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PSYCHOTHERAPY CASE REPORT

Psychodynamic Case Formulations:

Reflections of a neophyte therapist's experiences of how developing and using a psychodynamic formulation may have influenced treatment?

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ABSTRACT

Although it is generally acknowledged and accepted that case formulations are useful in psychotherapy treatment, there is significantly little research illustrating how case formulations are useful in treatment. Research also suggests that case formulations are seldom used in practice after initial training (Eells, 1997; Sim, Gwee, & Bateman, 2005). This research was premised on a particular case study which appeared to highlight shifts in psychotherapy treatment in the sessions directly after the writing or revising of the case formulation, thus prompting the inquiry into the influence of the case formulation on therapeutic work.

The research utilised a qualitative methodology and focused on a single case which was a 19 year old university student who expressed a problem with binge eating. The data was drawn from five original and revised case formulations. The participant was seen for 27 therapy sessions, over which time five case formulations were developed and revised. The findings in this study highlight the process of how a psychodynamic case formulation can influence therapeutic work, as reflected in three broad themes of adherence to the case formulation, the confidence of the therapist, and using the formulation as an intervention. The study contributes to arguments for the revival of the case formulation as a necessary therapeutic tool.

DECLARATION

I declare that *Psychodynamic Case Formulations: How do they influence therapeutic work* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE

(MS H.L. TEBBUTT)

DATE

“As we let our own Light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others.”

- Marianne Williamson

(Used by Nelson Mandela in his Inaugural Speech, 1994)

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CHAPTER 1: INTRODUCTION

Many authors believe that case formulations are a useful or even essential clinical tool (Sim, Gwee, & Bateman, 2005; Eells, 1997), yet Eells (1997) suggests they are seldom used in practice after initial training. Reasons for this lack of use in clinical practice include formulations been seen as time-consuming, only necessary for long-term therapy clients, or that it is seen only as a training tool (Perry, Cooper, Michaels, 1987). While a literature review into case formulations yielded much information regarding why they are useful, there is a significant dearth of research illustrating how case formulations are useful. To address this gap, the aim of this study is to reflect on the question, “How does a psychodynamic case formulation influence therapeutic treatment?” In researching this question, I will be documenting my reflections of writing a series of case formulations for a young woman struggling with an eating disorder and will be looking interpretively at the influence of these psychodynamic formulations on the therapeutic treatment for this specific case.

The literature reveals various definitions of a psychological case formulation. However, in their research on case formulations, Johnstone and Dallos (2006) suggest that all formulations share common elements. These common elements include a summary of the clients’ core problem(s), which draw from psychological theories and principles, and explain how the client’s problems relate to one another and why the client has developed these problems at this particular point in time and context (Johnstone & Dallos, 2006). Further, the formulation promotes thought to the intervention plan, and is open to modification and re-formulation (Johnstone & Dallos, 2006).

Sim et al. (2005) suggest the usefulness of case formulations lie in their link between: clinical diagnosis and treatment, theory and the practical application of this theory to the client, and the scientific principles of the diagnosis to the uniqueness of the individual client. They also suggest that beyond these links the case formulation provides many other uses such as consideration into aspects of the case such as the therapeutic relationship, anticipation of events that may interfere with the therapy process, and/or resistances to change in the therapeutic process (Sim et al., 2005). In this way they argue that this allows the therapist to understand the client beyond his/her problem, thereby experiencing greater empathy for the client (Sim et al., 2005).

The literature on psychodynamic formulations of eating disorders is also scarce, which may be due to the late start of psychodynamic therapy in proving evidence for its efficacy and effectiveness, as well as that psychodynamic therapy has been seen as not lending itself well to being empirically tested (Cooper, 2008; Lemma, 2003). It is understandable then that the evidence supporting the use of Cognitive Behavioural Therapy (CBT) in eating disorder cases has potentially influenced there being any literature of other ways of formulating eating disorder cases. However, recent research on attachment theory offers strong support to the psychoanalytic approach when working with clients who have an eating disorder (Cole-Detke & Kobak, 1996; O’Kearney, 1996; Ringer & Crittendon, 2007).

Thompson (1987, as cited in Goldfried, Greenberg and Marmar, 1990) suggests that research into the process of change, rather than research associated with outcomes, will help both the therapist and researchers understand how therapy works. In this way, it will improve not only the therapy work itself, but also add to the theory that informs and influences psychological practice. Thus a rich description of the process of how a case formulation influences therapy may help to revive the case formulation as a necessary therapeutic tool. It is in this light that I chosen to conduct this study, and thus contributing to the literature on how a psychodynamic case formulation influences therapeutic work.

Case Context:

The client, Jane, is a 19 year old female student, who referred herself to the Rhodes University Psychology Clinic where she was seen weekly from March 2011 to November 2011. She attended every session, a total of 27 sessions. Jane presented for therapy with a concern that she was binge-eating, and experiencing low mood. She felt she was overweight, and had been overweight and ‘dieting’ as far back as she can remember. Between ages 12 and 16 she successfully managed to lose weight, but only to put it all back on again. She reported binge eating or comfort eating almost every day of the week, and while she had once attempted to purge she had been unable to sustain this behaviour. Jane’s mother had also struggled with a lifetime of trying to be thin, and had constantly encouraged Jane to lose weight, criticising her for not being able to do so. Jane has two younger sisters. Her middle

sister (age 16 years) was diagnosed with Anorexia Nervosa during the course of our therapy sessions, to which Jane expressed envy that her sister had ‘got it right’.

During the course of our 27 therapy sessions, there were five revisions of this formulation by the therapist, myself, a trainee psychologist. In each session following the reworked formulation, there appeared to be a more substantial shift in the therapy work, prompting a search of the literature into the influence of the psychodynamic case formulation on therapeutic work.

Outline of the research:

Chapter one provides an introduction to this study in addition to the significance of research in this field of psychology. In chapter two, I review the literature on case formulations, focussing on three broad areas. These three areas include an overview of what a case formulation is and why it is useful; a history of how eating disorders have been formulated using a psychodynamic perspective; and a review of how process research can assist in understanding and explaining how an aspect of therapy, such as the case formulation, might influence therapy.

In chapter three I provide an overview of the methodology used and the procedures I followed. This is followed by the findings and discussion in chapter four, where the analysis confirms what other studies in this field have highlighted, yet gives greater depth of how the case formulation is a useful tool, particularly for neophyte therapists. In the final chapter I bring these earlier chapters together, and present some recommendations for further research in this area.

CHAPTER 2: LITERATURE REVIEW

Introduction:

This literature review will be divided into three main sections. In the first section I will define and outline the features of general psychotherapy case formulations and the clinical usefulness of these formulations, before distinguishing these from psychodynamic case formulations. I will also highlight reasons why case formulations are underutilised, despite a general acknowledgment among psychotherapists that case formulations are useful in clinical treatment (Eells, 1997). Since the client in this particular case struggled with an eating disorder, the second section will then examine the literature around case formulations of eating disorders. In this section I review how certain therapeutic approaches, such as Cognitive Behavioural Therapy (CBT) are seen as being more effective than other approaches when working with eating disorders, thus potentially influencing the dearth of information of other ways of formulating eating disorder cases (Cooper, 2008). I provide an overview of how eating disorders have historically been formulated using the psychodynamic approach, focussing more specifically on generic object relations theory formulations, which is the approach I used in my own formulations in this study. Finally I address the literature on psychotherapy process research, a form of research used to understand to gain an understanding of how a certain aspect of therapy, such as the case formulation, works. As this case study looks to reflect on how the case formulation may have on therapeutic work, this section will also address which factors may underlie therapeutic change, in order to understand which mechanisms may need to be examined when considering how therapeutic change has taken place due to formulating the case. Throughout this study, the terms psychotherapy and therapy are used interchangeably, as are the terms psychoanalytic and psychodynamic.

Psychotherapy Case Formulations:

What is a psychotherapy case formulation?

The literature on psychotherapy case formulations reveals various definitions as proposed by various authors (Johnstone & Dallos, 2006). While this may be understandable considering the number of available psychotherapy approaches, there also appears to be no agreed case

formulation definition between authors within the same theoretical approach (Johnstone & Dallos, 2006). A few examples of definitions of psychotherapy case formulations include the following: Bieling and Kuyken (2003) define it as an attempt to “describe a person’s presenting problems and to use theory to make explanatory inferences about causes and maintaining factors that can inform interventions” (p.53). Sim et al. (2005) summarise it as “a succinct description of the chief features of the case as well as an encapsulation of the diagnosis, aetiology, treatment options, and prognosis of the patients’ problem” (p.290). Eells (1997) defines a psychotherapy case formulation as “essentially a hypothesis about the causes, precipitants, and maintaining influences of a person’s psychological, interpersonal, and behavioural problems” (p.1). Ivey (2006) summarises these definitions, suggesting that “a case formulation is a considered answer to the following question: Why did this particular person, given his or her particular personality, current life circumstances, and personal and family history, develop this specific psychological problem at this point in time?” (p.325). Likewise, although Sim et al. (2005) provide a definition above, they remark that the formulation needs to capture the heart of the case, being both sensitive and specific to the client, and backed up by a theoretical basis. They believe that in this way, the clients’ behaviours and feelings can be better understood when seen in the context of why these behaviours and feelings were helpful to the client in the past, as well as how they are currently useful (Sim et al., 2005).

Eells (1997) suggests that there is more to a case formulation than the definition described above, and suggests that where there is confusing, incongruent, and/or multifaceted case information, a case formulation can help with organising and arranging this information about a person so that it can make sense. Further to this, a case formulation should guide the treatment plan, and serve as an indicator for identifying change (Eells, 1997). Finally, Eells (1997) argues that a case formulation is also a tool for the therapist to anticipate or predict any events that may arise from, and interfere with, the therapy work, and thus be able to provide greater empathy and understanding of the client.

These definitions all appear to have common elements about case formulations as describing, inferring, and thus trying to make sense of the reasons why an individual is currently presenting with their problems, given their particular history. Johnstone and Dallos (2006), agree with this argument that case formulations share common elements. However, after reviewing various definitions, they conclude that the common elements of case formulations

include: a summary of the core problem(s) of the client; draw from psychological theories and principles; explain how the clients problems relate to one another, and why the client has developed these problems at this particular point in time and context; promote thought to the intervention plan; and are open to modification and re-formulation (Johnstone & Dallos, 2006).

When considering these definitions and common elements, it is evident that they are different from a psychological diagnostic formulation. A diagnostic formulation is generally thought of as a concise label that identifies and summarises a recognised cluster of symptoms (Mace & Binyon, 2005). Mace and Binyon (2005) argue that while a multi-axial diagnosis offers information regarding different aspects of the patient, these aspects are restricted to the limited options prescribed by diagnostic classifications such as the Diagnostic Statistical Manual (DSM). They also argue that although a diagnosis is expected to be a guide to treatment, the diagnosis by itself has not been seen to be effective in deciding the treatment plan (Mace & Binyon, 2005). They believe that as formulations take in more of the uniqueness of a client, the expected prognosis for each client should be correspondingly unique as well, affecting the decisions around the treatment plan. Thus they argue then that when it comes to identifying and choosing treatments, psychological case formulations are more sound than diagnostic labels (Mace & Binyon, 2005). Although I have described diagnosis and formulations as separate concepts, there can sometimes be confusion between this distinction, as formulations have sometimes included diagnoses (Aveline, 1999; Eells, Kendjelic & Lucas, 1998). Aveline (1999) argues that diagnostic and psychotherapy formulations should not be seen as opposing functions, but rather that they work together. In this way Aveline (1999) argues that the diagnosis can condense the disorder to a more simple summary label, that provides areas of common ground with other clients who have similar disorders, while the formulation retains the complexity and rich uniqueness of the individual's problems.

Why is a psychotherapy case formulation useful?

Sim et al. (2005) assert that the case formulation has been recognised to be a basic, necessary, and useful conceptual tool, and a key clinical skill in psychotherapy. They believe that a diagnosis on its own, gives no attention to the underlying causes of a patient's problem/s, and dedicate a journal article to revitalizing the case formulations usefulness as a clinical tool. As

with Aveline (1999), they do not dismiss the value of diagnosis, but rather they argue that the case formulation can provide the link between diagnosis and treatment, by translating the diagnosis to a specific treatment plan and interventions (Sim et al., 2005). They continue that the case formulation is also the link between psychotherapy theory and the practical application of this theory to the client. Furthermore, they also link the scientific principles of the diagnosis to the uniqueness of the individual client (Sim et al., 2005). In this way, their views on formulations are much like the earlier definitions noted in this study, and do not deviate from the common elements of formulations referred to by Johnstone and Dallos (2006). However, in addition to these noted links and common elements, Sim et al. (2005) argue that the case formulation goes beyond these definitions, and provides insights into other aspects of the case, summarised as follows. The first aspect they refer to is integration of the case information, where the case formulation can identify and summarise the significant issues of the case quickly, particularly useful when the case is complex, with several problems (Sim et al., 2005). They also argue that the actual writing of the formulation helps the therapist to think about the case, organise these thoughts, and integrate the clinical details around a central focus of each case (Sim et al., 2005). In this way, they agree with Eells' (1997) suggestion that formulations assist with making sense of complex and contradictory case information. The second aspect is explanation, where Sim et al. (2005) argue that the case formulation acts as a framework in understanding how the problem developed, how it is being maintained (much like all case formulations), but that they also consider what the impact of the problem is on the client. Thirdly, Sim et al. (2005) refer to prescription, where they argue the case formulation provides a strategy that guides the therapy, and includes the setting of goals and choice of interventions. While this is fairly common to the other definitions of formulations, Sim et al. (2005) explain that this is an important part of the formulation, and is particularly useful for trainees, in helping to stay focused and on track, especially when they may feel pushed and pulled by the inconsistent moods or behaviours of the patient. The fourth aspect Sim et al. (2005) refer to is prediction, where they suggest the case formulation provides initial thoughts around the prognosis of the case. While this is not an uncommon element of formulation, Sim et al. (2005), believe it also provides a benchmark for indicating change. This is similar to the earlier suggestion by Eells (1997). However further to this, Sim et al. (2005) suggest that it also provides a platform for reformulating and reassessing the prognosis as new information unfolds in therapy. The final aspect Sim et al. (2005) refer to is that of the therapist aspects of the case. Here they suggest the case formulation allows the therapist to consider other aspects of the case, such as the therapeutic

relationship (both the nature of this relationship, and any associated difficulties), anticipation of events that may interfere with the therapy process, or resistances to change (Sim et al., 2005). Again, this is similar to Eells' (1997) argument noted earlier, in that both Eells (1997) and Sim et al. (2005) believe that by considering the aspects of therapy itself, the therapist is able to acknowledge the client beyond his problems, and thereby experience greater empathy for the patient.

Studies reviewing the usefulness and influence of case formulations:

Studies comparing case formulations between expert, experienced, and novice therapists in both the psychodynamic and cognitive behavioural therapy approaches (Eells, 2010; Eells & Lombart, 2003; Eells, Lombart, Salsman, Kendjelic, Schneidermanr, & Lucas, 2011) found that expert therapists produced higher quality case formulations than either experienced or novice therapists, in both of the approaches studied. The higher quality formulations were rated to be more comprehensive, elaborate, multifaceted, and more systematically organised, than those of the experienced or novice therapists. Not only were the formulations by the experts rated as higher quality, but they were also considered to comparatively offer a clearer description of the problem along with clearer interpretations and inferences regarding the problem, as well as being better linked to the treatment plan. Eells (2010) suggests that expert therapists proceed through four linear steps when formulating a case, which include first creating a list of the relevant problems of the case, followed by diagnosing the problems. The therapist then develops hypotheses explaining how these diagnosed problems came about, finally putting together a treatment plan. In this particular study Eells (2010) used both the nomothetic approach (where information on the case formulations were combined then analysed as a whole, thus providing us with the information on experts' formulations being of higher quality), and the idiographic approach (where formulations were analysed individually, and the results then combined as a whole). From these findings, Eells (2010) argues that the idiographic approach was better able to demonstrate the thought process behind how expert therapists' formulate a case. In this way, these studies suggested that the thought processes behind the expert, experienced, and novice therapist were all different, with the therapeutic outcome being more positive among expert therapists. This is relevant to my research in that being a novice therapist, the thought processes behind my formulations

are likely to be different from that of a more experienced or expert therapist, and therefore potentially have a different influence on the outcome of therapy.

Further to these studies, Betan and Binder (2010) argue that the reason behind expert therapists being able to produce higher quality formulations lie in the use of theoretical knowledge. Although case formulations are rooted in theory (as seen in earlier definitions of case formulations), Betan and Binder (2010) believe that while novice therapists may connect theory to the formulation, the more expert therapist goes beyond this simple connecting, and rather uses theoretical knowledge to think about the client in a more relevant, unique and meaningful way. They refer to this as “metabolising the theory” (Betan & Binder, 2010, p. 144), where therapists become so familiar and involved in a theory that it essentially becomes their own theory and part of their identity (Betan & Binder, 2010). They argue that in this way, the therapists regard of the theory’s key concepts, understandings of problems, and principles of change have become so automated, that the therapist is thus more able to formulate a client with flexibility and innovation (Betan & Binder, 2010).

What is of additional interest from these expert versus novice studies above, were the findings that few differences in the quality of case formulations were observed when comparing psychodynamic and CBT orientations (Eells, 2010; Eells & Lombart, 2003; Eells et al., 2011). Of interest to this research is that if positive therapeutic outcomes are influenced by the quality of case formulations, and the better quality formulations were seen to come from the thought processes behind the expert therapist, then it stands to reason that better understanding of these processes would help therapists to influence a more positive therapeutic outcome. Thus, the thought processes behind better quality case formulations appear to be more important than the theoretical orientation, and in need of more research to demonstrate how it works.

The findings of these studies (Eells, 2010; Eells & Lombart, 2003; Eells et al., 2011;) are supported by Persons, Curtis and Silberschatz (1991) who suggest that when comparing case formulations with regards to theoretical orientations, it is less about which therapeutic approach is used, and rather the act of formulating and the adherence to a case formulation, that makes a difference to therapeutic progress. They propose that case formulations in its self can influence clinical outcomes, stating that outcomes might be less about the interventions/techniques used and more about the process of developing an accurate

formulation (Persons et al., 1991). Although not specifically stated which process they are referring to it does support the idea that thought process influence outcome. They also suggest that formulations may help to develop a good therapeutic alliance, as well as enabling the therapist to feel more useful to their clients (Persons et al., 1991). They do not expand on their proposal regarding how the process of formulation may influence clinical outcome, which highlights the lack of research in this area of psychotherapy, and increases the usefulness of my current study to the literature. Similar to suggestion by Persons et al. (2005) that the process of formulating may influence therapeutic progress, Aston (2009), in a review of the efficacy of CBT case formulations, refers to this study by Persons et al. (1991), and highlights that the case formulation “might serve as a vehicle for other valuable components of the therapeutic process” (p.69). As with Persons et al. (1991), Aston (2009) suggests the formulation may assist in developing the therapeutic relationship, but that it also provides hope to the client, both of which Aston (2009) believes are important components of the process of providing change for the client. However, Aston (2009) argues that it is still unclear whether CBT case formulations influence therapy outcomes. Likewise, although CBT has been considered effective in reducing symptoms in many disorders, Bieling and Kuyken (2003) argue that there is no conclusive evidence to suggest that it is effective due to the formulation of the case. However, in their study of CBT case formulations, Chadwick, Williams, and Mackenzie (2003) found there to be a positive impact of the case formulation on the therapeutic relationship for the *therapist*, where therapists reported feeling more validated when their formulations were accepted by clients.

Eells and Kendjelic (2007) assessed whether training in generic psychotherapy case formulation improves formulation quality. They showed that therapists who received a two-hour training session in case formulation were rated as producing formulations that were of a higher overall quality than those therapists who did not receive any training (Eells & Kendjelic, 2007). These higher quality formulations were also rated as being more comprehensive, inferential (beyond descriptive information), and integrative (Eells & Kendjelic, 2007). Beyond the initial findings of this study, the authors concluded that therapists who have greater case formulation skills may be able to understand their clients’ better. Furthermore, improved formulation skills may also increase the confidence of the therapist, which in turn may increase the clients’ confidence in the therapist, which may positively influence the treatment process. Similarly, in their study regarding which criteria may be necessary for evaluating CBT case formulations, Bieling and Kuyken (2003) suggest

that from a scientific standpoint, there is little evidence of the reliability (where various therapists agree on the formulation of the same client) or validity (where the content of the formulation is confirmed as reason for the clients' presenting problem) of the CBT case formulation. However, they argue that this does not mean to say that if a formulation is scientifically unreliable that it may not have an impact on outcome, but rather that the impact may be through the case formulation leading to other mechanisms (such as increasing the therapeutic relationship or therapists' self confidence).

Are case formulations used in clinical practice?

Eells (1997) asserts that, if asked, most psychotherapists would probably agree that case formulation is an important, and even basic, clinical skill. Eells (1997) also contends that even though this may be the case, the seminal article by Perry, Cooper, and Michaels (1987) provides evidence that a comprehensive formulation "is seldom offered and almost never incorporated into the written record" (p.543). Eells (1997), amongst others (Ivey, 2006; Sim et al., 2005) believe a reason for this is that case formulations are largely untaught in psychotherapists' training. Perry et al. (1987) cite five misconceptions that might explain why clinicians may not construct case formulations as a part of their regular practice. They argue these misconceptions are that clinicians view case formulations as: only being necessary for those clients in long-term therapy; a training tool, and therefore unnecessary for experienced psychotherapists; time-consuming; being adequate to loosely produce in one's head; and finally, a concern that a clinician becomes fixated about a case formulation, and not 'hear the client' and thus not accommodate new information that does not fit with their formulation. While Perry et al. (1987) cite these view's, they also dispute them, and counter-argue that case formulations are equally important for short-term therapy as for long-term therapy. McWilliams (1999) supports this arguing that particularly in short-term therapy, where one has less time for therapy work, it becomes even more crucial to formulate a case. Perry et al. (1987) also counter-argue that formulations should be used as regular therapy practice, regardless of the therapist's level of experience, and that these formulations need not be elaborate or time-consuming. Like Sim et al. (2005), they argue that formulations are better when set out in written format. Finally, they argue that formulations do not hinder the therapist's understanding of the client's problems when it does not fit with the case formulation, but rather that it facilitates the therapist's understanding of these problems.

