, she didn't. She actually phoned and said could she have a session because she was going to miss that one; was there another time for her? I said there wasn't and I would see her at the one she was able to make.	(2) P's telephone request for an alternative session could not be accommodated by T who said that she would see P at the following session.
(3) When she came in the next session ... my feeling had been what was going on? Why, at the end of a session, she brought it up and in a very by-the-way manner. So I had thought, "Well, is this therapy not important to her? Has she not taken it seriously and what are her feelings about therapy that it can be so easily ... put aside?" And this I think was built on what had seemed to be emerging at different times throughout the therapy with her, the sense that I was getting.	(3) T had wondered during the interim therapeutic period why P had announced the matter in such a careless manner. T's uncertainty as to P's motivation in therapy was also based on her impressions periodically during the therapy that P did not value therapy.

(4) Anyway she came back the next session and she said to me can I tell her what I felt at the end of last session when she spoke about not coming? I said we would discuss it. I'd prefer to hear from her first what happened that she felt she needed to tell me in that way. She said she just suddenly got into a panic and realized that her children were leaving and she hadn't done anything and she just couldn't feel ... have any more obligations as such, and she just sort of wanted to clear her week to organize for them to leave. But she said she had felt that I had felt that she was avoiding and that she was inadequate and she was doing the wrong thing.	(4) When P returned she asked what T had experienced at the end of the last session in reaction to her announcement. T responded by inquiring as to P's manner of cancelling the session. P explained that the realization that her children were leaving made her panic and feel unprepared for their departure and not receptive to additional commitments. P had sensed that T believed she was avoiding therapy, was inadequate and was doing the wrong thing.
(5) And so what had made her feel that way ... she had said because I didn't answer her straight away and I didn't make her feel it was all right. And so I did give her feedback from my side and I said I had felt ... I felt taken aback by the way she had presented it and I had wondered what was going on.	(5) P had sensed T's apparent disapproval from her (T's) delayed non-accepting response. T replied that she had felt stunned by P's manner of disclosure and had questioned her attitude to and behaviour in therapy.
(6) She said that it had brought back memories of when she had done the wrong thing with her mother and if her mother hadn't approved, her mother had kept quiet and so she had left feeling very bad and that's why she had phoned to make another appointment. She said she hadn't been avoiding coming to therapy, and that's why she also phoned to show me that she didn't want to avoid therapy, but this was the situation.	(6) T's reaction had reminded P of her mother's silent disapproval when she had done the wrong thing. She had felt so bad that she had phoned to make another appointment to reassure T she was not simply trying to avoid therapy.
(7) While she was talking I did get a sense that it was a reality that she had to organize her children, but the other side of it was what was happening in her life that it was almost everything at the last minute. She knew her children were going overseas for quite a while and I'd never even heard that they were going overseas, which she hadn't brought in at all.	(7) Although T recognized that P's desire to organize her children was a reality, she nevertheless questioned why P had never revealed this material in previous sessions and had hastily divulged the matter at the last minute.

(8) But I think through the whole therapy session it did become clear that the reality was that I had felt she was avoiding and I was aware of that. I didn't feel she was inadequate though. I had felt that it had been done in a way that was almost dismissive of therapy. Perhaps her anxiety was so great in getting these children ... and this is how she responded to anxiety that everything had to be cleared up. So at those areas I could see her reality or the reality of how she was seeing me, and what I did to her. I could see the reality that she needed time as such to organize for her children but then, as I said, what came out after that was all the other issues that it evoked, all the other emotions that my response had evoked in her that weren't mine, they were hers.	(8) During the session T acknowledged to herself that she had indeed felt that P was avoiding therapy but had not experienced her as inadequate but rather as dismissive of therapy. T accepted P's response to the anxiety of her children's departure. While P's perceptions of T's response to her announcement had been partially correct, her additional evoked emotions, were interpreted as having their source in the past and were a distortion.
Researcher: And her perception of you at that moment? (9) At the moment when she said she wasn't going to come? Her perception of me at that point was more that I had ... I saw her doing something wrong, which I don't think was correct but that she felt that I was feeling she was avoiding and that's why she phoned. That was correct.	(9) P's perceptions of T viewing her as doing something wrong at that moment were rejected by T, who nevertheless acknowledged that P's experience of T feeling that P was avoiding was accurate.
Researcher: I wonder what you were feeling at that moment? (10) When she said it at that last minute I had an interesting sensation because I think I was almost shocked. I was actually taken aback. I was speechless, I wasn't trying to be speechless. I actually was speechless because I couldn't fit it into what had been said just prior, and what we had been discussing and talking and what she had intimated where we were going and this had then come up just almost out of the blue. I was speechless because I was speechless, not because I thought it was the right thing to do.	(10) T had felt genuinely shocked and speechless, taken aback by P's unexpected announcement because she could not make sense of it in the therapeutic context.
Researcher: It was a surprise for you? (11) Ja. I mean shock is too strong a word but it was almost like as if I had been stunned.	(11) T felt as if she had been stunned by P's response. Repetition of Theme '10'.

Researcher: What was the process that enabled you to realize that this was a reality orientated situation? That her unconscious perception of you was accurate and not a distortion? What was the process you experienced? (12) The part that I realized was real, the other part wasn't ... I went through within my own mind, why did I react like that? What was actually happening? What was happening inside me was an awareness that I had been feeling, which hadn't been actually dealt with in the therapy at all. By the various other things that had happened, I had felt that she wasn't taking ... that therapy was just being done. It wasn't serious in her life. She wasn't taking it seriously inside. There was within me a sense of irritation at her response at the end of the session, and at my not having perhaps dealt with it properly while I was beginning to feel that this was happening. That this shocked me into realizing that I needed to do something about it.	(12) After reflecting on why she had become speechless in reaction to P's response, T came to articulate previously unexamined feelings concerning P's disregard of therapy. T's feelings of irritation at P and herself was rooted in their mutual neglect of the therapy, and T's failure to deal with this trend. T now saw the need to manage the analytical relationship more responsibly.
(13) So her feeling that I was thinking she was avoiding therapy was correct, because within myself the process of my realization that I was almost beginning to feel annoyed by her behaviour ... because part of that was leaving me feeling that she was avoiding therapy. So I think her perception that I felt she was avoiding was correct.	(13) T's feeling that P was avoiding therapy was in part a culmination of her growing realization that P's behaviour was becoming annoying and counterproductive. Hence, P's interpretation was reality-based.
(14) I didn't feel that she was inadequate or that she was doing something wrong in the sense that she was doing something bad. But as I say that now, I suppose in my mind she was doing something wrong in relation to therapy but I must say I hadn't thought of that. I hadn't seen it really in that way. But I think the process that I worked through was that I was annoyed, I was irritated and, yes, I was thinking she was trying to avoid therapy.	(14) Although T did not originally feel that P was inadequate, nor evaluate her behaviour as being unsatisfactory, she (T) retrospectively acknowledged that she had negatively judged P's behaviour in therapy. Through the process of therapy, T came to appropriate both her previously denied angry feelings for and judgemental attitude towards P.

Researcher: And the process of differentiating that this was transferential or non-transferential? (15) I don't know if this is an answer but I felt that I was aware of my feeling annoyed, and I was aware of my thinking she had avoided after it had taken me a week. I had really mulled over it and I was aware of thinking about it on a daily basis. So when she said that to me, it really felt correct. It felt congruent with what I had worked through and what I was feeling. That when she said the other, the inadequacy and she'd done something wrong, I felt comfortable with that because I knew I wasn't thinking or feeling that at all with her. So it was more a congruency with my feeling, her feeling of my thinking she'd avoided.	(15) Having repetitively reviewed the situation, T had become aware that she had felt annoyed with P who she believed was avoiding therapy. When T's perceptions concerning P's avoidant behaviour were confronted T recognized that the congruity of her feelings and P's allegations demonstrated the reality of P's perceptions. This consensus was not experienced with respect to P's beliefs that T perceived her to be inadequate and to be behaving unsatisfactorily.
Researcher: How did this compare to other situations in therapy? Situations that you may have interpreted as being a distortion. In what way was this different from transferential responses? (16) It was fitting what I was feeling. In other transferential ... or where I felt there had been distortions, in some instances there had been a surprise as to where this was coming from, where the patient's feeling has been coming from; and at other times there has been an awareness that it isn't what I am experiencing at all, and then wondering if it isn't coming from the patient solely because of what they're saying because it isn't anywhere in me, in any part of me. So I think the difference was for me that ... I was aware of feeling that and I knew it after having worked through it myself.	(16) T described nontransferential responses as being characterized by a correspondence between her recognized and appropriated feelings and P's perceptions of T's experiences. Transferential situations were often marked by T's experience of surprise concerning the source of P's feelings, or at other times an awareness that there had been a lack of congruence between what P believed T had experienced and T's actual experience.

Researcher: You were aware of your client sensing accurately what you were experiencing at that moment? (17) Well, she was sensing accurately partially. It wasn't totally what she was sensing, because she sensed my silence as a rebuke and my silence was actually a stunned one, but the feeling I had about what she was doing at one level was correct in that it agreed with what I was feeling and how I did feel towards her. But the other side just wasn't at all anywhere near what I had gone through and thought about and considered.	(17) T believed that P's unarticulated impressions of T's experience at that moment were partially correct, insofar as there was a correspondence between T's lived experiences in the analytic environment and P's perceptions.
Researcher: Can you tell me more about what was opened up for you through this experience? **Researcher:** For yourself, maybe concerning yourself, but also concerning your relationship with your client. (18) ..... An irritation with her. Callous is not the right word but her "everything's fine" attitude, anything goes, everything's easy. I think the thing that really hit me was the confirmation of a sense of a lack of form, a lack of discipline, a lack of boundary for this person. And it came in the way it was "I won't see you next week". So it highlighted for me I think a process that had been slowly growing within me and that was that I needed to deal with her inability to maintain boundaries and I wasn't doing it very well. It should have brought me back to myself that I actually needed to be more boundaried and I needed to work with that because she wasn't going to do it without me doing it, and why had I been letting it go as well. Somewhere we've been ... I let something go that I shouldn't have. I think that's what it was. I think the mixture of the annoyance at her doing this and perhaps that behaviour confronted me with what I needed to do which I found quite difficult with this person.	(18) T's irritation concerning P's indifferent attitude to therapy confirmed for her that P experienced therapy as lacking form and this highlighted for T that she had failed to deal adequately with P's inability to maintain boundaries. T reprimanded herself for unintentionally colluding with P in maintaining an undisciplined relationship. T's realization that she was annoyed with both P and herself for acting-out facilitated that she confront her own difficulties in dealing with P's needs.

Researcher: Made you aware of something real about the way you were handling therapy? (19) That I actually wasn't confronting, I think, a very core issue of this person, what she actually was having problems with in life. And I wasn't working with that at all. I had a sense of it and I knew it but, for whatever reason, I was avoiding it.	(19) T realized retrospectively that she had avoided dealing with one of P's core issues, although she had intuitively sensed this all along. Although T had intuitively sensed throughout therapy that she had avoided dealing with this core issue, T had realized this consciously only after P had acted out.
Researcher: Something else that you spoke about briefly and that is that it also opened up something historical concerning your client? (20) Ja, she had on a number of occasions, but she had never done it in this way and I had never explored it with her, but she had missed a number of sessions and always told me she wasn't going to be here the following week or she had told me two weeks in advance that she wasn't going to be at another session. But she had done it in a more orderly way but I never explored why she wasn't and I think this is why when she did it like this, I think she was maybe unconsciously calling me to do something about it. Because the historical aspect of that, I had always wondered why is it so easy for her to miss a session here and miss a session there and we had a very sort of patchy therapy and this seemed fine for her but it wasn't fine for me. But I wasn't doing anything about it and so when she did this I just realized how perhaps, if I had dealt with it earlier, we might not have got to this point.	(20) Although T had recognized that the history of their (therapeutic) relationship was characterized by periodic cancellations, she had continued to avoid exploring the reasons for this until the recent occasion called T to attend to the matter responsibly. P's acting out behaviour unconsciously invited T to recognize and own her own inadequacies and failures as therapist with this P.

Researcher: You seem to be saying that her saying that she was going to miss a session kind of called you to structure the therapy differently. That she was evoking something within you that was not addressed until then.	
(21) I don't think sufficiently well addressed, ja, but it wasn't her saying she was going to miss a session, it was the way she said it. I think if she had, maybe if she had said she was going to miss a session in the way she had in the past, it would have been again overlooked in the way that I had, but it was the manner in which she did it that evoked me to do something differently.	(21) In comparison with more formally expressed cancellations, P's casual manner of cancelling this session evoked a different response from T who could no longer ignore the problem.
Researcher: There seems to be a mixture of transference and nontransference in the situation you refer to. If you can tell me more about that.	
(22) I don't know if I can say more except that maybe what ... confirms for me the feeling that the other emotions she was experiencing were transferential, was her thinking that and then moving into experiences she had with her mother and why that interchange with me had left her feeling the way it did because they were exactly the same feelings she had when she had experienced that with her mum. So I don't know if its more my process of understanding, except that I knew it wasn't anything that I had regarded.	(22) What confirmed for T that the other emotions experienced by P were transferential was that P herself connected the present therapeutic interchange with the past relationship with her mother.

