

**AN EXAMINATION OF PATIENTS' RESPONSES TO FRAMEWORK BREAKS IN
PSYCHOTHERAPY IN AN INSTITUTIONAL CONTEXT**

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Submitted in partial fulfilment of the requirements for the
degree of Doctor of Philosophy, Rhodes University

**Rhodes University
Grahamstown**

February 1998

ABSTRACT

This study examines the workings of the ground rules which make up the framework of psychotherapy, in an institutional context, by analysing transcripts of twelve audio taped sessions of therapy conducted in a psychiatric hospital. The breaks in the ground rules of the sessions are noted and the patients' responses to these breaks are analysed using Langs's (1982, 1988) method for decoding patients' material, suitably modified for use as a hermeneutic research method.

Although all of the ground rules are broken in the institutional context, only one of the ten ground rules appears to be essentially affected by this particular institutional context. Other ground rules are broken out of choice of technique or through error. The institutional context has a structural impact only on the ground rule requiring a one to one relationship with privacy and confidentiality and this ground rule is transgressed in a number of ways in all twelve sessions examined in this study. However the patients' responses to this breach only occur in ways predicted by communicative theory when the break in the ground rule involves actual entry into the therapy space by another person. Other contraventions to this ground rule that do not involve such an entry do not elicit the predicted patient responses. The many other ground rule breaks occurring in the institutional context evoke the predicted responses in the patients' material. In the study, no therapist interventions are found to comply with the communicative therapy requirements for sound interventions; concomitantly it was found that no therapist interventions receive the required derivative validation.

The results indicate that it is possible to conduct therapy of a substantially secure frame variety in this institutional context with minimum effort on the part of therapists and given proper training and supervision of therapists in the techniques of communicative psychotherapy. Furthermore the results lend weight to the importance of the communicative methodology for listening to patients' material in psychotherapy in an institutional context. However, further rigorous study of competently performed therapy, executed within the context of a secure frame within an institutional context, is needed in order to demonstrate the benefits of the communicative psychotherapy interventions and interpretations in this context.

ACKNOWLEDGEMENTS

I would like to acknowledge the supervision of Dr Kevin Kelly without whose support and encouragement this study would not have begun, let alone been completed.

I would like to thank Dr Gavin Ivey for introducing me to the work of Robert Langs and for his helpful comments and suggestions during the course of this study.

I wish to express my thanks to Dr David Smith for his generous assistance in supplying reprints of his own erudite work and in tracing other, difficult to obtain, articles in the field of communicative psychoanalysis.

I would like to thank Michelle for her support and patience during the completion of this dissertation.

I would like to thank the management of Lentegeur hospital for their support during the course of the study.

Finally, I wish to express my deep appreciation to my colleagues, the therapists who have courageously allowed me access to their therapy, and to all their patients for consistently, if indirectly, telling us how they perceive their therapy in the institutional context.

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CHAPTER 1

INTRODUCTION

In his introduction to Langs's (1993) *Empowered psychotherapy*, Grotstein makes the point that Langs's ideas have now been absorbed into the mainstream of psychoanalytic thought and that Langs has moved, during the twenty years of his writing and theorising, from being the *enfant terrible* of psychoanalysis to a position of being its superego. If Grotstein is to be believed, this has been a remarkable transformation and it has surely been due mainly to the enduring influence of Langs's theories and ideas regarding the framework of psychotherapy.

The importance of the setting or framework in psychotherapy has been emphasised by many theorists (Bleger, 1967; Modell, 1976; Quinodoz, 1992; Viderman, 1974; Winnicott, 1971, 1972, 1978) but especially by Robert Langs (Langs 1978a, 1978b, 1979, 1981a, 1981b, 1982, 1984, 1993). While other theorists have argued for the importance of the framework within a *psychoanalytic* context, Langs has emphasised the importance of the framework for *psychotherapy* as well as psychoanalysis. According to Langs (*ibid.*) this applies also to psychotherapy conducted within an institutional context.

In an institutional context the framework is more difficult to maintain in the face of organisational and bureaucratic pressures. Two issues raise themselves in such contexts. The first has to do with the institutional pressures that prevent the maintenance of an appropriate framework for therapy. The second has to do with the type of patients encountered in a psychiatric setting and the deviations from a secure framework that this would seem to necessitate. The first issue has to do with the restrictions of the organisation that impact on the framework and the second has more to do with theoretical constraints that prescribe that certain patients are not suitable for psychotherapy of an exploratory kind and should only receive supportive psychotherapy.

A previous study indicated that most of the therapy undertaken at Lentegur hospital is of the supportive variety (Rees, 1993). Many therapists working at Lentegur hospital adopt a broadly psychodynamic approach to therapy with a sense of the importance of the unconscious in the development of symptoms as well as the recognition of the importance of

interpretation in the understanding and alleviation of these symptoms (*ibid.*). Despite this broad recognition there is some confusion as to what actually constitutes good therapeutic practice in this institutional context and there are many contradictions that are thrown up by the tensions between organisational needs and the needs of therapists wanting to maintain the sanctity of the therapy space.

Previous research (Rees, 1993) had established that the dropout rate from psychotherapy in the outpatient department of Lentegur hospital was very high and the average number of therapy sessions in which patients participated, in this context, was low. Although on the face of it intercultural factors had seemed to be playing a role in the high rate of recidivism from psychotherapy and in the low utilisation of the psychotherapy resources, this initial assessment of the possible importance of these intercultural factors in this therapy context seemed to be much less important than factors relating to the actual implementation or lack of implementation of sound therapeutic techniques (Rees, 1993, 1996). In particular the ground rules of therapy (Langs, 1982, 1988) did not seem to be receiving the attention that they possibly deserved in this context (Rees, 1995, 1996). The current study is an attempt at examining some of the principles of sound therapy practice within the ambit of a broadly psychodynamic approach to psychotherapy, particularly the value or otherwise of these ground rules of psychotherapy as they apply in a psychiatric hospital context. This study is specifically concerned with how the patients themselves respond in a derivative manner to the implementation or lack of implementation of these ground rules in this psychiatric hospital context.

The preliminary part of the present study comprises an audit of the way that therapy is currently conducted in the institutional context by examining actual therapy sessions. This part of the study is not so much concerned with asking therapists what they do but concentrates on actually observing them in practice by examining audio tapes of sessions of psychotherapy. This scrutiny of actual sessions of therapy is supplemented by interviews with the therapists regarding the operation of the framework as it applies to each particular session. This focus is also supplemented by a broader observation, conducted by the researcher, of the workings of the institution in general as it impacts on the framework of

psychotherapy conducted at the institution. Thus this preliminary part of the study examines the broader institutional factors as they impact on the individual therapy space.

The main part of the study sets out to examine patients' unconscious responses to these framework conditions. This section of the study attempts to throw light on some of the predictions that Langs makes about the practice of therapy generally and in an institutional context in particular. Langs (1979) is unequivocal about his views on the lack of efficacy of supportive therapy techniques, even in an institutional context and with patients who would traditionally be regarded as needing this form of therapy (see section 3.3 below). Langs maintains that careful scrutiny of the derivative material of patients who have been subjected to this form of therapy clearly reveals their unconscious rejection of these efforts on the part of the therapist (*ibid.*). This main part of the study is not so much concerned with the various diagnostic categories and whether any particular category of patient should or should not receive a particular form of therapy. Neither is this study concerned with issues of evaluating the merits of various forms of therapy such as milieu therapy, family therapy or group therapy, all of which are commonly practised in the institutional context. Similarly the study is not concerned with assessing the validity or merits of other approaches to psychotherapy as opposed to individual psychotherapy of a broadly psychodynamic nature. Important and interesting as these inquiries would be they are beyond the scope of this study.

This study is primarily interested in investigating the use of the framework of psychotherapy in psychodynamically oriented psychotherapy in the context of a psychiatric hospital. Other forms of psychotherapy are not directly and specifically examined in this study although some of the assumptions and practices of other modes of therapy might be indirectly called into question by the communicative approach to psychotherapy and by the findings of this study. Psychodynamically oriented psychotherapy is seen as being on a continuum with psychodynamically oriented supportive therapy (Rockland, 1989; Dewald, 1994; Kernberg, 1984; Conte, 1994) and is broadly defined, for the purposes of this study as involving a 'talking cure', with the recognition of the curative value of the attainment of insight on the part of the patient primarily through the interpretive activity of the therapist, and a recognition of the importance of the unconscious and the importance of the relationship between the therapist and patient.

Finally the research has, as a broad purpose, the hope of pointing the way towards changing, where necessary and at the instigation of the patients' specific unconscious commentary, some of the broad institutional customs that would seem to be definitely impacting negatively on the therapy space, to those which are more appropriate for the practice of psychotherapy. At the same time it is hoped that, at the end of the study, some illumination will have been cast on the real practical problems of how to minimise the effects of those institutional framework violations which prove to be immutable in the hospital context.

Langs divides the framework into the fixed and fluid components (see section 3.4 and section 5.3 below). While the main focus of the study is on the fixed frame as it operates in this institutional context, it is impossible to separate this out from the more fluid framework of therapy which has more to do with therapist technique. Aspects of therapist technique will thus also be examined in this study.

1.1 THE LANGSIAN COMMUNICATIVE¹ PARADIGM

There are five broad areas where Langs's communicative approach is of fundamental importance to practitioners of psychoanalytic psychotherapy. Firstly he brings a relentless focus on the interactional elements of psychotherapy and a preoccupation with the bipersonal field (Langs, 1976) that constitutes psychotherapy. Associated with this is his methodical system for the understanding of unconscious, derivative communications and his concern with a rigorous approach to the unconscious validation of interventions. Finally Langs provides a sharp focus on the patient's unconscious as a valid supervisor of the therapist. Underlying all of this however, is his persistent emphasis on the ground rules of therapy and the importance of the framework of psychotherapy.

The single most important concept in the communicative psychotherapy conceptual edifice is a bold and radical assumption that Langs makes. All of the other aspects of Langs's

¹ Smith (1991a) traces the history of this term. Langs initially called his paradigm the interactional approach, which later became the interactional/adaptational approach and finally the communicative approach. (p124). Subsequently Langs (1993) has begun to use the term 'empowered psychotherapy' to describe his approach to teaching self processing.

methodology rest on the foundations of this assumption and in fact are built up and tested by the very working of this postulate. This proposition is best expressed in his own words. Langs (1984) states:

Once a patient enters psychotherapy, the interventions of the therapist are the most powerful stimuli for both the emergence of symptomatic responses in the patient and the conscious and unconscious communications that illuminate the meanings and functions of these symptoms (expressions of madness). On this basis, it is possible clinically to sort out a basic listening-formulating process that leads to the development of valid interventions - efforts by the therapist that are confirmed indirectly and unconsciously by the patient. (ibid. p4)

How can Langs make such a bold proposition; one that undermines the complacent assumption of generations of psychoanalysts that they are providing a calm neutrality that enables their patients to disentangle the intrapsychic web that ensnares them in their symptoms and entangles them in their past? Smith (1991a) explains this eloquently by drawing upon the less emphasised Freudian notions of screen memories and unconscious perception, claiming that Freud himself had a glimmer of the truth about interactional process but drew back from the brink of this discovery for narcissistic and defensive reasons. Langs maintains that particular memories are recalled in the session in a particular way and the patient unconsciously chooses to narrate particular incidents that ostensibly relate to outside events and situations, as a result of the patient's unconscious responses to issues that are coming to the fore in the 'here and now' of the therapeutic interaction. It is held that these issues pertain to the analyst and to the realities of the analyst's interactions with the patient and they are not to be dismissed as transference distortions but on the contrary are primarily to be seen as accurate, unconscious, perceptions on the part of the patient of what is occurring in the therapy space (ibid.).

Langs's assumption is also an echo of and reworking of the Kleinian² conceptualisation of transference as a much broader entity than Freud's concept. Klein (1952), elaborating on the differences between her idea of transference and that of Freud asserts:

My conception of transference as rooted in the earliest stages of development and in the deep layers of the unconscious is much wider and entails a technique by which from the whole material presented the *unconscious elements* of the transference are deduced. For

² Langs (1978a) acknowledges the interactional nature of the Kleinian approach and its inspirational effect on him.

instance, reports of patients about their everyday life, relations and activities not only give an insight into the functioning of the ego, but also reveal - if we explore their unconscious content - the defences against the anxieties stirred up in the transference situation. For the patient is bound to deal with conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past. That is to say, he turns away from the analyst as he attempted to turn away from his primal objects; he tries to split the relation to him, keeping him either as a good or as a bad figure; he deflects some of the feelings and attitudes experienced towards the analyst on to other people in his current life, and this is part of 'acting out'. (p209)

Langs has incorporated this complex and subtle idea of transference into his extremely methodical paradigm and like most of the ideas that Langs has assimilated from other theorists it has become simplified and operationalised. Langs offers a systematic and orderly manner of deciphering unconscious ideas and perceptions of patients and a specific method for decoding and understanding the interaction between therapist and patient. Following Freud's terminology Langs refers to these unconscious ideas as derivatives (see section 4.4.5 below).

In the communicative approach there is a very strong commitment to the growth of the therapist throughout the course of the therapy. Psychotherapy is seen as an interaction that affects both parties. The patient acts as an unconscious supervisor to any therapist who is sensitive to what the patient has to say unconsciously about the therapy and the therapist. The importance of this fact was acknowledged by Winnicott (1971) who dedicated his book to all his patients who had paid to teach him and the point is also elegantly made by Casement (1985, 1990) who has shown a preoccupation with learning from the patient in his two texts on psychotherapy, but in the communicative paradigm it has been raised to a level of great prominence. In communicative therapy there is mutual growth although the growth of the therapist is seen as a by product and is not the purpose of therapy. This aspect lends a very strong ethical element to communicative therapy. Clearly it is very hard to act unethically in therapy if the therapist is taking seriously what the patient has to say about the process of therapy and if the growth of the therapist is an important concomitant of therapy.