As this research specifically reviews how the case formulation from the psychodynamic approach may have influenced this particular case, I will now pay closer attention to the psychodynamic case formulation.

Psychodynamic Therapy, Treatment, and Case Formulations:

As much as there are varying definitions of psychotherapy case formulations, there are also varying definitions within the psychodynamic approach. 'Psychodynamic' is a general term for approaches that draw on psychoanalytic ideas, assumptions, and therapeutic treatments, but the field is very wide (Lemma, 2003). Some of these approaches include Freud's structural model, Ego Psychology, Object Relations theory, Self Psychology, as well as the Jungian, Intersubjective, and Interpersonal approaches (Lemma, 2003). More recently, Attachment theory has also been included under the psychoanalytic school of thought (Lemma, 2003). Each of these psychodynamic approaches would place a different emphasis on the initial assessment of the client, which would then reflect differently in the respective case formulations. Thus while a Freudian and an Object Relations therapist will both assess a client under the broad psychoanalytic perspective, (to be discussed below), these therapists would understand the clients' symptoms, and the causes behind these symptoms slightly differently (Ivey, 2006). Lemma (2003) believes two psychoanalytic therapists, would both elicit and neglect certain information in the assessment, depending on their respective schools of psychoanalytic thought to which they subscribe, and therefore formulate a case differently. As will be discussed later, there is thus no standard format used to formulate a client from the psychodynamic approach.

Shedler (2010) defines psychodynamic therapy and psychodynamic treatment as exploring aspects of the self that are not fully known (the unconscious), and in particular, how these aspects show themselves in the relationship between the client and the therapist. A review by Shedler (2010) identifies seven features that distinguish psychodynamic therapy and treatment from other psychotherapies. These include firstly a focus on the encouragement of the expression of a wide range of emotions, including incongruent and/or threatening feelings, as well as, secondly, a focus and exploration of the resistances and defences that a client may use to avoid painful thoughts and feelings. Shedler (2010) argues that an identification of the recurring patterns and themes within the clients' thoughts, feelings, and their relationship with themselves and others is the third feature defining psychodynamic

therapy, with the fourth being a focus on the developmental aspect of the client, with particular reference to their past experiences of early attachment (usually parental) figures. Shedler (2010) believes this focus is primarily on how the past is having an effect on the problems the client is presently experiencing. The fifth feature is the focus on interpersonal relationships as psychological difficulties are often due to the conflict between the clients' emotional needs and their challenging interpersonal patterns and the sixth being a focus on the relationship between the therapist and the client, especially with regards to how the clients' interpersonal patterns play out in this therapy relationship, which are monitored through the concepts of transference (the unconscious transferring or projecting of the clients' feelings and attitudes to the therapist) and countertransference (the feelings or response that is elicited in the therapist by the clients' unconscious transference communications). Shedler (2010) argues that the seventh distinguishing feature of psychodynamic therapy and treatment is an exploration of the clients' fantasy life which requires the client to speak freely about their mental world, including their desires, fears, and dreams, much of which has never been verbalised. This exploration allows for information on how the client views the self and others, what they avoid or fear, and what can hinder their ability of finding greater enjoyment in life.

This outline of the distinguishing features of psychodynamic therapy and treatment is important in terms of the above review regarding assessment, where it was discussed that during the assessment stage, therapists will focus on certain aspects of information from the client. Thus a therapist from a psychodynamic perspective, will ask the client questions around these features, and from the information they receive from the client due to this line of questioning, will begin to make sense of the client and their problems in a particular way. This is considered the beginnings of a psychodynamic case formulation.

What makes a psychodynamic case formulation different from other psychotherapy case formulations?

Lemma (2003) argues the distinguishing feature of a psychodynamic formulation is that of identifying clients' recurring themes in relation to their self (intrapsychic) and others (interpersonal). This refers to Shedler's (2010) third feature of psychodynamic therapy. These intrapsychic and interpersonal themes are usually drawn from inferences given from the clients' background information in the assessment. Aveline (1999) asserts that such

inferences come from observing the patterns of interaction between the client and the therapist, as well as the transference reactions and therapists' countertransference feelings. As discussed in the sixth feature by Shedler (2010), these interpersonal patterns in the therapeutic relationship, as well as any transferences and countertransferences need to be monitored through the course of therapy. Lemma (2003) continues that the psychodynamic case formulation usually include both the external circumstances and the internal factors that have contributed to, and maintained, the clients' problems, which refers to Shedler's (2010) fourth feature regarding how past experiences are affecting the clients present problems. Similar to this is Mace and Binyon's (2005) suggestion that the psychodynamic case formulation summarizes the relevant developmental patterns and events, and inferring (in the ways described by Aveline (1999) above), how these patterns have accounted for the clients' problems. Mace and Binyon (2005) argue that this account of the clients problems would usually make reference to the clients' internal conflict (a mental and often unconscious struggle between opposing wishes), developmental difficulties, and/or unconscious processes (a mental process that one is not directly aware of), which refers to Shedler's (2010) fifth feature of psychodynamic therapy.

An example of this may be of a client born into a single-parent family, whose mother was a busy professional. This client was raised by a nanny, and even when his/her mother was at home, he/she would engage more with other tasks than with her child. The client presented for therapy because he/she was experiencing low mood. As Lemma (2003) argued, the psychodynamic formulation would involve considering the external, developmental recurring themes of the client's life (a mother who was largely both physically and emotionally absent). Lemma (2003) argues the formulation would also consider these themes in relation to the client's self (intrapsychic), where the client sees him/herself as easily rejected and not worthy of others' attention, as well as in relation to others (interpersonal), where the client sees others as unavailable and disinterested in him/her. As suggested by Aveline (1999) these considerations of how the client sees him/herself and others, is largely inferred from the information given by the client, as well as the therapist noting any transferences and countertransferences. An example of transference may be the client calling the therapist many times to ensure the therapist would be there for the session, and thus projected his/her need for attention onto the therapist. An example of countertransference may be the therapist feeling smothered by this constant need for reassurance of his/her availability, and may feel inclined not to want to be available to the client, as others' might also have felt. As suggested

by Mace and Binyon (2005), a psychodynamic formulation would refer to the client's internal conflict. In this formulation example, the internal conflict (which is most likely to be unconscious) is possibly that the clients has a wish to be loved by others but does not actually feel that he/she is worthy of this love. While Lemma (2003) and Mace and Binyon (2005) refer to various aspects of psychodynamic therapy that they feel need to be included in a formulation, they do not refer to there being any one correct way to formulate a case. This view of there being no one 'correct' version of case formulation is in accordance with the view psychoanalysts have regarding all psychoanalytic data and knowledge: that there is 'a' truth where other subjective truths or meanings are possible, rather than 'the' truth which is objective (Frosh, 2006). This does not mean when it comes to psychoanalytic knowledge that 'anything goes', but rather that the validity of psychoanalytic knowledge should be judged according to how richly it communicates the clients experience, the extent to which it draws on the principles of triangulation of data to make a coherent argument and the extent to which the findings open up further areas for exploration (Frosh, 2006).

Ivey (2006) refers to a psychodynamic formulation as being an understanding of the development of a clients' psychological functioning, and suggests there are certain minimal requirements that need to be considered when taking into account a clients' psychological developmental functioning. These requirements are the considerations of (a) the conflicts arising from clients wishes, (b) the anxiety caused by these conflicts, and (c) the unconscious strategies the client resorts to in order to avoid the distressing awareness of these conflicts. Similarly, Malan (1979), speaks of a Triangle of Conflict in formulating a client psychodynamically, which consists of a clients fear, their defence or avoidance of this fear, and their wish or unconscious hidden feeling behind this fear. Malan (1979) explains this Triangle of Conflict as a client having a painful or problematic feeling or impulse (their unconscious hidden feeling) that begins to emerge into consciousness. This emergence into consciousness results in anxiety or fear, which in turn activates a defence mechanism, or avoidance of this fear, and in this way the client is able to avoid the fear. The aim of therapy then is to help the client gain insight into their behaviour by working through their defence, and bringing the hidden feeling in awareness, making it clear how these hidden feelings (wishes) have impacted on the client. Thus, continuing the example above, the internal conflict (which is most likely to be unconscious) is that the client has a wish to be loved by others but does not actually feel that he/she is worthy of this love. The anxiety caused by this conflict is that he/she fears that he/she may always be alone. The strategies (defences) used

to protect him/herself against this anxiety is to try to control others' behaviour by finding ways to ensure they will be there for him/her (such as continually calling them).

These minimal requirements speak to Ivey's (2006) definition of a psychodynamic formulation being a conceptualisation of a client's psychological functioning. Thus Ivey (2006) believes as a minimum requirement for a psychodynamic formulation, one needs to include the client's conflicts, anxieties, and defences. These refer to Shedler's (2010) first, second, and fifth features of psychodynamic therapy.

Various authors (Ivey, 2006; Lemma, 2003; Mace & Binyon, 2005) agree that the psychodynamic case formulation is a work-in-progress document, to be reworked and refined as the therapist learns more about the client during therapy work. Although this may be inferred from the above statement regarding case formulations being a work-in-progress, Ivey (2006) asserts that as the formulation is a process, the treatment goals would thus also need to be open for changes over the course of therapy. Ivey (2006) continues that the treatment plan needs to consider aspects of transferences, defence strategies and resistances, as ignoring these aspects would damage the treatment plan. Ivey (2006) argues this damage would be due to the interfering with and potentially compromising the therapeutic alliance. In the above example, if the therapist does not address the client's constant calls and need for reassurance as part of the treatment plan, the therapist may become increasingly irritated by the client, thereby compromising the therapeutic alliance, and thus not providing the client with an opportunity for a change to his/her recurring relational patterns.

Case Formulations and Eating Disorders:

As the study examines the psychodynamic case formulation with regards to a client with an eating disorder, I will next review the literature on case formulations concerning eating disorders. While the literature search on case formulations with regards to eating disorders yielded much information for CBT, there was little information found for the psychodynamic approach.

It is important to note that although the young woman in this case study has a problem with binge eating, this study relates to eating disorders in general. Fairburn and Harrison (2003)

define an eating disorder as “a definite disturbance of eating habits or weight-control behaviour, where either this disturbance, or associated core eating disorder features, results in clinically significant impairment of physical health or psychosocial functioning. Core eating disorder features comprise the disturbance of eating and any associated overevaluation of shape or weight”(p.408). According to the DSM-IV-TR there are three categories of eating disorders, namely anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (DSM-IV-TR, 2000). Binge-eating disorder, which has provisional diagnostic criteria in DSM-IV-TR, is the most researched disorder in this third category (Wilson, Grilo, & Vitousek, 2007).

Developmental Theories of Eating Disorders:

Although this study relates to the Psychodynamic approach, and my case formulation rooted in the Psychodynamic’s Object Relations theory, it is important to understand the wider literature as to how eating disorders have been seen to develop. According to Attie and Brooks-Gunn (1995), the development of eating disorders have been seen to arise from biological models, psychological models, and/or socio-cultural models.

Biological models of eating disorders look at the genetic predisposition of an individual, such as abnormalities in the serotonergic functioning of individuals who have an eating disorder, as well as abnormal satiety levels (Attie & Brooks-Gunn, 1995).

Psychological models of the development of eating disorders have focused more on the importance of family interactions, such as separation-individuation difficulties, as well as emotion regulation and self-esteem (Walsh & Delvin, 1998). Altman and Lock (1997) discuss the association between children who have feeding difficulties at a young age with those individuals who later eating disorders. In their review, Altman and Lock (1997) discuss how certain personality traits, such as being compliant, perfectionistic, goal-oriented, shy, and obsessive, can be associated with eating disordered individuals.

Socio-cultural models of eating disorders consider the influence of social and cultural standards of beauty as well as family and peer attitudes toward beauty, and how these are often impossible to attain, increasing the risk for the development of dysfunctional thoughts and behaviours (Attie & Brooks-Gunn, 1995).

Although it appears from the literature that there is no conclusive view on the etiology of eating disorders, and that biological, psychological, and sociocultural factors may all play a role, this research looks more specifically at the psychological theory of eating disorder development.

The influence of research on case formulations:

What has become known as the Dodo bird verdict in psychotherapy research literature is the understanding that no form of psychotherapy has proved superior to any other (Luborsky, Singer & Luborsky, 1975). According to Cooper (2008) there is currently a hotly contested debate around the relative efficacy and effectiveness of different therapeutic orientations. Within the psychotherapy field, efficacy is how well a treatment works in an ideal or controlled setting such as a randomly controlled trial (RCT), whereas effectiveness is how well that treatment works under 'real world' conditions. While this debate does not specifically relate to this research, it does have some bearing on why there may be relatively scarce literature on certain therapeutic approaches, particularly in relation to certain aspects of these approaches, such as how psychodynamic case formulations influence therapy work. Despite the Dodo bird verdict stating that no form of psychotherapy is superior to another, psychodynamic therapy has not, until recently, attempted to prove its efficacy and therefore running the risk of other efficacious psychotherapies being proven as superior (Lemma, 2003). Thus the literature around how psychodynamic therapy is effective (including aspects such as the case formulations) is relatively scarce when compared to other psychotherapies.

Empirically supported treatments (ESTs) have gained support world-wide in various fields. In fields such as the health service industry, confronted with over-stretched budgets, it has become essential to prove the effectiveness of a treatment (Cooper, 2008). Thus, certain therapies, such as those that lend themselves well to being empirically tested (for example those therapies that are conducted according to a manual, and focus only on symptom reduction), have gained more evidence of being effective (if they were found to be effective) than those therapies that do not lend themselves well to being empirically tested (Cooper, 2008). It is understandable then, that these therapies with the higher evidence of being effective, such as cognitive behavioural therapy, would gain increased support above those therapies, such as psychodynamic therapy, where symptom reduction alone is not the goal of

therapy. This is not to say that psychodynamic therapies are not effective, but rather that historically there has been little evidence collected, relative to that collected for CBT. However, according to Fonagy (1999, as cited in Lemma, 2003), the number of psychoanalytic studies on efficacy and effectiveness being witnessed is encouraging. Shedler (2010) also argues that there is scientific evidence supporting the efficacy and effectiveness of psychoanalytic, and indicates that often unacknowledged “active ingredients” (p.103) of the techniques and processes of other psychotherapies have long been defined as features of psychoanalytic therapy.

This lack of research is particularly evident when one considers the literature around eating disorders. Murphy, Russell, and Waller (2005) note that while there is substantial evidence base for the use of more recently developed therapeutic approaches being effective in treating bulimia nervosa or binge-eating disorder, there is very little evidence that psychodynamically based treatments are effective. They continue that although many studies support the use of cognitive behavioural therapy (CBT) for patients with bulimia nervosa and binge-eating disorders (Fairburn & Harrison, 2003; Knauss & Schofield, 2009; Mitchell, Agras, & Wonderlich, 2007) a substantial number of such cases do not recover with CBT alone (Wilson, 1999). However, when searching for literature related to eating disorders from a psychodynamic perspective, the lack of literature in this area was not surprising due to the late start of psychodynamic therapy in proving its efficacy and effectiveness.

The only recent evidence of working with eating disorders within a psychodynamic framework, comes with studies of Bowlby’s Attachment Theory (Chassler, 1997; Kenny & Hart, 1992; Orzolek-Kronner, 2002; Taska, Szadkowski, Illing, Trinneer, Grenon, Demidendo, Kryszanski, Balfour, Bissada, 2006). It may be argued that although Bowlby was originally trained in psychoanalysis, this does not translate to attachment theory being considered a psychoanalytic theory. If this were true, there would currently be extremely little evidence for working with eating disorders from a psychoanalytic perspective. However, in a review of psychoanalysis by Westen (1998, as cited in Shaver and Mikulincer, 2005), Westen argues that attachment theory complies with all the core assumptions that define psychoanalytic approaches and should thus be considered as a psychoanalytic theory.

As the formulations in this particularly study were rooted in Object Relations Theory, I will outline in the section below, the literature of how eating disorders have historically been

formulated from a psychodynamic perspective, ending with a more specific review of working with, and formulating eating disorders, with object relations theory.

Psychodynamic formulations of eating disorders:

Historical formulations of eating disorders:

When reviewing the history of eating disorders as understood from the psychoanalytic approach, the original explanations of eating disorders were generated first by Freud, as early as 1899 (Schneider, 1995). From Freud's Structural Model of the mind, which viewed the human psyche (personality) as having three different forces or drives (namely the Id, the Ego, and the Superego), Freud argued these drives each place their own demands on the functioning of the psyche. When two or more of these drives placed opposing demands on the psyche, internal conflict would arise, causing anxiety for the client. In this view, in order for the client to alleviate the internal struggle and anxiety, the client would develop strategies, known as defences, in order to cope with this internal pain (Schneider, 1995). In this way, Freud viewed eating disorders as a form of defence to an internal, often unconscious, conflict. (Lemma, 2003; Schneider, 1995).

Ego psychologists followed on from this model, describing eating disorders as arising from problems in ego functioning (how a client is able to maintain their sense of identity when faced with anxiety and distress), as well as early problematic mother-child relationships (Schneider, 1995). However, it was an Interpersonal psychologist, Hilda Bruch, who modified these views in the 1960s and 1970s (Schneider, 1995). Bruch (1977) suggested there was a link between eating disorders, and a fear of both abandonment and autonomy, and that this was reflected in the clients' current interpersonal relationships. Bruch (1977), amongst others (Broberg, Hjalms, & Nevonen, 2001; Chassler, 1997), viewed eating disorders more in terms of interpersonal problems, and specifically, the separation and individuation (independence) of the child from a mother who had failed to be responsive to his/her needs, but yet also wished to remain with his/her mother. Bruch (1977) described the family environments of eating disordered clients as characterised by being socially impressive and successful, intrusive, over-controlling, and with limited opportunities for the child to express herself. Bruch (1977) argued that clients defended against this type of parental environment by developing a highly compliant fake self, behaving as they are

commanded by others in response to a fear of not being seen as perfect. This fake, externally-defined self becomes the child's way of coping with their environment, however, at the cost to the child not being able to recognise their own feelings and individuality, act on their own initiative, or develop a sense of identity (Bruch, 1977). This lack of core personality was thus translated into behaviours, for example, starvation, in an attempt to gain some sense of accomplishment, control and personal power. Thus, according to Bruch (1977), eating disorders are understood in this framework as failing to successfully complete the separation-individuation process, a developmental task that is particularly acute during adolescence.

Similarly, in their observations of adolescent eating disordered patients', Corcos and Jeammet (2001) suggested that the relationship with the parent (caregiver) is based on an idealised relationship, free of conflicts, where the child (or adolescent) is more concerned about sustaining this ideal, conflict-free relationship, and thus complies or conforms to what he/she thinks the 'other' is wanting, sacrificing her own needs and wants. In this way, the adolescent creates an identity with respect to his/her parents. However, they suggested that this conforming behaviour does not assure the adolescent of his/her autonomy, but rather deprives him/her of developing self-esteem, leading to an internal emptiness which requires further dependence on others. Corcos and Jeammet (2001) suggested that particularly for females, dependency is centered on the body, wherein they believe the adolescents' identification takes place. They argued that the extent of the dependency is shown in the way the adolescent 'acts out' (in other words in the way they manage eating, be it bingeing, purging or restricting), and that this is the adolescent's way of affirming their identity with regards to their parents (Corcos & Jeammet, 2001).

The views of Bruch (1977) remained the understanding of eating disorders until object relations theory developed. Schneider (1995) states that it was mainly through the work of McDougall (1974) and Winnicott (1975), that a framework for understanding eating disorders from an object relations perspective came into being.

Object Relations Theory and eating disorders: Theory and formulations

Object Relations theory is a theory about interpersonal relationships, where objects are considered to be people, or rather, internal representations of people (Teyber, 2000).

According to Summers (1994), the core view in this theory is that humans are primarily motivated to have contact with objects, and to form object relations. This theory particularly focuses on how the relationship between parents and a young child is internalised by the child (Lemma, 2003). Object Relations theorists believe that the way a young child internalises the early care-giving relationship, becomes a template for the way children organise their interpersonal world, and establish further relationships with others (Summers, 1994). In the same way, this template also offers the child a foundation for the way they start to view themselves (Lemma, 2003; Summers, 1994).

Teyber (2000) explains that where the care-givers behaviours are internalised by the child to be emotionally available and reliably responsive ('good objects') to their fundamental needs, the child is secure in her emotional relationships. This internalised relational template allows the child to maintain this view of love and availability, even when his/her parents are away (Teyber, 2000). However, where parents have not been able to provide a consistent or responsive caregiving relationship, the child is stuck between not being able to receive emotional security from the caregiver, but still being driven by their need to establish an emotional attachment (Teyber, 2000). According to Lemma (2003), in this view, the child resorts to using the defence of 'splitting' to protect and maintain the emotional relationship with the caregiver. This splitting defence means the child splits the good (loving and emotionally responsive) and bad (rejecting, unresponsive) aspects of the caregiver, internalising these aspects separately (Lemma, 2003). In this way, the child is able to maintain the view that the unresponsive parent is actually 'all good', by rather believing that they (the child) are the ones who are 'bad' (Lemma, 2003). The cost of this distorted reality is anxiety and a diminished sense of self worth. The child believes that if they could be better, then the parents would be more responsive and loving (Teyber, 2000). Teyber (2000) further explains that this belief also allows the child to feel they have some control over the situation of being loved. Problems thus arise from clients who have developed maladaptive behaviours (symptoms such as eating disorders) in order to manage these 'bad' aspects of themselves, so as to preserve these relationships, and thus avoid feelings of rejection and being unloved (Lemma, 2003; Summers, 1994, Teyber, 2000). Similarly, Fairburn (as cited in Schneider, 1995), explains this by detailing the concept of how a client takes in a bad object in order to control this bad object and to make it a good object. Fairburn proposes that that infants, in their intrauterine state perceive their world as perfect, but that after birth the infant soon realises that this perfect intrauterine state cannot be replicated. This leads the infant to

splitting their world into good or bad elements. Fairburn argues that the infant does not need to internalise the good mother object, but if the infant feels that the mother has not proved to be satisfactory, it is necessary for the infant to internalise the bad object mother with the purpose of trying to control it and turn it into a good object. Thus although the infants relationship to the internalised bad object is one of repressed anger and hatred, a bad relation to an object is better than no relation to an object. This is due to Fairburns' assumption that "humans are most fundamentally object related, and that the need for other humans is more deeply felt than the need for water, food, or sex. Thus, no human being, no matter how good or bad, will be discarded" (p.181).