Researcher: How do you disentangle the tapestry of her emotions? What was transferential and what was not? How out of what you both experienced together was born this realization that it was a mixture of a transferential linkage with the past and a reality in the present? (23) When she started speaking about what she had experienced in that interchange she mentioned those three feelings; that I had felt she was avoiding or she had been led to feel she was avoiding, that she was inadequate and that she had done something wrong.	(23) With reference to the therapeutic interchange at the end of the session, P stated that T felt she was avoiding, and that she was inadequate and had behaved unsatisfactorily.
(24) I can't remember the exact sequence but I think I responded that I had felt stunned and I had wondered; and so my speechlessness was related to my inability to talk at that moment because I was trying to work out what was going on. And there was a feeling that she was needing to leave before she could discuss why she was going and she said the avoidance ... why she was feeling that I felt she was avoiding was because I hadn't said it was fine that I'd see her the following week. And when we explored that a little bit more, it felt that her feeling that I had felt she was trying to avoid, was linked to this boundary issue that that was something different and we came back to that later.	(24) Reflecting on that interchange, T replied that she had been stunned and her speechlessness resulted from her attempt to understand what had transpired between them. T sensed P's need to leave without explanations for her behaviour. P's "avoidance" interpretation was based on T's failure to give the usual approval of her request. When they explored the issue further, T acknowledged that she had been judgemental when evaluating P's request and that this was connected to her resentment concerning P's periodic cancellations and negligent attitude towards therapy.
(25) And then we went on to what it was that made her feel that I had felt she was inadequate or what had happened in that interchange that made her feel I was thinking she was inadequate; and she said it was something that had happened all her childhood when her mum had not responded to her when she had felt she'd done something wrong, and that whatever she'd done wasn't enough and that was the same feeling she had here.	(25) When P's other suspicions were explored, she revealed having had similar feelings as a child in relation to her mother, who had failed to respond to wrongdoing and whom she felt she could not satisfy.

(26) I said, "Tell me about those experiences," and her linking it more to those experiences of childhood and what she was experiencing with her mother at those times, was just a sense in me that this was more important than what we were dealing with now than the part that I had felt where she was avoiding. It was almost as if that was dealt with. It needed no more work.	(26) When T further explored P's childhood experiences, she sensed that this material was more valuable and needed considerable attention compared to the avoidance issue, which T felt had been sufficiently addressed.
(27) And I wasn't feeling ... there wasn't anything in me that was making me feel that this hadn't been sorted out and something more must be done here. This seems like good work is going on. It didn't feel attached to me at all, what was being said, and I think that's why we could carry on working it; whereas the first part there was an attachment to me. There was a sense that this does belong to me and it must be sorted out and got out of the way. So I don't know if that explains it, but it was just a clarity of feeling, I think, within me that this was her business and this was mine. Or perhaps the reality was "both of our businesses" because that's what she picked up and that's what I confirmed, but the other wasn't. It was her response to people not agreeing with her and how she dealt with it.	(27) T's intuitions motivated her conscious belief that the avoidance issue was now of secondary importance, and had received enough attention. T felt comfortable that because this transference based issue belonged solely to P it therefore required further insight-oriented work, unlike the avoidance issue which had been constituted by both of them and had consequently needed to be rectified by T in order to facilitate the development of a working alliance.

Researcher: How do you usually differentiate experientially what is their business and what is your business? What's your material and what's their material?	
(28) Well I know I'd spent as many days on this one. And I think what I do when something feels uncomfortable in therapy for me and there's a stuckness about it as well ... I'm aware of, after hours, mulling over it and I'm aware of not even consciously thinking of it but it comes up into my consciousness all the time and I try to, I suppose, identify what is happening that this keeps coming back. In some instances I don't think I do work it out but I think, for her specifically, I remember feeling, at one point, "This is what is happening." It was almost as if I had undone a knot and I had now straightened the line and there was a sense of things running clearly without a bungling up and getting into a mess.	(28) When T experienced uncomfortable phases in therapy leading to this sort of impasse, she would, after the session, both deliberately and spontaneously ponder over it trying to identify what was happening in therapy that maintained the frustration. For this P's solution of the problem brought a release from this sense of entanglement.
(29) How I normally do it, I suppose, is I reflect on it constantly between sessions and when the almost obsessiveness perhaps of looking at it or it doesn't keep coming back into my mind, then I know that it's been sorted out and what is mine I take and then I know where to work with the person in the therapy.	(29) T constantly reflects between sessions on her experiences of being blocked in therapy and when the rumination abates she knows the difficulty has been identified and she feels separate and therapeutically focused.
Researcher: There's a freedom?	
(30) Ja, and it doesn't seem to come back then. The issue doesn't seem to come back into my .... in the same way when I'm in between sessions as it does when there is an issue that has to be resolved.	(30) After resolution, T is freed of preoccupation with the matter between sessions.

Researcher: So a great part of the process of differentiating takes place between sessions? (31) Ja, I think in knotty situations like that one, but I think there are times in a session where I've been aware of something being said to me, where I've had a similar experience to what I had with her where there's sort of been a bolt but somehow, sometimes, I've been able to work out there and then that this has nothing to do with me. It is to do with what's happening with this person.	(31) T has also experienced sessions with other Ps where she has been shocked in a similar way but has been able to recognize immediately that this is transference.
(32) It might have been that, if she had said this in the session but I don't think so. Because, I think, of the history, I might have also just let it go in this instance. But I think this was a similar response that I get in sessions, this absolutely ... it's a shock almost and then it's a slow working through. She just took much longer, I think, because I think I had for too long let things build up from my side without doing something.	(32) T might have dealt with P's request in this way if it had been made during the session but because of the history T would most probably have neglected to attend to the therapeutic meaning of P's acting out. The similarity of her response to other responses alerted T to the need to manage the relationship's boundaries more adequately. Her failure to do so had delayed comprehension.
Researcher: What is the signal, the message of the bolt? What does it alert you to? (33) That something's happening here that I'm not in touch with or something's happening here that's touching me but I don't know what it is. It's at the moment of the bolt. It's a surprise, it's an unawareness sense, a sense of "what's going on?", "what's happened?". And I think when this physical shock subsides, then I can start working through it on a mental emotional level. It's almost a physical assault actually.	(33) Being surprised by an unexpected reaction alerted T to an unknown and threatening element in the therapeutic interaction. When T recovers from what is a sensation of almost physical shock she can begin to analyze the experience on both a mental and emotional level.

Researcher: You experience it bodily? (34) Ja, maybe bodily, but it's experienced as an assault on my solar plexus, that gets it. That once that sensation has subsided then I can start working through the emotional and the mental .... As I am speaking, I'm just wondering why that took so long ... because I was aware of it taking days. It definitely took the full week and it was almost only that day before the session that I had resolved within myself.	(34) T experiences this shock as an assault on her solar plexus and wonders in the present instance it has taken a full week to recover from and internally resolve the strange and threatening experience.
Researcher: You mentioned the emotional and the mental as if this disentangling or this unravelling is both an emotional and a mental process. (35) I think the mental is the understanding for me of what is going on and the emotional is the feeling of what is happening. So I can sometimes feel, or I might feel as in this instance I felt, annoyed and irritated and then I needed to work out what was that annoyance about and that's the mental for me. I may be using words that are used differently but that's how I see it. So I could have a feeling of annoyance but I didn't understand it fully, why I was annoyed, and once I got the feeling of annoyance, I then was able to sit and try and work it out on a conscious level.	(35) T believes that she first encounters a situation on a pre-reflective feeling level before consciously attempting to understand her response and its context fully on a mental level.
Researcher: How do you come to know that the situation that you are participating in is a transferential situation? (36) Maybe I can best describe it, if a patient attributes a feeling I have to them which is, I can say, either very opposite to what I'm feeling or else something I haven't at all experienced. One can argue then and say, "Well, maybe you're not in touch and you're not aware of that." But it doesn't ring anywhere in me their attribution. It doesn't spark off any part of me to think, "Well, maybe that experience I have," when it's so obviously a transferential experience. When it's an absolute bolt from out of space, then it's an awareness that it really isn't for me, it isn't mine, it is theirs.	(36) T evaluates a situation as being transferential when patients inaccurately attribute certain feelings to T or when P's response is experienced as totally unexpected, T realizes that this is definitely P-determined and indicates a transferential situation.

(37) Another example is the patient saying I'm not interested in them or I don't care. And I know because I know how much time I've spent on them other than therapy, that I do care and I am interested in them. So it's just something that feels so foreign to what I know I'm experiencing or I haven't touched anywhere, any of that experience at all. I think then I feel it's a transferential thing.	(37) T illustrates this by referring to the situation where a P claims that T is not interested in them, and T knows implicitly that patient's attribution is so unrelated to her experience that it is definitely rejected as being a distortion of T's reality.
(38) If transferential ... if we were to start working in that way and nothing comes of it, I am aware of sitting at the end of the session and wondering about what the patient has said and if it isn't something that I'm very aware that it's something opposite to what I feel or different to what I feel; and questioning then, "Is what they're saying, perhaps, is there some grain of truth somewhere?" and then it's that process again of .... and if it keeps coming back into my mind without me asking for it, then I think it needs attention.	(38) When a situation is initially accepted as indicating transference, but no progress is made following this therapeutic decision and T realizes at the end of a session that a P's comments do not necessarily contradict her experiences, the continued preoccupation with the matter suggests the necessity for further enquiry.
(39) But I think the immediate feeling of whether this is transferential or not is this surprise element or the sense that it's so right. It isn't something that I am. It is something from where they're coming from and we can work with it and it usually is correct. I suppose that is more of a feeling experience to differentiate if a feeling feels right or not, or neutral. There's a neutrality sometimes when someone accuses me of something that isn't ..... that I think is transferential. It's comfortable.	(39) T's immediate sense of whether a situation is transferential or not is determined by her experience of surprise or the intuition that P's attribution is definitely inaccurate and not generated by T. T's experiential differentiation is made on a pre-reflective, unarticulated level. When T experiences neutral feelings while rejecting a P's accusations she believes it indicates a transferential response.

Researcher: What is comfortable? (40) It's a sense of ... it's a knowledge that this is something happening inside of them. It's not something that I am doing to them. I think the bolt is such a shock, I don't know if it's at a different level or a different intensity or what, that that one is such a shock that I'm almost thrown back on myself and, at that point, I'm asking myself "Is this me? Isn't this me?" and so I'm going through that process then; but there are other times when the bolt isn't there and there's just a sense of it isn't and we can work with that. So it isn't me having to see if it is me, that process, first. The bolt makes me question myself because I wonder what's going on, that it's such a surprise. That once I go through that process and I feel it's sorted out ... then I can see what is for me and what is theirs.	(40) T's experience of comfort is a certain knowledge that a P's response is not determined by her but internally generated by the P him/herself.

4.5.2 PROTOCOL FIVE: CLINICAL SITUATED STRUCTURE

At the end of a session the patient announced casually that she would be missing the following session. The therapist's experience of the patient's offhand and unexpected response was shock amounting to speechlessness. She was taken aback by it in the context of recent therapeutic interaction.

It was in the midst of this "unawareness sense", while dwelling on a pre-reflective feeling level that the therapist first encountered this surprising situation. The therapist's experience of shock was sensed bodily as an assault on her solar plexus and alerted her to an unknown and threatening element in the therapeutic interaction. Beyond this experience of being stunned, the therapist recovered to be able to begin to analyze what had transpired between them on both a mental and an emotional level.

Both participants in this analytic interaction experienced the temporal flow and continuity of the dialogue as having suffered a sudden rupture. The patient appeared to the therapist to have become uncomfortable when making the announcement and later

disclosed that she had experienced the therapist's delayed reaction as a sign of disapproval. In the face of the therapist's speechlessness and supposed detachment, the patient was reminded of her mother's silent disapproval when she had done the wrong thing. The patient came away from this experience feeling so bad about herself that she had needed to phone the therapist to make another appointment to reassure her that she was not simply trying to avoid therapy. The uneasiness of the therapeutic interchange at the end of the session left the patient feeling that the therapist perceived her as having avoided therapy, having done the wrong thing and as being inadequate.

The therapist's closing impression at the conclusion of this session was that the patient needed to leave without giving explanations for her behaviour. The therapist separated from this situation wondering why the patient had announced the matter in such a careless and casual manner. It was within this interim therapeutic period that the therapist experienced great uncertainty as to the patient's motivation in and appreciation of therapy. When the therapist experienced uncomfortable phases in therapy which led to this sort of "stuckness", she would after the session both deliberately and spontaneously ponder over it trying to identify what was happening in therapy that maintained the frustration. Constantly reflecting on her experience of being blocked in therapy brought a release from this sense of entanglement, and with the elimination of the ruminations came the knowledge that the difficulty had been identified. It was only the day before the next session that the therapist felt separate and therapeutically focused. With this sense of imprisonment resolved, the therapist felt free of the preoccupations of the week. She had needed the fullness of this week to recover from and internally resolve the strange and threatening experience which had assaulted her both bodily and mindfully.

When the therapeutic dialogue was resumed, the therapist found herself being asked to respond to the patient's enquiry concerning her reaction to the patient's announcement. Although the therapist accepted the reality of the patient's explanation for cancelling the session, she questioned the manner in which this had been done. It was within this context of exploration that the patient disclosed that she had remembered her mother's silent disapproval through having connected the present therapeutic interchange with this past relationship. This awakened the therapist to the awareness that these additional

evoked emotions associated with wrongdoing, guilt and reparation had their source in the past and were therefore considered to be inappropriate in the present situation and thus transferential responses.