Running through the work of Langs is a very strong belief in the wisdom of the patient's unconscious and the accompanying ability of the patient to restore his or her equilibrium and become integrated if the right framework conditions are provided in therapy. This basically

humanistic assumption requires a non interfering approach to therapy and the therapist has to be constantly alert to his or her countertransferential input into the therapy. This is where the concept of the framework is an important foundation stone. In this approach it is important to provide as rigorously neutral a setting as possible in order to be minimally intrusive into the patients unconscious productions. As Langs (1978d) puts it, the framework separates the therapy from the rest of the patient's reality and facilitates the development and analysis of the transference illusion in that it ensures minimum gratification of the transference wishes. The therapist is strictly neutral and adopts a stance of attempting to understand the patient's unconscious desires which might be manifested in specific requests regarding the framework. Thus the therapist seeks to understand rather than gratify the request by acceding to it (see section 7.6.2 below). According to Langs the secure frame offers the patients a container into which their psychopathology can be placed for analytic modification. The security of the framework is also for the benefit of the therapist in that it reduces the *expression* of countertransference while at the same time providing the optimal backdrop for the analysis of this countertransference or for the therapist's self analysis.

Is there any scope for the insights and ideas of Robert Langs in the modern psychiatric institution with its increasingly medical and biological (Zabow, 1995) approach to psychiatry? This question posed in a previous paper (Rees, 1995a) is even more relevant at this point in the history of the provision of psychiatric services in South Africa, with its shrinking health care budget and the problems engendered by diminishing resources and closure of services.

1.2 PREVIOUS RESEARCH IN THE AREA

Communicative psychotherapy traces its origins to psychoanalysis and the generation and transmission of clinical facts is firmly within the psychoanalytic tradition. Consequently the use of anecdotal evidence reported in case vignettes in journal articles is prevalent. Very little by way of empirical studies of the propositions of communicative psychotherapy is available within the public domain.

Cheifetz (1984) studied 40 cases drawn from a number of mental health clinics which did not provide secure therapeutic settings in terms of the ground rules of psychotherapy. Cheifetz

presents data from just two patients "who were the most valuable for the study" (ibid. p246) and discusses their derivative communications in terms of the ground rules relating to fees, relative anonymity, confidentiality and privacy. She concludes that "the data presented in this study seem to support the hypothesis that the setting has an impact on patients' responses to therapy" and presents her general impression of the other approximately 40 patients as having benefited from the improved frame but the details of this improved frame are scanty (ibid. p 246).

Vlosky (1984) describes his efforts at therapy in the challenging environment of the community mental health centre. He describes many framework breaks in this environment and presents material from vignettes of therapy sessions that leads him to conclude that all of the patients "expressed the unconscious need for a secure psychotherapeutic framework" and that all of the patients "responded to breaks in the frame with a sense of disruption and distress" (ibid. p 263). However it is unclear on what basis these conclusions are drawn and whether Vlosky is reporting on data from transcripts of tape recorded sessions of therapy or on process notes drawn from memory.

Hoag (1992) reports on her study of psychotherapy in a general practice clinic in the United Kingdom. She collected data, from her own therapy sessions, on the number of failed appointments, the number of early terminations from therapy, and the number of sessions per patient, and reported improvements in these measures after implementing steps to generally tighten up the framework conditions in this general practice setting.

Quinn (1994, 1995) attempted to test a core concept of communicative psychoanalysis, namely that patients' material contains disguised references to the implications of their therapists' interventions. In order to test this concept he studied two aspects of the ground rules of psychotherapy namely therapist self revelations and confrontations as they occurred in therapy with two patients seen by three analysts of different orientations. Using the cross correlation function he tested the idea that therapist self revelations and confrontations were followed by specific patient themes and found limited support for this idea but conceded that results suggest that self revelations and confrontations have predictable implications for at least some patients.

The paucity of studies along the lines of those carried out by Hoag (1992) and Quinn (1994; 1995) is puzzling in view of the number of clear propositions discernible in Langs's work (see Langs, 1982, 1988). Much of the confirmatory, theory testing, and theory building work in the field of communicative psychotherapy takes the form of anecdotal reports in journals (see Anisfeld, 1984; Bonac, 1993, 1995; Dorpat, 1984a; Quinn, 1989, 1992; Troise & Quinn, 1991; Weil, 1984). The current study is an attempt at examining some of Langs's propositions and predictions using a more rigorous methodology than that encountered in these previously mentioned studies.

1.3 OVERVIEW OF THE STRUCTURE OF THE THESIS

The literature and the debate around unconscious perception will be reviewed in Chapter 2. In contrast to this idea of the patient's veridical, if unconscious, perception of the therapist are two other related and equally important concepts which are examined in dialectical relation to unconscious perception. These are, firstly, the question of transference and specifically its relationship to unconscious perception and secondly, the issue of the validity of the trauma theory of neurosis and the whole question of the importance of actual past events reported in the therapy room. Both of these two areas have, in the past, engendered lively debate, and are still today areas of lively contention in the field of psychoanalysis and psychoanalytic psychotherapy.

The question of the framework of psychotherapy will be addressed in Chapter 3 and the development of the ground rules of psychotherapy traced to their origins in the writings of Freud. Langs's ground rules will be contrasted with the tactics and techniques of supportive therapy and with modern psychoanalytic ground rules and techniques. Recent critiques of the framework of therapy will be reviewed in this chapter.

There is an injunction, attributed to Einstein, that holds that if one wishes to find out about the methods used by theoretical physicists then one has to study what those physicists *do* rather than what they *say* they do.³ This is no less true for Freud and for other psychoanalysts than it is for physicists. Freud's practise of psychoanalysis, as evidenced by accounts of

³ Quoted in Lothane (1985).

people who were in analysis with him is punctuated by startling breaks in the frame (Haynal, 1988; Lipton, 1977; Mogliano, 1987; Thompson, 1994). In addition Spence (1987) makes the point that the study of cases in psychoanalysis and psychotherapy, even Freud's cases, is not necessarily to be in touch with what is actually happening in the therapy room. The problem of 'narrative smoothing' (Spence, 1987, 1988) becomes apparent in this regard in that the cases are for the most part not verbatim accounts of what occurs in the therapy room. Transcripts of audio tapes of sessions of therapy are considered to be important to eliminate as far as possible sources of bias in the transcribing from memory, by therapists, of their sessions of therapy (Aveline, 1992; Smith, 1993b). Chapter 4 will address methodological issues in the study and the questions around validity generally within the intra-clinical situation as well as in the methodology of this particular study.

Chapter 5 will delineate the results of the first part of the study. The state of the framework of psychotherapy generally in this particular hospital context will be set out in this chapter. Institutional factors impacting on the ground rules will be examined and discussed. This will lead on to Chapter 6 which sets out the individual patients' responses to the framework conditions prevailing in each session of psychotherapy and provides an account of each particular ground rule across all of the sessions. These results are discussed in Chapter 7 which examines the breaks in the ground rules across the individual sessions of therapy and provides an account of the patients' responses to the framework conditions prevailing in the hospital context and, in addition, discusses the results in terms of some of the issues raised in the previous chapters.

Finally, in Chapter 8 the limitations of the research are discussed along with ideas for future research. In addition the study proposes certain ways that the institution can improve the framework conditions as they operate in and impact on the psychotherapy space in the hospital context and proposes ways of minimising the institutional impact on the individual psychotherapy conducted in the hospital context.

1.4 NOTE ON TERMS USED

Over the years Langs has developed his own large and unique lexicon which has become so removed from the terminology of psychoanalysis, let alone the language of everyday use that

he has felt compelled to include an extensive glossary of terms as an appendix to most of his books. Throughout this thesis, simple, everyday language will be used as far as possible but it is not possible to avoid the intermittent use of psychoanalytic terminology. In addition, in view of the fact that one of the aims of this dissertation is to broadly assess the contribution of Langs and communicative psychotherapy generally, in a hospital context, it will be necessary to use his terminology occasionally and it will be assumed that the reader is familiar with his lexicon. However certain specific concepts that Langs uses in his analysis of sessions and that are used in the analysis of sessions in this study are defined and clarified in section 4.4.6 below.

Throughout this dissertation the terms psychoanalyst, analyst, psychotherapist, and therapist will be used interchangeably as will the terms psychoanalysis, analysis, psychotherapy, and therapy. Similarly the terms patient and analysand will be used interchangeably. Use of the terms in any context will be determined by the prevailing usage, either in the body of literature under discussion or in the specific psychotherapy sessions under discussion. This convention follows Langs's usage and does not imply that there are no differences between psychoanalysis and psychotherapy but simply that, for the purposes of exposition of the points made in this dissertation, the two fields of endeavour are similar in character and the issues raised in the dissertation apply to both. More will be said about aspects of the tensions between psychotherapy and psychoanalysis in section 3.4 below.

CHAPTER 2

THEORETICAL UNDERPINNINGS

Three complex and extensively debated areas in psychology and psychotherapy are briefly reviewed and discussed in this chapter. The question of unconscious perception is reviewed in its own right in section 2.1 and is then contrasted with the concept of transference in section 2.2. The dialectic between psychic trauma and material trauma is reviewed in section 2.3 as a contrast to the concept of iatrogenic trauma or trauma in the therapy room which is at the heart of the Langsian communicative paradigm. This review is of necessity somewhat selective in that only those aspects of the literature and debate that relate more or less directly to the question of the communicative approach to understanding patients' responses to the framework will be dealt with.

2.1 UNCONSCIOUS PERCEPTION

Langs's (1982, 1988) communicative system of psychotherapy is based on the decoding or deciphering of unconscious ideas or derivatives. For Langs the derivative messages are always in response to a trigger and they are practically always constituted as narratives or images. They have three levels of meaning, the manifest content, the implications and the encoded or unconscious meaning. Thus Langs's method of decoding unconscious perceptions and ideas is based on important assumptions about the patient's capacity for veridical unconscious perception. But Langs does not really do justice to this important idea that underlies his methodology and one must turn to an excellent commentary by Smith (1991a) for elucidation.

Based on Freud's (1915b) topographical model, and following Langs (1982, 1988), Smith (1991a) divides the human mind into two basic systems, the conscious system and the deep unconscious system. Smith maintains that the deep unconscious system is specifically adapted to understanding intersubjective reality. He argues that:

It is able to understand emotional reality more completely and with much greater facility than the conscious system. Realizations which are available to the conscious system only after lengthy and laborious processes of reflection (if at all) occur to the deep unconscious system after only seconds, or perhaps milliseconds, of processing. The deep unconscious system is able to make bewilderingly rapid and highly accurate inferences about the unconscious motives, defenses, and implications of peoples'

behavior. According to communicative theory, then, each of us carries within us a brilliant psychoanalytic intelligence, and each of us is, unconsciously, a natural psychoanalyst. (ibid. p134)

Smith (1991a) advances the concept of 'unconscious perception' as a theory that has been discarded by Freud and revived by Langs as a backdrop for the Langsian methodology. Unconscious perception has been elevated by Smith (ibid.) to a position of accuracy above *conscious* perception which, as Freud amongst others has demonstrated, is subject to all sorts of distortions. Smith (1991a) also contends that:

...the theory of unconscious perception emerges as a truly formidable idea capable of resolving contradictions within Freudian theory, establishing powerful experimental support for psychoanalytic hypotheses, refuting philosophical objections to the theory of the unconscious mind, and drawing together diverse strands within the broad spectrum of psychoanalytic thought. (p69)

This position, with its implications of the wisdom of the unconscious has echoes in Jungian psychology (Bradway, 1985; Stein, 1985). Bradway (ibid.) remarks that "Analysts learn, in fact when we are patients ourselves, that the seeds of healing lie in the unconscious." (p282). It is an issue that has been picked up on by Langs in his later work geared towards teaching his methods to groups of students in a classroom context (Langs, 1993) and in his later exploration of science and evolution (Langs, 1995). Smith (1991a) accuses Freud of neglecting this concept of unconscious perception and of not systematically using it in his opus. However, it is not entirely clear why the axioms that apply to *conscious* perception shouldn't apply to *unconscious* perception and why the distortions that are inherent in our ordinary conscious perception are not also in operation with the unconscious variety and consequently why the veracity of unconscious perception is taken for granted by Smith. Langs himself, in his earlier work takes a more reserved view of unconscious perception, recognising its potential for distortion. Langs (1978d) comments:

The patient's unconscious perceptions may be utilized by the analyst as a means of checking out his own contributions to the bipersonal field and especially as a basis for the detection of unconscious countertransference-based inputs. However, it must be kept in mind that the *patient processes these unconscious perceptions in accordance with his own intrapsychic conflicts and needs*; ultimately they thereby become intermixed with distorted components. Further, the patient may communicate *unconscious misperceptions* whose presence can be determined only when the therapist has a very thorough knowledge of himself and the total bipersonal field. Technically, the distinction between unconscious fantasies and unconscious perceptive

communications from the patient is based on the recognition of the adaptive context of his communications, and on the sorting out of the manifest and especially latent content of his associations. (p316, italics added)

Thus Langs is clearly aware of the possibility for distortions in unconscious perception but is willing to attempt to untangle these distortions using his systematic methodology for understanding the patient's productions in therapy.

Langs's use of the concept of unconscious perception has an elegance and utility that helps to explain the neo-Kleinian concept of counter transference as a way of being in touch with the unconscious of the patient.¹ The therapist is unconsciously in tune with, or accurately perceiving, the unconscious of the patient and can use this information for understanding the patient in therapy. Langs takes this idea further in that he offers an operationalised method for understanding the patient's productions in therapy.

The theory of unconscious or subliminal perception has engendered a great deal of activity in experimental psychology (Debner & Jacoby, 1994; Dixon, 1971, 1981; Marcel, 1983a, 1983b; Silverman, 1983) with many elegant laboratory studies flowing from the curious, and seemingly paradoxical proposition that one can perceive something without being aware of perceiving it. As is generally the case in psychology this research activity has not been without its share of controversy (Dixon, 1971; Erdelyi, 1985; Greenwald, 1992; Holender, 1986; Loftus and Klinger, 1992) and there have been reports in the literature calling into question aspects of the methodology used to demonstrate it (Holender, 1986; Merikle, 1982; Purcel, Stewart & Stanovich, 1983).