When considering an eating disorder formulation using object relations theory, Fairburn (as cited in Schneider,1995) believes that they are explained by this concept of the child taking in a bad object (the unresponsive parent), believing that they are the bad ones, as a way to control the bad object and make it good. Fairburn (as cited in Schneider, 1995) believes that the relationship to the bad object becomes one of repressed anger and hatred, and in this way the child physically and aggressively feeds (or starves) him/herself (the bad object) as a way of asserting controlling over his/her situation. He/she does this in the hope of becoming a good object, worthy of securing the love from the caregiver, and thereby increasing his/her sense of worth and lovability (Fairburn, as cited in Schneider, 1995). Schneider (1995) explains this as "the food becomes a self-imposed 'oral rape', in the same way that rape is not about sex but is instead a sexual form of, or medium for, hatred, and in some cases the eating binge (in the case of bulimics) has more to do with aggression than with food or hunger. In the case of eating disorders, the relationship to the bad object becomes addictive relentless attempts to get love which clearly cannot be obtained" (p.182).

Process Research:

In this section I will be reviewing how process research can assist in understanding and explaining how an aspect of therapy, such as the case formulation, might influence therapy. I will initially look at the general psychotherapy principles underlying therapeutic change, as well as reviewing the change process more specifically linked to the psychodynamic approach, the theoretical approach of my research. As my research question aims to describe the process of how a case formulation may influence therapy work, this section will also

address the mechanisms which may underlie therapeutic change, in order to understand which mechanisms may need to be examined in identifying if any change /influence has occurred due to formulating the case.

According to Pachankis and Goldfried (2007), most psychotherapy research is thought of in terms of randomised clinical trials (RCTs), which is a methodology used to discover if a certain intervention works. Psychotherapy research originated as a means for establishing whether it (the actual psychotherapy) was able to produce personality change or not, known as outcome research (Pachankis & Goldfried, 2007). However, psychotherapy research later progressed to follow the medical model approach, which studies the treatment of psychological difficulties using RCTs, in the hopes of discovering if a particular treatment is better than an alternative treatment (Pachankis & Goldfried, 2007). This outcome research, using RCT's has its focus on if a treatment works, rather than how a treatment works (Pachankis & Goldfried, 2007). Thus it may be able to indicate a preferred treatment for behaviour change to the therapist, but gives no indication to the therapist of how to go about influencing behaviour change. To overcome this limitation of how a therapist goes about influencing behaviour change, psychotherapy process research needs to be considered.

Psychotherapy process research is a methodology used to understand how a certain intervention works, or in other words, it is the research undertaken to understand the mechanisms responsible for therapeutic change (Kopta, Leuger, Sanders, & Howard, 1999). According to Pachankis and Goldfried (2007), process research initially focused on creating measures for 'examining' therapeutic events, (for example, interpretations) and the immediate in-session outcome of this event. This was usually done through the analysing of verbal expression and emotional experience of in-session audiotapes. However, process research has evolved and more recently has started focussing on the process of what brings about psychological change, rather than just the therapy process (Pachankis & Goldfried, 2007). In this way process research produces useful information for the therapist. Examples of this include research on the therapeutic alliance, where Safran and Muran (2000) researched how to identify ruptures in the therapeutic alliance including how to repair these ruptures effectively.

An American Psychological Association task force was set up to conduct research into defining the principles of change, and guidelines for how to deal most effectively with

clients. According to Castonguay and Beutler (2006), senior members of this task force, the primary goal of process research was being able to identify mechanisms of change, with the likely mechanisms or principles of change lying with the client, therapist, relationship, and the intervention. With regards to the client and the therapist, Castonguay and Beutler (2006) suggest that both the client and the therapist have certain personal characteristics or variables that may influence the outcome of therapy. They argue that these characteristics have the potential to either increase or hamper the probability of change, thus affecting the outcome of therapy. In their research, they reported some of the following variables, for both the client and the therapist, to be important when considering the influences on the change process: resistance, coping mechanisms, expectations of therapy, attachment pattern, gender, religion, and cultural background (Castonguay & Beutler, 2006).

When considering the relationship factors as mechanisms for change, Castonguay and Beutler (2006) refer to both the quality of the therapeutic relationship, as well as the therapists' skill of working with this relationship. Some of the variables they reported as relationship factors include the therapeutic alliance, empathy, congruence and genuineness, repair of any therapeutic alliance rifts, self disclosure, countertransference management, and the quality of interpretations regarding the therapeutic relationship.

Finally, with regards to the interventions as being a likely mechanism of change, Castonguay and Beutler (2006) reviewed the specific procedures or techniques already identified as ESTs. To draw out which principles may underlie therapeutic change, categories under which procedures from various theoretical orientations could be grouped, were provided. These categories included the therapists' skill in being able to be directive when given client resistance; how insightful the therapist is regarding the outcome of therapy, versus the sole focus on symptom or behaviour change; the intensity of the intervention with regards to the frequency and duration of therapy; the focus on interventions of both intrapersonal (just on the client) and interpersonal (the client in relation to the therapist and/or others) factors; and the degree to which the intervention was intended to be supportive or interpretive and challenging (Castonguay & Beutler, 2006). The findings of this review are still considered as potential factors that may influence therapeutic change, and are not regarded as definitive of the therapeutic change process.

In terms of the methodology behind how these variables were extracted, members of the task force were instructed to review relevant studies (which excluded all biological treatments, and treatment of children) from a predefined list of recognised resources. Once a general list of principles from these reviews was established, the task force was asked to group these principles according to the participant factors (the client and therapist variables), relationship factors, and technique factors. However, although they were asked to review a predefined list of studies, the task force were also invited to add to these studies other reviews or factors they felt could convincingly support the evidence of what may lie behind the process of therapeutic change.

As this research is more specifically concerned with the how the psychodynamic case formulation influences therapy work, I will now review how the change process may be seen from this perspective. In her review of psychoanalytic change, Lemma (2003) notes that there appear to be several accounts of how therapeutic change may occur within this approach, with various overlaps between these accounts. Some of these accounts include the following: An excavation of the past, which suggests that change occurs when one remembers previously repressed events from the past, which, once explored with the client, leads to change through greater personal insight. In this way, Castonguay and Beutler (2006) change factor of the quality of the therapeutic alliance may be important to examine, as the client may only feel safe to explore repressed events once a good therapeutic alliance has been formed. Another account of psychodynamic change is considered to be working through the clients' transferences. In this account, change occurs from the therapeutic relationship where the therapist interprets the transferences as they unfold in the therapy sessions. The therapist believes these transferences are re-enactments of past relationships, and thus interpretations of the current (therapeutic) relationship is what leads to change. As mentioned above, transference and countertransference management are considered by Castonguay and Beutler (2006) to be a mechanism of change. Considered by Lemma (2003), Aveline (1999) and Mace and Binyon (2005) to be a part of the psychodynamic formulation, and emphasis of these as part of the treatment plan may influence the course of therapy, leading to change. Lemma (2003) argues that while most psychoanalytic therapists agree that the therapeutic relationship is essential to therapeutic change, it is not yet agreed how this relationship influences the change process. One account is through the corrective emotional experience where the therapist deliberately responds differently to the client, interprets this to the client, and therefore offers the client a new way of relating that can then become more internalised,

leading to a more positive view of themselves and of others. In this account, Castonguay and Beutler (2006) mechanism of change may be the focus on interventions of both intrapersonal (just on the client) and interpersonal (the client in relation to the therapist and/or others) factors. The final account I highlight as being put forward by Lemma (2003), is that which she refers to as “mutative exchanges” (p.86). Other than some overlaps with that of the corrective emotional experience, the above accounts have all relied in some way on the spoken word, including verbal interpretations, and would thus consider change as occurring at the explicit, declarative level of memory (the conscious recollection and account of facts and events). Lemma (2003) argues that mutative exchanges refer more to the qualitative process of what is going on within the therapeutic relationship, and can potentially influence therapeutic change. This qualitative process includes exchanges between the therapist and the client with regards to posture and facial expressions, the greetings and habits on arrival and departure of the sessions (Lemma, 2003) and Castonguay and Beutler (2006) reference to the quality of the therapeutic alliance may be important to examine here. The Boston Change Process Study Group (2002) offer that for change to occur, it need not necessarily be a conscious process for the client, but rather through the nature of the qualitative exchanges that are occurring between the therapist and the client. In this way, as the clients’ way of being with the therapist becomes more habitual, there is an opportunity for change to occur through the quality of this new non-verbal relational experience. Change in this manner is said to occur at an implicit, procedural level of memory, which is unconscious and manifests in performance behaviours such as our patterns of being with, or relating to others. Fosshage (2003) argues that working with both declarative and procedural memory provides the client with two essential processes of change.

The above general change principles from Castonguay and Beutler (2006), and the psychodynamic changes process described by Lemma (2003) gives a researcher many options to explore when considering how an aspect may work. Given that an aspect of the psychodynamic formulation is identifying the clients’ recurring themes in relation to their self and others (Lemma, 2003), it would seem that the therapeutic relationship (as inferred by the transferences and countertransferences) would be an important mechanism by which to evaluate change. This would also be important when considering how the developmental patterns of the client have accounted for their problems, thus the therapeutic alliance appears to be instrumental in assessing how the case formulation may influence therapy work. Ivey (2006) asserts that the clients defences are an essential part of the case formulation, thus

exploring the changes in the client's resistance may also be considered to be an influential factor in my research. These factors of change will be considered above other factors outline by Castonguay and Beutler (2006). However I will attempt to keep these other factors in mind as some of them may be found to be important factors in understanding how the case formulation influences therapy work.

Conclusion:

In this chapter I reviewed the understandings of what a psychotherapy case is, and why it is both useful, but underutilised. I have also highlighted how a psychodynamic case formulation is different other psychotherapy case formulations, and how eating disorders have historically been formulated using a psychodynamic approach. Further, I reviewed how process research can assist in understanding and explaining how an aspect of therapy, such as the case formulation, might influence therapy, as my research question aims to describe the process of how the psychodynamic case formulation may influence therapy work. In the following chapter, I will discuss the methodology employed in conducting this study.

CHAPTER 3: RESEARCH METHODOLOGY

Introduction:

Methodology connotes a set of rules and procedures to guide research. It is also against these rules and procedures that research claims can be evaluated and understood. Thus methodology is fundamental to the construction of all forms knowledge, and provides the tools that one can use to create understanding (Daly, 2003).

Daly (2003) also argues that it is crucial to realise that one selects methods and techniques as part of a broader package as it is widely accepted that the method one selects involves a set of standards that should be aspired to. However, less widely accepted is the fact that assumptions and values underlie all methods, as well as a particular view of how we are to understand the social world.

In this section of research methodology, I will begin by framing this research within the interpretive paradigm, and how this is suitable for psychoanalytic research. I will then give an overview of the methodology, the rationale and clinical setting of the case, sources of data, and analysis of the data. Finally I will give consideration to the credibility of the qualitative research methods, particularly the case study methodology, and highlight relevant ethical issues.

Research Aims:

My aim with this study is to answer the question, “How does a psychodynamic case formulation influence therapeutic work?” Based on the literature review, I have argued that while many authors believe that case formulations are a useful or even essential clinical tool (Eells, 1997; Sim et al., 2005), there is little research articulating how they are a useful tool in therapy. Some of the literature has detailed the benefits of case formulations (e.g. Sim et al., 2005), but these do not link the benefits of formulating to how they may influence therapy work. Other studies (e.g. Aston, 2009; Persons et al., 1991) have suggested that the case formulation influences therapy, however there is little detailed record of the process of how this influence unfolds over the course of therapy. While the literature review yielded greater research on the use and/or benefits of CBT or general psychotherapy case formulations than

psychodynamic formulations, there was particularly scarce information pertaining to psychodynamic formulations in this regard. Thus I am hoping that my aim of researching how psychodynamic case formulations may influence therapy work will add to this gap in the literature.

As the research question of how a psychodynamic case formulation influences therapy work is quite broad, with overlapping phenomena, the following two sub-questions will be investigated: (1) how do I interpret the experience of developing the psychodynamic case formulation, and (2) how do I interpret the experience of therapeutic treatment, alongside these case formulations?

This research will be reviewing the process of writing various versions of a case formulation for a particular client as they developed chronologically. Specifically, I interpret the influence of these case formulations on the therapist, the therapy itself, and the clients' progress. Thus the focus is on the process of how a case formulation may influence therapeutic work, and therefore may include both positive and negative processes reflecting the interrelationship of the formulation and the therapeutic work. By reviewing the sessions that directly follow each reworking of the formulation, I am hoping to contribute to the current theory on case formulations.

It is important to note early in this study that I will be working with the assumption that there is an influence on therapy work due to the writing of the case formulation. While the literature review revealed mixed evidence of an influence, it was my experience in this particular case that writing a case formulation prompted shifts in the subsequent therapy sessions of this case. My aim is therefore not to show that a causal relationship exists, but rather to describe how the case formulation influences therapy work.

Research Paradigm:

The goal of this research is to get a deeper understanding of the process of writing the case formulation and to interpret its influence on therapy work. This goal fits with the interpretive paradigm where the focus is on interpretive understanding and explaining the subjective meanings that lie behind social phenomena (Terre Blanche & Durrheim, 1999). Unlike the positivist paradigm which assumes an objective world in which one can uncover 'the truth' or

'reality', the interpretive paradigm assumes that reality is socially constructed, and there can thus be 'multiple truths' or realities, depending on multiple contexts, cultures, and social settings. Where the positivist paradigm places greater emphasis on statistical and quantifiable scores as a means to understanding behaviour, the interpretative paradigm is more concerned with the study of things that cannot necessarily be viewed in material, or 'cause and effect' terms. The aim then, is not so much to produce a universal truth, but rather to understand an individual's case in the cultural and historical context that it is embedded. (Messer, Sass, & Woolfolk, 1990). The interpretative paradigm is thus essentially concerned with subjective meanings, in other words, how individuals interpret, or understand and make sense of social activities. Subjectivity is therefore valued in this paradigm (Ajjawi & Higgs, 2007). The interpretative paradigm was viewed as the most appropriate paradigm for this research due to its potential to generate new understandings of a social phenomena, such as the understanding of how a case formulation can influence therapy. The focus is thus on my subjective interpretation and understanding of how the case formulation in a particular case of mine, influenced the course of therapy.

The Interpretative Paradigm and Psychoanalysis:

Sandage, Cook, Hill, Strawn, and Reimer (2008) contend that the use of the interpretative paradigm appears most pronounced amongst psychoanalytic therapists. They argue that this is due to psychoanalysis being mainly an interpretative therapeutic encounter, with an emphasis on understanding behaviour. Likewise, Frosh (2006) argues the current trend in psychoanalysis is the move away from seeking one causal objective truth, in favour of seeking a different understanding of truth. Thus Frosh believes psychoanalytic data is not understood as scientific or objective, but rather as subjective, with multiple meanings. However, he argues that while psychoanalytic data is not considered scientific this does not mean that when it comes to being judged on the validity of its data, that anything goes. Frosh disagrees with the criticism of some authors (e.g. Grünbaum, 1984, as cited in Frosh, 2006) who consider psychoanalytic data as unreliable and therefore invalid, due to its contamination by the presence of the therapist. Rather, he argues that the validity of the study should be judged according to how richly it communicates experience, the extent to which it draws on the principles of triangulation of data (a technique that makes use of more than one source of data in a study in order to facilitate validation the results) to make a coherent argument, and the extent to which the findings open up further areas for exploration (Frosh, 2006). When

considering these requirements of validity for psychoanalytic data in this case study, I am aiming to richly communicate an experience, that of how the psychoanalytic case formulation influences therapy work, by drawing on triangulation of data from various sources, and opening up the possibility for new theory regarding psychoanalytic case formulations. As discussed by Frosh (2006), the benefits of triangulation include not only a clearer understanding of the problem, but also increases confidence in the research data, and can challenge or integrate theories. This process of opening up the possibility for further areas of exploration is consistent with the interpretive approach.

Like Frosh, Spence (1987, as cited in Frosh, 2006) also questions the positivist claims that there can only be one truth, or one understanding of an individual or one explanation for how an individual behaves. Rather, he suggests that the psychoanalytic understanding depends more on how one person subjectively explores and understands another person. In other words, he suggests that where different therapists may explore the same client, a different understanding of this client will develop in relation to the different theoretical approaches and changing social contexts (Spence, 1987, as cited in Frosh, 2006). In this way, psychoanalytic evidence can only ever be provisional and limited by the conditions under which the data has been produced, being the therapy setting. When one considers this argument from the interpretive paradigm, it would follow that the meaning that one is seeking to find in this approach would depend quite highly on who is listening to and examining the material. It would also suggest that what the treating therapist perceives to be true at that specific time and place would never be true again. Thus, consistent with the interpretive approach, the reflexivity on the part of the researcher, and being aware of his/her own personal assumptions, is also important when considering what is psychoanalytic evidence. As the author of this research, I can only reflect on that which resonates with me, in the background of my own experiences and drawing on my subjective interpretations of the data. In this way my reflections and findings are truthful from my own lived reality and from my personal engagement with the data. In other words, I can only reflect on my own subjective interpretations of how I believe the case formulation to have influenced therapy, given my history and experience of working with both case formulations, and in therapeutic situations.

Given the concern with understanding individual's meanings, interpretative research often involves qualitative research methods over quantitative methods. One of the typical qualitative methods used within this paradigm, is the case study methodology, which is the methodology used in this research.

Qualitative Research and the Case Study Methodology:

This research is qualitative in nature as I am seeking to richly describe and interpret my understanding of how a case formulation may influence therapy work, rather than if the case formulation influences therapy work. As Morrow (2007) explains, qualitative research can be used to build on previous theories, particularly those which are not well understood, and as the literature review revealed little information on how the process of case formulations may influence therapy work, qualitative research is considered to be well suited to this study.

One of the typical qualitative methods used within the interpretive paradigm, is the case study methodology, which is the methodology used in this research. According to Creswell, Hanson, Plano Clark, and Morales (2007), case study research is a qualitative approach, where the researcher explores a single case (or multiple cases). They describe this methodology as a detailed, in-depth exploration of a case(s), where data is collected through numerous sources (such as observations, session recordings, case documents and reports), and then reported through a case description and relevant case-based themes. They also suggest that while many case studies focus on the individual(s) within the case, other case studies focus on a particular issue within the case, in order to provide insight into that issue (Creswell et al., 2007). My research, which is a single case study, falls into this latter category, that of focussing on a particular issue within a case. While consideration will be given to the individual client in this case, the focus will be more the issue of the case formulation, and whether this influenced therapy work for this client.

Given that the aim of my research is to provide a rich description of how the case formulation influences therapy work as it unfolded in this particular case, the case study methodology appeared to be most appropriate way to conduct this research as it allows for detailed exploration of a particular case or issue. This detailed description will start with my interpretation of the process of writing the formulations, and include my interpretations of the experience of therapy alongside these formulation revisions. This description will also detail my interpretations of the dialogues that transpired in those therapy sessions directly after revised formulations. According to McLeod and Elliott (2011), studies that examine a single case in depth have particularly advantages over those that are broader in scope, for a number of reasons: Firstly, this form of study is typically able to make a large number of observations, which allows for patterns of factors or processes, to be identified and examined. Thus as I will be examining the therapy sessions directly after the construction of a case

formulation and subsequent revisions of the case formulation, I will be specifically looking for themes or factors such as the adherence to case formulation or building the confidence of the therapist, that could be attributed to the influence of these case formulations. Secondly, as there are often numerous observations, these can also be looked at across time, which is useful in tracking and understanding how a process can unfold over time. In this particular case, these observations are not limited to once-off occasions, but can be tracked over multiple occasions, as I have five sessions in which to observe or look for patterns or themes. These five occasions come from the sessions after the revision or presentation of the formulation. For example I may be able to track a pattern such as the client's resistance to the same therapeutic question originating from the treatment plan of the case formulation, over various sessions during the course of the case. Thirdly, case studies can examine the contextual factors within a case, and how these may influence the case. While I will be examining one process with one client, the context of the case is highly relevant, as any influence of the case formulation may be due to contextual factors, such as external events for the client or the therapist, rather than the actual case formulation. Finally, case studies offer practical understanding to practitioners (therapists) and can thus assist to guide clinical practice. As this research aims to provide a rich description of how the case formulation may influence therapy work, this may assist other therapists in understanding this process, and consequently using case formulations as an intervention in itself.

McLeod (2011) suggests that case studies can have five different focus areas, each defined by the types of questions that the case study wishes to address. For example, studies that wish to address how effective a therapy has been in a case would have an outcome focus, and studies that wish to address the strategies and methods a therapist used in addressing an outcome may have a pragmatic focus. Case studies that wish to examine the process of therapy, and how this can be used to build, test and/or refine a theoretical model would have a theory-building focus. It is into this latter category that the focus of this study is located viz building and refining the current theory of psychodynamic case formulations, and how this may influence therapy work.

Rationale for selecting this case:

The client in this case study, is a 19-year old, female university student who was experiencing difficulties with binge-eating and low mood. As the therapy progressed, and our

relationship became deeper and more trusting, new information regarding the client came to light. As a trainee psychologist, I was encouraged by my supervisor to revisit my initial formulation of the case, reworking it on several occasions with the new information. During the course of our 27 therapy sessions, there were five revisions of this formulation, with each session following the reworked formulation appearing to provide a more substantial shift in the therapy work. While there is literature highlighting the benefits and usefulness of the case formulation (Mace & Binyon, 2005; Sim et al., 2005), there appears to be a scarcity of literature on exactly how this clinical tool is useful and how it can influence therapy work. The aim of this study is therefore to provide a thick description of the process of how the case formulation influences therapy work, as it unfolded in therapy with this particular client. Of further interest with this particular case, is the significant scarcity of literature regarding the psychodynamic formulation of binge-eating. Thus, a secondary outcome may be to add to the literature an understanding of the psychodynamic perspective to binge-eating, given the context of this particular case, and how this understanding appeared to influence therapy work.