While the therapist acknowledged that she had felt that the patient was avoiding therapy, she nevertheless rejected the patient's beliefs that she viewed her as doing something wrong, and as being inadequate. Instead, the therapist had felt that the patient was dismissive of therapy. The therapist's feeling that the patient was avoiding therapy was in part a culmination of her growing realization that the patient's behaviour was becoming annoying and counterproductive.

Reflecting on why she had become speechless in reaction to the patient's surprising response, the therapist came to articulate previously unexamined feelings concerning the patient's disregard of therapy. The therapist was awakened to feelings of irritation at the patient and herself for having acted-out. The therapist's irritation and annoyance concerning the patient's indifferent attitude to therapy beckoned her to confront the patient's experience of a therapy lacking in form. This highlighted for the therapist that she had failed to deal adequately with the patient's inability to maintain boundaries. Along with this realization of having acted-out herself by unintentionally colluding with the patient in maintaining an undisciplined relationship, the therapist became annoyed and dissatisfied with herself for not having faced her own difficulties in dealing with the patient's needs. The therapist's experience of being reflective allowed her to retrospectively thematize that she had intuitively sensed throughout therapy that she had avoided dealing with one of the patient's core issues. The patient's manner of having acted-out had unconsciously invited her to recognize and acknowledge her own inadequacies and failures as a therapist.

Although the therapist did not initially feel that the patient was inadequate, nor evaluate her behaviour as being unsatisfactory, she became aware, during the week, through repeated revisions of the situation that she had felt annoyed with the patient because of her periodic cancellations and negligent attitude toward therapy. Through the uncovering process of therapy, the therapist came to appreciate both her previously denied angry

feelings for and judgemental attitude towards the patient. The therapist's realization that she had negatively judged the patient's behaviour in therapy was crystallized during the interview with the researcher.

The therapist's ongoing experience of differentiating whether the patient's responses were transference-based or reality-oriented, shifted into the foreground when she confronted the relationship between her own feelings and the patient's attributions or unarticulated impressions of her. She recognized that the congruity of her feelings and the patient's allegations that she had viewed the patient's behaviour as avoidant, demonstrated the reality of the patient's perceptions. Besides this correspondence between her lived experiences in the analytic environment and the patient's perceptions of her, no consensus was initially experienced with respect to the patient's other beliefs. For this reason, the therapist entertained the thought that the patient's unarticulated impressions of her experiences at that critical moment were partially correct. For the therapist, nontransferential responses were characterized by a correspondence between her recognized and appropriated feelings and the patient's perceptions of her experiences.

Beyond the experience of having acknowledged the patient's nontransferential responses, the therapist resumed the enquiry into the patient's childhood experiences, an area the patient herself had offered up for exploration. The therapist's invitations were motivated by her conscious belief that this material was more valuable and insufficiently addressed, compared to the avoidance issue which was now of secondary importance and had received enough attention. Unlike the avoidance issue, which the therapist felt had been constituted by both of them, the issue of wrong-doing was believed to belong solely to the patient and was historically based and therefore in need of further insight-oriented work. In addition to the patient having connected the present therapeutic interchange with the past relationship and subsequently having associated the therapist's failure to respond with her mother's disapproval, the therapist considered transferential situations to be characterized by an experience of surprise concerning the source of the patient's feelings, or an awareness that there had been a lack of congruence between what the patient believed the therapist had experienced and the therapist's actual experience. The

intuition that the patient's attribution was definitely inaccurate and not generated by the therapist motivated the therapist to view the response as being distorted.

The therapist believed that she received this sensation of shock or surprise first on a pre-reflective feeling level, and that her experiential differentiation was located on this unarticulated pre-verbal stratum; or sometimes when neutral feelings were experienced by her while rejecting a patient's accusations, it indicated that the response was transferential. The therapist experienced comfort in knowing that the response was not determined by her but internally generated by the patient.

The therapist said that although the sensation of shock could be recognized immediately in some situations as indicating transference, often the process of disentangling experientially what material belonged to the patient and what was hers took place between sessions, through "mulling over it" both deliberately and unintentionally.

She emphasized that although a situation may have initially been accepted as indicating transference, the realization at the end of a session that the continued preoccupation with the matter of therapeutic differentiation and the recognition that a patient's comments did not necessarily contradict her experiences suggested the necessity for further enquiry.

4.6 Extended Description of the General Structure

In the situation of identifying and differentiating whether a patient's response is transference-based or reality-oriented, the therapist finds himself frustrated and discomforted by the patient's attitude to and mode of behaviour in therapy. In the midst of this ongoing uneasiness in therapy, the continuity of the dialogue may be ruptured by a sudden and unexpected response on the part of the patient, which jolts the therapist because of the seeming inappropriateness of the statement or its untimeliness. The therapist's sense of being caught unawares is first encountered on a pre-reflective feeling level, and may be realized bodily.

The suddenness and incongruity of the patient's response invites the therapist to attempt to gain a conceptual understanding of the analytic encounter. Once the therapist has distanced himself and partially recovered from the impact of the patient's startling response, a process marked by the dialectical interchange between the therapist's experiencing and observing modes of relating takes place. The therapist's evaluative endeavour, aimed at revealing the source of both the patient's and his own reactions is lived as a journey of disentanglement, which is characterized by his need to oscillate between accessing the intuitive wisdom of his pre-reflective world and the theoretical knowledge of his cognitive, rational faculties. This process is lived in the immediacy of the moment and reflectively beyond the climax of the arousing situation.

The therapist, intent on ascertaining whether the patient's perception of him is sound and whether his own reactions are warranted, is prompted to focus inwardly with the purpose of confronting himself. Sitting in judgement on himself the therapist scrutinizes his desires, motives and behaviour in therapy. His receptivity to the patient's communication and his own intuitive, pre-articulate impressions, informs him that his experience of being unable and unwilling to own the patient's attributions, incongruous with his own conscious intentions and perceptions of himself, is reason to view the patient's responses as transferentially-based. This recognition of the apparent dissonance between their experience of the reality of the present or recent situation illuminates for the therapist the pathological nature of the patient's responses and forms the basis of the therapist's process of differentiating whether the material of the patient is distorted or not.

The therapist's evaluative stance reinforced immediately or retrospectively by his increasingly evolved but not necessarily articulated global understanding of the patient serves as a pre-conscious foundation for his discriminations. With continued introspection and repeated reviews of the emotionally charged situation, the therapist's growing pre-verbal sense of invalidation of the patient's past behaviour is articulated. This frequently substantiates his immediate spontaneous assessment of the patient's response as being transference-based.

The continued exploration of the unarticulated world of the therapist, often in conjunction with retrospective analyses of past un-understood and emotionally burdensome transactions, frequently reveals to the therapist how he has sacrificed his authenticity by acting-out and colluding with the patient. The recognition and acknowledgement of past acts of collusion thematizes for the therapist retrospectively how he has responded to the covert infantile evocations of the patient, and concurs with his evolving interpretation of the patient's manner of dwelling in therapy. This unveiling may strengthen the therapist's conviction that his feelings have been induced by the patient and are rooted in the patient's concealed past. Alternatively, the process of self-appraisal and interpersonal deliberation may beckon the therapist to acknowledge and appropriate his own denied feelings and/or contributions in the analytic situation, thus allowing him to approach the patient's communications with an expanded sensitivity and openness. The latter attitude occasions the revocation of earlier judgements and permits the therapist to identify previously unnoticed reality-oriented reactions of the patient.

The interrim therapeutic period often unexpectedly nurtures the therapist with a purifying source of reflective material which enhances his ability to identify the nature of the patient's responses. This may be presented in the form of statements directed at the therapist which show attempted modifications by the patient of past erroneous comments. In addition, later manifest "connections" made by the patient which demonstrate recently developed insight indicate to the therapist that the patient's incongruous reactions were genetically linked and misplaced in the present. The contorted bodily posture of the patient at the time may also support the therapist's view of misrepresentation. Other patients' critical enquiries as to the therapist's demeanour over a certain time period can also throw the therapist back on himself and awaken him to the partiality of his views.

With the experience of reaching a greater understanding of what has transpired interactionally and having grasped what initiated his responses, the therapist's unresolved feeling of being burdened with incoherent material, begins to dissipate and the therapist comes to feel relieved, clear-minded and disentangled from the patient. Once in control of himself, the therapist feels liberated and challenged to engage fully and listen

comprehensively to the patient, and orientates himself to the unfolding landscape of the "in-between.".

The therapist's recognition of the infantile behaviour of the patient, experienced as invasive of the therapist's personal boundaries and generative of phases of inauthenticity, alerts the therapist to the pervading characteristic style of relating of the patient. It demands that he does not disregard this substratum of behaviour which endures far beyond the momentary manifest reality-oriented reactions of the patient. In other words, the therapist concludes that his own evaluative process is continuous and that within this human interpersonal context, the transference-based and reality-oriented responses of the patient reside side by side, often interwoven and inextricable.

4.7 LIST OF NODAL THEMES

1 The therapist's lived discomfort, the initiation of sensibility

2 The turning point

3 Self-confrontation in the service of differentiation

4 A reflective viewpoint: A window to the pre-articulate realm, a gateway to appropriation

5 Liberated from misunderstanding: A doorway to potential space

6 The unspoken insights and retrospective conclusions of the therapists

4.8 Summary of the Extended Description of the General Structure

In the situation of identifying and differentiating whether a patient's response is transference-based or reality-oriented, the therapist finds himself frustrated, discomforted

or stuck in the therapy. Alerted by the patient's reactions which are out of keeping with his own conscious intentions and perceptions of himself, the therapist focuses inwardly in order to examine himself to establish the source of the irritation or obstruction in therapy.

Living in duality, oscillating between inspiration and the rational mentations of the trained conscious, the therapist comes to experience himself as a patient, scrutinized by both his own and his patient's confrontations. Honest reflection leads him to recognize his own acts of collusion and inauthenticity in responding to the patient's covert evocations (transference-based communications); or he acknowledges his own role in what has unfolded interpersonally. This appraisal of his own participation in the analytic situation allows him to be present and receptive to the fullness of the patient's communications, and frees him to identify the reality-oriented responses of the patient.

The new openness achieved frees both therapist and patient. The therapist on his part feels liberated from misunderstanding and can engage more comprehensively with the patient and be attentive to what emerges intersubjectively in the therapeutic space. The therapist is enabled to distinguish between the patient's momentary reality-based responses and his characteristic and enduring style of relating. Forsaking fixed judgements, he becomes open to the interwoven reality-oriented presence and the historical transferential past, accepting them as inseparable and sometimes inextricable.

CHAPTER FIVE

5. DISCUSSION

5.1 Introduction

The intention of this research study was to address the central feature of analytic technique, the analysis of the transference, and to make a plea to therapists to view the analytic relationship with humaneness and flexibility. To this end I have proposed that therapists broaden their view of the analytic process to include the reality elements of the patient's communication and to acknowledge the existence of the total relationship between the patient and therapist as persons. It has been argued that not all the patient's perceptions of the analyst/therapist are manifestations of the transference. Consonant with this attitude to understanding the analytic relationship, it has been posited that unless therapists attain the ability to "accurately" discriminate the patient's reality-oriented reactions from their transference-based reactions, their (the therapists') need and zest to over-interpret will not be curtailed. For this reason it is imperative that therapists/analysts acknowledge the importance of correctly identifying and differentiating whether their patients' reactions are distorted or reality-adapted. It is contended that unless this first stage of the analysis of the transference be handled competently, analysts/therapists will continue to focus on their patients' pathological communications ignoring their adaptive attempts to re-own and authenticate their lives.

Interestingly, but unexpectedly, it appears that an implicit belief held by most authors and researchers alike in this vast field of analytic literature is that therapists/analysts "know" what process to follow when discriminating the communications of their patients. The literature abounds with sections on typical transference characteristics and detailed chapters on the various forms or types of transference reactions, but little mention has been made of the psychoanalytic therapist's first hand experience of actually identifying and differentiating the manifold communications of the patient.

The research aim of this study has therefore been to faithfully describe the inner experiences of the therapist as he attempts to make sense of the total communication of the patient in the intersubjective analytic situation. This quest attempts to fill a hiatus in the literature and is consistent with recent trends in the analytic field which have focused their attention on the mental processes of the analyst. For example, both Baranger (1993) and Jacobs (1993) have addressed a major issue in psychoanalytic work: "towards the awareness of the ways in which the analyst's work is determined."

The subject of the present research study attests to the need to investigate the "inner" landscape of the therapist and conforms with the main theme of the 38th Congress of the International Psychoanalytical Association in July 1993, namely "The Psychoanalyst's Mind: From Listening to Interpretation" (Schacht, 1993, p.6).

The following discussion of the research findings, which illuminate the lived experiences of the therapists, will be organized around the primary themes of the extended description, which is used as a point of reference. The process of identifying and differentiating the transference-based and reality-oriented reactions of the patient can only be artificially dissected into its respective steps, as the conscious-unconscious observational dialectic that informs the therapist of how he is being used by the patient is different for each therapist. More specifically, the process of oscillation between the experiencing and observing egos of the therapist is idiomatic to each passage of therapy. For this reason the delineated stages and noted sequence of the evolving process partially obscure the original lived experience of the therapist. Nevertheless, for pragmatic considerations and issues to do with research intent, the distinctions made serve as an informative guide to comprehending the inner experiences of the therapist during this evaluative process.