The minutiae of the debate within experimental psychology around the methodology, conceptualisation, and theorising of the issues in unconscious perception and other unconscious cognitive phenomena, while interesting in itself, is exceedingly detailed and complex and need not unduly concern us here. Suffice to say that the terms of the debate have shifted considerably over the years and have resulted in something of a paradigm shift

¹ Meacci (1992) believes that the neo-Kleinian revision of countertransference, which seems to have yielded such a fruitful debate in the psychoanalytic literature, has played a large part in the gradual abandonment of faithfulness to the patient's *text* in psychoanalysis.

within psychology (Greenwald, 1992) with even such critical commentators as Holender (1986) for example, cautiously declaring:

I, of course share the position of most modern cognitive psychologists that much of the processing of a clearly visible stimulus (strictly speaking, a stimulus that is going to become clearly visible through processing) is unconscious and that the processing of many of its aspects, including semantic aspects, precedes awareness of the subset of aspects that do become consciously represented. (p57)

Kline (1988) on the other hand, questions the trivial nature of the questions researched by experimental psychology as a result of its over emphasis on the 'scientific method'. While lamenting the lack of value to the real world that most of the research in experimental psychology displays, one of the few areas that Kline (ibid.) praises as being relevant outside of academia, is the work done broadly in the realm of unconscious perception.

Smith (1991a) remarks that while the studies on unconscious perception appear to offer impressive corroboration of Freud's ideas about the unconscious mind they are in fact an embarrassment because the hypothesis of unconscious perception is incompatible with Freud's insistence on the link between perception and consciousness. Smith (ibid.) concurs with Erdelyi (1985) who proposes that the Freudian model of the mind be expanded to encompass unconscious perceptual processes. Erdelyi (ibid.) proposes that perception be neutral with respect to consciousness. That is to say, that perception can be both conscious and unconscious and can enter the system unconscious without first having to enter consciousness.

Smith (1991a) contends that there are several passages in Freud's published work which suggest a theory of direct unconscious perception, even though this might have contradicted other components of his theory. He reminds us that Freud often expressed views that contradicted other parts of his theory and that these contradictions created tensions which remain unresolved to this day.

One of the tensions that Smith (ibid.) draws attention to is that the proposal of an adaptive, perceptive, unconscious component of the psyche is at odds with the bulk of Freud's theorising about the nature of the unconscious as being a seething cauldron of hallucinatory,

wish fulfilment, having no regard to reality. Curiously, Smith's (1991a) reading of this aspect of Freud's theory is at odds with the understanding of the Freudian unconscious by some of the more prominent American cognitive theorists who have made this paradigm shift into the recognition of unconscious cognitive processes (see Greenwald, 1992; Loftus & Klinger, 1992)². Greenwald (1992) comments that the current view of the *analytic simplicity* of unconscious cognition deviates from the psychoanalytic theories which informed research prior to the 1980's and hence the new view can be construed as constituting the (third) 'New Look' at unconscious processing.

Smith (1991a) contends that the type of perception likely to be handled by the unconscious is an interpersonal one of some emotional significance. This is in line with an intuitive understanding of the reasons for certain things being unconscious and is in harmony with psychoanalytic theory dating back to Freud's early work (Freud, 1915b). Smith (ibid.) following Marr (1982) maintains that the unconscious mind is selectively sensitive to emotionally charged perceptions. The demonstration of the inability of subjects in laboratories to unconsciously analyse sentences and other more complex semantic material (Greenwald, 1992; Holender, 1986) is hardly a refutation of the complexity of unconscious material, giving some substance to Kline's (1988) lament about the trivia of much of the laboratory work in experimental psychology.

It is not entirely clear why the concept of unconscious perception has to be invoked at all by the communicative psychotherapists. One can postulate that perception occurs, consciously, but very rapidly and part of the perception is then banished to the unconscious in a split second, leaving no conscious trace of itself, thus, for all intents and purposes, acting like an unconscious perception in terms of the communicative methodology. This is in accord with the concept of 'iconic storage', which Erdelyi (1985) defines as "a fleeting photographic form of memory, which everyone possesses, that, unlike later stage memories (short-term memory, long-term memory), loses its rich information content within a small fraction of a second" (p

² Loftus and Klinger's (1992) cursory understanding of the complexities of the Freudian unconscious is reduced to the somewhat simplistic question "Is the unconscious smart or dumb?", a title of an editorial article in the *American Psychologist*. Loftus and Klinger (1992) have it that "Freud, for one believed in the 'smart' view of the unconscious" (p761). In this superficial reading of Freud they equate "smart" with "complex", "flexible" and "doing what is best for us" (p761).

118), and appears to be in line with the more cautious critique of some of the methodological problems inherent in much of the research on unconscious perception (see Greenwald, 1992; Holender, 1986). Smith (1991a) himself makes the observation that "perceptions of the analyst can, of course, be obtained through the conscious mind and then used by the unconscious mind," (p63) but then he goes on to contend, somewhat polemically:

....but because the latter is assumed to be ruled by irrational energies the perceptions will be used for gratification rather than knowledge. The unconscious mental system is seen as a sort of psychological black hole that swallows up everything that comes within its sphere of influence. Everything that the unconscious touches, so the theory goes, is subverted to its own hedonistic and blindly repetitive aims. (p63)

Dorpat and Miller (1994) provide some much needed clarity on the subject when they remind us that the term unconscious perception is used in two ways. Firstly the term perception is used in its literal sense in a similar way to how the term is used in conscious perception; secondly it is used in a metaphoric way when used to describe what is happening in interpersonal interactions, but it is really taken to mean an unconscious processing of the interaction or an unconscious 'meaning analysis'. So the issue is less about perception as such and more about meaning analysis and judgement (Dorpat and Miller, 1994, 1992). Thus, much of what Smith (1991a) and Langs (1982, 1988) and the communicative analysts call unconscious perception can really be described as unconscious judgement and unconscious meaning analysis.

One can invoke the Jungian conception of the wisdom of the unconscious (Bradway, 1985) here in order to get around this difficulty, rather than becoming entangled in the debate around methodological issues in experimental psychology. And indeed, one can also invoke a passage from Freud himself which Smith (1991a) quotes which is a forerunner to this idea of the wisdom of the unconscious. Freud (1915b) states:

It is a very remarkable thing that the Ucs. of one human being can react upon that of another, without passing through the Cs. This deserves closer investigation, especially with a view to finding out whether preconscious activity can be excluded as playing a part in it; but descriptively speaking, the fact is incontestable. (p194)

Smith's (1991a) point, however, is that this idea does not fit into the rest of the Freudian paradigm of the unconscious as being a seething cauldron of primary process thinking. Erdelyi (1985) contends that Freud was hampered by a lack of suitable material to use in an analogous way to adequately describe the workings of the mind. According to Erdelyi, if Freud had available the analogy of a computer or of information processing systems generally then his formulation of the workings of perception and the unconscious would have been clearer and less muddled (*ibid.*). But this analogous representation of the mind has itself been overtaken by the 'connectionist' model of Rumelhart & McClelland (1986). Greenwald, (1992) comments that the model posits that the neural network is modified every time it is used, and because of the merger of the functions of memory and perception it overcomes the theoretically most problematic aspect of information processing. The model also goes some way to partially explaining how psychotherapy works in that it would posit the modification of memory every time items are recalled (see section 2.3 below), hence lending credence to Freud's (1914) well known concept of 'working through'.

The phenomenon of unconscious perception is critically bound up with the concept of displacement and to a lesser extent the concepts of condensation and symbolisation. Langs (1982) maintains that critical images, such as framework violations on the part of the therapist, are transformed into derivative material by the patient through primary process mechanisms, chiefly displacement but also condensation and symbolic representation. The concept of displacement is prominently associated with Freud's (1900) understanding of dreams, and as a factor involved in the defence mechanisms (Neubauer, 1994). Freud (1900) observes that the actual form assumed by any particular dream can be ascribed to the activities of displacement and condensation as the two factors that bring about the distortion of the 'dream-wish' as a defensive manoeuvre. Freud contends that:

The consequence of the displacement is that the dream-content no longer resembles the core of the dream-thoughts and that the dream gives no more than a distortion of the dream-wish which exists in the unconscious. (*ibid.* p417)

Laplanche & Pontalis (1980) declare that the phenomenon of displacement, although prominent in the analysis of dreams is also observable in a general way in every unconscious formation. They describe displacement as:

The fact that an idea's emphasis, interest or intensity is liable to be detached from it and to pass on to other ideas, which were originally of little intensity but which are related to the first idea by a chain of associations. (ibid. p121)

For Laplanche and Pontalis displacement is part then of every unconscious formation. Langs takes the concept of the unconscious to its logical conclusion and maintains that it is in operation, and can be observed in operation, at all times. By seeing through the manifest content of the patient's productions into the latent content that underlies them, and by using his specific method of decoding this material (see section 4.4.5) Langs contends that he opens up the understanding of the unconscious interactional material in a systematic manner. This transformation of these critical images into derivatives in the form of manifest content is additionally coloured by the patient's own "unconscious fantasy memory constellations" (ibid. p46), adding a complication to the process of decoding and deciphering the derivative material. The importance of this mechanism of displacement is emphasised by Langs who asserts that the presence of displacement is presumed to be in operation at all times, to the extent that Langs regards that even manifest references to the therapist are displacements from some other "unconscious raw message" (ibid. p104). This issue is further discussed in section 7.4.2 insofar as it applies to the question of transference.

2.2 UNCONSCIOUS PERCEPTION AND TRANSFERENCE

The concept of unconscious perception is at the core of the communicative approach to psychotherapy. It is one of the most important philosophical underpinnings of the communicative approach and Smith (1991a) recognises this and marshals much evidence in support of this concept. However, apart from marshalling evidence in support of the concept, Smith (ibid.) sets it up in opposition to the concept of transference which is one of the central concepts of psychoanalysis (Greenson, 1974; Laplanche and Pontalis, 1980; Person, Hagelin and Fonagy, 1993). Person (1993) asserts that the concept of transference is at the very heart of psychoanalysis.

Far from being viewed as an impediment, the development of the transference and its analysis are now viewed as the very heart of the psychoanalytic process. Transference analysis appears to have replaced dream analysis as the "royal road" to the unconscious. (ibid. p5)

Smith (1991a) commenting with approval on Langs's (1988) ostensible discarding of the concept of transference and its replacement with the term 'unconscious perceptual selectivity' remarks that:

If the communicative approach cannot fill this theoretical gap left by the departure of transference it will emerge as an impoverished 'here and now' psychology that cannot encompass the developmental dimension or offer convincing causal explanations of psychopathology. (p159)

The question is, has communicative psychoanalysis managed to fill the gap left by Langs's (1988) jettisoning of the concept of transference? The question would appear to be moot because it is apparent that Langs very shortly thereafter readopted the term in his work on teaching self processing. Langs (1993) claims that:

While a student's inner mental life and history is a strong factor in the selection of meanings he or she attributes to an intervention by an instructor, the real and actual implications of the instructor's behaviour also play a forceful role in what the student works over and must cope with - and communicate about. (p85)

Thus Langs would appear to be retrieving the concept once again, if it was ever in fact completely disposed of, in the earlier work (Langs, 1988). Langs (1982) in an earlier, more rigorous work does not reject the notion of transference although he questions the usefulness of the idea of a dual, real and transference relationship, between patient and therapist. Langs unequivocally emphasises the importance of understanding the patient's behaviour in the session as being primarily related to the behaviour of the therapist, that is to the relevant aspects of the frame. He regards the patient's productions in therapy as a disguised commentary on the actions of the therapist in the session. Once these accurate unconscious perceptions of the patient have been understood in terms of the deviations to the secure frame, and any framework deviations rectified, then, and only then can one attempt to understand the unconscious fantasy, or transference aspect of the patient's behaviour and productions in the therapy sessions (ibid.).

Consistent with his approach to the importance of the unconscious, and in contrast to common usage among psychoanalysts, Langs (1982) is doubtful about the value of the *manifest* fantasies involving the therapist and *direct, conscious* allusions to the therapist as

carriers of transference fantasies. Langs states that these more conscious fantasies would appear to be serving a more obvious defensive function in the therapy rather than providing any illumination on the patient's earlier relationships. In keeping with his views on unconscious perception Langs emphasises that transference can emerge only when the therapist's interventions do not justify the maladaptive response from the patient. In other words, before one can decode the transference one has to decode the patient's commentary on the therapeutic situation, specifically the state of the frame. But Langs concedes the genetic and developmental component of transference when he states that:

An *unconscious* fantasy and experience of a pathogenic nature in a relationship with an early childhood figure is at the heart of transference. This constellation is then attached to the therapist, and therefore pathologically influences the patient's perceptions of and reactions to the therapist. (ibid. p532)

Langs (1982) summarises his position by stating that patients should be understood as having a relationship to the therapist that comprises non-transference and transference elements. All of the patient's communications to the therapist have implications for the relationship at some level. The non-transference component involves reactions to the therapist that are based on veridical conscious and unconscious perceptions and these have to be analysed and understood in the light of the therapist's interventions before the residual unconscious distortions and fantasies that comprise the transference can be appraised.

Langs (ibid.) recognises two types of transference which he terms on the one hand the classical or displacement transference and on the other hand the interactional transference. In the case of classical transference, as would be expected, some aspect of a relationship with an earlier genetic figure is displaced onto the therapist. However the peculiar accent that Langs places onto this well worn psychoanalytic concept is evident when he states that these efforts on the part of the patient do not arise *de nova* from within the patient but instead always constitute maladaptive responses to the therapist's attitudes and interventions. But in this case it is the secure frame (see Chapter 3) that the patient is responding to with maladaptive responses.