Clinical setting in which the case was treated:

The client was seen for individual psychodynamic therapy at the Rhodes University Psychology Clinic, a teaching and training centre for clinical and counselling psychologists. The clinic is an outpatient setting on the university campus. The client was seen once a week for a total of 27 sessions. The client attended every session other than those weeks falling over the university vacation period, which included April (1 week), June-July (4 weeks), and September (1 week). Therapy terminated mutually due to the clinic closing at the end of October, and the therapist leaving the university after the final examinations. The case was supervised by an experienced qualified clinician once a week, and was also presented at a case conference attended by various clinicians.

Case records and sources of data:

As Stiles (2007) suggests, a requirement for a case study is a rich collection of information regarding the client and the case. As with the actual methodology of a case study, Stiles (2007) argues that there are no specific regulations about what sources of information must

be included, and adds that there have been useful case studies that have included only one or limited sources of information. Sources of information suggested by Elliot (2002) and McLeod (2011), to be part of the case study data include: Basic facts regarding the client and the therapist, multiple sources of data (such as recordings and transcriptions of treatment sessions, therapists' process notes, session assessments (repeated measurements of the clients problems, goals and symptoms), outcome assessments where possible, a time series analysis (a collection of observations obtained through repeated measurements over time) where possible, and other personal documents.

Considering the above, information for this case study was selected from the following sources:

- (a) Basic information regarding the client as taken from the initial assessment
- (b) Audio-recordings of sessions. Sessions were recorded with a digital audio recorder, which were saved in a secured file on the therapist's personal computer. The sessions directly after the construction and revision of the case formulations were transcribed verbatim.
- (c) Session records. Following each session, detailed session records were written. Other than the Mental State exam recorded after each session, these records included aspects of content, themes, defences, transferences and countertransferences.
- (d) Five versions of the case formulation, spanning the time period May 2011 – August 2011.
- (e) Notes of weekly supervision. Supervision notes detailing the theory and content, and the concerns regarding the case formulation, therapy process, and treatment plan for each session were recorded. The supervisor offered guidance, structure and support in both the clinical aspects of the case, as well as personal challenges I had with regards to the case.

- (f) Case Conference presentation. This case was presented to professional colleagues and clinicians in August 2011, where further advice and comments was provided and recorded.

Although Elliot (2002) and McLeod (2011) suggest using outcome assessments, it should be noted that Elliot (2002) recommends this source of data as part of his design regarding the efficacy of hermeneutic single-case studies. In his case study, the focus was on evaluating the causes behind an outcome, using both qualitative and quantitative methods. As I am not examining the outcome of therapy in this particularly case study, but rather aiming to qualitatively examine and describe a process occurring within a therapy case, I did not deem it necessary to include an assessment regarding the outcome of therapy.

Data Analysis:

According to Gephart (1999) the interpretive paradigm, (the paradigm used in this research) relies heavily on qualitative methods such as interviewing, observation, and analysis of existing texts. These qualitative methods ensure the researcher engages sufficiently with whom they interact, or texts they analyse, in order for meanings to emerge from the research process. This is consistent with the interpretive approach I've used to conduct this study, with its emphasis on the interpretation of what meaning the case formulation towards therapeutic work in this particular case.

When it comes to qualitative analysis of data, there are various methodologies one can use, such as conversation analysis, discourse analysis, grounded theory, narrative analysis, and thematic analysis (McLeod, 2011). McLeod (2011) suggests that when using qualitative case studies methodologies, there is no prescribed method of data analysis, and that it is possible to use a variety of analytic strategies. In considering data analysis, Braun and Clarke (2006) suggest that thematic analysis is more of a 'foundational method for qualitative analysis' (p.78), and recommends it for beginner researchers as it provides essential skills beneficial for conducting alternative forms of qualitative analysis. According to Braun and Clark (2006), thematic analyses have the freedom and flexibility to be applied across different theories and approaches, and thus can be applied to this case study methodology. The main benefits of thematic analysis are accessibility and flexibility, where a rich, detailed

description of meaning can be derived from qualitative data (Daya, Dhillon, Taylor, & Yildiran, 2011). Thus, since the case study methodology does not subscribe to any one method of data analysis, and as I am a trainee therapist and researcher, I will be using theoretical thematic analysis in order to identify, analyse and describe repeated themes in the case data that relate to the influence of case formulations. In their review of thematic analysis, Braun and Clarke (2006) argue that themes within data can be identified using either a theoretical or inductive approach. They describe theoretical thematic analysis as a more in-depth analysis of the themes of a particular aspect of the data, in comparison, to inductive thematic analysis, which reviews the entire data set, to identify themes in relation to the entire data set. For example, theoretical thematic analysis may identify and analyse only the themes regarding transference within therapy case, whereas inductive thematic analysis may review an entire therapy case to identify any themes within this particular case. In this way I am aiming to provide a rich description of particular elements of the case formulation as well as a description of how they qualitatively influenced therapy work. These elements were not decided on before the data analysis, but rather from the themes that emerged from the data. These themes thus guided me in informing which particular elements of the formulation may influence therapy, and then describing these elements in more detail.

While Braun and Clarke (2006) note that there is no defined way of conducting theoretical thematic analysis, they suggest the process follows specific stages.

Firstly, they suggest becoming familiar with the data set. Thus I started by reviewing in a systematic and chronological order, the various case formulations, then transcribing and reviewing the therapy sessions directly after each construction/revision of the case formulation, and the corresponding process notes. This sampling process thus followed a systematic process of looking at each formulation and the subsequent therapy session. I also reviewed relevant supervision notes, as well as notes taken from the case presentation of this case. In these reviews, I made notes that were relevant for coding, such as the specific times in therapy when I adhered more strictly to the case formulation, or times in therapy where referring to the case formulation allowed me to feel more useful as a therapist.

Secondly, they suggest generating codes from the reviewed data, identifying aspects of the data that appear interesting in relation to the research question. I thus generated codes from the reviewed data in terms of which aspects of the case formulations may be interpreted as influencing what is taking place in therapy. In this way I started organising my overall data

into groups of data relevant to my research question. As referred to at the beginning of this methodology section, the research question of how a psychodynamic case formulation influences therapy work is quite broad. I therefore started organising my coded data according to the two sub-questions of: (1) how do I interpret the experience of developing the psychodynamic case formulation, and (2) how do I interpret the experience of therapeutic treatment, alongside these case formulations?

Thirdly, Braun and Clarke (2006) suggest sorting the codes into prospective themes. Once I had organised and coded the data, I arranged the coded data into broader themes in relation to case formulations and therapy work. I anticipated these themes to include some of the aspects identified in the current theory, such as the adherence to the case formulation.

Fourthly, they suggest reviewing and refining these themes. I thus refined these broad themes in relation to the current theory, as some themes appeared to link to the theory and some were thought important for identifying potential new theory.

The final stage Braun and Clarke (2006) suggest is to define and analyse each identified theme. Here I referred back to those mechanisms of change by Castonguay and Beutler (2006) outlined in the literature review. I thus looked at the main themes that come through from the coding, and analysed and interpreted these themes with regards to how they manifest in the case formulations and in the subsequent therapy session.

Credibility of qualitative research and the case study methodology:

Too frequently qualitative research is evaluated against criteria appropriate to quantitative research. Qualitative researchers contend that, because the nature and purpose of the quantitative and qualitative traditions are different, it would be erroneous to apply the same criteria of merit (Krefting, 1991). Therefore, where terms such as reliability and validity have been considered part of quantitative research language, qualitative language speaks of terms such as credibility, accuracy of presentation, and authority of the writer (Krefting, 1991).

Credibility refers to the trustworthiness that truthful findings will result in the study (Krefting, 1991). A qualitative study is credible when it presents such accurate descriptions or interpretation of human experience that people who also share that experience would immediately recognise the descriptions. This is accomplished by prolonged engagement with

the data, allowing for reflection. With regards to the authority of the writer, as the author of this investigation, I can only reflect on that which resonates with me, in the background of my own experiences and drawing subjective distinctions. In this way my reflections and findings are truthful from my own lived reality and from my personal engagement with the data.

When it comes to the consideration of credibility of case study methodology there has been considerable variance in the scientific opinion concerning case studies as a form of research. Case studies have been referred to by some as the “bedrock of scientific investigation” (Bromley, 1986, p.ix), but also as “the weak sibling among social science methods” by others (Yin, 1984, p.10). More recently, Messer (2007, 2011) raises the issue of the challenges presented by the case study methodology as a scientific form of investigation. While case studies have traditionally been criticised for a number of reasons, it is now generally accepted that so long as measures are taken to maintain the credibility of study, case studies form an important way in which clinical knowledge is recorded and publicized (McLeod, 2011). I will briefly discuss these traditional methodological challenges presented by Messer (2011), and ways in which I have tried to overcome these limitations. Firstly, he argues that case studies have traditionally been criticised for a reliance on the therapists’ memory or limited therapy notes, with the data therefore subject to distortion. In my study, I audio recorded every therapy session. Secondly, the data sources were seen to be restricted to the therapist alone which may result in the omission of contradictory evidence. I have used multiple data sources, many of which have been come from outside sources such as from my supervisor, as well as from comments from other psychologists present at the case presentation of this case. However, no use of quantitative measures in this study by the client is seen as a limitation of this study. Thirdly, the subjective selection of the data by the therapist alone has been criticised. As discussed by Messer (2011), this is usual, even in published case studies. Fourthly, interpretations of the case data are often given in terms of the therapists’ theoretical approach, with no regard to other theoretical approaches. Certain themes may arise in the analysis that link the case formulations of this case with existing general theory of case formulations. However, since this case was specifically formulated using the psychodynamic approach and is part of the research question, there are likely to be specific links to the psychodynamic approach. This will be discussed in later sections of the study. Finally case studies have been criticised for insufficient, or no context of the case given, thus not allowing

for the reader to either accept or contest the therapist's argument of the case. The case context of this study was provided as at the beginning of this study.

Messer (2011) thus believes that clinical case studies can now fulfil the scientific methodological standards. Messer (2011) argues that while it is better for case studies to try to attend to as many of these scientific criteria as possible, even partial fulfilment can lead to credible case studies.

Confidentiality and ethical aspects:

Ethical approval for this case study was granted by the Rhodes University Psychology Department's Research Project and Ethics Review Committee. Confidentiality and ethics, in accordance with the Rhodes University Psychology Clinic's rules and guidelines, were discussed with the client from the very first session. This included the nature and limits of confidentiality, and the name of the supervisor who would be overseeing the case. This also included an understanding of the right to withdraw from treatment. Although the client was advised that aspects of the case may be used for training or research purposes, the research and therapeutic process did not occur simultaneously and the client was thus not advised that withdrawing from treatment may have any impact on the research with this case. An informed consent form was signed by the client in this initial session, confirming her understanding and permission for the sessions to be audio-recorded, and for the material to be used for research purposes. This consent form is filed in her case record. In both this study and the August 2011 case presentation, all identifying information has been changed, as well as a pseudonym used, in order to protect the client's privacy. This change in name and identifying information in no way affects the dynamics reported in this study. Thus care has been taken to protect the client's rights with regards to ethics and confidentiality. As a final note on the ethical consideration, the research was conducted upon conclusion of the therapeutic treatment of the client, thus there was no concern of the dual nature of being both the therapist and researcher when undertaking the treatment with this particular client.

Conclusion:

In this section I provided an overview of how (methodology), where, and with whom this study was conducted. I tried to give an account of each step of the research design and analysis, and to provide a rationale for the particular methods and techniques I selected out of a range of alternatives. In the following section I will present the findings, discussion of identified themes, and my interpretations of how the psychodynamic case formulation influences therapy.

CHAPTER 4: THEMES AND DISCUSSION OF FINDINGS

Introduction:

In considering my research question, I subdivided these reflections of the influence of the formulations on treatment into two smaller research questions. These included: (1) how do I interpret the experience of developing the psychodynamic case formulation, and (2) how do I interpret the experience of therapeutic treatment, alongside these case formulations? This section below will be divided into these two research sub-questions, and include my interpretation of writing and developing the case formulation, as well as the broad themes that emerged from my analysis. These themes will be discussed in relation to this case, and alongside relevant theory derived from the literature review. In each theme I will draw on extracts from sessions directly after the five case formulation revisions, highlighting how therapy progressed in these particular sessions.

My interpretations of developing a psychodynamic case formulation:

Although there are various definitions of a case formulation, Bieling and Kuyken's (2003) definition, as taken from the literature review, explains the case formulation as "a description of a person's presenting problems, using theory to make explanatory inferences about causes and maintaining factors that can inform interventions" (p.53). This definition will assist the section below where I discuss my interpretations of writing a psychodynamic case formulation.

When I received my first psychotherapy case as a trainee psychologist, I had not received training on case formulations. Thus I relied on my psychotherapy supervisor to guide me through my first formulation. My supervisor suggested I begin my first formulation by giving consideration to the factors that predisposed the client to her problems, and the factors that maintained the problem. She also suggested I outline my clients Triangle of Conflict (Malan, 1979), which considers the client from a more psychodynamic perspective. Finally she suggested I put together a treatment plan for the client. As we received training in case formulations over the course of this case, the formulations were revised to include theory thereby grounding the case with a theoretical frame. These expanded revisions also gave

consideration to the clients affect, the psychoanalytic frame, and transferences and countertransferences.

After the initial assessment sessions with the client, it felt like I was sitting with an enormous amount of information, but still unsure about what I was really doing in therapy. Writing the first formulation was extremely helpful in organising this information, and compiling similar aspects of the case under a particular heading, such as ‘predisposing factors’, and ‘maintaining factors’. This helped to fit the many pieces of information together, helping me make sense of the case information, and gaining a deeper understanding of the client and why she presented with the problems she did. For example, under Predisposing Factors, I included information such as the clients’ family having little emotional communication; that she had been unconsciously conditioned to behave in a certain way (being a good daughter/sister); that negative emotions such as anger, frustration, sadness were not “allowed” and family members should always only show their good side; and that the client was continually encouraged by her mother to lose weight. I became more acutely aware of a sense of restriction in the family – that it was seen as good to restrict both your emotions and your food intake. While I was aware of these predisposing factors, as they arose over the initial sessions in therapy and discussed in supervision, they started to help me see the client differently, and to gain a greater appreciation of the problems she was experiencing. Thus seeing these aspects of the case, compiled under one heading, all fitting together, helped me to get a firmer picture of why the client had developed her presenting problems.

Likewise, the maintaining factor of brushing any negative emotion aside, also seemed to make greater sense, given the clients predisposing factor, which improved my understanding of the client’s problem. While I was aware that the client often brushed aside many feelings, I had not yet placed these feelings in the context of the case, and had not given thought to if and how this should be incorporated into the treatment plan.

As part of the first case formulation, I put together a rough outline regarding the clients’ psychodynamic Triangle of Conflict (Malan, 1979). The three aspects of the triangle, namely the Wish, the Defence, and the Fear, helped me to consider the client from a more psychodynamic perspective. The Wish is that feeling which is often unconsciously hidden from the client, which in this case I determined to be a desire to be unconditionally accepted and loved. The clients’ Defence was to ignore negative emotions, and to pretend not to care, or to walk away from conflict when others emotionally hurt her. Although I had already

written about these defences as ‘maintaining factors’, I had not really thought about them as ‘defences’, both as part of understanding why the client maintained her eating behaviours, as well as how this needed to form an important part of the treatment goal. Thinking and writing about the clients Fear, which I deemed to be the possible loss of her fathers’ respect, her mothers’ love, and her sisters’ friendship if she did not behave in a certain way, I gained a deeper sense of empathy for the client. Although I had gained a deeper understanding of the client by compiling her predisposing factors, it was consideration of her possible fear, that lead to a deeper sense of empathy for the client.

Thus, in understanding the client more deeply, and in particularly her reasons for why her defences were to so important to her, helped me with gaining greater empathy for the client. In other words, my understanding lead to empathy for the client. This concurs with the reviews of Eells (1997) and Sim et al. (2005), who both suggest that the case formulation is particularly useful in identifying, summarising and arranging case information so that it can make sense to the therapist, and thus lead to greater understanding of the client. Likewise they also suggest that by considering certain aspects of therapy, such as the client’s defences or resistances to therapy, the therapist is able to acknowledge and understand the client beyond her presenting problem, which they believe allows for greater empathy for the client.

In considering therapeutic change, Castongauy and Beutler (2006) argue that one of the mechanisms of therapeutic change may lie with the variables of empathy and genuineness. In other words, they argue that therapeutic change is possible when the therapist can convey his/her genuine sense of empathy towards the client, thereby strengthening the therapeutic alliance. Similarly, Lemma (2003) suggests that using the therapeutic relationship to give the client a new way of relating (such as allowing others to be able to respond with empathy without this feeling like pity), is one of the ways therapeutic change can be viewed when working psychoanalytically. Thus this empathetic therapeutic relationship could be used as part of the treatment plan to model a corrective emotional experience.

While these initial formulations met most of the common elements of case formulations as outlined by Johnstone and Dallos (2006), I had included no reference to theory. The three later reformulations of the case were based on the psychodynamic guidelines of case formulation from Lemma (2003). These revised formulations included reference to theory (object relations theory), which became more in-depth as the formulations were revised.

While writing the initial Object Relations section and drawing on Object Relations theory, I became more aware of the client's familial patterns, which helped me to get a deeper understanding of how the client was repeating her mothers' behaviour. The client described her mother as very self sacrificing, and putting Jane's father's needs above her own (and her daughters), and representing a way of showing her daughters that you cannot be lovable if you are overweight. While I had known this behaviour regarding her mother in the back of my mind, it was only when I had written and contextualised this information, that I saw the significance of the pattern that was playing out for the client. The inclusion of this theory is consistent with the argument made Betan and Binder (2010), who suggest that expert therapists produce higher quality case formulations than novice therapists due to the way they use of theory in the formulating the case, and suggest that where novice therapists merely link theory to the formulation, more experienced therapists use theory to think about their clients in a more relevant, unique, and meaningful way. This argument coincides with my own experience, as while I am a novice therapist, it appeared that as I grew in my theoretical knowledge and began to apply this knowledge to my case formulations, my understanding of the client grew in a more meaningful way. In this way, I have started to gain a greater appreciation for psychotherapy theory, and how it relates to psychotherapy itself.

The final part of all of my case formulations included a treatment plan for the client, which was the most beneficial aspect of the case formulation for me as a trainee therapist. Although the other factors of the formulation assisted with understanding the client, and in some way leading to the treatment plan or goals, the actual treatment plan really helped me to feel I would know what to do in each session, and to feel more confident that I could go into a session knowing there was something fairly specific that I needed to do.

For example, the goals written in the first formulation included: Identifying defences against feelings of anger, frustration, resentment; Asking the client for instances and elaborations of how she expresses these feelings; Asking the client how would it feel for her if I said she ate when she was not able to express a negative emotion? In this way I felt more confident knowing I could 'do' something that would help towards the treatment goal. Although much of this had been discussed during supervision, it helped to not just consider the clients' treatment plan on a session-by-session short term basis, but to consider the longer-term treatment plan for the client, and how this longer-term goal can be reached by breaking the goals down into smaller goals. It also felt that by having these specific tasks, I had a focus in therapy. It also felt that I would more easily be able to 'see success', possibly not as defined

by therapeutic progress by the client, but as progress as a trainee therapist, leading to increased confidence in myself as a therapist.

Sim et al. (2005) argue that the case formulation provides a strategy of goals and interventions that guides therapy, which they suggest is particularly useful for trainee therapists in helping to stay focused and on track. However, while they suggested this being useful with regards to the trainee therapist being pushed and pulled by the inconsistent moods or behaviours of the client, I felt this strategy was more useful for having an in-session focus. It allowed for a sense of knowing I was doing something 'useful', and increasing my sense of confidence as a competent therapist.

As the formulations were revised, the goals started to broaden to include working with both declarative memory (the ability to consciously recall facts and events) and procedural memory (the unconscious behaviour of how we do things, or how we automatically behave around others, in the absence of any conscious recollection of this learning these behaviours). In this way I was now looking to explore not only the facts and events that Jane could remember that may have lead to her defences (declarative memory), as I had been doing, but also try to bring procedural knowledge into consideration. In order to include working with procedural memory, I would need to give attention to how the client unconsciously behaved, in other words, her usual patterns or ways of being with people. To do this, I would need to give more emphasis in therapy to the transferences and countertransferences so that I could try to bring about change through the therapeutic relationship.

Documenting the transferences and countertransferences brought with it the realisation that the countertransference in particular, was contributing to my insecurity as a trainee therapist, that I was not being helpful enough to the client. This was then discussed in supervision which was useful, as I could now reframe this insecurity of not being helpful and useful to the client, and even address it in therapy sessions with her, which I might otherwise not have done. Thus writing about them in the formulation, led to these feelings of inadequacy being addressed with my supervisor, and allowed me to feel more confident as a therapist, possibly influencing how I conducted myself in therapy sessions with the client.

This is in accordance with Castonguay and Beutler (2006) who suggest that likely mechanisms of change lie with the personal characteristic of therapist, as well as countertransference management. While I did not often work directly with my countertransferences in therapy, they were always written about in my case formulations, and

discussed in supervision. Thus since my countertransferences had the potential to decrease my confidence, writing about them, and discussing them in supervision assisted in helping me to understand these feelings, and to not allow them to interfere with my confidence as a trainee therapist.

Finally, in writing the later, more expansive formulations, I gave consideration to the clients affect and behaviours, and the psychoanalytic frame. The client's behaviour of always trying to keep a smile on her face, despite often being extremely tearful, supported the initial formulation of the client believing it is not acceptable to show what you feel, but rather to show the side of one's self that is more acceptable to others. Likewise, she was always early for sessions, and never missed a session, allowing me to think about the clients' behaviour, and how this might be explained in the client not wanting to disappoint me, or behave inappropriately. Including consideration of the psychoanalytic frame was useful in reassuring me that I was already doing something helpful to the client, thereby increasing my confidence. In other words it was an important tool in 'holding consistency' in the clients' life, just by being physically available at the same time and place for the client, as well as consistently being emotionally available to the client during this time. This was important as the client's mother had been a source of 'holding inconsistency' for her. Thus this was essential in order for therapy to be a consistently safe and containing experience for the client.

This increase in confidence by revising and expanding the case formulation concurs with Eells and Kendjelic (2007) who suggest that improved case formulation skills may increase the confidence of the therapist, which may increase the clients' confidence in the therapist, which may positively influence the treatment process.