Considering that the essence of this evaluative process concerns the therapist's capacity to resonate with his patient's rhythm within the realm between fantasy and reality, and yet simultaneously be anchored within himself, the nature of the experience demands a description of the interrelationships that obtain between and among certain of the respective stages of the spiralling process. Consequently, the discussion has been

organized around broad nodal themes which include a consideration of two or three of the overlapping constituent patterns noted in the extended description. It is hoped that this representation will amplify the experiential dynamics of the therapist as he in turn plays alone in the presence of the patient. It is in this transitional space that the therapist through self confrontation and self contemplation, coupled with the maintenance of an interactional viewpoint, comes to differentiate himself from his patient.

The discussion follows the sequence in which the patient's communications are identified, differentiated and processed by the therapist; 1) the therapist's lived discomfort, the initiation of sensibility, 2) the turning point, 3) self-confrontation in the service of differentiation, 4) a reflective viewpoint: a window to the pre-articulate realm, a gateway to appropriation, 5) liberated from misunderstanding: a doorway to potential space, 6) the unspoken insights and retrospective conclusions of the therapists. This sequence is consistent with the nodal themes listed in section 4.7 of the results chapter.

5.2 Exploration of nodal themes

5.2.1 The therapist's lived discomfort, the initiation of sensibility.

In the situation of living in relation to one's patient, the therapist in the process of listening, understanding and interpreting, often finds himself frustrated, discomforted or stuck in the therapy. Although this experience is immediately felt, it is not necessarily fully articulated and understood in the moment as being related to the attitude of the patient and his mode of behaviour in therapy. Some of the therapists interviewed in the study reported experiencing an ongoing uneasiness in the therapy, a sense of frustration or irritation they could not make sense of, nor feel in control of. Only retrospectively was this lived, but unarticulated discontent brought to language and conceptual understanding. For others the unrelenting, demanding, infantile behaviour of the patient was clearly apparent and the therapist's stuckness or helplessness was associated as being its eventuation.

Although most of the therapists described deprecatory or disharmonious situations in therapy, the few affirmative situations that were depicted were also experienced as being uncomfortable. A precis of the individual experiences of the therapists is presented below to demonstrate the above findings.

Therapist number two felt for a long time in the beginning of therapy that it was very difficult to understand her patient, and because of this found herself talking quite a lot in the sessions in order to clarify what the patient was saying. She needed to concentrate and found herself working hard in the sessions, making more interpretations than she normally did. The therapist knew that she was talking a lot but didn't know why.

Therapist number eleven (protocol five) had a growing realization that her patient's behaviour was counterproductive and that the patient's indifferent attitude to therapy irritated and annoyed her. The patient's periodic cancellations and negligent attitude toward therapy niggled the therapist but because of its insubstantial nature did not warrant that this culminating displeasure be immediately attended to and understood. This underbelly of discontent served as a pre-conscious foundation for later discriminations made by the therapist.

Therapists number three, four and six (protocols three, two and four respectively) were all engaged in long term therapy with patients manifesting narcissistic and borderline type features. The intrinsic element in all three cases was the infantile, regressed nature of the patients' functioning. Whereas therapist number four experienced a cumulative sense of being disregarded and used as an object to gratify her patient's insatiable needs, therapist number six felt excessive anxiety being on the receiving end of her patient's ongoing verbal attacks. Her intensified feelings of inadequacy coupled with the self-conscious and self critical reactions to the patient's verbal barrages engendered a general feeling of being victimized. In addition to this, she also felt trapped by the patient's sensitivity to her reactions.

Irrespective of the patient's reason for entering therapy, the nature of the patient's neurotic or character-disorder, or the professional experience of the therapist, the

outstanding characteristic for many therapists was the patient's primitive mode of relating. This was evident in the case of therapist number three whose patient's radical paranoid type statements clearly demonstrated deep seated mistrust and sensitivity to being persecuted. The therapist felt tyrannized at times by his patient's sensitivity to his vulnerabilities and acknowledged that his patient was able to get to a very real part of him. Both therapist number three and number six sensed all along that the denigrating accusations levied at them throughout the first year of therapy were indicative of primitive object relating.

In contrast to the experiences of the latter two therapists, therapists number five and number nine both described feeling indecisive or stuck. Therapist number nine felt self-critical and questioned whether he understood his patient because, whatever he did for her, he sensed was not good enough. He had the overriding feeling that he was either interrupting too much or was being too withdrawn and passive with his patient. His self-doubt led to feelings of frustration, anger and at times "a lot of absolute alienation".

Therapist number five's frustration and consequent stuckness was centred around his patient's setting up "this approach-avoidance thing". His patient would come to him with a particular goal and as the therapist began to help him, he would begin to withdraw and get depressed and angry with the therapist. In reaction to the therapist's contingent detachment the patient would once again seek help in having his life structured. "He invites you in, and then one gets in there, and he says he wants to be left alone." The therapist also added: "It's almost like a child-like thing of 'leave me alone'".

Therapist number seven felt inappropriately split and went as far as typing out the sessions in order to give herself "a chance afterwards to get to what she (the patient) was doing and what she was at." The first thing that struck the therapist was the inappropriateness of the patient, who although being a professional worker was dressed as a little girl in an all-in-one jumper-suit. The patient's infantile manner of hopping on the couch surprised the therapist who struggled to accord this behaviour with her intellectual way of speaking. For a long time the therapist felt that the inappropriate split in her patient had an effect on her too. This experience corresponds to therapist

number one's (protocol number one) immediate feeling of discomfort. He too was effected by the "demandingness" of his patient's infantile posture. The patient's position on the edge of the seat pressurized him from the beginning and he sensed "if she could, she would like to sit on my lap." (protocol one, MU3)

Discomfort is not always associated with being reproached or incessantly abused, either subtly or covertly. Therapist number ten described how difficult it was to bear the idealizations of his patient. He claimed that "when it's only one dimension which is projected onto you, there's a part of you that wants to rectify the one-sided projection." The unconscious pressure on him in the room demanded that he always be totally ideal and this tugged on his conscience.

Heimann (1950) noted that transference feelings cannot be sharply divided from the realistic feelings of the patient and that "the differentiation between the two kinds of feelings is not always easy" (p.74). It is here argued that the analyst's/therapist's immediate emotional response to his patient is not only a significant pointer to the patient's unconscious processes as a whole, but an essential guide towards a fuller appreciation of the "intrapsychic role - relationship" (Sandler, 1976) which the patient attempts to impose on the therapist.

The analytic task of differentiating the "two kinds of feelings" of the patient is made easier if we shift or extend our emphasis from the content of the patient's associations to the "atmosphere or mood that is created in the session" (Stewart, 1992, p.78). This enables the therapist not only to focus on the projections which develop in regard to him, but to understand what particular use the patient is making of him (object usage) in the analytic situation. For this reason I strongly advocate Sandler et al.'s (1973) definition of the transference concept which states that "transference need not be restricted to the illusory apperception of another person but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships" (p.49).

All the therapists interviewed in the present study monitored their internal responses to their respective patients and considered how they were being drawn into different kinds of relating to them. In other words, their "feeling perceptions" (Searles, 1963) were operative from the very beginning enabling them to use their countertransference associations diagnostically. Although many of the therapists had not reached an evolved conceptual understanding of the dynamics of the total therapeutic relationship and needed to delay making any definitive evaluative decisions, for some of the therapists the severity and intensity of the emotional abuse they endured was enough evidence of the pathological nature of their patient's functioning. These therapists did not actually require that "a point of discomfort" in the passage of therapy be reached before they could punctuate the communicational text of the patient as being transferential (protocols two, three and four). It appears that for these therapists the basis of their later judgements had already been laid, yet not confirmed.

Greenson (1967) contended that transference resistances, one of the categories of clinical transference reactions, is the most important and frequent cause of obstruction to the analytic work. The term transference resistance, according to Greenson (1967), is a condensation and refers to many different clinical constellations. Therapist number three intuitively sensed throughout the first nine months of therapy that his adolescent male patient's rivalrous and hostile reactions was a defense against homosexual feelings. It was only later in supervision that the patient's "reaction formations in the transference" were reflected upon and understood as being defensive transference reactions. Therapists number four and six (protocols two and four respectively) progressively realized that their patients' infantile, regressed behaviour respresented their habitual, typical responses to people at large, what Greenson (1967) has termed "generalized transference reactions". Yet, this did not preclude them from viewing the total therapeutic situation as generative of reality-oriented moments.

It must be emphasized that transference is only one dimension of the total therapeutic relationship and that although unconscious phantasy serves as a fertile matrix for the

patient's behaviour and perceptions, this does not negate the existence of the patient's correct unconscious perceptions, nor disqualify his purposeful, self-restorative behaviour.

5.2.2 The turning point

It is not surprising that most of the therapists interviewed in this study selected a therapeutic situation which, because of it's "impactfulness", was not only suitable as an example for differentiation but was also "unforgettable". It appears that most of the therapists recalled a "critical moment" in therapy, which served not only as a landmark in the passage of its development, but was also a place to punctuate the ongoing uneasiness and stuckness they experienced.

The common denominator for many of the therapists was the "inappropriateness" of the patient's response, the unsuitability of the patient's reactions in terms of the current context of therapy. Although therapists number three and six (protocols three and four respectively) were accustomed to the capricious nature of their patients' reactions, they were nevertheless jolted by the qualitative inappropriateness of their patients' communications. Therapist number three was astounded by his patient's "bizarre" reaction which floored him and dislocated him from the flow of his thoughts. He described his immediate reaction as follows: "I didn't know where on earth this was coming from, I had no contextual reference. I thought to myself, 'What's he talking about?'" (protocol three, MU 5).

Therapist number six described the climactic moment in therapy in a similar way. Her patient's accusations, addressed to her in a letter, "sort of came like a bolt of lightning." She later added: "That clarified something for me. It was the very unreality of that kind of statement...that started to alert me to what was happening on a more transference kind of level" (protocol four, MUs 10 and 11).

It is noteworthy, that although this therapist had endured many months of dehumanizing remarks she needed a "signal light" to alert her to the degree of inappropriateness of her patient's communications. According to Greenson (1967), the inappropriateness of a

reaction to a current situation is the prime sign that the person who triggers the reaction is not the "true" object. He contends that generally intense emotional reactions to the analyst/therapist are indicative of transference. Sandler et al. (1973) believe that the label of "special forms of transference" should be applied to these grossly unrealistic transference reactions, which are typical of patients with severe personality disorders.

It appears that for some of the therapists engaged in the process of differentiation a certain "point of discomfort" needs to be reached for them to seriously reflect on themselves, the behaviour of their patient and the interactional domain. This point has been made by Hamilton (1986) and Thorpe (1989) who found that therapists experienced difficulty identifying positive projective identifications, as the experiences were ego-syntonic and did not unsettle them, nor invite them to explore their own experiences.

The continuity of the dialogue may be severed by the inappropriateness of the patient's manner of handling separations in therapy, or their intense emotional responsiveness to the therapist's benign reflections or surface interpretations.

When therapist number twelve interpreted to his patient, "I notice that you always tend to announce the end of the session", his patient became overwhelmed with emotion. The patient verbalized that he had no power and that the therapist had it all. The therapist was stunned by his patient's intense emotional reaction, which for him defined that moment as being "no arbitrary event". He emphasized: "There was a sense of amazement at the degree to which he in the relationship felt me as being so powerful."

Therapist number eleven (protocol five) was shocked by her patient's unexpected announcement that she would miss the following session. At that moment the therapist was actually taken aback. "I was speechless...because I couldn't fit it into what had been said just prior..." (MU 10). "It's a surprise, it's an unawareness sense, a sense of 'What's going on?'" She described this as a physical shock, "a physical assault". This communication from the patient was immediately perceived as "an absolute bolt from out of space" (MU 36), and because of its "foreignness" was perceived as belonging to the patient... "it isn't something that I am - it is something from where they're coming from..."

(MU 39). This encounter served as a beacon for the therapist in a landscape she had become accustomed to, but felt out of touch with. The alarming experience served as a prerequisite for her to begin to observe herself and review the road of therapy.

This situation is illustrative of a transient, sporadic "acting out" reaction which, as a form of nonverbal communication, served a constructive purpose in calling the therapist's attention to her ability to manage the therapeutic framework. Greenson's (1967) statement that acting out is always a resistance even though it may serve some useful function temporarily is endorsed, and pertains particularly to therapist number four's experience (protocol two). The patient's nagging phone calls, aimed at obtaining the name of a book, angered the therapist who felt "overwhelmed and sucked dry" by an unappreciative, intrusive patient. Despite its resistance functions, the acting out behaviour by the patient was later understood to be her immature means of reaching out for help.

The primary value of these emotionally intense reactions by the patient, perceived as inappropriate or untimely by the therapist, is that they often throw the therapist into a necessary state of uncertainty which subsequently enhances the therapist's capacity to understand his fate as the patient's object. In other words, these states of "not-knowing-yet-experiencing" (Bollas, 1987, p.202) act as turning points for the therapist in his quest to understand, through his evoked feeling perceptions, the nature of the patient's communication.