There appears to be some confusion in the case of interactional transference because here Langs argues that, while this form of transference also arises within a sound therapeutic

context and evokes pathological interactional efforts directed towards the therapist that derive from earlier relationships and have a genetic dimension, the therapist must examine the 'activated intervention contexts at hand' to determine whether the patient's pathological projective identifications are in fact in response to pathological projective identifications emanating from the therapist and hence are non-transference phenomena, or if they arise primarily from patients' pathological unconscious fantasies prompted by their inner needs and hence are transference phenomena. This appears to be something of a logical, category mistake in the sense that Langs is calling interactional transference a form of transference, in the first place because it arises within a *sound* therapeutic context, but yet could be non-transference if it arises in response to the therapist's projective identification or interactional pressures, which would surely be an *unsound* therapeutic context. The answer to this apparent confusion would appear to be that Langs recognises that a therapeutic framework can never be completely secure and free from the therapist's countertransferential inputs not matter how well maintained the ground rules of therapy are. The therapist is obliged to continually monitor the bipersonal field, with the help of the patient's productions in therapy, for his or her own inappropriate inputs, thus using the patient as a type of internal supervisor.

Langs (1982) concludes by stating that:

The goal in therapy is to provide the patient with as few opportunities as possible for nontransference expression, and to maximize his or her transference-based communications. In actual therapeutic experience, under optimal conditions, these emerge for interpretation at selected moments in light of sound intervention contexts. Much of the balance of the therapeutic experience involves the patient's benefit from the therapist's capacity for secure holding and containing, and from the interpretive efforts that involve the patient's non-transference based responses to the therapist's countertransference-based interventions. (p545)

This conclusion from Langs could well serve as a summary of his approach to the technique of therapy at that point in the development of his theory. While it serves to underline the importance of patients' non-transference responses based on their veridical unconscious perceptions of the therapist, it also unequivocally makes explicit his view on the value of the concept of transference.

While unconscious perception (Smith, 1991a), or unconscious meaning analysis (Dorpat and Miller, 1994) is an important philosophical underpinning of the communicative approach, it is not necessarily in direct opposition to the concept of transference. There is no intrinsic reason why the two concepts cannot coexist and be equally useful, as explanatory theories, to practitioners. This issue is put into perspective in a later article by Smith (1993a) who draws the distinction between the clinically observable phenomena that has been labelled transference by psychoanalysts and the hypothetical explanation that Freud advanced for certain phenomena and that has been labelled transference. Smith (ibid.) concludes in this paper that the question of the concept of transference has perhaps not been settled but that the communicative approach has reopened and enriched the debate. A slightly polemical tone is adopted by Smith (1991a, 1993a) on this issue in order to emphasise the veridical perception of the deep unconscious system of the patient as opposed to other psychoanalytic approaches which tend to see the patient's unconscious productions as distortions of the reality of the therapy situation.

The danger with the rejection of the concept of transference and other notions of developmental or genetic antecedents to the patient's symptomatology and productions in therapy, as Smith (1991a) has observed, is that it leaves the communicative paradigm without an adequate perspective on developmental psychopathology and narrows it down to a rather impoverished 'here and now psychology'. Troise (1992) summarises the problem neatly:

The fact of the matter is that neither a psychoanalytic model of the mind nor a science for psychoanalysis can be totally comprehensive without an understanding of how contemporary cognition and behaviour is influenced by early developmental memories stored only in the unconscious mind. (ibid. p110)

Langs's (1988) system allows for a foray into typology, when he admits to some differential between people in the way they communicate in therapy, but he does not extend this into a developmental theory or explain how patients come to communicate as they do. Langs's penchant for inelegant neologisms is evident in this classification system. He divides people into three categories. Firstly there are the 'nontransformers', who only rarely report from the deep unconscious system using transformed or encoded associations. Secondly there are the 'nonderivative narrators', or 'narrative producing nontransformers' who communicate extended narratives and dream reports that do not organise as derivative perceptions in light

of the prevailing adaptive contexts.³ Finally there are those who do transform material into the encoded references to the adaptive contexts and they are, of course, known as 'transformers' (ibid. p28).

Langs (1988) opens the way to his specific version of transference when he comments that the derivatives are reactions to the triggers, or adaptive contexts, or interventions by the therapist, that are strongly shaped by the intrapsychic factor. In other words the derivative is a mixture of what the patient brings to the perception as well as the event that is perceived. Smith (1992) feels that the problem is solved, not by invoking the, in his view, dubious and thoroughly discredited notion of transference, but rather by positing a connectionist model of the mind which he sets out in some detail in an earlier paper (Smith, 1991b).

Bonac (1995) proposes that while transference might well exist as an intrapsychic phenomenon that the patient 'brings', as it were, to the therapy, transference is observable only in relation to what the therapist does and hence only in relation to the therapeutic frame. At first sight this appears to be avoiding the issue. This slight fuzziness about the concept is cleared up somewhat when Bonac (ibid.) discusses her ideas regarding the frame impingements and frame deviations that children experience in their past, often at the hands of their parents, which can be contrary to the child's needs. But here Bonac is using the concept of the frame outside of its strict intended use within the communicative paradigm and contrary to her own definition of the concept of the frame in an earlier paper (Bonac, 1993) in which the definition of the frame is confined to the ground rules of the psychotherapeutic interaction. It is questionable whether such a broader use of the frame is of value and whether it does not simply serve to cloud the issue. Some of this confusion is evident when Bonac (1995) states that patients come to therapy in order "to have their reactions to the breaks in the frame explained to them" (p67). This really appears to be

³ There is no thought here that they might be organising around other material apart from Langs's very specific triggers or adaptive contexts. Langs has it that experiences outside of psychotherapy are of secondary importance and they seldom evoke transformed or derivative communications. He contends that whatever their power, these experiences are "...rarely the most significant factor in the vicissitudes of the patient's madness. As already noted, this power falls to the interventions of the therapist." (ibid. p25) This is a proposition that can be observed in the material from patients at Lentegeur and is explored in this thesis.

turning the reasons for coming to therapy upside down, but Bonac concedes that patients also come to therapy to gain understanding of their own initiating of pathological relating. However Bonac (ibid.) has "...come to believe that the understanding of their own pathological functioning may actually be the patient's primary therapeutic need" (p67).

Bonac (1997, personal communication) attempts to synthesise the concepts of unconscious perception and transference by building on her observations of the well documented phenomenon of 'secure frame anxiety' (Langs, 1982, 1988). She links transference to the acting out that patients demonstrate in the presence of a secure frame and surmises that it must be a result of prior, unintegrated, developmental experiences. She defines transference in these terms as "the claustrophobic response to the securing of the analytic frame, when the frame-breaking triggers by the parents in the patient's past, drive the patient's own frame-breaking indicators of the therapeutic relationship in the present" (ibid.). This conception goes some way to rescuing communicative psychotherapy theory from the twin difficulties of having no adequate conception of developmental psychopathology (Troise, 1992; Smith, 1991a) and the incongruous concept of 'secure frame anxiety' and the difficulties that certain types of patients have with dealing with the secure frame generally (Langs, 1982, 1988). This point is further discussed in section 7.6.2 below.

2.3 ACTUAL TRAUMA, PSYCHIC TRAUMA AND TRAUMA IN THE THERAPY ROOM

Do Langs's assumptions not deny the importance of the realities of the patient's past and indeed the miseries of the present of many patients? The work of Alice Miller (1981, 1983, 1984) ranged explicitly as it is against Freud's drive theory and against his abandonment of the seduction theory⁴ would seem, at first glance to provide much evidence against Langs's postulates.

In 1917 Freud wrote about his discovery that fantasies possess psychical reality as opposed to material reality and that the psychical reality of these fantasies is as real as the material

⁴ This theory is expounded in *The Aetiology of Hysteria* (Freud, 1896). Miller (1984) on the other hand deliberately avoids use of this term, preferring the term "trauma theory" because, as she correctly asserts, there are also non sexual traumas that play a role in the genesis of neurosis. However, in addition, she is concerned that the term "seduction" implies that the child is a "mature sexual partner" (ibid. p41).

reality in its influence on symptom production (Freud, 1917). The implications of this discovery made in the context of the aftermath of his treatment of hysterical patients led Freud to abandon his theory of seduction as a prime factor in the aetiology of these patients and caused him to focus instead on the subjective experiences and unconscious fantasies of his patients. The concept of psychic reality can be said to have given rise to the whole psychoanalytic edifice, for if it is psychic reality that requires explication, explanation or interpretation then psychoanalysis or its equivalent has to provide the tools for the task.

The implications of the discovery of psychic reality continue to this day to be a source of controversy and debate (Crews, 1996; Davies, 1996; Masson, 1984; Miller, 1984; Mitchell, 1996). Mitchell (1996) remarks that the controversy over memories of childhood sexual seduction is the longest running controversy in the history of psychoanalysis. Some of the issues in this debate have a direct bearing on this dissertation in that patients who attend psychiatric hospitals tend not only to be more disturbed than other kinds of patients but they also tend to have experienced more instances of actual traumatic events in their lives than people who consult private practitioners. This would appear to be a self evident fact., a truism and I bring no specific epidemiological evidence, or references to support it apart from its inherent self evidence.

Caper (1994) observes that Freud's seduction theory appears to be enjoying a resurgence. Also undergoing a resurgence, is the number of reported cases of child sexual and physical abuse (Davies, 1996). The link between these two phenomena is suggested by the recent prominent court cases in the United States brought by patients claiming to have discovered, with the help of their therapists, and sometimes under hypnosis, that they had been sexually molested, seduced, or otherwise physically abused, in childhood, by their parents.⁵ Davies (1996) points out, perhaps somewhat optimistically in view of the furore described by Pope (1996) and Crews (1996), that the terms of the debate around recovered memories in therapy have changed in that the relevant question has moved from one of "who is right?" to one of, "articulating a clinical-theoretical context for evaluating the meaning of sexual abuse memories that do arise for the first time in the course of intensive psychoanalytic treatment" (ibid. p194).

⁵ For a review of this issue as well as the subsequent 'false memory syndrome epidemic' see Pope (1996) and Harris (1996).

Davies (1996) struggles to reconcile her seemingly contradictory belief in the 'primary pathogenicity' of sexual abuse and other trauma, and her belief in the constructivist nature of the psychoanalytic process. She reminds us that most of the literature on dealing with actual trauma in the therapy room points to the necessity of validating the patient's belief in the occurrence of the events but she contends that this is not enough. She points out the interactional nature of these productions in therapy and points to their transference and countertransference re-enactments in the therapy dyad, with both therapist and patient adopting ever changing roles of abuser and abused over the course of the therapy. In line with this formulation Davies (ibid.) warns of the dangers of a *prominent* focus on the part of the therapist, on sexual abuse in therapy, as being, not only the possibility of an encouragement of 'false memory syndromes' but also, more insidiously, the danger of imposing the therapist's reality on the patient and thus re-enacting aspects of the earlier abuse.

Brenneis (1996) on the other hand adopts an either-or approach to the question of the meaning of the patient's productions in therapy, specifically those concerning sexual abuse. He concedes the value of the interactional meaning of the patient's productions, as being transference related but contends that this interactional understanding has to be independent of an understanding that validates the actual events in the patient's past. He argues that patients who report earlier sexual abuse are either reporting past trauma or they are commenting on the therapist's forceful and abusive interventions, but not both.

Criticism of Freud's abandonment of the seduction theory comes in a variety of forms, ranging from a polemical attack on Freud and psychoanalysis by Masson (1984) through the more carefully reasoned approach of the Swiss psychoanalyst Alice Miller (1983, 1984) to the almost fraternal, revisionist approach of some American psychoanalysts such as Rangell (1981, 1995).

Masson's (1984) account of Freud's abandonment of the seduction theory delves more into Freud's hesitations and lack of immediate conviction as to the correctness of his view; a lack

of confidence that the psychoanalytic hierarchy was not particularly anxious to share with the public at large. Masson (1984) simplifies Freud's position somewhat when he asserts that:

Freud is saying that whether seduction actually took place or was only a fantasy does not matter. What matters for Freud are the psychological effects and these effects, Freud states, are not different where the event is a real one or imagined. But in actuality there is an essential difference between the effects of an act that took place and one that was imagined. (ibid. p133)

It is apparent that Masson is using the term 'fantasy' in a restricted sense, more restricted than that envisaged by Freud, as a kind of day dream. Clearly there is the world of difference between attacks that take place and those that are fantasised in the sense that it is used by Masson. Most therapists would be only too aware of the difference in stance that has to be adopted towards patients who have recently suffered real trauma (Davies, 1996; Dewald, 1994; Harris, 1996; van der Kolk, 1987) and even Langs (1982, 1988) recognises that there is a place for counselling as opposed to psychotherapy. Masson (1984), with a lack of appreciation of the nuances of memory, unconscious phantasy, screen memories, deferred action and the concept of overdetermination of symptoms, continues boldly:

A real memory demands some form of validation from the outside world - denial of those memories by others can lead to a break with reality and a psychosis. The lack of interest in a person's store of personal memories does violence to the integrity of that person. (ibid. p133)

Alice Miller (1984) adopts a more restrained approach in her critique and makes a reasoned plea for an open minded, non dogmatic approach to the laboratory that is the therapy room. She asserts that:

If, instead of interpreting new material in its uniqueness, analysts are taught during their training to regard it not as something new but as corroboration of theories that claim to be eternal, they will learn to ignore the far-reaching potentialities psychoanalysis has for bringing the truth to light before they even perceive what these potentialities are. (ibid. p5)

Miller (1984) is quite clear about her position as regards the aetiology of neurosis and she makes her point with a clarity and lack of ambiguity. She believes that society has suppressed trauma as the source of neurosis and she contends that Freud was quite wrong to move away from his trauma theory. For Miller:

The healing process begins when the once absent, repressed reactions to traumatization (such as anxiety, rage, despair, dismay, pain, grief) can be articulated in analysis; then the symptoms, whose function it had been to express the unconscious trauma in a disguised, alienated language incomprehensible both to patient and to those around him, disappear. (ibid. p53)

Miller reiterates that it is the repression of the painful trauma and the unwillingness to experience the pain associated with trauma that leads to neurosis. She believes that somehow therapists and patients collude to spare the parents and this is what results in repression although she concedes that no theoretical formulation of this insight yet exists (ibid. p211).