While Sim et al. (2005) suggest that the actual writing of the formulation helps the therapist to think about the case, organise their thoughts, and integrate the clinical details, I am hoping by providing my experience of writing the case formulation can go beyond these suggestions. I am hoping my experience opens up space in the literature for how the writing of the formulation can lead to a greater understanding and empathy of the client and her problems, along with building the confidence of the therapist. While it is outside of the scope of this study to examine whether these themes did influence the therapeutic outcome for this client, they can be considered for further research.

Themes emerging from my interpretations of the therapeutic treatment experience alongside the case formulations:

Adherence to the Case Formulation

As an anxious trainee therapist, I adhered fairly rigidly to the case formulation. As discussed in the previous themes of writing the formulation, the treatment goals from my formulation were my guide in feeling that I could enter a session confidently, knowing that I had a specific focus. However, while adhering to the formulation was helpful to me as a therapist, I believe this rigid adherence to the formulation had both positive and negative influences for therapeutic progress and treatment, which I will discuss in turn.

Positive Influences:

As a positive influence on therapy, I believe adhering to the case formulation allowed me to persevere with the treatment goals, despite the client initially continuously defending against some of these goals. One of the goals I had written in the formulation, was to identify and explore the various expressions of negative emotions. In the session directly after this first formulation, I started noticing how the client was significantly defending against negative emotions, and I asked the client thrice how she addresses negative emotions, particularly anger, each time receiving a different answer. Until writing the formulation, I do not think I had realised just how often she did this. Almost at the beginning of this session, the client told me that she was about to buy a personal scale on which to weigh herself, but said she was feeling sad that this might mean she was going back to her old ways of weighing herself every day. When I asked her about this sadness, she completely ignored my question and went on to tell me about her new 21-day eating plan. As I have since grown in experience, I would have gone back to that deflection of my question. However, at the time, I felt assured that I was now noticing her defences towards negative emotions, which I may not have done without this specifically forming part of the treatment plan of the formulation.

Later in this session, I asked the client how she expresses anger, but in my excitement of asking a relevant question from the treatment plan, I did not give the client time or space to answer before I moved onto another question. This will be discussed under a later section of this theme regarding negative influences of adhering to the case formulation.

However, by rigidly adhering to the formulation, I went back to this expressing of negative emotions for a third time during the session. The conversation went as follows:

Therapist: I'm just not sure with certain emotions, like anger, that it gets expressed.

Jane: Ja, that's a point, because I don't know how I express anger. I kinda mix feeling angry with sad. And I know when I'm sad I eat, so I probably eat when I'm angry too. Ja... When I feel sad I just feel that I don't have anyone to talk to or anyone who would understand or would be there for me when I need them. I mean they all say they'll be there for me but I don't trust any of them. I wouldn't tell them what's happening.

This was the first time throughout the course of therapy that the client had spoken about how she expressed her negative emotions. It was also one of the first times I had persevered with asking these questions. It felt so good that it was consistent with the formulation, and a huge relief for me to feel on the right track, and I gained more confidence in both myself and in the formulation, and in adhering to the formulation. This felt like quite a shift for me in my progress as a therapist towards achieving the formulation goals, which was done by adhering to the formulation.

The session directly after the second revision of the formulation had a similar pattern, where Jane was talking about her sister, and saying that she is angry with her sister. The following extract was taken from this conversation:

Therapist: Are you ever concerned you will erupt at Sarah?

Jane: Yes, am scared I will shout at her and storm off, or just be numb. I have no idea.

Therapist: How do you express anger?

Jane: If it's too someone, I'll probably let them know....(gaps for thought). Don't really know. I think there's connection between anger and depressed. (The client again avoided the topic). This emotion seems to lead to depression, or at least to feeling low and worthless, and then I become even more moody, and then even more eating.

Therapist: It seems like anger is linked to eating?

Jane: Ja...!

This comment, along with the expression on the clients face (her affect), seemed to indicate a further connection for the client in the link between unexpressed anger and eating, which felt like quite a shift in therapy. As with the session after the first formulation, it felt for me like I was getting somewhere or making progress in treatment by staying directly with the formulation. It felt like if I was making progress as a therapist, this would in turn help the client to make progress in therapy.

As therapy progressed over the year, Jane started to gain further insight into the fact that she does not confront anger, but rather that she walks away from it, as her mother does. While I will discuss her mother's behaviour under the next theme of this research sub-question, I would like to draw some extracts on how Jane progressed with this insight of the link between negative emotions and her eating, acknowledging how my adhering to the goals of the treatment plan in the formulation helped to influence the course of therapy:

In the session after the fourth formulation revision, Jane commented that she felt that her sister was perfect and had 'got it right', (meaning her sister had become thin to the point of Anorexia Nervosa) and acknowledged she was jealous of Sarah. I made reference to a particular evening where the family had had a, and that Sarah was seen as the only 'brave' one to say what she really felt. Jane again replied that she feels she does express her feelings before they get to boiling point (this has been consistent over a number of occasions where I have asked this question). However, on this occasion, despite commenting that she says what she feels before it reaches boiling point, she added:

"What I have noticed, is that I think I tackle the issue but I don't....like with that friend...I let it go and I was miserable, and I realised I was ignoring her, and just walking away...and being distant. And I told her I wasn't ignoring her, and that I was going to come and talk to her, but to honest, I don't think I was...but I thought I did tackle issues when they were bothering me... I realise I don't."

This also felt like quite a shift in therapy. I felt had I not kept on referring to this in previous sessions (which started as part of my original formulation and treatment plan), and not

adhering to the fact that she does not express her feelings, Jane might not have got to this realisation that she does not face her concerns, that rather keeps them to herself. This session felt particularly good in terms of progress for both the client and myself. That due to adhering to the treatment plan, I finally started to see changes in what the client was saying. It is interesting that this particular session had, what I felt, the greatest amount of therapeutic change, and followed from a revision of the formulation, along with a formal presentation of this formulation. It was also the session that prompted me to consider this as a study for research purposes.

In the first two case formulations, I had outlined, with regards to Malan's (1979) Triangle of Conflict, that Jane's Wish (or feeling that is hidden from her consciousness) was the desire to be unconditionally loved and accepted. In order for Jane to gain insight into this hidden feeling, I formulated that she would need to first start acknowledging the feelings she had originally been defending against. As the extracts below highlight, by adhering to this treatment goal of the formulation, the client was starting to gain insight into these hidden feelings.

In the session directly after the third revision of the formulation, the client was very distressed and tearful. She explained to me that she had confronted her mother about various issues and feelings. While this conversation had little to do with the latest formulation, it gave me hope that the client was starting to express her emotions, and that there was some influence from my previous sessions about her keeping her negative emotions inside. However she expressed surprise that in this conversation with her mother, her mother had actually asked about 'her', and about how things were going for 'her'. This conversation redirected me to the initial formulations, regarding the wish, that the client wants to be loved and cared about. I then asked her about this comment, saying that it sounded like she gives her mom signals that she (Jane) 'is always fine' and that she might not be giving her mom the opportunity to know how she is really feeling. This got directly defended by her saying "but I AM really ok, there is nothing to worry about, I probably am ok, it's just one of my moments". She immediately went on to talk about the scale again. However, while this interpretation was rejected, it reminded me of the client's desire to be loved, which was an important aspect of the initial formulation.

Later in the session an opportunity arose to revert to this conversation regarding the client defending against any love or attention. I interpreted to Jane that it feels like it's quite hard to

go home and have all the attention on someone else (her sister Sarah) when she also had so much change, for example coming to Grahamstown, starting a new life, new friends, living on residence, adjusting to university world, and that there's not much space in the holiday for all the changes that she had experienced. This brought on the following conversation:

Jane: But as I say, I don't want the attention... [Crying profusely]

Therapist: I hear that, but I also hear some fedupness that it's also YOUR time. I know you would love Sarah to be better, but a part of me wonders if you would like some attention with all YOUR changes.

Long silence.....

Jane: Today, I woke up... [crying]....just stayed in bed...thinking....I didn't want to get out...

Therapist: I wonder what that was about?

Jane: I'm just detaching myself from everything. I've done it before.

Therapist: Does it worry you?

Jane: I don't know how I feel about it. Don't know what's happening. The thing is I want to be left alone, but I also don't... I want people to care. [crying...]

Therapist: Sounds like there's maybe a fear that we don't want to tell others to come to us when we need them, in case they don't come to us, then we will be hurt and feel rejected...so maybe this is a way to protect yourself from possibly being hurt...?

Silence...

Jane: Then the scale at home....they've taken it away and put it in the storeroom...

This felt like for the first time there was progress towards that 'wish', that desire to be cared about and by extension loved, which the client had previously not been able to articulate.

Although she was only able to touch on it before immediately protecting herself and moving to familiar territory regarding the scale, it felt like a real shift in therapy. It also felt like Jane now trusted me with this information, which deepened our therapeutic alliance. While it is hard to say that this conversation was directly due to the original formulation, I am convinced had I not written specifically about the wish, my attention in therapy might not have been drawn to it, and this conversation might not have taken place.

Similarly, the following conversation took place in the session after the fourth revision of the case formulation:

Therapist: I don't know how this sits...? And how you find people talking about your positive qualities, and how does it feel for you?

Jane: No, it's not too bad. [Laughs nervously].

Therapist: But you usually push it away, and onto someone else...and you don't want the attention.

Jane: Ja, you know how I always say I put on a fake smile, ...that's what I've started doing again. Even if I'm sad, I don't feel they're there anyway, so I may as well just fake it...! When asked about university now, I just say it's ok, I don't even say its fine....it's just ok...which is what it is.

Therapist: So you feel you're not lying to yourself...

Jane: No, exactly. But I don't want to say it's bad – I don't want people to feel sorry for me. And I've also found that I DO like attention. I need attention. I think that's what I'm striving for, its attention, [laughs]..and like no one's giving it to me...you know like through friends or anything...like I say, it doesn't matter whether I'm happy or sad, I still don't get the attention...

This again felt like a shift in therapy. It felt like Jane was now able to admit this, not only to herself, but also to me. I felt not only very trusted due to her telling me this information, but also that in some way I had lead her to this realisation by consistently trying to bring the

conversations back to these hidden feelings of wanting love and attention. Thus adhering to this part of the formulation helped to feel I was competently working towards therapeutic progress.

In the session after the fifth revision of this formulation, the client was extremely tearful. The Sunday prior to this session, she had put up a status on Facebook which read “I can’t do this anymore”. Her parents had seen this status, and were immediately on the phone to ask what this was about and to find out if she was okay. After detailing this account to me, the conversation went as follows:

Jane: Ja like Sunday, I felt really really bad, so I put up that status. I just needed to talk and let people know...

Therapist: So its sounds like this mixed message again, of wanting them to know but not wanting them to know. Or allowing them to care...and something stops you.

Jane: Exactly. The thing is if I put up a negative status, I end up deleting it...just putting it up for a few seconds. No, people shouldn't see it. And if people start commenting, I delete it quickly. Even this one I deleted.

Therapist: So by putting it up it seems that you did want to talk. Sounds like frustration of wanting to talk, but WHO to talk to about it.

Jane: Ja...

This extract felt like just one more occasion where Jane was realising that she did want attention, that she did want to be cared about and loved. She had been so tightly defending against this, but was starting to admit this a little more in therapy, which felt like progress. Every piece of progress that I felt the client was making, allowed me to feel progress as a therapist. Again, it felt like had I not adhered to the treatment plan of the case formulation, I would not have kept on and on about wanting this love and attention.

Negative Influences:

However, there were also times where I felt that rigid adherence to the formulation had either negatively influenced the therapy work, or at least, hampered positive progress. I felt I was particularly rigid about using certain words or phrases from formulation. For example, using the word 'guilt' and Jane's tendency to 'cover up guilt'. Likewise the use of the word 'control'. While these words or phrases were more the terminology I had heard from my supervisor, and I had included them in the case formulation, I do not believe I fully understood their meaning in the context of this case. However, once they were in the formulation, I felt they were cast in stone, and that I needed to refer to them. This quite often left me feeling confused and stuck, and not confident that I knew what I was doing.

For example, in the session after writing the first case formulation, the following conversation took place:

Jane: So now I finally have a reason for feeling moody, not just moody because I am moody. Can't really explain the reason I'm moody. I'm sad and negative about what I said about my sister, but happy as it gives me a reason to be moody.

Therapist: But it sounds like you feel guilty when you feel those things, like you should not be feeling those things because she's your sister. So feeling bad for feeling guilty?

At this point I had lost a bit of confidence. I realised that although I had written about this guilt in the formulation, this was taken from brief conversations with my supervisor, and I did not fully understand what I was meaning by this guilt. My speech was very hesitant and broken.

Therapist: Feels a lot like your feelings for your mom, where you want to be there for your mom...errr.....but why can't someone else be there for her. It's always just that you HAVE to be strong. Is there any space for any other feeling other than to be strong for others? It's how you MUST be.

Again this felt like I was being lead by a part of the formulation that I did not fully have my head around, and did not give the client an opportunity to answer but rather gave the answer myself.

Jane: ...Ja [timidly]

Therapist: *Is this guilt covering up something else?*

Jane: *Ja.....but at least now when my friends see me as moody they think it's about my sister, not just me being moody. So at least it is now ok to have a moody day and I'm not judged or questioned. So I feel guilty about that. So when my friends ask about how I am I would also see how I can help them, but when I tell them, they just say ok, and move on. But I've always been the listener, or the counsellor in the group.*

I felt my question got defended, but I do not think I had addressed it confidently enough, or really explained what I was really after, and I am not sure that I even knew what I was after. However, I had put the word 'guilt' into the formulation as a defence, and felt it was a task of mine to ask about it, but I wasn't really sure what I was asking. I think I may have confused the client, and lost some confidence in myself.

Later in the same session, I also found myself getting lost in the formulation, not really sure what I was asking:

Therapist: *And are you scared you might lose your trust, or have your dad lose trust in you (here I am very hesitant in the way I am talking), what is the fear around that, and it sounds like you're quite strict on yourself for behaving in certain ways, so we'll go back quite a few of those examples that you've given me, but it feels like in a lot of your world there is no room for behaviour or being outside a certain way...*

I jumped around various parts of the formulation, grasping at as many parts of it that I could pull together as possible, not allowing the client an opportunity to answer, and not really

being sure about what I was saying or what I was asking of the client. I felt this need and safety in adhering to the formulation had stifled any therapeutic progress.

Likewise, in a conversation in the session after the fifth revision of the case formulation, Jane was telling me about some of the concerns and pressures with trying to transfer to the University of Pretoria. It appeared that these concerns were a large part of her current distress. I asked her if she felt preoccupied with all these concerns for next year. The conversation continued as follows:

Jane: Ja, it bothers me, as there's nothing set in stone. Everything's unsettled at the moment. I don't like not having a plan. I'm trying to be positive that I will be accepted. But I have plan A, B, and C...which doesn't sound positive.

Therapist: Sounds like you like structure. And that there's not a lot of structure at the moment. Nothing you can control yourself. This lies outside your control. So maybe when things are not in your control, when left to outside forces, then you are left very uncomfortable.

This conversation regarding 'control' was purely brought in due to the fifth revision of the formulation, which was based on discussions with my supervisor.

Jane: Ja definitely is. (Jane's agreement here felt like I had the right word here, which helped my confidence). And there's a poster up now saying we need to apply for res accommodation next year already. And that also set me off. It's like, if you don't apply, it should be at least one of your options. But I blocked it out – you're NOT coming back. But it did worry me.

Therapist: When you try to block things, how easy is it?

Jane: This particular one was easy as I had something to block it with, like transferring to Pretoria.

Therapist: And generally, how easy is it to block something?

Jane: It depends on what. It takes time. And I do it through music, and just listen...and eating...I'm eating even more now.

Therapist: So maybe when we don't have control, we try to block things out....like through eating. And at the moment there're a lot of things not in your control, and you are eating even more, and this is probably a big reason for the extra eating. So there might be a link between control and eating. Food is one thing that we CAN control. So even if our parents try to make us do this or that or behave in a certain way, the one thing we have is control over eating.

Again, I would not have gone into this explanation regarding control had it not been in the new formulation. Given Jane's earlier agreement that this had to do with 'control' I kept this conversation, trying to give an explanation, hoping this might help the client gain insight.

Jane: But I don't understand why I can't control my eating then...

This was where I felt I got really stuck. I was able to offer Jane an explanation regarding that there was a link between why one might eat more when things aren't in our control, but I do not think I understood it deeply enough to back it up, and I felt Jane caught me out on this. This had happened previously, when I had tried to give an explanation of a part of the formulation, but because I did not fully understand it myself, I felt it may have negatively influenced therapy. I felt that it was obvious that I did not know what I was really saying, that I did not know the treatment strategy, which may have caused Jane to lose some confidence in me.

The final area to this theme of adhering to the case formulation, which also may have negatively influenced therapy, is that of not allowing the client reflecting or answering time when posed with a question from the formulation. This was particularly evident in the early stages of therapy, when I felt I had the opportunity to refer to treatment goals or terminology from the formulation, and would put these forward to the client. However, in my haste and excitement of feeling I had done something competent, I did not stop and wait to hear the clients answer. It felt more like I was assessing my own progress, and not waiting to see if the

client would progress. In hindsight, this felt like a lot of missed opportunities for positive therapeutic progress.

For example, as referred to earlier in this theme regarding asking the client about how she expresses her negative emotions, she initially ignored my question. However, the following conversation displays the second time I asked her how she expresses anger:

Therapist: So I know you said to me when you came back from holiday that you were really angry with Sarah but that you didn't want to show her that you were angry...

Jane: A-huh...? [Curious]

Therapist: ...Because as an older sister you are expected to be a comforting person, someone that she can come to, and someone that can be strong for her because she needs you to be strong for her. So you can tell me that you are angry with her...

Jane: But that I can't show her... (Jane finished my sentence)

Therapist: So where does that anger sit, or where does it go?

I was so intent on asking the 'questions from the treatment plan/formulation' that I did not give the client time to answer the question before continuing on with another topic or question. I felt so excited that I had the 'right' question and could ask it, that I went straight into the next conversation, forgetting that therapeutic progress would come from the clients answers to these questions, rather than the questions in themselves.

...But maybe now that you're removed from the family it will be better for you. Even this hiding thing you were talking about earlier, it seems like such an established pattern for you. Are you comfortable with sitting with these feelings, or are you trying to squash them away by eating?

Again, I felt confident and useful to ask the question, but I forget the reason for the question is for the client to answer, not for assessing my own progress. I continued straight on, giving the client no opportunity to answer.

... I'm wondering if you're thinking I'm talking absolute rubbish, and if you do ever get cross with me if you'd be able to say that you're cross with me?! Or would you feel it's not your place to get cross with me?

Again, I allowed no chance for the client to answer, missing an opportunity to talk about the therapeutic relationship, another one of the goals of psychodynamic therapy (Lemma, 2003). In this way I was possibly negatively influencing or at least hindering an opportunity for positive therapeutic progress.

Later in the same session, Jane was telling me how she feels when friends ask her about her sister Sarah, who suffers from anorexia. She explained that she has never been able to tell her friends that Sarah is anorexic, rather that she has an illness, avoiding any reference to the illness being around eating. When I questioned her about this, she said that it was not her place to tell her friends about the anorexia. She admitted that the fact that Sarah has anorexia nervosa is really affecting her, but that despite this, she couldn't talk to her friends about these feelings. The extract below displays our conversation regarding this:

Jane: I feel I'm betraying her (Sarah), she doesn't want others to know. Now my friend knows her business. And I'm scared my friend focuses more on Sarah and less on my feelings. Attention-wise, I don't want my friend to focus on my feelings above her illness, but the fact that I mentioned Sarah's business and that friend may now want to think of this illness, and not how it's affecting me. It's Sarah's secret, and I'm betraying her. I have no right to talk about it. Even when talking about me feelings I'm feeling bad – so it's all about guilt.

Therapist: So that's quite hard, you're almost not allowing yourself to have the feelings that you have. So you're feeling guilty, but it sounds like your covering up the guilty feeling. Is there a discrepancy between what you're feeling and what you think you should be feeling?

Again, it felt like I was in two places, I was trying to be with the client, but I was so anxious to stay within the boundaries of the case formulation, I did not allow the client to answer. I immediately jumped to the part of the formulation where I mentioned guilt, and the covering up of guilt. As with the other occasions when I did this, this may not necessarily have had a negative influence, but possibly hampered an opportunity for a positive influence.

Fortunately, all of these instances of not giving the client time and space to answer my questions, were after the first formulation, and that helped by supervision, I did not make these mistakes again.

Persons et al. (1991) explains that adhering to the formulation may make a difference to therapeutic progress, my experience was that it definitely does make a difference to therapeutic progress. While some of this difference may not always be positive, I felt that particularly as a trainee therapist, I needed to have the formulation as a strong guide when going into a therapy session.

However, further to this, if adhering to a formulation that the therapist does not fully understand, or is not using terminology that is fully her own or that she is not comfortable with, this therapeutic progress may be negatively influenced. While the therapy may not necessarily be directly negatively influenced, this may come indirectly from the therapist losing confidence in her ability. Likewise, it also hampers opportunities for positive progress.

In terms of the mechanisms of therapeutic change as discussed in the literature review, Castonguay and Beutler (2006), suggest that the therapists' skill in being able to be directive when given client resistance may influence therapeutic outcome. In this study, there were times that my adherence to the case formulation, such as continually asking about the negative emotions, allowed me to be more directive than I may otherwise have been, and was felt to positively influence therapy. However, there were occasions, when my directiveness was confusing, and not fully thought through, and which was felt to negatively influence therapy.

Thus this understanding of how by adhering to the case formulation may influence therapy, either positively or negatively, should be included in the literature regarding case formulations. This understanding would also be particularly useful for neophyte therapists in developing and using psychodynamic case formulations.

Confidence of the Therapist

As with the theme above of adherence to the case formulation, there were times the case formulation lead to either an increase or a decrease in my confidence as a therapist, which may have lead to positive and negative influences for therapeutic progress respectively.