It may be postulated that these direct, unadulterated communications, referred to as "projective identifications" by Ogden (1982, 1990) serve as a first line of identification of transference reactions for analysts/therapists working with pre-psychotic or borderline type patients. The therapist flung back upon himself by the impact of the patient's reaction experiences the thrust of the pressure on him to actualize "a segment of the patient's internal object world" (Ogden, 1982, p.69).

When working with relatively well functioning neurotics who do not require the same degree of feeling-participation (Searles, 1963) on the part of the therapist, the initial

recognition that a patient's "behaviour" is transferential is based more on conceptual identification. This was succinctly expressed by therapist number five. He stressed the importance of recognizing the patient's patterns of relating outside of therapy and then seeing them "actually happening here too." He noted: "I don't really reach it through my own experience in a sense - it's not like I'm drawn into a certain strong sort of feeling with him. I recognize it because he's doing this all over the place and I recognize it here. I don't feel drawn in at a projective identification sort of level. I feel that he sets this thing up and I slip into it. I can easily slip out of it in the sense that I allowed it to happen in this relationship."

The instances referred to demonstrate that the continuity of the therapeutic dialogue is not always ruptured by an intense emotional reaction from the patient. It must be emphasized that not all therapists reach a "point of discomfort" or experience considerable confusion or surprise before they begin to recognize what they define as the pathological reactions or behaviour patterns of the patient. Nevertheless, the term "turning point" is relevant to all therapists who have reached a certain depth of understanding of their patients' total communication or experienced an "unmistakable" intensity of involvement with their patients. It is essential from this point in the therapeutic passage that the therapist maintain a bilateral listening stance in order to hear the vibrations of the inner heart and to sense the pulsations of the intersubjective relationship.

5.2.3 Self-confrontation in the service of differentiation

There is no understanding of human beings other than dialogical. In the human realm each person is defined by the other. Nowhere is this more pronounced than in the analytic relationship in which both participants come to encounter the mature, the infantile and the neurotic in the other. It is that space, according to Racker (1968) in which two persons are involved, each with a neurotic part and a healthy part, a past and a present, and a relation to phantasy and to reality. To appreciate why therapists observe their own visceral reactions to their patients' material, or monitor their own emotional responses to their patients, it is imperative that we view the analytic

relationship as an intersubjective field. The analytic field is a product of the two participants in the relationship but which in turn involves them in a dynamic and possibly creative process (Baranger, 1993). Langs (1981) refers to it as a "bipersonal field" which embodies both interactional and intrapsychic mechanisms and every event within the field is perceived as receiving vectors from both participants.

Without the concept of the "analytic field" which has as its core the intersubjectivity of the analytic dialogue, it becomes conceptually difficult to understand the insightfulness of Heimann's statement (1950): "The analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is part of the patient's personality" (p.77).

No-one understood this interconnectedness between the participants of the analytic relationship better than Freud himself, and the following quote highlights his acknowledgement of the deep unconscious rapport between the patient and therapist.

> It is a very remarkable thing that the unconscious of one human being can react upon that of another, without passing through the conscious (Freud, 1915b, p.194).

It is within this context of intersubjectivity that the therapist's capacity to observe his own reactions in relation to the presence of his patient can be illuminated. Although only some of the therapists interviewed described articulately how they came to know that which was intrinsically their own and that which belonged to their patient, implicit in all the protocols was the relationship between self-confrontation and receptivity to the "otherness" of the patient. In other words, the therapist's need to either actively confront himself or be present to himself during contemplation was an implicit part of the structure of every interview, and attests to the importance of the relationship between self-analysis, self-awareness and receptivity to the existence of the other.

It is only by an effort of abstraction that the question can be asked: When does self confrontation operate in the service of differentiation? Although self-analysis is hopefully

present throughout the journey of therapy, there are times when the atmosphere calls it into the foreground of the therapist's experience, referred to as "heightened moments of self-confrontation". It is assumed that this state of living in judgement of oneself is more prominent when the patient needs to unload pain or evil into or onto the therapist, what Redfearn (1980) calls living at the level of the "primal relationship". It is often during these periods of primitive relating of the patient that the therapist is more sensitive to the emotional atmosphere in the analytic environment as the direct scrutinizations by the patient engender increased self-monitoring behaviour.

Therapist number six (protocol four) felt a need to recoil a bit from the blow of her patient's venomous accusations and "sit back and assess...[her] own reactions and feelings" (MU 15). It is especially at these times of being tuned in to the primitive psychic dimensions of the patient that we are most vulnerable to becoming lost in the patient's world. Therapist number six experienced the patient's attacks as disrupting her own personal boundaries, her own perspective of who she was. "It's a feeling of a kind of dissolving inside, a collapsing" (MU 29). From being projected into the world of the patient, the therapist felt she needed to return to her own position, a position of distance and observation. She described this need to live in duality in the following way:

> On a feeling level, it's sort of needing to do a double-take, check out as to whether she is seeing something that I'm trying to deny. So I think what actually happens a lot is kind of a self-analysis going on at the same time as being there with her (protocol four, MU 18).

It is postulated that the therapist's sense of being caught unawares by the incongruity of the patient's response characterizes sudden shifts in direction during the process of oscillation from being empathic and other centred to being separate, observant and self-centred. From being responsive to the depths of the existence of the other, caught up in his narrative and partially fused with his self, the therapist is called by the jolting reaction of the patient to return to himself, to sit back in introspection and observation. These "turning points" invite the therapist to shift from a position of identification and empathy to one of distantiation and self-observation.

Therapist number three corroborated therapist number six's experience of vulnerability. He, too, felt that there were certain patients who got to a very real part of him, who were capable of penetrating his emotional flaws. His need to observe himself and monitor his feelings served as an interactional tool for him, a receptive organ to track the patient's emotional movements.

> I would say I'm pretty much always faced with thinking 'where am I in all this and what are they doing to me?' I'm always looking what they're doing to me, what I'm doing to them, are they arranging me into something? (protocol three, MU 30).

It is well documented in the literature that the therapist himself must be open to regressing in the vessel of analysis, temporarily shedding his professional attitude and wading through the infected waters of the co-constituted ritual bath (Bollas, 1989; Jung, 1946; Reik, 1949). Bollas (1987) eloquently summarizes one of the major paradoxes of analysis when he says that "the transference-countertransference life-time is necessarily a going mad together, followed by a mutual caring and a mutual establishment of a core self" (p.254).

It is posited that during the process of grasping the unconscious dynamics of the patient, the therapist is susceptible to living as a patient in the same analytic environment and that his own psychological knowledge of self is enlarged. Racker (1968) maintains that in setting up an analytic situation the analyst commits himself to what he calls a "predisposition", a certain willingness "to identify oneself with the analysand which is the basis of comprehension" (p.134). Kopp (1983) ironically notes that "one of the luxuries of being a psychotherapist is that it helps to keep you honest. It's a bit like remaining in treatment all of your life" (p.17).

It is in the context of attempting to fulfil the most difficult requirement of psychoanalytic work, the alternation between being the "involved empathizer and the detached sorter" (Greenson, 1967, pp. 365-372), that the direct verbal communications of the patient aimed at the therapist need to be understood, as they comment upon the developing

analytic relationship, particularly the working alliance. Typically, the patient's responses that have been perceived as being focused on the therapist's character, style of working and professional stance, have most unsettled the therapist and have prompted him in the moment to turn towards himself to ascertain the validity of the patient's perceptions. It must be emphasized that other "less critical comments" concerning the therapeutic situation have also invited the therapist to confront himself in order to determine the accuracy of the patient's perceptions of the analytic situation.

Therapist number three (protocol three) explained that he differentiated the responses of the patient on the basis of his "internal self-experiencing" which informed him in the moment whether the patient's perceptions of him "fitted or not". In reaction to the patient's remark that he (the therapist) appeared "worried as though something had been taken away from him or he had been emptied out" (MU 5) the therapist felt, "No, this is mad. I'm feeling nothing like that, and I was quite in a sense outraged because it was so far from my internal truth" (MU 6).

These initial evaluative judgements based on the gut feelings of the therapist in the moment rely on his capacity to "sort of compare it (patient's perception) quite quickly with my (his own) self image" (MU 14). Therapist number six (protocol four) reasoned that being unable to identify with the feelings attributed to her by the patient enabled her to perceive the patient's accusations as being distorted. For her the essence of the process of discriminating was her unwillingness to appropriate feelings that she considered to be blatantly different from her own. In other words, what formed the basis of her "acceptance or rejection" of the veracity of the patient's statements was her own self-knowledge and sense-of-self, accrued from life experience, psychotherapy supervision and time spent in her own therapy.

Generally, the label of transference is founded on the basis of the therapist's recognition that the patient's interpretation of their relationship contradicts his (therapist's) experience of the same situation. Therapist number one (protocol one, MU 22) affirmed that "transference for me is when a patient has experienced something which doesn't seem real to the situation to what I'm feeling - that there's a dissonance in what she's

feeling and where I'm at." Before the therapists in the present study began to engage in "horizontal analysis" (Klauber, 1987), the outstanding feature that indicated to them that the patient's reactions were transference-based was the recognition that the patient's response was incongruous with their (therapist's) image of themselves or their therapeutic style.

For most of the therapists the bedrock of their process of identification concerning the nature of their patient's communications was their immediate pre-verbal impressions and intuitive associations concerning the "correctness" of their patient's statements. If the therapist believed that the patient's perceptions contrasted with his own view of the situation, the apparent dissonance between their interpretations suggested to him that the patient's perceptions were distorted. If, on the other hand, the therapist's perception or experience of the situation concurred with the patient's claims, the benefit of the doubt was given to the patient, unless further enquiry concerning that matter proved otherwise (for example protocol two).

It would be a grave error to believe that the therapist's efforts to comprehend the powerful, direct comments of the patient were based solely on rational considerations. The therapist, in the moment when he turns to listen to his inner voice, is informed as to the apparent accuracy of the patient's remarks. Before any therapist can turn to his observational powers and understand the unfolding drama interactionally, he needs to first look honestly at himself as every psychological enquiry bears the motto: "It is you who are discussed here" (Reik, 1949, p.422).

These initial discriminations made by the therapist in reaction to the compelling verbal communications of the patient are born out of his pre-articulate impressions of his patient in conjunction with his developed image-of-himself. The therapist's supposed instantaneous cognitions about his patient's behaviour are built on a pre-articulate foundation of being-in-relation to his patient over the history of their professional relationship. The history of the analytic relationship and of the process that was constituted between them acts as a backdrop to his current perceptions of the situation. It would be naive to believe that his "memory of the process" (Baranger, 1993) was

isolated during these periods of decision making. Over the years the therapist has built up what Greenson (1967) calls a "working model of the patient", an inner album of pictures and associations concerning the appearance, behaviour, defenses, values, desires and attitudes of the patient. The therapist scrutinized by the patient's verbal commentaries shifts this "working model of the patient" into the foreground of his experiencing and attempts to capture what the patient was experiencing at that moment and questions whether his own reactions are warranted. The words used by the patient, and the manner in which they are expressed, stir up associations in the therapist and lead to an "aha" experience, which on the level of critical observation and explanation is often taken by the therapist to mean that the patient's reaction does not fit with his interpretation of the situation.

An important discovery in this study was that all the therapists interviewed focused on the patients' direct references to them as their main or sole clinical referent for transference. In other words, they emphasized the conscious experiences of the patient in relation to the therapist and attended to the level of the manifest content. Except for the occasional reference to disguised and derivative material in dreams, the therapists in the present study adopted the traditional classical conception of transference.

Langs (1982) has argued that transference is not the conscious fantasies about the therapist, nor the totality of the patient's relationship to the therapist. He criticizes therapists who automatically think that the patient's direct allusions to treatment or themselves are expressions of transference. His communicative-interactional view urges therapists to understand their patient's reactions in relation to the activated intervention contexts in therapy.

> In terms of their derivative functions, manifest references to the therapist may indeed reflect unconscious transference fantasies, but they also may portray unconscious nontransference perceptions or, as is frequently the case, may prove to be poor carriers of encoded meaning (Langs, 1982, p.62).

This indicates according to Langs (1982), that until a full analysis of the conscious and unconscious implications of the intervention-adaptive context has been carried out, the distinction to be made is premature. Until the therapist has carefully evaluated his manifest intentions in intervening, and in supervision partially "fathomed out" his unconscious communications to the patient; he cannot be sure that his initial inclination to view the patient's behaviour as transferential was not defensively invoked as a way of denying his own pathological inputs. This point made by Szasz (1963) highlights a possible clinical function for the therapist who uses the concept of transference and also places the issue of the therapist being "the reality perceiver and speaker of the truth" (Barton, 1974, p.30) in perspective.

It is evident from the case examples sighted that all the therapists defined transference in terms of a distortion model, a model that gave them the power to be the arbiter of what is reality and what is distortion in the analytic arena. Jordan (1992) holds that one of the risks of viewing transference in this narrow way is that it reifies the therapist's perception of reality and underlines the implicit belief that "the reality of the analyst is something the analysand can never attain to" (p.729).

It is my contention that the notion of transference should not be disembedded from what Schwaber (1983) calls "a hierarchically ordered two-reality view," but this does not imply that the analyst's frame of reference can or should be elevated to the status of objective fact. To prevent therapists from invoking the concept of distortion when their patients' feelings contradict their self-perceptions, it is argued that therapists should adopt a self-validatory model based on self-analysis and interactional-reflection. In addition to this, therapists should extend their definitions of transference to include the unconscious promptings of the patient which attempt to provoke situations with the therapist.