Miller's arguments against the drive theory and against Freud's abandonment of the seduction hypothesis is the result of her belief that the drive theory denies the pervasive reality of various kinds of child abuse that she regards as widespread in our culture. Miller (1981) asserts:

The drive theory, then, entails denial of reality, insensitivity to childhood suffering, refusal to give credence to the patient's grievances - which ultimately means refusal to take him or her seriously - and, above all, misunderstanding and denial of the roots of neurosis. As I have already emphasized more than once, it is my belief that these roots lie in the enforced repression not of the child's so-called instinctual drives but of his or her awareness of having been traumatized and in the prohibition against articulating this, which was internalized at a very early age. Freudian drive theory reinforces this prohibition to the fullest because it is still caught up in the system of assigning blame and thinks parents must be protected from their children's recriminations. (p216)

It would be an intriguing exercise to reinterpret Miller's case material using communicative methodology. With all of this, apparently genetic, material surfacing in her sessions, according to Langs's theory of veridical unconscious perception communicated by patients in the form of derivative material, there must be many frame violations which are unconsciously perceived as cruel, abusive seductions by her patients and which are disguised as derivative material relating to prior seductions. On a more earnest note however, Miller's work, although it has a proselytising feel to it and is flawed in some respects as will be illustrated below, does exemplify a possible point of criticism of the communicative methodology, in that patients, by the very fact of being patients, are more likely to bring

material that is loaded with negative imagery. Therapists, by the very fact of being human, are liable to make mistakes in the area of the framework and around the ground rules of therapy, and, if they work in a hospital context, these ground rule breaks are likely to occur more often (see chapter 5). The coexistence of these two phenomena could lead to premature conclusions regarding their causal relatedness, or indeed even their thematic relatedness.

While most therapists, including Langs (1982, 1988) would not contest the point that patients who have been recently severely traumatised do not make good candidates for the more passive approach of psychoanalysis (Dewald, 1994), theorists like Masson (1984) and Miller (1983, 1984) seem to be making too sharp a distinction between internal and external, between a real memory and a fantasy memory, between psychical reality and material reality and they thereby reduce psychoanalysis to a form of sociology. Without the concept of psychic reality there is no psychoanalysis, only a documentation of a patient's social history and a supportive therapeutic environment to encourage the abreaction to the traumatic parts of that social history.

Caper (1994) contends that contact with one's psychic reality is in fact contact with one's relationship to the external world. In other words it is contact with our reaction to these events that one experiences and not the events themselves. Caper reminds us that this is, in effect, the opposite of the idea that psychoanalysis is useful to make us more aware of repressed *external* events. Using psychoanalysis to become aware of repressed external events, Caper contends, is simply a modern version of Freud's pre-psychoanalytic seduction theory.

After Freud's discovery of psychic reality the next major advance in our understanding of the concept, according to Caper (*ibid.*), came with Melanie Klein's discovery of the internal object and her elaboration of the concept of unconscious fantasy. Isaacs (1948) has extended Klein's work in this area and emphasises the inter-relatedness of perception and knowledge on the one hand and phantasy on the other hand. Isaacs recognises the impossibility of separating the external and internal events. Hayman (1989) gives some indication of the controversy that these ideas caused in psychoanalytic circles, despite the assertion on the part

of the Kleinians that they were merely extending and elaborating on the work of Freud. For Hinshelwood (1989) the whole thrust of Klein's work and that of her collaborators has been to show how unconscious phantasy permeates and gives meaning to *external* events.

Brennan (1988), in an article examining the importance of the 'controversial discussions'⁶ for contemporary feminist debate, points out that psychical reality is denied and loses its importance for psychoanalysis if a direct correspondence between psychical life and social reality is insisted on, as is the case with much contemporary feminist criticism of psychoanalysis. Basing her critique on the work of Lacan she emphasises the need to distinguish the 'symbolic' from the 'imaginary' and argues that many analysts rely on too sharp a distinction between internal and external reality in order to explain subjectivity. She contends that the feminist arguments (and by implication arguments by writers like Masson, 1984 and to a lesser extent Miller, 1984) neglect the significance of phantasy and at the same time the inevitability of 'desire' in shaping psychical life. She gives an instructive example and it is worth quoting her extensively here.

For instance, phantasies of a depriving or cruel mother begin to figure not because the child is (necessarily) deprived in fact, but because it feels deprived through the nature of its own desire. It is easier to find someone to blame than to accept an unpleasant, inevitable verity: namely, the lack or loss at the base of all desire. Putting this another way: the child wants everything, and where it senses lack it invents reasons as to why that lack is there. These 'reasons' are phantasies. They are defined as such because in whole or part their relation to reality is distorted, although (I repeat) reality is present, and figures in the child's understanding of what is going on. The thing is, it does so through the lens of the child's own interpretation. (ibid. p266)

This approach is echoed by Rangell (1981, 1995) who believes that behind every psycho neurosis there is a traumatic neurosis but his formulation is more nuanced than that of Masson (1984) and more heavily bound up with drive theory than that of Miller (1984). Rangell (1981) emphasises the vital and generally overlooked role of anxiety in the genesis of neurosis as well as character disorder. He contends that: "The psychoanalytic process is a recapitulation of the patient's history of developmental anxieties. The task for each patient is a reconstruction of the nature and composition of his individual 'traumatic state' " (ibid.

⁶ This refers to the series of meetings of the British psychoanalytic society held in 1943 intended to deal with the problems arising from the differences between Anna Freud and Melanie Klein (see Brennan, 1988).

p123). Rangell (1981) believes that all of his patient's need to develop insight into their original traumatic state. He argues that the anxieties that resulted from this original trauma frequently become disguised and are transformed into behaviours and he maintains that all anxieties can be distilled down into two basic anxieties, namely castration and separation. Rangell (1995), discussing Freud's discovery of psychic reality, emphasises the dialectical nature of psychic reality and external reality and puts the point succinctly:

The discovery of a new reality did not exclude or diminish the reality previously known. It is a truism to say that man is influenced by his external world and shapes it as well. (ibid. p15)

Part of the thinking that goes with an emphasis on material reality is the adoption of a more sympathetic and understanding attitude to the accounts that patients bring regarding their traumatic backgrounds. Rangell (1995), in line with his conception of the fusion of internal and external reality, maintains that the 'analytic attitude' is supportive while being understanding and he asserts that "empathy resides properly and naturally within the standard analytic theory and technique" (ibid. p17).

Kirshner (1994) remarks that the increasing attention paid to psychic trauma warrants an overdue appreciation of the merits of Ferenczi's contribution to psychoanalysis. Kirshner attempts to link aspects of the theories of Klein, Winnicott, Lacan, Ferenczi and Freud around this nodal point of psychic trauma and proposes that this link revolves around the perception of trauma as the loss of the 'good object'. He redefines the 'good object' in Lacan's terms as "a function of symbolic representation of the human world of cultural meanings and value" (ibid. p236) and argues that:

...what is fundamentally at stake across the theories of trauma of Ferenczi, Klein, Winnicott and Lacan (and the list could easily be expanded) is the constant threat of destruction or loss of 'the good object' and that the therapeutic efficacy of psychoanalysis is, therefore, closely connected with its function of maintaining or restoring this symbolic object. (ibid. p236)

Kirshner suggests that part of the clinical approach to dealing with this trauma is the approach advocated by Ferenczi who actively attempted to become the good object for his traumatised patients. Kirshner steps back from the brink of actually advocating the active methods of Ferenczi in the treatment of trauma and instead supports the technical approach

advocated by Stone (1981) which operates safely within the ego psychological model (see section 3.2 below).

Schimek (1975) speculates on some of the reasons, both personal and conceptual that caused Freud to embrace and then abandon the theory of infantile trauma in the aetiology of neurosis, including the death of his own father and deep aspects of his own conflicts following this event that were uncovered in self-analysis. McGrath (1986) concurs with Freud's ostensible personal motives, speculates about additional political motives, and reminds us that the existence of personal or political motives for the advancement of a theory or hypothesis does not automatically detract from its scientific usefulness or validity.

Schimek (1975) makes the interesting point that Freud did not give up his belief in the universality and aetiological importance of childhood sexual experiences when he gave up the seduction theory but "...on the contrary, he saw the need to base this universal factor on a firmer foundation than variable accidental events" (p848) and hence Freud's positing of the Oedipal complex as a universal childhood phenomenon.

Schimek also discusses Freud's little known and little appreciated exposition of the concepts of phylogenetically inherited schemata, which he expounds at the end of the celebrated Wolf Man case (Freud, 1918) and which act like the Kantian categories (see Körner, 1977) in helping to organise experience. He points out that this concept of schemata is very close to contemporary structuralist thought but that they (schemata) are not fixed and rigid but are themselves remodelled by experience. These schemata help shape the child's experience of and interpretation of interactions with the world. Schimek contends that:

In its core content, psychical reality is created by such schemata, which makes use of whatever material accidental individual experience provides (for instance, the observation of animal copulation can provide material for the primal scene fantasy...or...the reality of a mother's bodily care of the infant can play the same role in relation to the primal fantasy of seduction by the father). Unlike unconscious wishes, which acquire their contents from memories of actual events and their cathexes from actual experiences of satisfaction, these inherited schemata are not derived from individual experiences nor is their determining influence in shaping basic wishes and motive accounted for by the process of drive discharge. (ibid. p856)

Freud's archaeology metaphor and his need to ground his interpretations in a core of recovered objective truth is explored by Schimek (*ibid.*). It has almost become a cliché to cite Freud's immersion in the empirical philosophy of science ideology of the age (see Chapter 4 below) and his ensuing need to ground interpretations in the factual reality of the past, but Schimek also questions the validity and necessity of Freud's reducing interpretations to an objectified causal process. He argues that it is based on a tacit assumption about the relation of thoughts to external reality, an assumption which he contends is part of an old epistemological tradition that is at the heart of nineteenth century associationism and modern behaviourism. In this tradition the contents of the unconscious are grounded in the passive registration of external events. Schimek wants to liberate Freud and psychoanalysis from the constraints of associationism and a restricted model of causal explanation and he posits that *psychic reality* is the 'primary common matrix' that gives meaning, not only to memories (as postulated by Freud) but also to everyday experience. He reminds us that perception is not a passive registration, but is influenced by schemata, motives, and past experiences all of which he lumps under the broad rubric of 'psychic reality'. There are also obvious similarities between Schimek's use of the concept of 'psychic reality' and certain aspects of the Kleinian concept of unconscious phantasy as elaborated by Isaacs (1948). Wallerstein's (1992) lament about the lack of dialogue between various schools of thought in psychoanalysis would seem to be justified in this case.

Schimek stresses that the dichotomy between factual reality and fantasy is a fruitless one and leads to hopeless dead ends. Staying with the theme of childhood seduction he reminds us that the original 'reality' of a childhood seduction could be some kind of interaction which was experienced and reacted to as a seduction even though it did not necessarily meet some objective *adult* criteria of a seduction. Schimek remarks that even though this formulation accords with the spirit of Freud's concept of psychic reality is difficult to fit it into his conceptual framework. It is evident that the contemporary psychoanalytic position as postulated by Schimek is much more open to the possibility of the occurrence of childhood trauma and would thus be more easily defended against the criticism levelled against Freud that, when he abandoned the seduction theory by focusing on the intricacies of psychic reality, he abandoned also the traumatised and abused child (Masson, 1984; Miller, 1983, 1984).

A postulate that lies at the heart of psychoanalysis, namely that the remote past remains essentially preserved in the present and consequently can act as an immediate causal agent in the present, is brought into question by Schimek (1975) who refers to it as an example of the 'genetic fallacy'. He laments the fact that "psychoanalytic interpretations and constructions do not aim at creating something new but try to bring out the past living in the buried depths of the present, as a kind of archaeology" (p861). The main thrust of Schimek's argument, anticipating some of the later work of Spence (1982, 1987, 1994) and others in the field of the narrative tradition in psychoanalysis, is that the reconstructions and interpretations in psychotherapy relate to present phenomena not past events. The particular emphasis that Schimek brings to the debate is that the transformational process of interpretations impacts on future events through a realignment of *current* relationships and meanings, not past events. The validity of an interpretation is a psychical one and its effectiveness is judged, not in terms of its approximation to past events, but in terms of its impact on the patient's psychical reality, from which Schimek wants to exorcise the ghosts of the past.

However, for most analysts a patient's psychical reality is inextricably bound up with past events. Malcolm (1988) supports the view that the past is alive in the present and that the analyst, by analysing the transference is analysing an amalgam of past and present simultaneously. By working with the transference the therapist is dealing with early conflicts which can only be fully comprehended and worked out when actually lived through with the analyst in the present. She puts the position succinctly:

The patient, by repeating with us again and again his problems with his internal objects, portrays in the analysis the way that his relationship with those objects evolved. The interpretations mobilize defences which correspond to the old defences used in infancy and childhood. The understanding of those defences is formulated in new interpretations. Those interpretations form the actual reconstruction. It is only here that the patient understands his own past and his relation to his real external objects. (p87)

Current conceptualisations by memory researchers and theorists (Bonanno, 1990; Pope, 1996; Rose, 1992) are in accord with the position that the remote past is not a static entity but is constantly being reshaped and recreated by the present, lending some credence to the wry slogan "It's never too late to have had a happy childhood". Hence Rose (1992) contends:

Thus brains do not work with *information* in the computer sense, but with *meaning*. And meaning is a historically and developmentally shaped process, expressed by individuals in interaction with their natural and social environment. Indeed, one of the problems of studying memory is precisely that it is a dialectical phenomenon. Because each time we remember, we in some sense do work on and transform our memories; they are not simply being called up from store and, once consulted, replaced unmodified. Our memories are recreated each time we remember. (p9, italics in original)

The influence of the past on the present and the present on the past is not a simple matter of linear causality. Lacan has drawn attention to the concept of deferred action whereby events are reinterpreted and gain a new meaning in the light of later developments (Laplanche and Pontalis, 1980). The concept arose out of Freud's seduction hypothesis and the quintessential example is the idea of a traumatic event such as a seduction having a delayed pathogenic effect at a later developmental stage, say puberty, when the original traumatic event could be more fully assimilated into a meaningful context. However, the concept has wider implications for the understanding of pathogenesis and indeed for the whole idea of the workings of both consciousness and recall of remote memory and hence, for psychotherapy. Laplanche and Pontalis (1980) comment on the wider implications:

Seen from another angle, the idea of deferred action may also suggest a conception of temporality which was brought to the fore by philosophers and later adopted by the various tendencies of existential psychoanalysis: consciousness constitutes its own past, constantly subjecting its meaning to revision in conformity with its 'project'. (p112)

Laplanche and Pontalis (ibid.) concede that the Freudian conception of deferred action is much more precise and they contend that it is not simply *any* lived experience in general that undergoes a deferred revision, but only those experiences that were impossible to assimilate or incorporate into a meaningful context. Deferred action involves a complex reworking and reinterpretation culminating in a new understanding and hence has cognitive and conceptual components and cannot simply be subsumed under the general concept of abreaction.