Positive Influences:

As a trainee therapist, I was anxious that the client might think I did not really know how to help her. Thus whenever the client agreed with me regarding a phrase or statement which stemmed from the case formulation, it felt like a huge relief that my formulation felt accurate, and that I was on the right track. This helped me to gain a lot of confidence in myself, and my ability to formulate accurately. These moments in therapy, where the client agreed with a particular word or phrase, not only increased my own confidence and belief in myself as a therapist, but also increased my confidence that the client believed in me. It felt that when the client believed I truly understood her and her problems, she could have increased confidence in me as a therapist, which could have had a positive influence on therapy. While there is very little literature regarding the accuracy of case formulations, and how this may influence therapy, Persons et al. (1991) do suggest that therapeutic progress may be influenced more by accurate formulations than techniques or interventions. They do not however, give any further information or evidence regarding their suggestion. While this study does not examine if there was therapeutic progress, my experience was that agreement from the client regarding the accuracy of the formulation, increased my confidence, which may in turn have influenced therapeutic progress.

For example, through discussions with my supervisor about my clients' negative self talk, I included making the client aware of this self talk as one of the revised goals of treatment in the formulation. In the sessions directly after the fourth and fifth formulation revision, I constantly referred to the term 'critical internal voice' with the client, as I had put it in the formulation. In this way I felt I was showing Jane my commitment to her and my competency in being continuously able to highlight the times I was aware of this critical voice of hers. Thus when I did refer to this voice, it not only increased my own confidence as a therapist in that I could detect the times this voice was at work, but also could give Jane faith and confidence in myself as a therapist.

While there is no clients' voice in this study, I believe that my belief in myself and the formulation as my guide, may have had an influence on therapy work. In the session directly after the fourth case formulation revision, after a long silence, the following conversation occurred:

Therapist: I know I've said a lot to today (regarding this critical voice) and it's a lot to process. I think a lot is in trying to recognised this critical voice that comes up, and I will keep trying to bring attention to it....so instead of just saying it's 'who I am', and just accepting that you don't feel good about yourself.

Jane: I weighed myself today, which is also why I don't feel good about myself...I haven't put on anything, but I know how it works- bam, it will just catch up. I never learn... (The client completely ignored by comment regarding the critical voice this time).

Therapist: And that's the voice that I'm talking about. It's that "I never learn"...like why don't I ever learn...and there its already putting you down...

Jane: Ja!...[laughs...nervously, but appears to understand what I am saying, and nodded her head in agreement].

This conversation felt quite strong in terms of therapeutic progress. I felt like I had stuck to my treatment plan in the formulation, and my commitment to Jane by looking for times when this voice belittled her. It felt that by sticking to both the formulation and my verbal commitment in therapy to Jane that I would be looking for these occasions, that I was being a competent therapist, thereby increasing my confidence as a therapist.

This conversation above also led me down a path that asked if this critical voice ever allowed her to see any positive qualities about herself. She mentioned that her friends point out that she is always smiling, and that it's good to hear that others see her as a 'smiley' person. I commented that she had told me her friends always come to her when they have a problem, and that she is therefore perceived as a caring person. This lead to the following conversation:

Jane: Ja, that also comes about as a way to feel I'm needed. Because if I don't have that....then what else do I have.

Therapist: But again, you've just doubted yourself so much...and I want to start making you aware, that every second comment, you...you... you don't allow yourself to take credit that they still trust you...and want to speak to you...despite that you say you need to feel wanted...they are still coming...

I felt really good that I had noticed and highlighted another time when Jane had belittled herself, and was feeling that all this formulating and even the earlier discussion with the client around the critical voice, was making me feel not only a lot more confident in myself as, but that I was also offering something really useful to the client, further increasing my confidence.

Likewise, in the session directly after the fifth case formulation, I was still referring to this critical voice:

Therapist: At this point on Sunday, that made you put up this status...has this been a slide from the holiday

Jane: Ja, I just came back homesick, and I couldn't get on track with my eating plan....and I'm just beating myself up.

Therapist: Its sounds like this critical voice is leaping in, saying to you that this is not good enough, you should be able to do better...you were doing well at a time....and I wonder if there's any voice to say that you were doing well... This self criticism sounds quite loud.

One further point of interest regarding this particular session, was when I questioned Jane about her approaching holiday at home, and how she was going to deal with her anger to her sister. I asked her directly if she was worried that she would 'explode'. She replied that she did tell her mother that she was worried she would explode, but that her mom ignored her comment and changed the subject. This drew my attention to the object relations part of the

formulation, where the client's behaviour was replicating her mothers' behaviour, in that when faced with a challenge, it is better to ignore it. This allowed me to feel more confident that my formulation was accurate, and that I was progressing as a therapist.

Another vehicle where the case formulation appeared to increase my confidence as a therapist, was through a sense of feeling that I was being useful to the client. The client had come to therapy primarily regarding a problem with binge-eating. She felt she wanted to understand *why* she behaved in this way, particularly since her sister did the opposite and severely restricted her food intake. I was thus often compelled to explain certain sections of the formulation to her, in the hopes this would be answering her questions. By doing this, I felt I was being useful to the client, which increased my confidence.

For example, in the session directly after the fourth formulation revision, the client arrived for this session in good spirits. She reported that she had been reading 'The Secret', a self-help book about attracting good things into ones' life. When I asked her to tell me more about her good mood, she explained that now when she feels sad for no reason, she just 'blocks' this feeling, and thinks of transferring to another university. The conversation meandered for a while, not really going anywhere, and staying with the content of her wanting to lose weight before she transferred. Noticing the silence, and feeling confident after rewriting the case formulation, and presenting it to a number of psychologists, I delved into the following conversation:

Therapist: I know we touched on it last week about this voice that says to you [nervous laugh], you must lose this weight, and why am I not able to and...err...err...you know you should be doing this...and you should be rather eating something better...errr and, and this voice that's kind of at the back of your mind, always, saying you should be doing this, and you know you shouldn't be doing this and you shouldn't be.... And I know you're feeling that you are trapped in this cycle...errr....of....well.....errrrr.....when you have a low mood day ...the eating....errr....you eat....and then it spirals into ...errr...the low mood again....but almost because this critical voice won't let you out of that low mood.... It's it's it's.... it wants to keep you feeling down

until you actually get out of it and say ... And maybe something like The Secret will be that kind of trigger to help get that mood to change...umm.....so this critical voice is....er....er...going to keep telling you you mustn't do this and you must do that and you shouldn't do that and you should do this and.... and it's not going to allow you to be ok with who you are.....it's going to keep trying to pull you down....

I did not feel confident with what I was trying to say here, and exactly how this cycle worked, and felt like I may have been confusing the client.

Jane: Ja... I agree....

Fortunately, I did not lose the client, she appeared quite engaged in this conversation.

Therapist: And until...errrwe can try and separate this, saying this voice is not who we are...errrr..... it's a voice that is from your mom or wherever to say...Lose a bit more, come on...if you lose a bit more you'd be so much better...so it's an outside voice, it's not your voice...and I think that we need to....and I will try every time I hear yousaying those condemning things to yourself...and remind you that that voice is not allowing you to lift your mood, or have a happier mood.... and if you can't have a happy mood....you're going to resort to eating, and eating is the symptom...that's going to say when I'm not feeling good about myself, what the hell, I'm just going to eat.

Again, this was very convoluted, and I was trying to throw in as much from the formulation as possible, thinking I was being useful if I could explain what was going on. This speaks to my wanting to explain to the client why she had the problem she did, which was the request the client often came with: why did she binge-eat.

Jane: Ja...ja...ja...

I was relieved the client was still engaged in this conversation.

Therapist: And I think that voice is....and I know you said last week that...that that's who I am and who I've always been, and I think that that voice has always been part of you, it's been there since you were so little that, even from those ladies that sell mielies, would say something to you... that that critical voice saying it's not ok to be like this, or...I mustn't... I mustn't... I must...be thin....that that's always been there...and it feels like that voice is now just part of your genetic makeup. Ummm.....but it is a critical voice.

Jane: So there IS a way to quieten it down...

The client appeared both relieved and excited.

Therapist: I think the way to see it is that it's not your voice, it's not who you are....it's a kinda outside defence to thinking you're not ok as you are....and if you try to quiet that voice ...and say you know, you are actually ok as you are ...but the eating feels like a symptom of that low mood, and the low mood is because you are just not going to be allowing yourself to feel good, and loveable as I am. I can get a boyfriend as I am....and not when I'm thin or when I'm outgoing...or when I put my smiley face on...I AM actually ok....and it feels like this voice keeps saying If you could JUST lose this, or be this way...or I don't have anything to offer to friends...or...and it seems like that voice is there in every thought ...and just doesn't allow you to be happy about yourself...

Jane: Ja, that voice..!

Although some of the selected extracts displayed my lack of confidence around explaining parts of the formulation to the client, they mainly appeared to be well received by the client, and she went on to give me various explanations of where she talked down to herself. Particularly the references to internal critical voice appeared to give her something tangible to

consider and to work with. In this way, I believe giving this explanation, despite it being convoluted and confusing, helped the client to have something to consider not only during therapy but also in between therapy sessions, and thus possibly influencing progress. This made me feel extremely useful to the client, like I had given her a guide to hold on to, much like I had the formulation to hold on to. This sense of usefulness contributed to a feeling of confidence in myself, which may in turn have influenced therapy.

In this particular session, I spoke to the client a lot about the case formulation, and why she was eating the way she did. This was not only due to the revision of the case formulation, but I had also presented this case at a case conference earlier that day. In presenting this case, other psychologists had the opportunity to discuss their formulations of similar cases, and their own countertransferences. These formulations and countertransferences were very similar to my own, particularly around the slow process of working with clients with eating disorders. This came of a huge relief and reassurance to me that other psychologists with similar cases were also not able to produce a 'quick fix', thereby increasing my confidence that the formulation was accurate, and that I was a competent trainee therapist. It gave me the courage to speak to the client more about the formulation, and about her eating behaviour, which may have increased her insight, and therapeutic progress.

Negative Influences:

However, as with the earlier theme of adherence to the case formulation, there were occasions where I tried to be useful to the client by explaining parts of the case formulation, but in words that were not my own, and which I did not completely understand. These explanations, using terminology I did not fully understand, often proved to be detrimental to my sense of confidence. There were also occasions where I would ask the client certain questions, and felt I needed to justify why I was asking them. In my mind, my justification was that they were in the formulation, and were thus relevant, but in hindsight, I think these justifications were more a sense of being useful to myself and building my own confidence, rather than of being useful to the client. I do not believe these occasions necessarily negatively influenced therapy, but rather that they gave no influence at all.

For example, in the session directly after the second revised formulation, Jane was telling me about a friend who had confronted her about her about her new eating plan and how she was

concerned about Jane's food restrictions. Jane told me she was unhappy about this, and that this friend had such a nerve to even say that she is watching Jane food portions. Jane said that she is now avoiding this friend at meal times. This led me to think of confrontation being one of those 'other' negative emotions that I had referred to in the formulation, and that I might not have picked up on this had I stuck to the original emotions I was looking for such as anger and frustration. The following conversation ensued:

Therapist: Do you worry about confrontation?

Jane: I doubt she'll say something again.

Jane avoided directly answering my question, so I noticed she was defending confrontation even with me.

...At the time I thought it was ok, but afterwards it bugged me that she's watching. Think also because I told her I'm going to start doing this. I told her in advance I will be eating at different times due to study schedule. I don't care now, so what if she sees me...

Therapist: If confronted, do you say I'm fine, or do you confront later? This draws to not expressing emotions....errr.....errr

I really wanted to tie up various parts of the formulation, instead of just staying with the conversation. I felt in order to be useful I needed to explain and justify why I was asking this question. While I felt this would be useful to the client, I think it was more useful for me in being able to link this to the formulation and treatment plan.

Jane: If can't manage day to day stuff will always go back and speak to the person, but this hasn't affected me THAT much. I'm moving on. But I will if it really bothers me.

I left it there as I felt stuck. I realised that when the client defended my main goal in treatment, I wasn't sure how to proceed. I felt I was unsure of my own treatment strategy, which caused a decrease in my confidence as a therapist.

Of additional interest in this case, was that as my formulations expanded, and included further goals such as working with procedural knowledge (as inferred through transferences and countertransferences), I felt there were increased opportunities to feel useful to the client. In this way, the more goals I had, the more opportunities I had to feel useful. Thus for a trainee therapist, it was good to start off with only a few, specific goals, but that as I grew in confidence and experience, these goals could be broadened to include further aspects of therapy, attributing to a growing sense of usefulness to the client. Likewise, as mentioned under the writing of the case formulation, the inclusion of how the analytic frame can be used as a goal in the formulation, helped me to feel that I was already being useful to the client, increasing my confidence as a therapist.

Persons et al. (1991) suggested that case formulations may enable the therapist to feel more useful, which is in accordance with my experience in that it definitely did make me feel more useful as a therapist. I felt like the client had a constant curiosity regarding why she behaved the way she did. I felt a sense of duty in trying to answer these questions, and I felt these answers always came from the formulation. In this way I felt I was being useful to the client.

However, although I often explained things to the client in a convoluted and confusing way, she still appeared to appreciate and engage in these explanations. They thus appeared to be useful to the client. In this way, I felt I grew in confidence, not only in myself, but in my belief in the formulation, and in turn my need to adhere to the formulation. While these confusing explanations may not have directly positively influenced therapeutic progress, they did not seem to hamper it. Likewise the respective effect they had on my confidence, may have influenced therapeutic progress indirectly.

As discussed under the sub-question of my experience of writing a case formulation, I refer to the study of Eells and Kendjelic (2007), where they suggest that improved case formulation skills (through increase training) may increase the confidence of the therapist, which may increase the clients' confidence in the therapist, which may positively influence the treatment process. The processes outlined above, describe the ways in which I felt useful to the client, thus increasing my confidence in myself as a therapist.

Similarly, as discussed under my experience of writing the case formulation, Castongauy and Beutler (2006) refer to one of the likely mechanisms of therapeutic change to lie with the personal characteristics therapist. While they do not list the therapists' confidence as a direct mechanism of change, they refer to 'resistance' as a likely mechanism of change. In this

study, it appeared that when I felt confident that the client agreed with my terminology and explanations referred to from the case formulation, I was less resistant to use these again. Likewise, when I felt confused in my terminology and explanations, and lost confidence in my ability to understand what I was wanting to say, I was hesitant and resistant to use these words again. In this way, I believe that my confidence as a therapist had the possibility to influence the therapy work both positively and negatively.

As stated previously, although this study does not consider the clients' voice regarding the outcome of therapy, it was my experience as the therapist, that felt that an increased confidence in my competence which often stemmed from the development of the case formulation, had an influence on the therapy work. As with the adherence to the case formulation, the usefulness of knowing that developing and using the case formulation can influence the confidence of the therapist, and should thus be added to the literature regarding the reciprocal nature of case formulations and therapy work.

Using the case formulation as an intervention

Another theme in this analysis was the way I used the case formulation as a tool in therapy when I felt stuck. These were times when I felt there were uncomfortable silences in the therapy room, particularly where a conversation seemed to have taken its course, rather than silences for processing of thoughts. As a trainee therapist, I felt uncomfortable in these silences, and the case formulation allowed me to quickly consider other relevant parts of the formulation or treatment plan that I could use to start a further conversation. It was often in these conversations, directly related to the case formulation, that prompted therapeutic progress. While some of the extracts below are repetitions of conversations shown in earlier themes, they highlight the occasions where the formulation was used to break the silence, resulting in conversations that appeared to lead to shifts in therapy.

While there is little literature regarding using the case formulation in times when the therapist feels stuck, Aston (2009) suggests that the case formulation may serve as a vehicle for other areas of therapy. In this particular case, the case formulation acted as a vehicle to prompt further conversation, which in turn appeared to influence therapy itself.

Examples of how the case formulation was used when I felt stuck or in moments of silence can be seen in the extracts above. While I referred to the extract on page 65 with regards to

becoming more confident in my ability as a therapist, had I not had the formulation to refer to when I felt stuck in this silence, that conversation may not have come about. Likewise, the extract on the beginning of page 24, also came about due my discomfort with the silence in the room, and feeling stuck as to how to start a new conversation. The result of this particular conversation appeared to have an effect on the client, which may not have happened had I used the formulation to break the silence.

Similarly, the extract below, part of which was reflected on page 66, also highlights the use of the formulation to break the silence in the room:

*Jane: Ja, that also comes about as a way to feel I'm needed.
Because if I don't have that....then what else.*

Therapist: But again, you've just doubted yourself so much...and I want to start making you aware, that every second comment, you... you don't allow yourself to take credit that they still trust you...and want to speak to you...despite that you say you need to feel wanted...they are still coming...

Long silence...

Therapist: I don't know how this sits...? And how you find people talking about your positive qualities, and how does it feel for you?

Jane: No, it's not too bad. [Laughs nervously].

Therapist: But you usually push it away, and onto someone else...and you don't want the attention.

Jane: Ja, you know how I always say I put on a fake smile...that's what I've started doing again. Even if I'm sad, I don't feel they're there anyway, so I may as well just fake it....! When asked about university now, I just say it's ok, not even say fine....it's ok...which is what it is.

Therapist: So you feel you're not lying to your yourself..

Jane: No, exactly. But I don't want to say it's bad – I don't want people to feel sorry for me. And I've also found that I DO like attention. I need attention. I think that's what I'm striving for, its attention, (laughs)..and like no one's giving it to me (except therapist!) you know like through friends or anything...like I say, it doesn't matter whether I'm happy or sad, I still don't get the attention...

While this felt like a huge shift in therapy, it was previously discussed under the first theme of how adhering to the formulation can influence therapy. However, I believe this conversation was prompted due to feeling stuck, and wanting to break the silence in the therapy room.

This final extract occurred in the session after the fifth formulation revision:

Therapist: Its sounds like this critical voice is leaping in, saying to you that this is not good enough, you should be able to do better...you were doing well at a time....and I wonder if there's any voice to say that you were doing well... This self criticism sounds quite loud.

Long silence.

Therapist: I know I speak about it a lot, but I'm not sure you are with me on this...?

Jane: Ja, I understand, it's just hard to come to terms with this.

Therapist: Sure, I'm sure it's just always been there and been part of your mindset

Jane: Ja, but it seems like it's taken over completely now. Ja like Sunday, I felt really really bad, so I put up that status. I just needed to talk and let people know...

Therapist: So its sounds like this mixed message again, of wanting them to know but not wanting them to know. Or allowing them to care...and something stops you.

Jane: Exactly. The thing is if I put up a negative status, I end up deleting it...just putting it up for a few seconds – No. people shouldn't see. And if people start commenting, I delete it quickly. Even this one I deleted.

Therapist: So by putting it up it seems that you did want to talk. Sounds like frustration of wanting to talk, but WHO to talk to about it.

Jane: Ja...exactly.

As with the above extracts, I felt uncomfortable with this long silence, and was not sure how to proceed. It felt that by adhering to the formulation, I had a place to open up a new conversation, which influenced the direction of the conversation.

One final point on this theme of using the formulation as an intervention, was to help build therapeutic alliance. Particularly in the early stages of therapy where I was extremely anxious, and the client kept asking for explanations of 'why' she was binge-eating, I offered her an outline of the formulation, but from the perspective of my supervisor's voice:

Therapist: And I can understand it's not easy as that's what you've had your heart set on for the last three years. And continuing on what we were chatting about last week about restrictions, I've been chatting to my supervisor, as she's been wanting a bit more time to make sense what's really happening here, but I think she still gets this feeling that you live with quite a few restrictions. That even from when you were a little girl there have been restrictions, like if you come home late, or have a boyfriend, or...or do something 'wrong', what's the impact of that going to be.

I felt like I was heading into a conversation with the client about the formulation of her case, but was worried that it may offend her, and wanted to protect our therapeutic relationship, so started to talk about the 'restriction' part of the conversation from the part of supervisor. This felt a safe way to assess how the client may feel about the formulation.

Jane: Mmm (sounded interested in where this was going)

Therapist: And are you scared you might lose your trust, or have your dad lose trust in you (here I am very hesitant in the way I am talking), what is the fear around that, and it sounds like you're quite strict on yourself for behaving in certain ways, so we'll go back quite a few of those examples that you've given me, but it feels like in a lot of your world there is no room for behaviour or being outside a certain way...

I jumped around various parts of the formulation, grasping at as many parts of it that I could pull together as possible, not allowing the client an opportunity to answer).

Jane: ...or box (Sounded really interested now)

Therapist: So let's have a look at what would happen if you went outside the box?

Jane: Huh!

This exclamation felt like this statement was a revelation, and was followed by silence while she thought about this for a while.

This appeared to be both useful to the client, and helped me to feel more confident about the formulation and myself as a therapist. I might not have needed to use it from the perspective of my supervisor's voice, but as it was the first time I had offered an explanation, I was not sure how it would be received, and I did not want to damage 'our' therapeutic relationship.

Although Castonguay and Beutler (2006) refer to interventions as a likely mechanism of therapeutic change, they refer to those interventions already identified as EST's. Thus, using the case formulation as a means to break uncomfortable therapeutic silences, may be considered less as an intervention, but rather as a coping mechanism for the therapist. However, in this particular case, it appears that using the case formulation as a means of interrupting the silence and to ignite a further conversation regarding therapy, helped to influence the therapeutic conversation and thus the course of therapy.

This theme regarding how the case formulation can be useful when a therapist is feeling stuck during a therapy session, should be included in the literature regarding the usefulness of case

formulations. This would be particularly useful for those neophyte therapists who are uncomfortable with extended in-session silences.

Conclusion:

In this chapter I described some of broad themes found in the analysis of how the both writing the formulation, and the therapy sessions directly after the formulations, may have influence therapy work with this particular client. Writing the formulation assisted with developing a deeper understanding of the client and her presenting problems, leading to greater empathy for the client. Writing of the treatment plan also increased my confidence as a therapist in knowing what to do in sessions in order to achieve the treatment goals. Three broad themes were identified when analysing the transcripts from the therapy sessions, which included adherence to the case formulation, the confidence of the therapist, and using the case formulation as an intervention. Both the adherence to the formulation, and the confidence of the therapist were found to have potential positive and negative influences on therapeutic work.

CHAPTER 5: CONCLUSION AND RECOMMENDATION

Introduction:

In this chapter I present a synthesis of the findings reflected in the previous chapters. Some of the limitations of the study are noted, along with personal reflections on the study. I also highlighted suggestions for future research in this area.