Gill's (1982) assertion that we cannot distinguish transference from nontransference on the basis of its incongruence with current reality supports Langs's (1982) view that the contributions from the analyst in the here-and-now need to be ascertained in order to determine whether the patient's unconscious commentaries on the therapist's behaviour are accurate or not. Implicit in this process of self-reflection lies the vital task of

unveiling the pre-articulate impressions of the therapist, the feeling foundation for his attitudes, judgements and interpretations of his patient.

5.2.4 A reflective viewpoint: A window to the pre-articulate realm, a gateway to appropriation

The therapist's apprehension of the patient is not restricted to his conscious perceptions. His psychological impressions of the patient are the result of the joint assimilation of conscious and unconscious perceptions. Before the therapist can insert the logical links in the chain of understanding, he should look into himself in order to hear the language of the inner voices and to sense the pre-verbal strains of being covertly manipulated and used by the patient. Clues to the unconscious inner-role relationship which the patient is trying to impose on the therapist come to him via his perceptions and his countertransference analysis (Sandler, 1976).

Bollas (1987) has emphasized that "because the patient cannot express his conflict in words, so the full articulation of pre-verbal transference evolves in the analyst's countertransference" (p.230). For this reason he urges therapists to locate the gestures from the subterranean unconscious in their freely associated ideas. This recommendation supports Reik's (1949) position that therapists should "listen with the third ear" in order to receive the subtle communications of the patient, and when this organ of intuitive wisdom is turned inward the pre-reflective whispers of the remembering body are heard.

It is postulated that the therapist's evaluative stance concerning the nature of the patient's communications is expanded by his receptivity to his own pre-articulate impressions of his patient. In other words, the pre-reflective global understandings that the therapist has embodied in relation to his patient serve as a pre-conscious foundation for his discriminations and, if accessed comprehensively, can be used as diagnostic keys to unlocking the patient's "transference usage" (Bollas, 1987) of the therapist. It is contended that at certain times therapists need to actively confront themselves to monitor their own mental associations, and that self-contemplation or entering a state of rest

which facilitates the emergence of evocative images and associations is not always sufficient to work through the confusing feelings overwhelming the therapist.

This was found to be the case for therapist number three (protocol three) who needed at crucial times to shift his internal "working model of the patient" into the foreground of his experiencing in order to intuitively grasp what his overall impressions of the patient had been. Calling forth the pre-articulate, embodied feelings stirred up within him by the patient enabled the therapist in the moment to evoke an intuitive global understanding of his patient's effect on him. Accessing the level of his cumulative emotional responses lived in relation to his patient served as a link between his conceptual perspective of the nature of his patient's perceptions, and the experience of surprise that had befallen him. It was on the basis of intuitively accessing this "accretion of knowledge" (MU 32) about his patient, that the therapist was able to formulate an explanation that accounted for the patient's inappropriate comment and his own experience of surprise and later a sense of outrage.

The value of this phase in the evaluative process lies in its resourcefulness as a bridge between the conceptions of the observing ego and the pre-reflective impressions of the experiencing ego. The function of this evaluative phase is one of amplification and deepened understanding, through binding the disparate moments of confusion with the earth of primordial experience. Implicit in this evaluative phase is a gravitation towards coherence, a covert movement towards appropriation.

In the case referred to above, the therapist's evaluative stance was reinforced by his capacity to access through introspection the pre-conscious foundations for his discriminations. His growing pre-verbal sense of dismissal of the patient's claims as being ungrounded and absurd substantiated his original spontaneous assessment of the patient's response as being pathological (MU 6).

Assimilation of one's pre-intelligible sensations concerning a particular patient usually comes about through continued introspection and repeated reviews of the changing interactional scenarios. Retrospective analyses of the critical moments in therapy, in

conjunction with ongoing self-analysis, often thematize for the therapist what he has always experienced but not fully articulated concerning the analytic relationship.

Therapist number four (protocol two) could not articulate what had irritated her concerning her patient's nagging demands to borrow a book. When her patient confronted her about her inappropriate unprofessional behaviour the previous week, the therapist recognized that her patient's perception was correct and this reinforced her own retrospective comprehension of the past uncontained session. The therapist's acknowledgement that she had acted untherapeutically in reaction to the patient's intrusive behaviour led her to appropriate her own previously denied feelings of hostility towards her patient, to realize that in addition to the patient's valid manifest perceptions there existed a partially concealed "strata" of transference-based behaviour. Reflecting on her own pre-articulate feelings of being continuously "abused" by her patient unveiled for her the intensity of her own anger and lifted into unconcealment the magnitude of the patient's effect on her.

It is surmised that until this therapist was "able to hate the patient objectively" (Winnicott, 1949, p.69-74) she postponed recognizing that her countertransferential behaviour was unconsciously prompted by the patient. Only through repeated re-evaluations of the past outburst in therapy did this therapist come to understand more intricately the concealed dynamics of the transference-countertransference interplay. Up until the interview with the researcher, the therapist believed that her own issues concerning being overworked and unmotivated as a therapist were primarily responsible for her outburst. Having resorted to self-analysis and having examined the adaptive intervention contexts for her behaviour, she came to accept that her hate in the present setting was justified and that her behaviour did not derive entirely from within herself but could be seen as a compromise between her own tendencies and the role-relationship which the patient was unconsciously seeking to establish. This supports Sandler's (1976) suggestion that:

> Very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blindspot of his own, may

> sometimes be usefully regarded as a compromise-formation between his own tendencies and his reflexive acceptance of the role which the patient is forcing on him (Sandler, 1976, p.276).

The evaluative approach followed by this therapist (protocol two) entailed first acknowledging her own invalid interventions. This led to her recognizing the nontransference components of her patient's manifest behaviour and then searching for the patient's pathological perceptions.

This evaluative stance approaches Langs's (1982) "rule of thumb" concerning the order in which the patient's communications should be identified. He notes that "it is best to identify all possible nontransference reactions first, and to consider the balance as transference-based as long as there is reason to justify such formulations" (p.533).

Langs (1982) has argued that the appraisal of the extent of the patient's unconscious nontransference functioning depends in large measure on a full comprehension of the adaptive contexts for the patient's subsequent communications (i.e. therapeutic interventions). This in turn depends largely upon the therapist's capacity for honest self-reflection and openness to appropriating rejected aspects of himself. Only through following a path of self-understanding and receptivity to how one has acted as "a bait" (Jordan, 1992) in the analytic situation can the therapist develop an expanded view of the interwoven nature of the patient's transference-based and reality-oriented communications.

Therapist number eleven (protocol five) had delayed exploring the reasons for her patient's periodic cancellations until the recent occasion when her patient acted out in such a casual manner prompted her to do so. The therapist retrospectively believed that she was incited at the time to explore the interactions in the bipersonal field in order to understand the adaptive contexts for the patient's behaviour. The patient's belief that the therapist viewed her as avoiding therapy was corroborated by the therapist, who believed that the congruity of her feelings and the patient's belief demonstrated the accuracy of the patient's perceptions.

Reflecting on her growing pre-verbal sense of irritation revealed to the therapist the stark presence of the patient's indifferent attitude to therapy. This strengthened the therapist's perception that the patient's belief concerning her attitude was correct. In addition, it further illuminated for the therapist that the patient had experienced therapy as lacking form and awakened her to how she had colluded with the patient in maintaining an undisciplined relationship. The patient's acting out behaviour was interpreted by the therapist as a signal or invitation to confront herself and recognize her own inadequacies and failures as a therapist and to acknowledge that she had maintained a "therapeutic misalliance" (Langs, 1975) with the patient.

Being receptive to the unconscious cues of the patient, the therapist came to appropriate both her previously denied angry feelings for and judgemental attitude towards the patient. This act of inner change, referred to by Symington (1986b) as the "x-phenomenon" freed the therapist to later recognize that the patient's belief that the therapist viewed her as "doing wrong" was correct.

The therapist who tended to focus on the patient's manifest content did not attend to the patient's allusions to the transference and this precluded her from thematizing that the patient's unconscious perceptions of her being avoidant and inadequate were valid. Nevertheless, the therapist's openness to learn from the patient enabled her to recognize the nontransference perceptions of the patient and consequently led her to rectify her interventions in therapy.

This case illustrates that if a therapist is willing to explore, through countertransference analysis, the pre-articulate dimension of his existence, not only will he come to have a more balanced view of himself but also of his patient's functioning.

Casement (1990) has underlined the importance of recognizing the patient's unconscious search for new solutions and the above case clearly demonstrates that the analytic process has a direction that expresses unconscious hope.

An invaluable point made by Symington (1986b) that has direct bearing on the latter two cases (protocols two and five) described deals with work at a pre-verbal level, a level at which the patient knows unconsciously the analyst's internal attitudes. Symington (1986b) posits that until the therapist changes his inner attitude toward the patient (eg. anger) and is freed through the process of appropriation, the patient will be unable to move forward psychically. This act of inner freedom "causes a therapeutic shift in the patient and new insight, learning and development in the analyst" (p.260).

5.2.5 Liberated from misunderstanding: A doorway to potential space

The philosopher Immanuel Kant said: "Intuition without concept is blind: concept without intuition is empty" (cited in Coltart, 1986, p.190).

Applying this foresight to the field of psychoanalytic therapy, one realizes that "intuitive sensing" (Bollas, 1987) without conceptual understanding leads to interpretations being made on the basis of "acts of faith" (Bion, 1970). Creative understanding is achieved through the merging of the two, the consummation of thinking and feeling. Such understanding is based on the premise that memory and desire cannot be suppressed totally and that analytic theory forms the implicit framework which gives shape to the interpretations of the therapist.

The final stage of the cycle of revealing the source of both the patient's and the therapist's own reactions, of disentangling what is the patient's creation from the therapist's contamination, consists of the therapist synthesizing the intuitive revelations of the private self with the observations of the professional self. From being partially involved in the patient's unconscious psychic drama, the therapist retraces his footsteps and through self-introspection coupled with maintaining an interactional perspective comes to partially understand how his feelings and thoughts have been shaped by his experience with the patient. This process of countertransference analysis is ongoing and the understandings of the therapist are never final. In the course of further dialogic development through oscillating between the moments of the un-understood past to the confusing present, shifting from the woundedness of the patient to the vulnerability of the

self, the therapist comes to articulate more fully his role and identity in this interpersonal system.

Only once the therapist has recognized his participation in the externalization of the patient's internal object world and acknowledged his technical errors can he unshackle the heaviness of his confusion and be liberated from misunderstanding. This stage in "the movement towards understanding" (Thorpe, 1989) forms a valuable viaduct in the process of working through a projective identification according to Thorpe. His study showed that once therapists had recognized their feelings as being components of a projective identification and had constructed an accurate formulation, the psychological strain experienced by them was diminished.

In a similar view Heimann (1960) has emphasized the importance of grasping the lived predicament of the patient as a precursor to understanding one's own feelings. She noted that the experienced analyst finds himself in situations in which:

> he notices that he is puzzled in a disturbing way with somewhat intense feelings of anxiety or worry which appear inappropriate to his assessment of the events in the analytic situation. As he waits - which he must do in order not to obscure the already puzzling situation still more by irrelevant and distracting interpretations - the moment occurs when he understands what has been happening. The moment he understands his patient, he can understand his own feelings, the emotional disturbance disappears and he can verbalize the patient's crucial process meaningfully for the patient (Heimann, 1960, pp. 152-153).

This statement by Heimann echoes the experience of therapist number one (protocol one) whose confusion cleared up when he began to reflect on why he was feeling so frustrated, lonely and "frozen out". He was able to relax once he "could understand her symptoms...why she was so needy or why the space was so difficult for her" (MU 26). This enabled him to comprehend his own responses and to feel more in control of

himself. Once he had understood her difficulty and had reflected on his style of working which he believed frustrated her, he "wasn't lost anymore" (MU 29).

For most therapists the ongoing process of unravelling the knottedness of confusion and misunderstanding comes through "sifting out" (MU 25, protocol four) what's happening between the analytic partners and takes place between sessions. This need to gain reflective distance from the power and intensity of the transference-countertransference cauldron accords with the views of Greenbaum (1978). He extended Isakower's concept of the "analyzing instrument" to the field of the analytic interaction. The "analyzing instrument" is a metaphor, which captures the integrated "team" nature of the analytic partners and highlights that the function of observation and exploration is located in both halves of this interpersonal "composite.".

Greenbaum (1978) affirms that it is during periods of the severance of the "team" boundary that the therapist becomes aware of his half of the analyzing instrument, i.e. he is able to observe "the surface which is opposite the patient's half" (p.194). The withdrawal of the patient when the analyzing instrument is "switched off" (p.193) allows the therapist to re-integrate that part of himself which was acutely attuned to the patient and in the moment of separation to observe himself in relation to the other.

This pertains especially to therapists working with patients who display problems concerning boundary issues. Therapist number six (protocol four) reported that she needed to be disconnected from her patient in order to disentangle the feeling threads of the emotional tapestry that was co-constituted by both of them. Her capacity to gain reflective distance from the accusations of the patient enabled her to sift through and compartmentalize between sessions on "an internal level" (MU 27) the reactions of her patient. "A sort of subliminal process" (MU 27) was needed to complement the intentional, conceptual work of differentiating the patient's material, and this unburdened her of the "internal turmoil" she had experienced.