This concept of temporality is taken up by Romanyshyn (1988) who, following Merleau-Ponty (1962), describes the reciprocal nature of meaning and intention between the past and the present and puts the position succinctly when he states:

In short, one's past changes in relation to the present from which one re-members the past and in light of a future which one now intends. The childhood I recall now at 40 or so is not the same childhood I remembered in my 20's. Moreover, it serves us ill here to retreat into the formula that the meaning of the past changes but not the past itself, for what is the past for any individual except that which one is in relation to? (ibid. p42)

This has obvious implications for depth psychotherapy and specifically for the process of reconstructing and working through. The problem then is *not* how can we reshape and recreate our memories, indeed, following Rose (1992), how can we *fail* to, but rather, how can we reshape our memories in the *desired* way. Rangell (1981) points to the dangers consequent to engaging in a solitary regurgitation of past traumatic and anxiety laden memories. The unchecked workings of the repetition compulsion results, not in mastery of the traumatic events, but in an escalation of traumatic memories going around in vicious circles and resulting in an ascending spiral of cumulative trauma "more voluminous and intense than the original dose" (p134). Rangell is at pains to point out that this is not a cumulative *external* trauma but a steady accumulating accretion from within (ibid.).

Here the question of the relationship to the therapist enters prominently into the equation. The transference, the working alliance, the working relationship, the holding relationship and the framework of psychotherapy are paramount for any reshaping that takes place; a reality that has been apparent to practitioners since almost the beginning of psychoanalysis. Blum (1982) claims that all interpretation involves transference because there is a transference dimension to all analytic process and without transference there can be no acceptance of interpretation.

For most analysts the most efficient way to access past events, conflicts and current relationship difficulties is through the 'here and now' of the transference. Kernberg (1994) summarises the position thus:

The most general formulation of change derived from transference interpretation is that an enactment in the transference is transformed into a subjective experience that reflects a growing understanding, on the patient's part, of that enactment. (p1194)

Schimek (1975) concludes that Freud's rationale and explanation for the process of interpretations are no longer adequate. He objects to the views that psychic reality and

factual reality are dichotomous and that the past exists as a static entity, either psychic or factual, in some inner space and is energised by blind forces, waiting to be reconstructed or discovered in therapy. He outlines an alternative approach that bears a similarity to the later work of Spence (1982) and proposes that a modified version of Freud's 'inherited schemata', suitably altered to take account of current conceptualisations of the flexibility of remote memory and emphasising the importance of later experience in transforming previous schemata, would be a more appropriate model. Insight through interpretation then is the process of the creation of new schemata through the analytic interaction. The new schemata remodel the data of experience, including the experience of the past. How these new schemata are actually constructed in the process of the therapeutic interaction is not something that Schimek deals with in this paper, but this is really the crux of the matter. How are these schemata built up in the mind of the patient and how do they take on the force of schemata? What gives ordinary concepts the organising power of schemata? This question is really at the heart of the matter of how psychoanalysis cures. Schimek proposes "study of the process of interpretation itself, of the kinds of rules, logic, and transformation processes that the analyst uses in finding hidden meanings and constructing new connections" (p863). This is precisely where Langs's work becomes important, Langs having devoted the greater part of his working life to the study of precisely these issues.

Schimek's conceptualisations clear the way for the entry of some of Langs's more fruitful ideas about psychoanalysis. Schimek cuts adrift the baggage of the past in the *treatment* of the individual and yet recognises its importance for the development of psychopathology, leaving the way clear for the composition of interpretations that are built up around the patient's current experience within the therapy and the framework of therapy. Thus Langs's understanding of what patients are talking about in therapy and his explanation of this to patients in the form of his unique communicative, interactional, interpretations is given some epistemological support by this line of thinking. Crucial, however to the composition of these interpretations is Langs's concept of the framework of therapy and this will be dealt with more fully in the following chapter.

CHAPTER 3

THE FRAMEWORK OF PSYCHOTHERAPY

One of the most important and enduring ideas in Langs's communicative theory is the concept of the framework of psychotherapy. Langs has taken the original recommendations from the early work of Freud (1911, 1912a, 1912b, 1913, 1914, 1915a) and turned them into a specific set of rules governing the relationship between therapist and patient. The framework is important for containing the patient and giving expression to the verbal productions of the patient as well as helping the therapist understand the patient's productions without providing a source of contamination of those productions. Langs (1982) declares that:

The setting, ground rules, and boundaries of the therapeutic relationship are among the most critical and yet most neglected aspects of psychotherapy. Shaped implicitly and explicitly by the therapist, with active or passive participation by the patient, this particular dimension of the therapeutic experience proves to be fundamental to virtually every other aspect of treatment. The shaping and maintenance of a framework for the transactions of therapy proves to be the single most important determinant of the background or core relationship established between the patient and therapist. This backdrop critically determines the nature of the foreground exchanges between the two participants to treatment, both in regard to form and meaning, as well as providing the means by which they will be handled. (p303)

Smith (1991a) following Langs (1982, 1988) points out that a secure frame offers the patient a profound sense of being held and contained, providing a sense of basic trust, clear interpersonal boundaries which create appropriate intimacy and distance, unconscious support for the patient's reality testing capabilities and the foundations for a healthy therapeutic symbiosis. The secure frame presents the possibility of a cure that will involve insight, and in addition it offers an unconscious image and introject of a sane therapist with a sound identity and an inner state of healthy narcissistic balances. The framework is the backdrop to everything else that occurs in therapy; it is the container within which therapy can take place. One of the most important aspect of the frame is that it provides the patient with the protected psychological space wherein therapy can occur. Smith (1991a) makes this point forcibly when he says:

When the therapist structures the frame according to the deep unconscious requirements of patients, an extremely powerful, creative therapeutic atmosphere is established. Such an environment encourages most patients to bring their deepest unconscious fears and concerns to the light of day and to form strongly constructive introjects of the therapist. (p173)

Smith (ibid.) goes on to explain that a thorough knowledge of the components of the secure frame as well as their specific properties is vital for therapists. Langs's concept of the framework is the one concept that has not undergone any significant modification in his lifelong work in the field. It is the one consistent component and Langs (1982) remarks that it has been backed by the close examination of patients' material and this has consistently shown the importance of the secure frame.

There is an appealing similarity between the concept of the frame as a container for the patient (and at times, although in a slightly different way, also the therapist) and the Jungian concept, taken from alchemy, of the *vas bene clausum*, the well sealed vessel (McCurdy, 1985; Newman, 1981; Siegelman, 1990) which has therapy as a kind of crucible wherein therapist and patient merge together for the purpose of change. This Jungian idea has at its centre the requirement that there be no leaks from the 'pressure cooker' therapy situation, as any leaks would dissipate the power and effectiveness of the therapy.

It is not possible to generalise about a Jungian approach to the ground rules of psychotherapy in that there are almost as many approaches to this question as there are Jungians (McCurdy, 1985). Zinkin (1969) comments that Jungians seem to concern themselves less with issues of technique than any other group of therapists. Samuels (1985) reminds us of the difficulty in generalising about 'Jungians' in that various groupings of Jungian analysts place different emphases on various aspects of Jung's ideas. It would seem that there is a great deal of difference between different Jungian analysts in their relation to the technical ground rules of psychotherapy.

Jung himself advocated a position of flexibility on the part of the analyst when it came to the question of technique (Samuels, 1985). McCurdy (1985) maintains that Jung did not give precise directives about how analysts should structure the setting or their work with patients and that Jung's analysis might be described as "nontechnical, with its emphasis on the

personal equation and on the analyst being in analysis as much as the patient" (ibid. p51). Perhaps this wide diversity of approaches amongst latter day Jungians to the issue of ground rules of therapy is a consequence of Jung's original attitude to the technical rules of analysis. McCurdy gives some indication of the degree of flexibility of the broadly Jungian position when he states:

Other technical issues, such as the contract, payment, vacations, personal revelations from the analyst, and whether the patient should sit or lie, must be thought through and resolved, but always in context. The analyst's realities are an integral part of this context and, if consciously faced, can be made an effective part of the therapeutic structure. (ibid. p63)

McCurdy goes on to elaborate that the 'analyst's realities' might include the psychological functioning or even neurosis of the analyst and this must not be hidden or avoided by the analyst but should be brought into play and used by the analyst in the therapeutic situation without the analyst symbolically 'bleeding' on the patient. It seems clear from the above that there is a great deal of latitude tolerated by Jungian analysts in the therapy space.

The vast differences between analysts on the different ends of the spectrum as it relates to the technical ground rules of psychotherapy can be illustrated by the example of Goodheart (quoted in McCurdy, 1985), on the one hand, who advocates a position similar to that of Langs on the need to maintain the framework of therapy as an important symbolic container for the patient, and Hillman (1975, 1983) on the other hand who acknowledges the importance of the ritual of the therapy to lend a solemnity to the therapy discourse but who tolerates a degree of flexibility in the setting of analysis. The issues around the importance of rigidity versus flexibility of the therapist's application of ground rules of therapy are more fully discussed in section 7.6.2 below.

Despite the Jungian concept of the *vas bene clausum*, which relates particularly to the requirement that there be no 'leakage' from the therapy container and would seem to apply specifically to the ground rule requiring a one to one relationship with privacy and confidentiality, Jungian analysts appear to be less concerned with the technical ground rules of therapy. Langs on the other hand has taken the concept of therapy as a container to its

logical conclusion and operationalised a set of ground rules which specifically make up the framework of psychotherapy and these will be examined in section 3.4 below.

Langs (1982) emphasises that the framework of psychotherapy is made up of ground rules which set off the therapeutic and analytic relationship from other relationships. These ground rules pertain to three broad areas namely the physical setting of the therapy, the relationship between the therapist and patient, and the treatment methodology. For Langs (*ibid.*) the totality of these ground rules makes up the framework of therapy and psychoanalysis and for Langs there are no differences in ground rules for psychotherapy and psychoanalysis. This is a controversial claim and one that seems to go against intuition, common sense, and the accepted wisdom of many theorists. But Langs argues that the similarities between psychoanalysis and psychotherapy are many and consequential and it is more important to distinguish types of therapies on the basis of other properties. These other characteristics could apply equally to psychoanalysis or psychotherapy and they involve chiefly the type of listening undertaken by the analyst or therapist. The crucial characteristics are, for Langs, the types of listening implied by 'manifest content' listening, 'type one derivative' listening and 'type two derivative' listening. Essentially type two listening takes into account the input from the therapist into the patient's productions. Formulations are made in terms of the implications of the therapist's interventions or lack of interventions and the patient's material is understood as being in response to these inputs from the therapist. 'Type one listening' on the other hand disregards the implications of the therapists interventions or else does not accord them specific importance in the understanding of patient's material but focuses specifically on the so-called genetics and dynamics of patient's material. Thus supportive therapy and counselling would involve manifest content listening. For Langs, conventional psychoanalysis with its emphasis on intrapsychic factors would mostly involve 'type one listening' whereas interactional psychotherapy and psychoanalysis would generally embrace the 'type two listening'.

This blurring of distinctions between psychoanalysis and psychotherapy is perhaps one of the more controversial points that Langs makes, although there certainly appears to be merit in Langs's arguments emphasising the importance of the methodical and systematic examination of the *interactional* element in psychotherapy and psychoanalysis. Other theorists tend to

accept the orthodox wisdom inherent in the recognition of the conventional differences between psychoanalysis and psychotherapy, chiefly embodied in, and flowing from, the difference in the frequency of sessions between the two modalities. Quinodoz (1992) for example maintains that different settings give rise to different treatments and she implies that there is an important distinction between psychoanalysis and psychotherapy which is based on the specific ground rules of psychoanalysis. She gives the example of the difference in the quality of the interaction and the difference in the aspects of the patient's psychical life which would be revealed by a therapy session lasting for 15 minutes and one which lasts for the full therapeutic hour. This has specific implications for the modifications imposed by, for example Lacan¹, into the time frame of psychotherapy but it is not a convincing example of the assumed difference between psychoanalysis and psychotherapy in that both psychoanalysis and psychotherapy have no difficulty in justifying and utilising a standard therapeutic hour. The specific debate as to the validity of the assumed differences between psychoanalysis and psychotherapy will not be directly addressed in this study but the tensions between the two modalities will receive indirect commentary at various places in section 3.4.

This chapter will be divided into sections dealing firstly with Freud's recommendations to physicians practising psychoanalysis which will be set out in section 3.1. This will be followed by a review and discussion of some of the more current literature dealing with the setting of psychotherapy and psychoanalysis in section 3.2. The literature relating to supportive psychotherapy will be briefly reviewed in section 3.3 as a contrast to Langs's concept of the framework of psychotherapy. Section 3.4 will set out the individual Langsian communicative ground rules of therapy and will compare and contrast these individual ground rules with Freud's original recommendations, the tactics of supportive therapy of Dewald (1994) and Quinodoz's (1992) concept of the setting of psychoanalysis. Other selected commentaries about specific ground rules will be included in the appropriate places in this section. This part of section 3.4 does not propose to be an exhaustive review of the vast literature on all of the aspects of the technique or ground rules of therapy but provides

¹ Lacan's variable length sessions are well documented (see Forrester, 1990; Macey, 1988; Turkle, 1978) but not well explicated in his writings (Forrester, 1990; Macey, 1988). Lacan's (1977) approach to this and other technical issues in psychoanalysis is handled in section 7.6.2.

more of a cross section of some of the issues that are currently being *debated* in the latest psychoanalytic journals. It will be noted that there is a dearth of acceptable clinical and extra clinical *evidence* for many of the positions adopted in this section. This section will be followed by a brief discussion of the implications, according to Langs (1982, 1988), of breaks in the ground rules of therapy in section 3.5 and a brief review of some of the recent critiques of Langs's views on the framework of therapy in section 3.6.