As mentioned in chapter one, although it is generally accepted that case formulations are useful clinical skill in psychotherapy treatment, there is significantly little research illustrating how case formulations are useful to treatment. Although most psychotherapists agree that case formulations are known to be useful for therapy, research shows that they are underutilised in practice.

Central issues:

This research provides a number of reflections around the way in which developing and using the psychodynamic case formulation may have influenced treatment in this particular case. In analysing the two sub-questions of this study, various themes were identified to suggest how this influence may have occurred. These include gaining a greater understanding of the client and her presenting problem, adherence to the formulation, the confidence of the therapist, and using the formulation as an intervention. However, adhering to the formulation, as well the therapists confidence levels appeared to have had both positive and negative influences of my interpretation of therapy.

As this research is my, the therapists', interpretation of how the case formulation influenced therapy, a limitation of this study is the lack of client's voice of her interpretation of therapy. When considering the themes across both sub-questions, what appears to stand out is how the case formulation can both increase and decrease the therapist's confidence. This is in part consistent with the study by Eells and Kendjelic (2007), where they suggest that case formulation skills may increase the confidence of the therapist, which in turn may increase the clients' confidence in the therapist, which may positively influence the treatment process. However, as seen from my research, the converse may also be true in that case formulation

skills may decrease the confidence of the therapist, which in turn may decrease the client's confidence in the therapist, which in turn may negatively influence the treatment process.

Through the writing of the formulation and the subsequent revisions, particularly in the organising and structuring of all the case information, I developed a deeper understanding of the client, and why she presented with her current problems, and why it was difficult to change these problems. This understanding assisted with developing my empathy for the client. When it comes to therapeutic change, Castongauy and Beutler (2006) argue that empathy is a mechanism of therapeutic change, in that it strengthens the therapeutic alliance. Likewise, as my formulations were revised to include relevant theory, my understanding, and thus empathy, deepened for the client. This should thus be reflected in the literature of why case formulations are useful, as it may allow for therapeutic change. It appears from the literature that this has not been explicitly noted. In other words, where it has been included as a possible mechanism for change, it has not been explicitly explain as to how empathy is developed or used as mechanism of change. Finally, writing the treatment plan in the formulations increased my confidence going into the therapy sessions, as it gave me a sense of what to do on a session-by-session basis. Although Sim et al. (2005) suggest that this therapy strategy, or treatment plan, is useful to trainee therapists in that it allows them to stay focussed and on track in therapy sessions, I felt this strategy went beyond their suggestions. Thus not only did it help me to stay focussed and on track, but it also helped for me to feel useful to the client, which increased my confidence. Likewise my confidence as a therapist further increased once I had written about, and discussed in supervision, my countertransferences to the client. Further to this, the inclusion of how the psychoanalytic frame, particularly my 'holding consistency', reassured me that I was already being useful to the client, thereby increasing my competence and confidence as a therapist. Thus while the current literature may reveal that case formulations are useful, particularly to trainee therapists in staying on track in therapy, there appears no literature to reflect how the concepts of feeling useful, or using supervision to discuss transferences and countertransferences, or considering the psychoanalytic frame, increases the confidence of therapist, which may lead to possible therapeutic change.

When analysing the transcripts from the therapy sessions directly after the case formulation and revisions, three broad themes were found, namely adherence to the formulation, the confidence of the therapist, and using the formulation as an intervention.

While adhering fairly rigidly to the case formulation was helpful to me as a trainee therapist, I believe this rigid adherence had both positive and negative influences for therapeutic progress. As a positive influence, this adherence allowed me to persevere with the treatment plan, even when the client defended against some of these goals, and this perseverance appeared to assist the client in making the connections between her unexpressed emotions and her eating patterns. This increased insight for the client felt like therapeutic progress. As a negative influence, in therapy sessions I occasionally used words or phrases from the formulation that had been used by my supervisor. In explaining these to the client, I realised I did not always understand their full meaning or context, which when the client questioned me on them, I felt stuck, and felt it was obvious to the client that I was unsure of what I was doing in therapy, thereby losing her confidence in me. Similarly, there were occasions where I posed relevant questions straight from the treatment plan to the client, but did not give her adequate time to answer before launching another question, thus not necessarily negatively influencing therapy, but hampering an opportunity for positive influence. These experiences concur with the Persons et al. (1991), that adhering to the formulation may make a difference to therapeutic progress. However, this study reflects more explicitly how adhering to a formulation may influence therapeutic progress, whereas the review by Persons et al (1991) merely states that it may make a difference. Similarly there appears to be no explicit literature to highlight that this influence to therapeutic work may be both positive and/or negative, making this study important in increasing the literature in this field of case formulations.

The second broad theme, namely the confidence of the therapist, also appeared to have both positive and negative influences on the therapy work. As a positive influence, when the client agreed with me regarding aspects of the formulation, or words or phrases used from the formulation, it helped me feel my formulation were accurate and that I was on the right track, thereby increasing my confidence. Research by Persons et al. (1991) suggests that therapeutic progress may be more influenced by an accurate formulation than techniques and interventions. While this study does not examine if there was therapeutic progress, my experience was that agreement from the client regarding the accuracy of the formulation, increased my confidence, which in turn may have influenced therapeutic progress.

As discussed regarding the adherence to the formulation, using terminology from the case formulation that I did not fully understand, allowed me to occasionally lose confidence in my understanding of the intricacies of the case, which may have in turn caused the client to lose confidence in my ability to help her.

As mentioned under my experience of writing of formulation, the study by Eells and Kendjelic (2007) suggests that the increased confidence of the therapist may increase the clients' confidence in the therapist, which may positively influence the treatment process. However, what is not overtly discussed in their study, is that a loss or decrease in the therapists confidence in themselves may lead to decrease in the clients' confidence in the therapist, which may in turn lead to a negative influence in the treatment process. This theme thus highlights the importance of the therapists confidence, and particularly how the therapists confidence or lack of confidence may influence therapy, and how their confidence can be increased by developing and using the case formulation.

The final broad theme identified was that of using the case formulation as an intervention, particularly when as a therapist, I felt I did not know how to proceed with therapy during a session. Thus, in times where there was a prolonged silence during the session, I reverted to the formulation in order to facilitate a further conversation. It was often these conversations, directly related to the case formulation, which prompted shifts in therapy. Thus where Castonguay and Beutler (2006) refer to interventions as a likely mechanism of therapeutic change, one of these interventions could be to use the case formulation when a therapist is feeling stuck during a therapy session, and should thus be included in the literature regarding the usefulness of case formulations to influence treatment. This intervention of use of the case formulation would be particularly useful for those neophyte therapists who are uncomfortable with extended in-session silences.

Limitations of the case study:

While I have described my experience of the process of writing the formulation, along with the subsequent therapy sessions from a psychodynamic perspective, there is little with regards to the adherence to the formulation that relate specifically to how the psychodynamic case formulation may have influence therapy. However, regarding the case formulation enabling the therapist to feel useful, there were some interesting findings. I felt compelled to

explain to the client why she behaved the way she did. In this way I was contributing to her insight into the problem, which is a goal of psychodynamic therapy, over and above that of symptom reduction. In doing so I referred heavily to the case formulation. This appeared to be useful to the client, despite the confusing way in which I explained the reasons. However, her interest in these explanations gave me belief in the formulation, and my adherence to the formulation. These explanations, while possibly not directly influencing therapeutic progress positively, due to my hesitant and confusing manner of explaining it, may be a vehicle in which psychodynamic case formulations can influence therapy in future. There is thus a call for further research in this area. Likewise, as suggested by Person et al (1991), it may be less about which theoretical orientation or explanation was given to the client, but rather that she had an explanation regarding her problem. Thus, I am not sure whether explaining the problems from an object relations theory or attachment theory view would have made any difference to the client. Again, this may be open for future research. Similarly, Bieling and Kuyken (2003) suggest that it might not even matter if the formulation is reliable to have an impact on therapeutic outcome, as they argue that the case formulation may influence therapy through other mechanisms such as the therapists' self confidence, or an improvement of the therapeutic relationship.

Reflections on the case study:

When reflecting on this case, and particularly the findings, it is hard to state what I felt had the greatest influence on therapy. While I do believe the case formulation was a major vehicle in influencing the therapeutic progress of this client, I am not sure there is any one specific aspect of the formulation I can attribute this to. Adhering to the formulation definitely had some influence, however it felt like there was a cycle within the aspects of formulation and therapy that repeated itself. It felt like it started with writing of the formulation, and gaining a deeper sense of understanding the client, and gaining empathy for the client through this understanding. However, by writing the treatment plan, it appeared to give me a sense of confidence, in that I had certain tasks I could take into the therapy sessions. Once in therapy, I adhered strongly to these tasks, most of which helped me to feel confident, and useful to the client, and helped me to gain increased confidence in using the formulation. Through this confidence and sense of usefulness, I further adhered to the formulation. Within this cycle, it also felt that by having these specific tasks, I would more easily be able to 'see success',

possibly not as defined by therapeutic progress by the client, but as progress as a trainee therapist, which increased my confidence.

Thus it appears there are several ways, either directly or indirectly, in which I interpreted therapy work in this case to be influenced by the formulation. As all of these suggestions of the influences of the formulation may have been due to my inexperience as a trainee therapist, it would be useful to re-conduct this study once I have gained greater experience as a therapist, or for future study by another, experienced therapist.

Further reflections:

My early experience as a trainee psychologist was that of anxiety. I tended to stay with the content the client came with, and was afraid to go deeper. Thus my interpretations of ‘shifts’ for the client may be considered more ‘my shifts’ of going deeper, which were often due to the formulation.

Due to my timetable, supervision always fell the day before seeing this client. Thus I was always able to discuss my formulations with my supervisor before therapy sessions with this client. Once these were discussed with my supervisor, I felt reassured that I was on the right path, and could work with the formulation more confidently in therapy with this client.

Recommendations:

There are three recommendations I would like to put forward with regards to this study. Firstly, if this study were to be re-conducted, it would be useful to have an understanding of the clients’ experience of the therapy. In this regard it would be useful to gauge if she felt there had been therapeutic progress, and possibly in which areas of her life she felt there had been the greatest change. For example she may have felt therapeutic change had been greater in terms of gaining insight and understanding of her problem, or rather in symptom change.

Secondly, it is recommended that this study is repeated by both trainee therapists and more experienced therapists, to gain a deeper understanding of whether the findings in this study could be generalised to other trainee therapists only, or if they could be broadened to include a wider population of therapists. Included in this it is recommended that this study be

conducted to review more specifically how the changes from each of the formulation revisions (from a basic to a more thorough formulation), thereby gaining a greater understanding to the usefulness of formulations to all therapists.

Finally, it would be beneficial to conduct a study such as this study, simultaneously to the conducting therapy with the client. In this way, one would have been able to track more explicitly the reciprocal influence the case formulation and treatment have on each other, and not only how the case formulation influences treatment. In other words, specifically reviewing the influence of the case formulation on the therapeutic work, from which any changes in therapy session are then included in the subsequent revision of the formulation, which may in turn again influence the treatment.

Conclusion:

This research hopefully adds to the literature around how developing and using the psychodynamic case formulation may be able to influence therapeutic work. The study set out to provide a thick description of how the case formulation influences therapy work, as it unfolded in therapy with this particular client. As the findings in this qualitative case study are of only one particular case, they cannot be generalised to a broader population. They should instead be understood for what they are: detailed subjective illustrations of my experience of working with the case formulation with this particular client. Thus I am unable to generalise that this was my experience for my other cases as a trainee psychologist, or whether other trainee psychologists had similar experiences. However, according to Kruger (1979), such qualitative findings should be transferred to new contexts and other studies, where they can serve as frameworks for understanding new meanings. Thus I am hoping this study can revitalise the interest in the usefulness of the case formulation, particularly how it can contribute to and influence therapy work. In this way I am hoping that this research can be transferred to future studies in order to further understand how the case formulation can be used as a clinical tool to influence therapy work.

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APPENDIX A:

Case formulations

Case Formulation 1: “Jane”

11 May 2011

Jane, a 19yr old female student, presented for therapy with a concern around binge-eating. She has a desperate desire to be thin, partly so that she can receive the compliments that go with looking good, but more so that she would not have to think about what food she puts into her mouth, in other words, to have a day where she does not have to think about food.

Predisposing Factors:

Jane has grown up in a family where there has been little emotional communication. She has never wanted to disobey or disappoint her parents, and unconsciously been conditioned to behave in a certain way that represent being a good daughter and sister. Certain behaviours (around negative emotions) have been not been considered ‘allowable’ and could not be freely expressed. She is the eldest of 3 siblings (all daughters), and her sister (15 yrs) has recently been diagnosed with Anorexia Nervosa.

Jane has had a problem with weight (overweight) as far back as she can remember. Her mother has also always had a (over)weight problem, and would continually encourage Jane to lose weight. This would either be in the form of direct conversations, of letters, or snide comments which were hurtful to Jane. Jane learned that to be overweight was not acceptable.

Jane describes her family as ‘close’. The family have only had one specific conflict was around eating, which occurred during a particular dinner at home. As emotions are not freely discussed (her father is cold an unemotional), Jane has believed that negative emotions are not to be discussed, and should rather be pushed under the carpet. She described her sister as being the only one to challenge the family in this regard (blowing up at her father, and causing the particular dinner conflict). Jane described that neither she nor her mother had been brave enough to do that.

There appears to be a sense of restriction in the family, of both emotions and eating.

Precipitating Factors:

Jane has on two occasions lost weight. The first weight loss came at around age 12 when she was moving to high school and she only just managed to fit into the biggest size school uniform (where after she would have to get one custom-made). The second occasion was to lose weight for her ‘Sweet Sixteen’ party which was a big event for her family and community. However, she has also put the weight back on soon after losing it.

There have been numerous other hurtful comments made by various family members and friends, which have made a big impact.

Maintaining Factors:

There are various factors which maintain this binge-eating. When faced with a particular harmful negative emotion, the feeling is pushed under the carpet. Jane tends to walk away from conversations where she could potentially get angry, or opts to tell people first that she has a particular problem before they can make a potentially hurtful comment.

Conflict Triangle:

What is the function of this system?

Wish:

The desire to express feelings of anger, frustration, resentment, wanting to be accepted, loved and cared for. (Instead, I eat)

Fear:

What afraid it might mean if feel that?

If not obedient, loses Fathers respect

If not supportive, loses mothers love

If not supportive, loses sisters friendship

If I express certain emotions, family relationships will fall apart.

Defence:

What defending from? Pretend not to care (friends, 'I don't really care');

What happens to the original fear? Can't act on it or use it.

Jane has lots of negative emotions in her, and defends against these by bottling them inside. Feels restricted, and resentful – thus eats.

Compromise: Eating

Treatment:

Look for defences against feelings of anger, frustration, resentment

Ask for instances of her expressions of these feelings.

Appears they get blocked by roles expected of her (e.g. eldest) or by constrained expression (e.g. family had no conflicts other than food).

Doesn't want to hurt anyone in family's feelings – what would happen if this happened?

What afraid of?

Focus on feelings of the unnamed.

Elaborate 1. (Hidden feeling) Feelings expressed (explore anger?) Dig deeper

2. (Fear) How is it for you to feel angry? How would it be expressed?

Address fear of feeling angry. Anger is a human feeling.

3. (Defence) Go back to feeling guilty. At what cost is this defence (not being angry)? Is it possible to be angry and have a relationship with mother, father, Sarah? Is there a way to express anger in a way that won't break relationships?

How would it feel if I said you eat when you are not able to express an emotion? Process of therapy is to not need to eat when feeling these emotions – there are other ways of feeling these emotions. Need to make room to feel these. So it's great to feel like a big sister, but what's the other side?

Case Formulation 2: “Jane”

30 May 2011

Jane, a 19yr old female student, presented for therapy with a concern around binge-eating. She has a desperate desire to be thin, partly so that she can receive the compliments that go with looking good, but more so that she can would not have to think about what food she puts into her mouth.

Predisposing Factors:

Jane has grown up in a family where there has been little emotional communication. She has never wanted to disobey or disappoint her parents, and unconsciously been conditioned to behave in a certain way that represent being a good daughter and sister. Certain behaviours (around negative emotions) have been not been considered ‘allowable’ and could not be freely expressed. She is the eldest of 3 siblings (all daughters), and her sister (15 yrs) has recently been diagnosed with Anorexia Nervosa.

Jane has had a problem with weight (overweight) as far back as she can remember. Her mother has also always had a (over)weight problem, and would continually encourage Jane to lose weight. This would either be in the form of direct conversations, of letters, or snide comments which were hurtful to Jane. Jane learned that to be overweight was not acceptable.

Jane describes her family as ‘close’. The family have only had one specific conflict was around eating, which occurred during a particular dinner at home. As emotions aren’t freely discussed (her father is cold an unemotional), Jane has believed that negative emotions are not to be discussed, and should rather be pushed under the carpet. She described her sister as being the only one to challenge the family in this regard (blowing up at her father, and causing the particular dinner conflict). Jane described that neither she nor her mother had been brave enough to do that.

There appears to be a sense of restriction in the family, of both emotions and eating.

Precipitating Factors:

Jane has on two occasions lost weight. The first weight loss came at around age 12 when she was moving to high school and she only just managed to fit into the biggest size school uniform (where after she would have to get one custom-made). The second occasion was to lose weight for her ‘Sweet Sixteen’ party which was a big event for her family and community. However, she has also put the weight back on soon after losing it.

Maintaining Factors:

There are various factors which maintain this binge-eating. When faced with a particular harmful negative emotion, the feeling is pushed under the carpet. Jane tends to walk away

from conversations where she could potentially get angry, or opts to tell people first that she has a particular problem before they can make a potentially hurtful comment.

Conflict Triangle:

Wish:

The desire to express feelings of anger, frustration, resentment, wanting to be accepted, loved and cared for.

Fear:

If not obedient, loses Fathers respect. If not supportive, loses mothers love. If not supportive, loses sisters friendship

If expresses these emotions, family relationships will fall apart. Who will be there for the family if she not?

Defence:

Jane bottles all negative emotions inside. Although Jane is aware of these negative emotions some of the time, they are not acceptable to her sense of self, and she quickly replaces them with feelings of guilt for even having these feelings. She tightly defends against these emotions by finding some reason to justify her guilt.

Compromise to the wish and fear:

Since there has been no outlet for these restricted negative emotions, Jane opts to eat.

Treatment:

Elaborate :

1. (Hidden feelings). Look for defences against feelings of anger, frustration, resentment or other unnamed negative feelings, and focus of these feelings. And ask for instances of her expression of these feelings.

2. (Fear) How is it for you to feel angry? How would it be expressed? What is she afraid it might mean for her to feel anger. Address fear of feeling angry. Anger is a human feeling.

3. (Defence) Her reasons for always resorting to going back to feeling guilty. At what cost is this defence (not being angry)? Is it possible to be angry and have a relationship with mother, father, Sarah? Is there a way to express anger in a way that won't break relationships?

Explore other ways of feeling these emotions.

Case Formulation 3: “Jane”

17 June 2011

Description of the problem:

Jane, a 19yr old female student, presented for therapy with a concern around binge-eating. She has a desperate desire to be thin, partly so that she can receive the compliments that go with looking good, but more so that she would not have to think about what food she puts into her mouth.

Description of the psychic cost of the problem:

Jane does not believe she will be happy unless she is thin. She has few friends, and feel's she has nothing to offer in a friendship – that she herself is not enough. She has often turned down invites for coffee etc with friends because of her weight, and thus feels she has no social life. Jane has never had a boyfriend, and would really like a relationship, but feel's she is not lovable as she is. She feels no boy would ever approach her, saying that she would have to be the one to approach a boy, and she is too scared to do this for fear of rejection. This all leads to feelings of loneliness.

Identification of relevant predisposing factors:

Jane has grown up in a family where there has been little emotional communication. She has never wanted to disobey or disappoint her parents, and unconsciously been conditioned to behave in a certain way that represents being a good daughter and sister. Certain behaviours (around negative emotions) have been not been considered 'allowable' and could not be freely expressed. She is the eldest of 3 siblings (all daughters), and her sister (15 yrs) has recently been diagnosed with Anorexia Nervosa.

Jane has had a problem with weight (overweight) as far back as she can remember. Her mother has also always had a (over)weight problem, and would continually encourage Jane to lose weight. This would either be in the form of direct conversations, of letters, or snide comments which were hurtful to Jane. Jane learned that to be overweight was not acceptable.

Jane describes her family as 'close', although not necessarily happy. The family have only had one specific conflict which was around eating, occurring during a particular dinner at home. As emotions are not freely discussed (her father is completely unemotional), Jane has believed that negative emotions are not to be discussed, and should rather be pushed under the carpet. She described her sister as being the only one to challenge the family in this regard (blowing up at her father, and causing the particular dinner conflict). Jane described that neither she nor her mother had been brave enough to do that.

Description of the patients most dominant and recurring object relationships and how these predisposed the client to the problem

Object Representation: Jane's parents were not emotionally available to her as a child. Jane's mother attended more to her father, and encouraged all three daughters to do the same. In other words, Jane's 'Object' (her mother) was self-sacrificing, putting Jane's father's needs above, and representing this as the correct way to behave. Her mother has also always had a weight problem (being overweight), and would continually be on diets herself, along with encouraging Jane to lose weight. This would either be in the form of direct conversations, or letters, or snide comments which were hurtful to Jane. Jane learned from this object representation that to be overweight was not acceptable. Her mother's low self-esteem due to her weight has led her mother to live with the anxiety that her husband would leave her if she did not lose weight, allowing Jane to believe that no boy/man would love her if she was overweight.

With the object representative being a self-sacrificing object (in fear of rejection), Jane has learnt that her own needs are not important, and that it is more important to show loyalty to, and not disappoint her father. When faced with a particular harmful negative emotion, the feeling is pushed under the carpet. Jane tends to walk away from conversations where she could potentially get angry. For fear of rejection, Jane also opts to tell people first that she has a particular problem before they can make a potentially hurtful comment.

Self Representation: Jane believes no one will love her and want to be her friend the way she is, and that happiness can only be found if you're thin.