In parallel fashion therapist number eleven (protocol five) stated: "What I do when something feels uncomfortable in therapy for me and there's a stuckness about it as

well...I'm aware of after hours mulling over it and I'm aware of not consciously thinking of it..." (MU 28). The therapist's continual reflection on her experience of stuckness freed her from being preoccupied with the matter. When the rumination abated she knew that the difficulty had been identified and she felt separate and therapeutically focused.

To master the pre-articulate impressions inwardly (i.e. assimilation) demands a certain distance from them, a capacity to allow them to "lie fallow" (Khan, 1983) until a need arises to recognize their significance. Before the therapist can communicate the wisdom of the "instinctual knowledge" to the patient in the form of interpretations, he needs to wait for the spontaneous re-emergence of these impressions from the storehouse of the unconscious. The intermediate step between assimilation and conceptual comprehension is the reception of the memories, images, motor activities and fleeting thoughts into consciousness.

Therapist number two only came to grasp that the present analytic relationship "was a recreation of an object relation which originated with the patient and her mother" after she had received a visual image of a bulldozer. This instant communication from the "mundus imaginalis" (Samuels, 1985a), the shared dimension of imaginal experience, served as a "momentary identification" (Beres & Arlow, 1974) with the patient's concealed, private experiences. Once the fleeting visual image was translated through the cognitive operations of the observing ego into an interpretation and communicated to the patient, it lifted into prominence for the patient the parallels between the present and the past. This creative therapeutic mode of accessing the personal narrative of the patient has been referred to by Malcolm (1991) as "imaginative empathy".

Once the therapist has recognized the "transference positions" of the patient and retrospectively comprehended his role-responsiveness in the interpersonal dialogue, he can then "consolidate" (protocol three, MU 31) the process of differentiation and orientate himself to the unfolding landscape of the "in-between".

In this unique setting in which both therapist and patient emotionally transfuse each other, and communicate through the medium of shared unconscious fantasies (Beres & Arlow, 1974), it is presumed that the inner knowledge of the one is pre-reflectively known by the other. At this level of deep unconscious rapport the therapist's experience of being separate and disentangled, having reached a greater understanding of the interactional dynamics, resonates a sense of clearing for the patient as well. The new openness achieved frees both participants to inhabit a space that potentializes further productive understanding.

The words of Symington capture this sense of mutual search and discovery in analysis, of co-constituted exploration and understanding.

> Truth in psychoanalysis emerges between the analyst and the patient, and in the moment of understanding there is a change in both. The glimpse of truth demands that a preconception is abandoned in both, for both have come to the encounter with their own preconceptions (Symington, 1986a, p. 19).

The illumination of the foreground dimension of the therapeutic interchange ushers in its separation from centrality, and as a new horizon of misunderstanding emerges the participants herald its arrival into prominence. In this manner the process of oscillation from engagement to separation is continued and the evolving cycles of understanding perpetuated.

5.2.6 The unspoken insights and retrospective conclusions of the therapists

Retrospective reviews of the intersubjective nature of the analytic relationship and the dialectical composition of the transference-countertransference matrix crystallized for many of the therapists that there was a confluence between the reality-oriented and transference-based responses of their patients. Implicit in their descriptions of past

analytic experiences was the growing recognition that the patient's material comprised of intermixtures of both nontransference and transference responses.

Irrespective of the nature of their patient's disorder, the duration of the therapy or their style of interpreting and manner of evaluating their patient's communications, the therapists realized that they could not overlook the strong presence of their patient's valid conscious and unconscious perceptions.

Although all the therapists interviewed tended to focus on their patients' manifest fantasies and reactions, disregarding the value of content that alluded to the transference, they nevertheless were receptive to the unconscious communications of their patients which they intuited through countertransference analysis.

It was apparent that for some of these therapists their acknowledgement of the valid unconscious perceptions of their patients followed their retrospective realizations that they had acted out and colluded with their patients. Being open to learning from their patients' communications, these therapists were offered unconscious interventions that prompted them to acknowledge their own neurotic countertransferences and to correct their technical errors.

The major pathway taken by most of the therapists in recognizing the reality-oriented and transference-based elements of their patients' communications incorporated their subjective awareness of their ongoing feelings and fantasies toward their patients and the nature of their interventions. This approach facilitated the possibility of revoking earlier judgements and gave the therapists the opportunity to identify the previously concealed reality-oriented reactions of their patients. It is posited that although the therapists did not state explicitly during the interview that they engaged in this exact passage of evaluation in order to attend to both the transference-based and reality-oriented communications of their patients, there was a growing understanding during the interview that they had travelled that road and identified the full range of their patients' communications. Therapist number four (protocol two) referred to this as being "a sort of analysis after the fact" (MU 40).

One of the discoveries made by the majority of the therapists was that the manifest reality-oriented reactions of the patient could not be observed in isolation. Complementing the surface communications of the patient which were often valid commentaries about the alliance sector of the analytic relationship or inappropriate, distorted claims about the therapist, lay a substratum of enduring infantile, maladaptive behaviour. In other words, all the therapists recognized that in addition to the sound and nonpathological responses of their patients, they experienced a pervasive immature mode of relating that enticed them to either violate the boundaries of the therapeutic framework or engage in behaviour they retrospectively observed was incongruous with their professional image.

The pre-reflective feelings of the therapists when articulated through self-reflection thematized for them the existence of a pervading characteristic style of relating of their patients and expanded their view of the totality of the patient's "behavioural" repertoire. The therapists came to realize that the presence of momentary reality-oriented responses of the patient did not preclude the existence of a latent level of pathologically-based behaviour.

Being receptive to the total communications of the patient, it is suggested that the therapists identified the transference reactions of their patients on two levels. Firstly, the level of the manifest content where the surface communications of the patient were detectable for conceptual scrutiny. Secondly, the latent level where the unconscious provocations of the patient alerted the pre-verbal senses of the therapist. It is postulated that when the therapist consolidates the impressions gained from both these levels, he comes to affirm that regardless of the "quantity or quality" of the patient's reality-oriented behaviour the presence of transference as a dimension of human relating is undeniable. It is believed that this reasoning process served as the basis for the therapists' conclusion that the transference-based and reality-oriented responses of the patient reside side by side and are often interwoven and inextricable.

The therapists' conclusion that the reality-oriented and transference-based responses of the patient are contiguous is concordant with the theories of Greenson (1967) and Langs

(1980, 1982). Both of these analysts postulate that every aspect of the therapeutic relationship has elements of transference and nontransference. Greenson (1967) has gone as far as saying that all object relationships consist of different admixtures and blendings of real and transference components. He noted that:

> There is no transference reaction, no matter how fantastic, without a germ of truth, and there is no realistic relationship without some trace of a transference fantasy (Greenson, 1967, p. 219).

The notion that no dimension of object relating should be viewed without a consideration of transference based influences is shared by Greenson and Langs and is demonstrated by the insights attained by many of the therapists in the present study. It is suggested that the retrospective conclusions and unspoken insights of the therapists in the present study are most coherent with Sandler et al.'s (1969) intermediate view of the concept of transference. Unlike the views of Langs (1980, 1982) which are perhaps too focused on the unconscious perceptions of the patient, and those of Greenson which tend to be too surface oriented, Sandler et al.'s (1973) perspective of the communications of the patient includes both the unconscious provocations by the patient and the associated apperceptions. The theory propounded by Sandler et al. (1973) provides a balanced framework to elucidate the pre-articulate impressions of the therapists (concerning the unconscious promptings of the patients) and the manifest perceptions and attitudes of the patients.

5.3 Limitations of the present study and suggestions for further research

The intention of this section is to briefly discuss some of the conceptual and methodological limitations of the present study and to offer recommendations which could possibly provide alternatives for future research projects in this field. More specifically, limitations concerning the definition of transference utilized in the present study, and the interview approach taken, will be focused on and possible alternatives to the traditional psychoanalytic research methodology suggested.

The psychoanalytically-oriented therapists interviewed in the present study were asked to describe the process they followed in differentiating whether a situation in psychotherapy was transferential or reality-oriented. In order to clarify the question the therapists were asked how they distinguish between their patients' transference "distortions" and their correct perceptions of their therapist. Although there is no single all encompassing definition of transference that satisfies most psychoanalytic adherents, the researcher retrospectively believes that the emphasis placed on the patient's illusory perceptions (conscious and unconscious) of the therapist was too narrow. This possibly embedded the subjects in a theoretical framework that underlined the "perceptual" distortions of the patient and consequently underplayed the importance of recognizing the concept of transference as also including the patient's "unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships" (Sandler et al. 1973, p.49).

The application of Sandler et al.'s definition of transference would have presented an expanded account of the term's vicissitudes and may have facilitated more concrete accounts of therapists' personal pre-reflective experiences in therapy, thus revealing their countertransference feelings more openly. It is therefore recommended that further research in this field focus on tapping the heart of the transference - countertransference matrix, the level of the unconscious proddings by both the patient and the therapist. The idea of transference as a concealed provocation by the patient to engage the therapist in actualizing his internal object relations is a necessary adjunct to the conceptualization offered to the therapists in the present study.

It may be argued that the above recommendation is unnecessary as many of the therapists in this study were familiar with this profile of transference. However, retrospective views of the current research study reinforce the author's belief that a definition of transference that illuminates the multiple faces of this phenomenon is necessary to preclude the therapist focusing on a single dimension of the transference phenomenon.

It is also hoped that future research endeavours will augment the "one-interview snapshot approach" of uncovering examples of "floating transference reactions" (Glover, 1955) which, because of their fleeting nature and alarming effect, strongly contrast with the genuine, appropriate and accurate communications by the patient. It is recommended that a series of in-depth interviews with each therapist be carried out to complement the version obtained in this study which possibly focused on difficult moments or crises experienced by therapists. Most of the cases referred to in the present study concerned situations which were characteristic of acting-out of transference reactions.

A series of three or four in-depth interviews with each therapist may give them the opportunity to defocus from disparate transference reactions which are ordinarily specific and circumscribed, thus enabling them to recall and to recapture vividly what Greenson (1967) has referred to as generalized transference reactions. In other words, it would be very valuable to ascertain how therapists differentiate what is the typical and habitual infantile object relations of the patient from their healthy, purposeful, reality-oriented behaviour in therapy. Although the present study did not focus on this technical issue, interesting hypotheses were made concerning the interwoven nature of the generalized transference reactions and the apparent momentary reality-oriented behaviour of the patient.

Another advantage of tracking the therapist's experiences over a series of interviews with respect to the topic of this study, would be to unveil the experiential process therapists follow when identifying shifts in the transference and the parallel process of recognizing the development of the nontransference dimension of the therapeutic relationship especially as it crystallizes in the latter phases of the evolution of therapy. An offshoot of this recommendation concerns the difficulty encountered by some therapists ascertaining whether or not certain positive communications by the patient are indicative of what Freud (1912) referred to as the unobjectionable part of the transference or reality-oriented appraisals and honest gestures of appreciation and gratitude to the therapist.

In light of Hamilton's (1986) contention that therapists experience difficulty identifying positive projective identifications as the induced experience is consonant with the

therapist's experience of himself and does not invite the therapist to urgently confront himself as to its veracity, the question is posed, "how do therapists make the distinction between a non-erotic positive transference reaction and a genuine remark made in appreciation or respect?" The findings of the present study strongly support a research project of this nature as most of the protocols explicated were characteristic of negative transference reactions. In addition to this, it is not uncommon for therapists themselves to use their patients as transference objects to be nurtured with praise and adoration. How does the therapist in the midst of the patient's ongoing reasonable and rational behaviour determine whether this is a form of a defensive transference reaction or characteristic of a consistent working alliance? Questions such as these need to be explored to substantiate the controversial belief held by many analysts that "transference is ubiquitous".

One of the methods utilized by many psychoanalytic therapists to identify transference-based reactions involves the detection of what Gill (1982) has referred to as the patient's veiled "allusions to the transference". Interestingly, the majority of the therapists did not adopt this approach and instead concentrated on the patient's direct references to the therapist. It is hypothesized that a greater number of subjects representative of the different psychoanalytic camps would be required to participate in a study of greater magnitude in order to ascertain whether this means of identification is invaluable or not.

Gill (1982) has argued that instead of adopting the traditional classical conception of transference which centres on the patient's distortions of the therapist, one should acknowledge the provocations by the analyst which act as "bait" for the patient's unconscious wishes and instinctual frustrations. He believes that if we regard the transference as conjecture we are respecting the sanity of the patient. It is therefore proposed that future psychoanalytic research which attempts to ascertain whether the patient's interpretations of the analytic situation are "distorted or plausible conjecture" (Jordan, 1992), should investigate the experience of both analytic participants. This will not only preclude the production of retrospective monocular reports by the therapist of the analytic setting, but will also prevent a tribunal concerning the patient's sense of reality without him being present to defend his interpretations of the analytic situation. It

is believed that the reported experiences of both patient and therapist concerning past analytic situations will present a more global and less prejudiced appreciation of the co-constituted nature of therapy.

It is strongly recommended that psychoanalytic research should not be restricted by, nor limited to, its traditional research methodologies. Psychoanalytic researchers should seek alternatives to that of the traditional case study method which tends to uphold the narrative of the analyst whose reality is treated as absolute and "something the analysand can never attain to" (Jordan, 1992, p.729). Instead of being immersed in the theoretical preconceptions which shape the analyst's narrative of analysis, psychoanalytic researchers should adopt a fresh outlook of the analytic experience, one that is steeped in respecting the lived reality of both the analyst and patient, who after all are also "two real people of equal adult status" (A. Freud, 1954 pp.618-619). The experiences of both participants concerning critical moments or phases in therapy needs to be heard, to forestall one-sided translations of the process of therapy.