3.1 FREUD'S RECOMMENDATIONS TO PHYSICIANS PRACTISING PSYCHOANALYSIS

As with so many other facets of psychoanalysis and psychoanalytic psychotherapy, Langs's ground rules have their origins in Freud. Despite Freud's extensive writings on psychoanalysis, very little has appeared in Freud's work specifically on technique and purely technical matters. It has been suggested by Freud's editor that this neglect is deliberate for the very important reason that the simple application of technique and technical rules on the part of a novice without a comprehensive understanding of what underlies the rules would be dangerous. Consequently a large part of Freud's papers on technique is addressed to the mechanism of psychoanalysis generally (Freud, 1911, p87).

Freud's recommendations to physicians are an important source of information about his approach, not only to the clinical and technical side of psychoanalysis but also to the 'philosophy of science' aspects of psychoanalysis. It is here that Freud introduces the idea that the analyst should not actively try to remember or record what is being said but, as a counterpart to the fundamental rule of free association (see section 3.4.5), should become attuned to what the patient is saying in a form of free floating attention (see section 3.4.6) and in that way allow what the patient is saying to resonate with ideas in the analyst's mind. Freud maintains that by not actually striving to remember, the analyst will be able to respond to the important parts of the of the patient's material, as they relate to the patient's problems. Thus Freud specifically argues, for technical reasons, against the use of a complete record of the patient's material in the session and for the same reason would have argued against the use of recording devices if they had been available at the time that he wrote and worked. The philosophical and epistemological aspects of these issues are touched on again in Chapter 4.

It is in this section that Freud proposes his well known metaphor of the unconscious of the therapist being attuned with that of the patient in order to reconstruct the unconscious of the latter. The reconstruction of the patient's unconscious, through being attuned to one's own unconscious as a analyst, is at the very heart of psychoanalysis. Technique, although necessary, is not sufficient to carry this out and Freud makes this plain in his articles on technique (Freud, 1912b, 1913, 1914, 1915a).

Freud (1912b) is at pains to point out that his technical rules are gleaned from years of experience with patients but have evolved to suit his personality and he modestly asserts that perhaps other practitioners, "who are differently constituted", might adopt a different attitude to the patient (p111). Freud (1913) also makes clear that his technical rules are recommendations because they are not to be universally or unconditionally adopted as hard and fast decrees to be obeyed at all costs. While Freud (ibid.) opposes any simple mechanisation of the application of technique in psychoanalysis and psychotherapy, he suggests that his recommendations on technique should be followed because they are effective on average. Freud's recommendations will be discussed under each of the ground rules separately.

A substantial portion of Freud's opus is fundamentally concerned with interpretation. The aim of psychoanalysis is to make conscious that which was previously unconscious through the activity of interpretation. Laplanche and Pontalis (1980) maintain that interpretation is the core of psychoanalysis stating that "psychoanalysis itself might be defined in terms of it, as the bringing out of the latent meaning of given material" (p227). Thus for Freud (1913), although the technique has changed from the one employed in an earlier context with hysterical patients, the aim of the therapy remains to fill in gaps in memory (p148) through interpretation. And still later, when Freud's theory and model of the mind have changed from the topographical model to the structural model (Freud, 1923), the aim is to restore the ego, to give it mastery over the id, through reversal of earlier repressions via interpretations made by the analyst.

For Freud it makes no sense to speak of interpretation as one of a set of rules to be followed or indeed as following a specific set of rules. Freud likens psychoanalysis to the game of

chess wherein it is possible to give some rules regarding the opening phase and perhaps the ending phase but the middle game has to be negotiated by the players without the help of guidelines. For Freud interpretation is not a technique so much as it is the body of the work. It is difficult to conceive of interpretation as part of the framework or ground rules of therapy until one remembers that there are two aspects to the meaning of the word (Kelly 1994a). On the one hand it means what the therapist understands by the patient's verbalisations and on the other hand it means what the therapist tells the patient, his verbal activity *vis a vis* the patient and the two meanings do not necessarily always coincide. The second part of the meaning of interpretation has more relevance to the issue of the framework or ground rules of therapy.

An important point to note about Freud's 'recommendations' is that he did not necessarily follow them to the letter himself and there are numerous accounts of very deliberate and obvious breaks in these recommendations on his part. Lipton (1977) discussing the advantages of Freud's technique as demonstrated in his treatment of the Rat Man cites examples of Freud offering him a meal, sending him a postcard, and lending him a book. Lipton argues that these and other actions of Freud formed part of what has become known as the real relationship, rather than part of his actual psychoanalytic technique as such. Lipton differentiates modern technique from classical technique and equates the former with ego psychology. Haynal (1988) presents accounts from Freud's analysands who recall him breaching confidentiality by mentioning material from sessions with other analysands and taking them into the adjoining room, to show them antique objects in order to illustrate a point, directly communicating his own feelings to his patients, giving analysands gifts and money, reducing his fees for certain patients when they were struggling to pay them, making small talk with them, and mentioning personal matters to his analysands (*ibid.* p8). Similarly Mahoney (1993) presents evidence of Freud's interference in the personal lives of some of his analysands during and after their analysis. Ellman (1991) reminds us of how Freud, despite advocating avoidance of dual relationships with patients ended up seeing friends, relatives of friends and even his own daughter for analysis. Thompson (1994), restating the evidence about Freud's clinical deviations from his 'recommendations' cited in Haynal (1988) and Lipton (1977), and lamenting the latter day criticism of Freud, states somewhat polemically:

It's a sad commentary on what psychoanalysis has become when analysts like Freud, who have the courage to be themselves and take risks, are condemned for the very virtues that the "neutered" analyst lacks. (p239)

Mogliano (1987) recounts how some of Freud's patients followed when Freud and his family went on holiday and these patients continued with their sessions in this different setting. Similarly Mogliano recounts numerous instances of Freud's interactions with patients outside of the strictly abstinent framework. Freud was not averse to analysing siblings and married couples, occasionally allowing them to swap sessions. Similarly he received the spouses of one or two of his patients, continued to receive one or two special patients into his home and saw friends and acquaintances in analysis. Mogliano comments that "In respect of the rule of abstinence which he had advised us to observe, Freud also considered himself entirely free" (ibid. p383).

3.2 THE FRAMEWORK OF PSYCHOANALYSIS

This section briefly reviews precursors to Langs's concept of the framework, and similar concepts to the framework from other writers. The terms psychoanalytic setting (Modell, 1976, 1988), situation (Stone, 1981), framework (Langs, 1982, 1988), frame (Milner, 1952, 1987), holding environment (Winnicott, 1956, 1972) or therapy space (Casement, 1985, 1990) can be best described as the formal aspects of relating and the set of arrangements which are constant and unchanging and which are explicitly and implicitly contrived to regulate the interactional behaviour between therapist and patient.

There are two functions of the framework which are dialectically related. Firstly the frame acts as a kind of constraint on action by both parties (Bleger, 1967; Quinodoz, 1992; Spruiell, 1983) and secondly as a kind of protective layer which encloses the separate reality of the therapy from the reality of the everyday external world and allows patients the space and safety to explore their internal and external worlds (Casement, 1985, 1990; Milner, 1987; Modell, 1988; Winnicott, 1956).

For Winnicott (1972) the psychoanalytic setting, which is made up of the totality of the analyst's 'management' and the constants of the relationship between analyst and patient, serves as a psychological 'holding' of the patient which, together with the analyst's empathic

understanding, is an important ingredient in the patient's development and cure. Although Winnicott privileges the role of the analytic setting with patients from the more disturbed end of the spectrum and he advocates a more cautious approach to interpretation, he does not advocate dispensing with interpretation altogether. It is useful to conceptualise the holding and interpretation for Winnicott as being in a dialectical relationship (Rees, 1995b) with the analyst moving from one to the other. Winnicott does not specifically define the analytic setting nor does he go into great detail about the holding relationship but he likens this analytic holding to the maternal holding and he uses this metaphor many times in his work. As with his concept of 'good enough' mothering Winnicott (1956) advocates 'good enough' adaptation to the more disturbed patient's needs in the analytic setting and he acknowledges the impossibility of meeting all of these needs. In this paper Winnicott (1956) introduces two related and crucial ideas in his work. Firstly he maintains that the patient's resistances are more likely than not to be the result of the analyst's mistakes and failures in the setting and they need to be analysed as such. Secondly he argues that it is helpful to conceptualise these failures on the part of the therapist as being devastating for the patient because of the patient's experiences of past failures. Winnicott advocates the use of this conceptualisation in the analysis by allowing the patient to be angry with the analyst (symbolically destroy the analyst) which then leads to the patient's subsequently being able to use the analyst if the analyst has not retaliated to the patient's anger and destructive attacks.

Winnicott does not develop this concept of the setting and the holding relationship to the extent that Langs does and relies more on the containing presence of the therapist to provide this holding relationship rather than a coherent set of rules (Rees, 1995b; Siegelman, 1990). Like Freud, Winnicott provides many instances in his actual analytic work of deviations from the ground rules of therapy (Siegelman, 1990).

Bleger (1967) describes the psychoanalytic frame as an 'institution', or set of constants in the relationship between analyst and patient in which are included the role of the analyst, the set of space and time factors, and parts of the contract regarding fees and interruptions to the analysis. Bleger insightfully observes that these background constants which make up the *frame* are only foregrounded when there is a problem which calls attention to them, for example, as one becomes acutely aware of one's breathing when there is a difficulty with

breathing. Bleger asserts that there are two frames, the frame of the patient and the frame of the analyst and he regards it as important for the latter to remain constant in order to understand and interpret the former. For Bleger, patients do not attack the frame of the analyst so much as project their own frame onto that of the analyst and for Bleger it is this projection that requires understanding and interpretation.

Viderman (1974), in an article arguing for the importance of the 'analytic space', describes Freud's setting out of the technical rules for psychoanalysis as an attempt at organising a perfect analytic situation, akin to an 'ideal' experiment in the natural sciences. Viderman lists and discusses the interdependent rules which go into making up the analytic space and he remarks that these rules are necessary for the "unfolding of an authentic psychoanalytic process" (p470) and without them genuine psychoanalysis cannot occur. This analytic space is, for Viderman, of course, simultaneously in the physical world and an imaginary place in that the space obviously exists in the physical world located within a therapy room circumscribed by four walls, but the analytic space is also circumscribed by the rest of the ground rules and so exists within the mind of the patient as an imagined place of safety. The transference is discussed by Viderman as something that is brought into sharp relief by this analytic space and he describes the importance of both of these concepts, transference and the analytic space, for effective constructions and interpretations. He observes that:

No construction of meaning, especially when it is a question of the earliest unconscious fantasies, can be either accepted by the patient, or be effective if it is not supported by a *force* which is that of the affects of the transference neurosis developed in and by the space in which the analytic process takes place. (ibid. p 478, italics in original)

Vidermann alludes to Freud's difficulties with the analysis of the Rat Man as being due, ironically it would seem in view of Freud's position as the founder of psychoanalysis, to the lack of a properly constituted psychoanalytic space. This is a reference to Freud's well known deviations from the ground rules of psychoanalysis in this case in particular. Viderman leaves open the possibility of the development of iatrogenic symptoms in psychoanalysis when he asserts that it remains to be proved that the analyst has no part in the development of the transference (ibid.).

Modell (1976, 1988) points to the importance of the setting for psychoanalysis. He discusses the holding environment created by the analytic setting as an object relationship and he draws on Winnicott's concept of maternal holding as a metaphor for psychoanalytic holding. He points out the obvious limitations of this metaphor but concedes that there are actual elements in the analyst's technique that are reminiscent of an idealised maternal holding environment. Modell (1976) takes pains to emphasise that, even though the analyst's stance is likened to a maternal holding and there are gratifications which result from this holding environment, the elements of this stance are inherent in classical analytic technique and are not the result of any special activity on the part of the analyst and consequently are not equivalent to supportive therapy.

Modell (1976) makes the interesting point that although the holding environment is brought about by the analyst's technique it may become separated from the analyst and take on a life of its own. He describes the case of a patient nearing termination who dreamed that she was sitting on the floor holding a life sized doll while the analyst sat behind her. The patient identified this doll as the analytic process which she was in danger of losing, illustrating that the analytic process itself, and not just the person of the analyst, is vested with the properties of a transitional object (Winnicott, 1972, 1978).

Modell (1988) observes that many patients test the limit situation of the setting by acting out or attempting to do certain implicitly or explicitly forbidden things in order to disconfirm for themselves certain faulty ideas that they might have had about analysis or analysts in general. These ideas could have been operating at both a conscious or unconscious level. In this way patients establish for themselves boundaries of safety in their relationship to the therapist.

Spruiell (1983) discusses the way that the psychoanalytic situation is spelled out and delimited from other situations. He describes this delimited psychoanalytic situation as being framed, or separated off from other situations, much in the same way that Milner (1952) uses the concept. Spruiell hastens to add that his use of the term in no way implies any similarities with the Langsian use of the word, but despite his protestations, it is difficult to see how this can be the case especially given that his description of the component parts of the frame, where they are spelled out by Spruiell, generally coincide with those of Langs².

Spruiell summarises his description of the purpose of the psychoanalytic frame by saying that it is empirically constructed to facilitate both the recovery of facts and the recovery of illusions (ibid. p17).