Affect: Although Jane cries through the sessions, she always smiles when she arrives and when she leaves, and in between the tears, supporting the idea that it is not acceptable to show what you feel, but rather what others expect of you (as with Winnicott's notion of the False Self)

Description of the patients defences:

Jane bottles all negative emotions inside. Although Jane is aware of these negative emotions some of the time, they are not acceptable to her sense of self, and she quickly replaces them with feelings of guilt for even having these feelings. She tightly defends against these emotions by finding some reason to justify her guilt. Since there has been no outlet for these restricted negative emotions, Jane opts to eat.

Goals for therapy and how these are linked to the above:

1. (Hidden feelings). Look for defences against feelings of anger, frustration, resentment or other unnamed negative feelings, and focus of these feelings. And ask for instances of her expression of these feelings.
2. (Fear) How is it for you to feel angry? How would it be expressed? What is she afraid it might mean for her to feel anger. Address fear of feeling angry. Anger is a human feeling.
3. (Defence) Her reasons for always resorting to going back to feeling guilty. At what cost is this defence (not being angry)? Is it possible to be angry and have a relationship with mother, father, sisters? Is there a way to express anger in a way that won't break relationships? Explore other ways of feeling these emotions.

With regards to transference, the initial transference I picked up on, was that : I need a solution to being overweight, I can't take it anymore, and I need you to fix me within my 10 free sessions, as I cannot afford to pay for therapy thereafter.

My initial countertransference was a desperate want for Jane to be thin. The pain I felt for her lifelong battle with being overweight, along with its psychic costs, was quite large.

Case Formulation 4: “Jane”

10 August 2011

Description of the presenting problem/symptom:

Jane, a 19yr old female student, presented for therapy with a concern around binge-eating. She has a desperate desire to be thin, partly so that she can receive the compliments that go with looking good, but more so that she would not have to think about what food she puts into her mouth.

Description of the psychic cost of the problem:

Jane does not believe she will be happy unless she is thin. She has few friends, and feels she has nothing to offer in a friendship – that she herself is not enough. She has often turned down invites for coffee etc with friends because of her weight, and thus feels she has no social life. Jane has never had a boyfriend, and would really like a relationship, but feels she is not lovable as she is. She feels no boy would ever approach her, saying that she would have to be the one to approach a boy, and she is too scared to do this for fear of rejection. This all leads to feelings of loneliness and worthlessness.

Identification of relevant predisposing factors:

Jane has grown up in a family where there has been little emotional communication. She has never wanted to disobey or disappoint her parents, and unconsciously been conditioned to behave in a certain way that represents being a good daughter and sister. Certain behaviours (around negative emotions) have been not been considered ‘allowable’ and could not be freely expressed. She is the eldest of 3 siblings (all daughters), and her sister (15 yrs) has recently been diagnosed with Anorexia Nervosa.

Jane has had a problem with weight (overweight) as far back as she can remember. Her mother has also always struggled with her own issues of being overweight, which has magnified the importance of weight in the family system. She would continually encourage Jane to lose weight, which was either by suggestions of dieting together, or in the form of direct conversations, or letters, or snide comments which were hurtful to Jane. She experienced criticism from her mother, as well as perceived rejection from her peers. The impact of this was that Jane learned that to be overweight was not acceptable, and a sense of self as unworthy and unlovable, and that worth is conditional on looking or being a certain way. This all led to Jane starting to keep ‘bad’ foods out of sight and eating them when no one could watch her, which she continues to do here at Rhodes University.

Jane describes her family as 'close', although not necessarily happy. The family have only had one specific conflict which was around eating, occurring during a particular dinner at home. As emotions aren't freely discussed (her father is completely unemotional), Jane has believed that negative emotions are not to be discussed, and should rather be pushed under the carpet. She described her sister as being the only one to challenge the family in this regard (blowing up at her father, and causing the particular dinner conflict). Jane described that neither she nor her mother had been brave enough to do that.

Description of the patients most dominant and recurring object relationships and how these predisposed the client to the problem

Object Representation: Jane's mother attended more to her father, and encouraged all three daughters to do the same. In other words, Jane's 'Object' (her mother) was self-sacrificing, putting Jane's father's needs above her own, and representing this as the correct way to behave. Her mother has also always had a weight problem (being overweight), and would continually be on diets herself, along with encouraging Jane to lose weight. Jane learned from this object representation that to be overweight was not acceptable. Her mother's low self-esteem due to her weight has lead her mother to live with the anxiety that her husband would leave her if she did not lose weight, allowing Jane to believe that no boy/man would love her if she was overweight.

With the object representative being a self-sacrificing object (in fear of rejection), Jane has learnt that her own needs are not important, and that it is more important to show loyalty to, and not disappoint her father. When faced with a particular harmful negative emotion, the feeling is pushed under the carpet. Jane tends to walk away from conversations where she could potentially get angry. For fear of rejection, Jane also opts to tell people first that she has a particular problem before they can make a potentially hurtful comment.

Thus Jane has learned, in accordance with the Object Relations Model, to also sacrifice her real self in favour of a false self in order to maintain object ties and preserve the relationships with her mother and father. The cost of this is Interpersonal distance in relationships, in that she cannot truly feel accepted or worthy because she does not share her real self.

Self Representation: Jane believes no one will love her and want to be her friend the way she is, and that acceptance and happiness can only be found if you're thin.

Affect: The affect between the self and object representatives is one of wanting to please (and not disappoint). Regardless of how she feels (she is not actually able to articulate how she feels), she feels she must be there for her mother, regardless of what her own emotions are. She feels her mother needs her and has no one else to talk through things with, so she needs to be there for her. Although Jane cries through the sessions, she always smiles when she arrives and when she leaves, and in between the tears, supporting the idea that it is not acceptable to show what you feel, but rather what others expect of you (as with Winnicott's notion of the False Self).

Description of the patients defences:

Jane has a harsh internal critic which functions as the 'ideal self' to repress aspects of herself viewed as unattractive. This is an attempt to get the self in line with what is attractive to others (being thin, outgoing, sunny). Jane restricts and bottles all negative emotions inside. Although Jane is aware of these negative emotions some of the time (albeit not much of the time), they are not acceptable to her sense of self, and she quickly replaces them with feelings of guilt for even having these feelings. She tightly defends against these emotions by finding some reason to justify her guilt. Since there has been no outlet for these restricted negative emotions, Jane opts to eat, seeking comfort from self.

Jane diminishes any positive feelings about the self, and is critical and judgemental towards herself. She defends against feelings of anger or sadness, replacing with feeling of guilt. All of these feelings maintain the symptom (eating), and intensifies the internal critic, and the vicious cycle is exacerbated, with persistent guilt, resentment, anxiety, sadness.

Goals for therapy:

(Hidden feelings). Look for defences against feelings of anger, frustration, resentment or other unnamed negative feelings, and focus of these feelings. And ask for instances of her expression of these feelings. (These have been met with great resistance).

(Fear) How is it for you to feel angry? How would it be expressed? What is she afraid it might mean for her to feel anger. Address fear of feeling angry. Anger is a human feeling.

(Defence) Her reasons for always resorting to going back to feeling guilty. At what cost is this defence (not being angry)? Is it possible to be angry and have a relationship with mother, father, sisters? Is there a way to express anger in a way that won't break relationships? Explore other ways of feeling these emotions.

Focus on problematising happy, sunny, carer role on relationships

Rename the problem : eating as a symptom and not the problem. The current focus is on the 'internal critic', and to see this as a defence and not as 'truth', but as separate from self. Following that, the next goal would be to facilitate her to turn against the defence – to highlight the underlying need (feel worthy, lovable, competent, secure) and how the defence works against that. The next goal would be to weaken that defence and facilitate a more stable self esteem.

With regards to transference, the initial transference I picked up on, was that : I'm desperate; I need a solution to being overweight, I can't take it anymore, and I need you to fix me within my 10 free sessions, as I cannot afford to pay for therapy thereafter. Although not compliant, I still felt that Jane would not like to disappoint me – she was always early for sessions, never missed a session, smiles a lot especially at beginning and end of therapy, and although she talks about 'feeling' negative emotions, I see not real expression of this.

My initial countertransference was a desperate want for Jane to be thin. I felt desperate for her (Projective identification?) The pain I felt for her lifelong battle with being overweight, along with its psychic costs, was quite large. As therapy has progressed, countertransference included feels of helplessness to the constant resistance to defences – it feels like she is not allowing me to really see her, or that neither of us actually ‘can see or know her true self’ – it feels that hidden.

Case Formulation 5: “Jane”

29 August 2011

Description of the presenting problem/symptom:

Jane, a 19yr old, overweight, female student, presented for therapy with a concern around binge-eating. Her binges are usually mid afternoon, and evening, almost every day. Her mood fluctuates from low to ‘numb’, and two years previously she suffered a two-month depressive episode, which she fears is possible of being repeated. She has a desperate desire to be thin, “partly so that she can receive the compliments that go with looking good, but more so that she would not have to think about what food she puts into her mouth”.

Description of the psychic cost of the problem:

Jane has been overweight for as much of her life as she can remember, and is ‘always on a diet’. Jane does not believe she will be happy unless she is thin, always equating being overweight with unhappiness. Jane has few friends. She withdraws from friendships and isolates herself because she feels she has nothing to offer in a friendship – that she herself is not enough. She has often turned down invites for coffee etc with friends because of her weight, preferring to isolate herself in her room with television and food. She thus has a poor social life. Jane has never had a boyfriend, and would really like a relationship, but feels she is not lovable as fat as she is. She feels no boy would ever approach her, saying that she would have to be the one to approach a boy, and she is too scared to do this for fear of rejection. This all leads to feelings of loneliness and worthlessness.

Identification of relevant predisposing factors:

Jane has had a problem with weight (being overweight) as far back as she can remember. Her mother has also always struggled with her own issues of being overweight, which has magnified the importance of weight in the family system, and there has been frequent anxiety in the family around food in general. Jane’s mother low self-esteem due to her weight has lead her mother to live with the anxiety that her husband would leave her if she did not lose weight, allowing Jane to believe that no boy/man would love her if she was overweight. Jane’s mother would continually encourage Jane to lose weight, which was either by suggestions of dieting together, or in the form of direct conversations, or letters, or snide comments which were hurtful to Jane. These ‘forms of encouragement’ may well have been attempts by Jane’s mother to control the way Jane presented externally. She experienced criticism from her mother, as well as perceived rejection from her peers. The impact of this was that Jane learned that to be overweight was not acceptable, and that others determine how you should be. Jane also started equating being overweight with a self that is unworthy

and unlovable, and that worth is conditional on looking/being a certain way. This all lead to Jane starting to keep 'bad' foods out of sight and eating them when no one could watch her, in order to gain back some control. Although this behaviour began at home about two years ago, it continues here at university.

Jane has grown up in a family where there has been little emotional communication. She has never wanted to disobey or disappoint her parents, and unconsciously been conditioned to behave in a certain way that represents being a good daughter and sister. This conditioning to certain responses have led Jane to have thoughts and feelings that have been imposed on her, and may not be her own responses, in other words, she has not had the freedom to control her own responses. Certain behaviours (around negative emotions) have been not been considered 'allowable' and could not be freely expressed. Food appears to be the one thing that she is able to control. Jane is the eldest of 3 siblings (all daughters), and her sister (15 yrs) has recently been diagnosed with Anorexia Nervosa.

Jane describes her family as 'close although not necessarily happy'. The family have only had one major conflict which occurred around the dinner table at home evening. Jane's sister had an issue about the way dinner was being served up and 'blew up at her father'. Emotions are not freely discussed in the home (Jane's father is completely unemotional), and Jane has believed that negative emotions are to be kept under control and should rather be pushed under the carpet. Jane has tried to accept this form of emotional control for fear of losing her parents respect. However, Jane's sister has been the only family member to 'rebel' against this control (by blowing up at her father, and causing the particular dinner conflict). Jane described her sister as "being the only one to challenge the family in this regard and that neither herself nor her mother had ever been brave enough to do that". This incident has lead Jane to believe that she is not able to stand up to her parents, and would rather sacrifice (swallow) her negative emotions than risk losing her parents' love and support. This 'swallowing of emotions' has in previous research been seen as a risk factor in many eating disordered clients.

Description of the patients most dominant and recurring object relationships and how these predisposed the client to the problem

Object Representation: Jane's mother has always has been both a source of love and pain for her. She has always been opening affectionate and loving to Jane, with lots of hugs and kisses, and open verbalisation that she loves her. However, her mother has also been her deepest source of pain. Jane gives numerous accounts of how her mother has hurt her with comments about her weight. Jane understands this as that her mother would really like her to be thin. If you are thin, you will have greater self-esteem and happiness. Jane started watching what food she ate at meal times (in front of her mother), then when her mother wasn't around, she would take food from the kitchen and store it in her cupboard for when she wanted a snack later. Even at university, Jane feels she is watched by everyone with

regards to what she eats, choosing to eat very little in the residence hall, but later going to buy snacks to eat when no one can watch her. As her mother does not appear accepting of Jane's weight, Jane feels that others will not accept her as she is either. She is particularly sensitive to rejection, and prefers to isolate herself than initiate social activities in fear of rejection from peers. Jane feels that she has disappointed her mother in not being able to be thin, and that her mother takes pity on her that she is not able to lose weight. Pity is one emotion that Jane cannot tolerate. She finds it very difficult to differentiate between love/care and pity. Jane definitely perceives acquaintances (she is not sure they are actually friends) to pity her being overweight.

Although Jane knows her mother loves her, she is always wary that any comment her mother makes, however benign, is about her weight. Jane is extremely sensitive to weight comments, and any slightest comment around food is taken as some indication that she is overweight. This sensitivity reoccurs in various other friendships, extending to unrelated Facebook comments. She feels she is always on guard for people to comment on her weight. This extreme sensitivity has also extended to her sense of trust in both her mother and others. Jane is never quite sure who she can trust with information that can't come back to hurt her. This form of uncertainty of who is friend or foe stems from her mother's fickleness to love or hurt her. Jane feels if she opens up to someone, they 'must' open up to her – so that if she is hurt by them, she has some 'control' to hurt them back. This sense of 'control' leads back to the only part of Jane's life that she actually has control over – food and eating.

As Jane is the eldest child, her mother has often given her adult status before it was possibly due. Jane was ten years old when her baby sister was born, and felt that she then 'had a role to play'. Over the last year while the middle sister has been ill with anorexia, Jane has been the shoulder for her mother to cry on. Although she resents this position, she feels she needs to be there for her mother as her mother has no other support system. This continues into her friendships where she feels others come to her when they need someone to talk to. She is thus very giving of herself, even though she often resents this. She is extremely uncomfortable when the roles are reversed and does not like being asked how she is (she is sensitive to this), or to have the spotlight on her.

Jane has spoken very little of her father. He has been relatively uninvolved in her life, and although he is not physically absent, it appears he has been emotionally absent. In the particularly family dinner conflict mentioned earlier, Jane's father criticised Jane for not being social enough. Since that time, Jane has tried to be a more outgoing person. With her move to Rhodes, she not only thought this was an opportunity for her to lose weight, but also an opportunity for her to acquire a big group of friends, and an idealised social life. However, Jane is still unable to define what she considers to be a friend, or even what 'fun' actually means. She doesn't believe she has truly experienced either, and wants to move to another university next year where she can start afresh and meet new people. She does not feel the students at Rhodes are like her (she prefers coffee/cake outings as opposed to bars and clubs). Jane feels when her parents call her, that she needs to tell them that she has

friends and is going out. Sometimes she will force herself to go out just to be able to tell her father that she has gone out. The family as a whole are not a social family and attend very few social activities. Jane feels that it is expected of her, particularly now at university that she should have a big group of friends. She feels when her old school friends ask her how Rhodes is, that she should be able to tell them that she is having a great time socialising with all her new friends. She feels she has to put on a pretence all the time, and that she does not really have any real friends here, but she is scared of what her father, and friends back home will think of her. That she is a failure. This negative affect is 'not allowed to be seen' and is therefore 'swallowed in the form of food' as it is not acceptable to Jane's sense of self representation. Jane's father has always been quite strict, and Jane would not feel it correct to disappoint him, again covering up any negative feelings she may have towards him, and 'consuming' those to.

Thus Jane has learned, in accordance with the Object Relations Model, to also sacrifice her real self in favour of a false self in order to maintain object ties and preserve the relationships with her mother and father. This has been shown to her father by pretending to have a social life, and by swallowing her negative emotions (anger and resentment) in feeling she cannot disobey him. With regards to her mother, this has been shown by her constant dieting to prove to her mother she really is trying to be the person her mother (and Jane herself) wants her to be.

Self Representation: Jane believes no one will love her and want to be her friend the way she is, and that acceptance and happiness can only be found if you're thin.

Affect: The affect between the self and object representatives is one of wanting to please (and not disappoint), which could be regarded as a passive aggressive defence. Regardless of how she feels, she feels she must be there for her mother, regardless of what her own emotions are. She feels her mother needs her and has no one else to talk through things with, so she needs to be there for her. Although Jane cries through the sessions, she always smiles when she arrives and when she leaves, and in between the tears, supporting the idea that it's not acceptable to show what you feel, but rather what others expect of you (as with Winnicott's notion of the False Self). It seems that in therapy, Jane is wanting to gain my acceptance and approval.

Description of the patients defences:

Jane has employed a harsh internal critic which functions as the 'ideal self' to repress aspects of herself viewed as unattractive. This is an attempt to get the self in line with what is attractive to others (being thin, outgoing, sunny). Jane restricts and bottles all negative emotions inside, to protect herself from showing a side of her that is not considered acceptable by her parents or others. Although Jane is aware of these negative emotions some of the time (albeit not much of the time), they are not acceptable to her sense of self, for fear of disappointing her parents and possibly losing their love and affection. She is very quick to rationalise and replace these emotions with feelings of guilt for even having these emotions,

thereby defending her parents from the possibility of loss of idealisation. She tightly defends against these emotions by finding some reason to justify her guilt, usually that her parents do everything out of love for her. Guilt is her main defence against any negative emotion, especially when it comes to her parents. Since Jane feels that she should only think or speak well of her parents, there is nowhere for any negative emotions to go, and Jane acts out by eating. Once she has acted out by bingeing, her internal critic is reactivated where she again defends her parents trying to control her to be something other than who she is (and the anger and resentment she feels towards them, knowing they want only the best for her), and turns the anger inwards, resulting in persistent guilt, and sadness.

Goals for therapy:

To help Jane understand that the eating is not the actual problem, but rather that it's a symptom (a compromise formation between the hidden feeling of anger, and the defence of suppressing anger (passive aggression)). In trying to bring Jane's defences (of maintaining idealisation of her parents by criticising herself) into her awareness, she maybe be able to understand the fear of what she is defending against (losing her relationship with her mother and father). Once the fear has been acknowledged, and the hidden feeling of anger exposed, the compromise formation (symptom of binge eating) may be able to be diminished. In order to do this (increase Jane's awareness and insight), we would need to look at both declarative and procedural knowledge. With regards to the declarative knowledge, we may need to explore all the facts and events that Jane can remember that may have lead her to develop these defences. The procedural memory or knowledge is largely unconscious and might only be able to be inferred through transference and countertransference.

With regards to transference, the initial transference I picked up on, was that: I am desperate; I need a solution to being overweight, I can't take it anymore, and I need you to fix me within my 10 free sessions, as I cannot afford to pay for therapy thereafter. This may be the same desperate message she gives her mother in a passive aggressive way. Although not compliant, I still felt that Jane would not like to disappoint me – she was always early for sessions, never missed a session, smiles a lot especially at beginning and end of therapy, and although she talks about 'feeling' negative emotions, I see no non-verbal expression of this. I also sometimes feel I'm being tested by her – that she is showing me her 'most unacceptable parts of self' to see if I will still accept her.

My initial countertransference was a desperate want for Jane to be thin. I felt desperate for her. I am not sure how much of this is projective identification, or actual identification. I share her belief in feeling more worthy and lovable if you are not overweight, and can also turn to food to avoid certain painful emotions. The pain I felt for her lifelong battle with being overweight, largely stemming from critical and controlling parents, was quite large, and in most sessions I just wanted to give her a hug and let her know she is safe with me – that I will accept her and love her as she is. This countertransference thus also brought up feelings of anger towards her parents that they could do this to her, and similarly (to Jane),

felt that they were doing purely thinking it would help Jane. Again, this may be because I have my own issues with anger to my critical parents. As therapy has progressed, countertransference included feels of helplessness to the constant resistance to defences – it feels like she is not allowing me to really see her, or that neither of us actually ‘can see or know her true self’ – it feels that hidden, and I’m not certain we will get there.

The keeping of the analytic frame is important in this case. As Jane’s mother is a source of ‘holding inconsistency’ it is important that therapy is a consistent safe and containing experience for Jane. The frame has remained consistent throughout her time in therapy with only one major break over the June/July holiday. She was extremely anxious to separate from therapy for this length of time (and at a particularly ‘angry’ time with her mother), and asked if she could email me over the holiday. Although I consented to this with some boundaries, she did not email.

APPENDIX B:

Informed Consent Form

Informed consent

I confirm that prior to engaging in this process I was given or referred to sufficient information to understand the nature of the process. The information included the nature of the services, the psychologist's professional identity, possible risks and benefits of assessment and/or therapy, nature of confidentiality - including legal and ethical limits, and alternative treatments available. My signature below affirms my informed and voluntary consent to this process.

I give permission to the following:

(Initial below)

i That sessions may be audio or video taped for training purposes. I am however also aware of the confidentiality policy of the Clinic.

K.S

ii That an appropriate fee is charged for services for which I am responsible.

K.S

iii That the Clinic may use case material, as stipulated in the document, for research purposes, but in such a manner that my identity will be protected.

K.S

iv I was informed that the primary supervisor for my involvement at the Clinic will be Shayne Horsman.

K.S

v I give permission to the Trainee Psychologist in charge of my case to consult with the following professionals who might be able to provide information relevant to my assessment or therapy:

- 1. _____ 2. _____
- 3. _____ 4. _____

With the understanding of the above information and conditions, I agree to participate in the assessment and therapy process with the knowledge that the trainee psychologist and registered supervisor will act in good faith at all times and release the RU Psychology Clinic from any liability.

In case of a Minor client

I furthermore affirm that I am the legal guardian of _____. With an understanding of the above information and conditions, I do grant permission for my child to participate in the assessment and therapy process.

[Signature]
Signature

24/03/2011
Date

[Signature]
Psychologist in Training

24/3/2011
Date

[Signature]
Supervisor

13/04/2011
Date