Recent empirical phenomenological studies which have been impregnated with rich material from both the patient and therapist include Becker's (1984) work on the experience of psychotherapy, Fessler's (1978) dissertation on interpretation, and Kelly's (1993) very recent exposition on hermeneutics in psychotherapy, a study of interpretation in the context of the psychotherapeutic dialogue. This phenomenological research alternative advocated by Fessler (1983) will enable us to comprehend issues such as the patient's experience of transference interpretations or their side of feeling admiration and respect for the therapist.

All the same, the traditional methodological approach concerning the recollections of therapists about their own work does give us valuable insight into the imaginative lived world of the therapist and facilitates our understanding of the influence of their theoretical fore-structures on their clinical expertise and presence as therapists.

A further consideration for researchers embarking on psychoanalytic projects of this nature is to investigate their subjects' underlying philosophical assumptions, the basis of their assumptions about analytic technique. Hamilton (1993) found when interviewing sixty five analysts that their responses with reference to issues such as countertransference, extra-transference and the "real" relationship were clearly influenced by underlying philosophical assumptions concerning subjectivity and objectivity, psychic and external reality and narrative and historical theories of truth. Attention to this research step is especially important when the research subjects are therapists who are naive as to the power of their conceptual "fore-structures" (Heidegger, 1927/1962). This supports Stein's (1991) warning that the analyst's theory forms part of the woodwork of his countertransference, and unless his theoretical "fore-structures" are laid bare, many of his own feelings will be attributed to the patient's projections and not his own conceptual predilections. This highlights the need for the researchers themselves to reflect on the influence of their academic structures and to recognize how interwoven their research material is with the questions they have asked.

CHAPTER SIX

6. Evolved conceptualizations: "The play of differentiation"

By way of conclusion, the fate of the therapist as he shifts from being projected into the world of his patient to being in a position of observation and self-reflection is outlined in the hope of illuminating the main evolved conceptualizations of the present study.

The oscillating process of the therapist as he accesses the preconscious and articulated cognitions and reflections of his patient, his emotional dives in and out of the unconscious orbit of his patient, characterize not only the essence of psychoanalytic therapy but is the fulcrum around which the therapist evaluates the totality of the communications of the patient. This oscillating movement of the therapist is continuous, at times being in the foreground of his experience overwhelming him with intense emotions, at other times forming a backdrop to his encounter of the patient. Irrespective of the therapist's experience of his patient, he cannot refrain from participating in this rhythm of immersion and observational disengagement - he is servant to its momentum.

The quintessence of the therapist's role in the analytic relationship is one of understanding his patients' dynamics, the nature of his patient's communications and their co-constituted intersubjective history. This endeavour requires that the therapist commit himself to an ongoing process of discrimination, a process made possible by his inherent capacities of self-awareness, self-understanding and interpersonal empathy. It is because there are universals in the human condition that the therapist can project himself into the being and plight of his patient, an inherent pre-requisite for countertransference identification.

The psychoanalytic therapist's capacity to engage in "the play of differentiation" is dependent on his ability to alternate between being empathic and other-centred to being interactionally observant and self-reflective. It is postulated that the "transitional ego" of the therapist enables him to be receptive to the fullness of the patient's communications and mediates between the complementary functions of empathy and observation, helping

to avoid being pulled into a one-sided view or relation to the patient. This dialectic between the empathic and observational modes of relating to one's patient mirrors Addison and Packer's (1989) theory on the forward arc of projection and the return arc of uncovering, both essential reciprocating attitudes and approaches leading to progressive deepened understanding. Their dialectical model of circular understanding and interpretation focuses on the therapeutic application of Heidegger's (1927/1962) work on the hermeneutic circle.

The therapist's capacity to be in two places at once availing himself to his patient as a containing transformative figure, temporarily and partially identifying with the raw substance of his existence, yet simultaneously being professionally observant, discriminatory and separate, forms part of his repertoire of countertransference play. Without a recognition of this central transitional capacity we as therapists are restricted to experiencing our patients' communications from the mental watchtowers of our detached professional chambers. It is contended that without the concept of "countertransference play" the therapist cannot "regress in the service of the ego" (Kris, 1950), and consequently cannot experience periods of imagined fusion and secure detachment. The therapist's journey of disentanglement, his endeavour to differentiate his responses from his patient's actions, is rooted in this capacity for "countertransference play".

It is suggested that the play of countertransference makes possible the therapist's transitional presence in the analytic environment which is the basis of his ability to be invoked by the pre-verbal promptings of the patient. It is posited that Bollas's (1987) contention that there is a "generative split" in the therapist's ego and Casement's (1985) belief that the therapist's ego is dissociated, undermine the integrated, "holistic" nature of the therapist's meeting with and discovery of the other. Instead, it is suggested that the therapist has developed a "transitional ego" which potentializes his ability to live in duality, to embody two primary modes of relating to his patient. These complementary modes of encountering the other stand in a dynamic, perennial relationship with one another, "creating, informing, preserving and negating the other" (Ogden, 1990, p.208). Both of the therapist's primary modes of encountering the patient are always active,

moving in and out of prominence, sharing in the journey of discovering the uniqueness of the other, and the originality of their relationship.

It is essential that the therapist's experience of participating in the evolving evaluative process be contextualized in an analytic framework that recognizes the intersubjective nature of the transference - countertransference field. A conceptual framework that illuminates the transference - countertransference playground and recognizes the existence of that intermediate area of experiencing cohabited by both participants in the analytic relationship opens the door to exploring the mystery of countertransference analysis, transference usage and the role-responsiveness of the therapist.

Having outlined an analytic framework that addresses the circular communicative nature of the transference - countertransference playground, a potential space is opened for the enumeration of the main conclusions of the present study:

1. The evaluative process carried out by the therapist is characterized by both intentional reviews of the co-constituted "analytic historiography" and pre-reflective deliberations which take place during and between sessions. The meaning attributed by the therapist to the developing interactional scenarios is embedded in an evolving historical context. The therapist's understanding of the nature of the patient's communications is never complete as his appreciation expands with additional circuits of self-understanding and interactional revision which inform each other reciprocally and regularly. The evaluative discriminations of the therapist are therefore always in the process of unfolding, as each successive dance of engagement and separation has the possibility of uncovering new horizons of understanding.

   Gaining access to the manifold ways that the patient can reveal himself to and "use" the therapist facilitates the expansion of what is brought to unconcealment through countertransference analysis.

2(a) The sine qua non of this circular process of understanding and discrimination, empathy and observation, is not the conscious, rational perceptions of the therapist which are "enframed" (Heidegger, 1927/1962) but his pre-articulate impressions of the pre-verbal cries of the patient which seek satisfaction. The lifeblood of the evaluative functioning of the therapist is located in the "tissue of his gut reactions", that place which is most sensitive to the subtle stirrings of his patient. It is on this pre-conscious level that the patient's covert evocations are immediately sensed and the indelible imprints of his infantile demands found.

2(b) The deliberate and conscious observations of the therapist are insufficient on their own to fully elucidate the nature of the patient's communications, especially the concealed projective identifications of the patient which disorient the therapist and throw him into a state of confusion and shock. It is imperative that the therapist has the capacity to acquaint himself with his pre-articulate impressions of his patient and to thematize these "instinctual sensings" as they bear witness to the intense strains he has experienced but not understood during the therapy.

2(c) The key to illuminating the level of deep unconscious rapport shared by both participants, the ground of the therapist's emotional stamina, lies in the therapist's ability to unveil his pre-articulate impressions of his patient. It is this "instinctual knowledge" that re-roots him in his most original experiences of the other and acts as testimony to the unconscious provocations by the patient. The therapist's commitment to lift into articulation his pre-socialized impressions of the patient, enables him to more accurately expose the patient's transference domain of functioning. This allows the therapist to evaluate the totality of the patient's communications without being anchored in the classical psychoanalytic model which focuses on the conscious perceptions of the patient which are interpreted as being either distorted or accurate and sound. It is the atmosphere in the analytic environment which harbours the premature infantile demands and attitudes of the patient, not only the content of the patient's verbal associations.

2(d) It is for this reason that not all therapists require that a "climactic moment" in therapy be reached before they can identify the patient's communications as transferential. In other words, the direct, "unadulterated communications" of the patient, defined as being inappropriate and impactful by the therapist, are not always necessary as a first line of identification of the patient's transference reactions. For some therapists the severity and intensity of the emotional abuse they have endured is enough evidence of the patient's primitive mode of relating.

2(e) It must be emphasized that,although many of the therapists' discriminations of the nature of their patients' communications were based on their belief that their patients' conscious perceptions and interpretations of the analytic relationship contradicted their experience of the same situation, their judgement was also built on a substratum of pre-conscious intuitions which were rooted in their lived, pre-reflective appraisals of the patient. The pre-reflective global understandings that the therapist embodies in relation to his patient serve as a pre-conscious foundation for his discriminations and, if accessed comprehensively, can be used as diagnostic keys to reveal the pathological nature of his patient's functioning.

3. For those therapists working with less disturbed patients, a certain "point of discomfort" may need to be reached in the therapy before they can be alerted to the unreality of their patients' communications. This may come about through the presence of direct, unadultered communications which shock and disorient the therapist, often serving as his first line of identification of the transference-based reactions of the patient. These jolting reactions of the patient invite the therapist to shift from a position of identification and empathy to one of observation and introspection. These intense and inappropriate reactions serve as turning points in his understanding of the patient's behaviour, the intersubjectivity of the analytic relationship and his fate as the patient's object.

The patient's unexpected, intermittent primitive manner of relating encites the therapist to engage in self-confrontation, which is an essential step in the process of differentiating the nature of the patient's communications.

4. Until the therapist has recognized and comprehended the adaptive contexts for his patient's communications, engaged in honest self-reflection and appropriated the previously denied feelings for and attitudes towards his patient, he cannot appraise the nature of his patient's communications accurately, nor fully. It is for this reason that the therapist must maintain an attitude of openness to learn from his patient's unconscious communications and be willing to rectify his erroneous interventions in the therapy.

5. Only once the therapist has recognized his participation in the externalization of the patient's internal object world, acknowledged his technical errors and begun to realize and own his neurotic countertransference, can he rid himself of his un-understood discomfort and be freed to explore the changing interpersonal landscapes before him. The therapist's continuing engagement in self-reflection and interactional analysis, both deliberately and unintentionally, during and between sessions, brings about this sense of freedom and separateness.

6. The presence of momentary, manifest reality-oriented responses of the patient does not preclude the existence of a latent level of pathologically based behaviour. It is therefore posited that there is a confluence between the reality-oriented responses and transference-based reactions of the patient. Both these dimensions of human relating exist side by side and are often interwoven and inextricable.

7. Sandler et al.'s (1973) definition of the concept of transference is advocated as it does not reduce this clinical phenomenon and dimension of human relating to the level of the patient's illusory apperceptions of the therapist. Instead, they incorporate the unconscious communications and provocations of the patient which the therapist senses in the quality of the atmosphere in the analytic environment. Sandler et al. (1973) state that:

> Transference need not be restricted to the illusory apperception of another person but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships (p.49).

8. The belief that the cornerstone of the therapist's process of differentiation is countertransference analysis is founded on the premise that the therapist's intricate knowledge of himself is the origin and pathway to understanding the other. This basic principle is strongly upheld and reinforced by the findings of the present study.

APPENDIX A

MOTIVATING LETTER TO PROSPECTIVE SUBJECTS

June 4, 1992

Rhodes University
Psychology Department
P.O.Box 94
Grahamstown, 6140
South Africa.

Fax. (0461) 2-5049
Telephone: (0461) 2-2023
Ext. 500

Dear

Your participation in this psychoanalytic research project is greatly appreciated. The intention of this study is to investigate the psychoanalytic psychotherapist's experience of the analytic relationship. In essence, the study proposes to investigate the psychoanalytic psychotherapist's lived experience of being receptive to the total communication of the patient in the analytic situation. For this reason it is vital to come to an understanding of what the therapist experiences in the analytic relationship which enables him/her to identify the patient's reactions as either transference based or reality-oriented.

To facilitate that the time you have allocated for the pre-arranged interview will be utilized fruitfully, it is suggested that the following research questions be deliberated on.

Can you describe the process which led you to differentiate whether a situation in psychotherapy was transferential or reality-oriented? If so, please describe your experience of the situation as accurately and in as much detail as possible. In other words, can you describe the process in psychotherapy which led you to distinguish

between the patient's transference "distortions" of you and their correct perceptions of you?

It must be emphasized that the focus of this qualitative research is not to ascertain the academic/theoretical skills of the therapists concerned, but to explore their experiential presence in the analytic situation. Your co-operation in providing descriptions revelatory of the process under investigation is sought.

It must be noted that the research study is fully supported by the Department of Psychology at Rhodes University and that the confidentiality of both the therapists and their clients is ensured.

It is hoped that this academic endeavour will have creative implications for the practice and training of psychoanalytic therapists in South Africa.

I look forward to meeting you on June at .

Sincerely

L.M. Danilewitz
(Clinical Psychologist/PhD Psychotherapy student)

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