Stone describes the psychoanalytic situation mainly from the perspective that it occupies as a unique and dynamic relationship which is made up of various components (Stone, 1981; Langs and Stone, 1980). The components of interest in this review are those brought by the analyst such as the analyst's attitude of anonymity, neutrality and indestructibility. Stone's important contribution to this debate is his advocacy of the classical stance of abstinence and anonymity but tempered by warmth and concern for the patient. Stone (1981) asserts that:

...the classical attitude performs an essential function in the psychoanalytic process. To the extent that it does not become equated with coldness, aloofness, arbitrary withholding, callousness, detachment, ritualization, or panicky adherence to rules for their own sake, it is an integral, indeed central element in the rule of abstinence, without which there is no analysis. (ibid. p100)

Casement (1984, 1985, 1990) takes up the thread of this stance towards the patient within the context of a secure analytic space which he sees as a mental and emotional entity, rather than as something concrete and embodied by strict rules and regulations. Casement, operating from the British independent tradition, brings his special brand of concern for the patient and for the patient's commentary on the therapy and the therapist in the context of this analytic space. Casement (1990) acknowledges the influence of Langs, Winnicott and Bion, amongst other theorists on his thinking and refuses to be confined to one particular theoretical approach to therapy. He acknowledges a lack of theoretical completeness about his "series of statements about clinical issues" (ibid. p15) but makes no apology for this state of affairs, preferring an open minded approach, and an openness to the richness of the clinical setting, to one of theoretical dogmatism. Milton (1993) compares Langs's concept of the frame with that of Casement, notes the many similarities, and concludes that Casement appears to value a more flexible approach to that of Langs when it comes to the maintenance of the frame.

² Raney (1984) believes that Langs's work has largely been ignored out of a narcissistic defensiveness on the part of theorists. He presents work from a range of writers on psychoanalysis which demonstrates a familiarity with the work of Langs but which nevertheless fails to acknowledge this acquaintance.

Casement's (1990) theoretical flexibility comes across in his clinical vignettes and he openly acknowledges the need for this when he remarks:

Different patients need different approaches. Most patients at some time need firmness, to provide containment for states that are chaotic or which threaten to get out of control. But also, many at some time need to feel that they are with an analyst who can offer an exploratory space within which the patient's own individuality and creativity can develop more fully. Analysts therefore need to acquire the capacity to work in different ways at different times. (ibid. p167)

Despite this plea for flexibility there is a strong element of firmness about Casement's understanding of the need for the protection of the analytic space from both internal and external influences. Casement recognises the need for this protection of the analytic space in order to show up in sharp relief, and hence more clearly understand, the influence of the patient's past on the present, through the concept of transference.

Quinodoz (1992) regards it as vital to have regulations with regard to the setting of psychoanalysis if there is to be uniformity regarding the kind of work that is done by psychoanalysts and hence meaningful dialogue between psychoanalysts. She argues that different settings will have varying effects on the process of psychoanalysis.

Quinodoz (1992) enumerates four facets of the psychoanalytic setting, namely the spatial, temporal, financial and refraining aspects. Despite her advocacy of uniformity in the psychoanalytic setting, Quinodoz discusses the setting, not in terms of an authoritarian set of rules and regulations to be slavishly obeyed but rather as an instrument of a container function that is active and alive and which is essential for the analyst to use in his or her interpretative function. While decrying a rigidity about implementing these rules and advocating that analysts be aware of their own unconscious aggression in rigidly applying them, she nevertheless emphasises that it is important for the analyst to understand the latent meaning of the patient's objections to the setting and their demands for changes to the setting. Quinodoz emphasises that if the analyst fails to pick up the latent meaning of the patient's demand and gives way to it, this will have allowed the patient to strip her of the container which would have produced the results for the good of the patient, in the analysis. Quinodoz (1992) contends that:

....the analyst's concern for the analytical setting shows the patient, even before there has been any interpretation, that the analyst will not allow himself to be castrated and that he regards his container as alive and essential to any creation. (ibid. p633)

Quinodoz emphasises that the setting is not simply a juxtaposition of rules but is an active container which interacts dynamically with the process of the analysis. Consequently requests for the modification of these rules can be used to understand not only the attacks on the creative container function of the therapist but also that of the creative container function of the *patient*. Thus to the extent that the patient succeeds in an attack on the setting, without it being understood and interpreted by the therapist, so, to that extent, is the therapist undermined and also at the same time, to that extent is the patient's understanding of himself or herself impoverished (ibid.).

3.3 ANTITHESIS TO THE FRAMEWORK: THE SUPPORTIVE APPROACH TO THERAPY

Part of the pressure on Langsian communicative therapy in a hospital context is the institutionalised use of supportive therapy and supportive techniques for a wide variety of patients. Supportive therapy is, in one sense, the very antithesis of the Langsian communicative approach and its relative merits need to be explored as the potential alternative to communicative therapy, in a hospital context, for certain kinds of patients.

Supportive therapy, a long neglected topic in the psychotherapeutic literature, is currently enjoying something of a renaissance with an increasing number of articles and books devoted to it (Buckley, 1994; Conte, 1994; Dewald, 1994; Pinsker, 1994; Rockland, 1989). This renaissance is accompanied by and has been influenced by the increasing medicalisation of psychiatry (Rockland, 1989; Zabow, 1995) which tends to see only a minor, supportive role for psychotherapy in this medical, biological context. There is also the perception that supportive therapy is more cost effective than other forms of therapy. Buckley (1994) has it that the upsurge of interest in supportive psychotherapy has much to do with Wallerstein's (1986a) study that showed that supportive therapy was as effective on some measures as expressive therapy and psychoanalysis in the treatment of patients traditionally seen as suitable for psychoanalysis. Langs (1982) would claim that any success enjoyed by

practitioners utilising the frame breaking techniques of supportive psychotherapy is of little lasting benefit.

Rockland (1989) traces the history of the concept of psychodynamically oriented supportive psychotherapy from its origins in psychoanalysis and expressive, psychodynamic psychotherapy. Within a psychiatric context, the practice of supportive psychotherapy is given more prominence because of the kinds of patients that are encountered. Rockland (1989) and Buckley (1994) contend that supportive psychotherapy is becoming more extensively used, especially in institutional settings as the treatment of choice because of the nature of the patients seen. A recent survey indicated that over 90% of the *outpatients* seen for psychotherapy at a large psychiatric hospital in Cape Town were seen for supportive psychotherapy (Rees, 1993).

Most commentators lament the lack of clarity in the theoretical conceptualisation of supportive therapy and similarly lament the subsequent confusion in the minds of practitioners. There are two major strands of thought in regard to a conceptualisation of supportive therapy. Most theorists (Applebaum, 1989; Conte, 1994; Dewald, 1994; Goldstein, 1997; Kernberg, 1984; Luborsky, 1984; Rockland, 1989) see supportive therapy as being on a continuum with expressive or psychodynamically oriented psychotherapy, with all therapies on this continuum having to a greater or lesser degree, some supportive elements and psychoanalysis on the rarefied end of the spectrum containing very little supportive content.³ Pinsker (1994) on the other hand has proposed that supportive therapy can be conceptualised as a kind of 'shell' of techniques that can be imposed on most therapies much as a computer 'shell program' fits over the core program and makes for easier operation.

A third strand of thought does not see a therapeutic role for supportive techniques and is epitomised by such diverse views as that of Crown (1988) who regards supportive psychotherapy as a contradiction in terms, Ornstein (1986) who takes a self- psychology line

³ Curiously Kernberg (1984) places Langs within this tradition saying that he "...point(s) to the supportive aspects of interpretive approaches in psychotherapy, continuing the tradition of the 1950s and 1960s, which saw psychoanalytic psychotherapy as a combination of supportive and interpretive techniques" (p150). This appears to be a selective interpretation of Langs's work and a misreading of Langs's work as a whole. Langs is of course opposed to the inclusion of supportive techniques in psychotherapy.

and regards the systematic use of empathy as inherently supportive so as not to require a separate form of supportive psychotherapy and of course Langs (1976, 1978a) who believes that supportive techniques are unconsciously perceived by patients as seductive and inherently destructive. Perhaps this third strand of thought can be exemplified by the nameless psychoanalyst, quoted by Rockland (1989) who asks rhetorically "what can be more supportive than lying on someone's couch five times a week and having him listen to and accept all the boring and nasty thoughts and feelings that I pour out" (p9) .

A deliberately different setting, leading to a different therapeutic experience is a tactic that is discussed by Dewald (1994). Dewald (ibid.) discusses the strategies of supportive therapy in relation to those of expressive therapy. The two therapies are seen as being on a continuum with expressive therapy being closer in technique to psychoanalysis.

Whichever point of view one adopts there is generally more consensus on what constitutes supportive interventions and techniques. Conte (1994) lists the important supportive techniques as: support of the patient through the central relationship, focusing on conscious material as opposed to unconscious material, openly acknowledging and accepting the patient's adaptive repertoire, encouraging positive behaviours, suggestion, persuasion, ventilation, advice giving, limit setting, reality testing, reassurance and finally, serving as a role model for identification.

These are very similar to the tactics and strategies listed by Dewald (1994) who, in an authoritative article without a single reference to any other theorist, discusses techniques for supportive therapy that are completely at odds with the recommendations for securing the frame advocated by Langs. Dewald (ibid.) advocates a flexibility regarding the length and frequency of the sessions as well as the context of the therapy, being happy to change from an outpatient to an inpatient hospital context as the situation warrants. Dewald attempts to foster conscious reporting and discourages introspection and access to the patients unconscious. The rationale behind this, according to Dewald is to minimise the stress and conflict for the patient.

Langs (1982, 1988) on the other hand recognises that stress is attendant on the regressive pull provided by the secure frame and that it is necessary for growth and progress in therapy. Langs sees the role of the therapist as largely managing this stress with its concomitant demands from the patient for framework deviations. Langs also recognises the stress that the regressive pull of a secure framework provides for the *therapist* as well as for the patient (Langs, 1978c). He comments that this regression leads to the exposure of primitive mental contents and primitive drive wishes and needs that are often directed towards the therapist himself. These are difficult for therapists, and especially unsupervised, novice therapists to bear, and the temptation is to draw back into a more frame deviant, supportive modality. This regression would clearly be dangerous for psychotic patients and one can understand Dewald's concerns applying to this class of patient. However Dewald (1994) lists a fairly wide variety of patients for whom supportive psychotherapy is indicated and it is here that his divergence from Langs is greatest. Dewald (1994) claims that:

Across the entire spectrum of psychiatric disorder the majority of patients who present themselves for treatment are seeking prompt symptomatic and behavioral relief, and thus want supportive and manifestly symptom oriented psychotherapy. (ibid. p506)

In this wide spectrum of patients that he finds suitable for supportive psychotherapy, Dewald (ibid.) includes patients in a temporary crisis, patients exposed to recent trauma or grief or other recent interpersonal life experience, patients with limited capacities for effective interpersonal adaptation, patients for whom affective experience is very threatening, patients who have limited or unstable interpersonal relationships, patients who are not introspective or curious about themselves and their psychological functioning and patients whose reality resources preclude the necessary frequency or expense of intensive psychotherapy.

Dewald (ibid.) emphasises the importance of having clear goals and strategies in therapy and consequently of selecting compatible tactics and techniques for achieving those goals. Thus the tactics and techniques for supportive therapy would be much more flexible than those for expressive therapy. Consequently the setting and ground rules for supportive therapy, according to Dewald (ibid.) will be very different to those advocated by Langs (1982, 1988) for psychotherapy in general.

Langs's views on supportive psychotherapy are relatively straightforward: he contends that it is not effective and far worse, can have destructive effects. Langs (1979) says in this regard: "I have found that so called supportive interventions prove quite destructive in the treatment situation....while implicitly supportive interventions serve quite well" (p90). Implicitly supportive interventions are, for Langs, the understanding that is conveyed to a patient by a well timed, insightful interpretation that addresses directly the interactional dimension of the therapy and hence takes into account the patient's unconscious commentary on the therapeutic process and the therapist's interventions or lack of them.

Langs's approach to therapy turns the conventional wisdom of supportive therapy on its head in that he believes that it is not only ineffective but also harmful to the patient (Langs, 1978a, 1981b). He states categorically:

.... I have, based on repeated empirical documentation, demonstrated that such seemingly well meaning interventions evoke responses in the patient that are, as a rule, split: manifestly and consciously, the patient is grateful, while unconsciously - in his derivative communications - he uniformly experiences the unconscious communications contained in these interventions as seductive, destructive, and nonsupportive, and as a violation of his autonomy, an assault on his ego- and self-boundaries, and a reflection of the analyst's lack of faith in the patient's ego capacities. These interventions are essentially in the service of the analyst's unresolved countertransferences. (Langs, 1978e p649)

Langs (1979) is on record as saying that the most supportive thing that can be done for a patient is to understand him dynamically within the context provided by a secure framework. He remarks that even in an acute emergency the maintenance of the framework "offers the patient the best hold and implicit ego support available, the greatest opportunity to use you as a container for this pathological inner mental world" (p117). In addition, maintaining the framework in these circumstances facilitates the emergence of the sort of material which could be used to interpret the unconscious dynamics of the acute emergency (ibid.).

Langs (1988) makes the point that one of the chief functions of the ground rules is to enhance meaningful communication and that consequently the deviations from the ground rules impairs communication, especially regarding the patient's unconscious difficulties (ibid. p136). This is particularly the case with ground rules to do with technique (ground rules 4, 5,

6 and 7, see sections 3.4 and 3.5 below) but in another context Langs (1982) also argues that severe breaks in the frame destroy meaningful unconscious communication altogether. Thus, for Langs, supportive therapy would destroy the possibility of important communication from the patient.

3.4 LANGS'S GROUND RULES OF PSYCHOTHERAPY

The ground rules specified below are taken from a combination of *Psychotherapy: A basic text* (Langs, 1982) a lengthier and more rigorous work, and the more recent *Primer of psychotherapy* (Langs 1988). The latter work, apart from being more readable, is in some respects, a slight revision of his previous work. The differences between the two texts, when they occur, will be enumerated below. The ground rules will be discussed together with their implications for the therapy and the consequences, according to Langs (1982, 1988), of not maintaining them, thus providing a set of predictions to be evaluated in the later analysis of patients material (see 3.5). Each individual ground rule will be matched with the original recommendations for practising psychoanalysis (Freud 1911, 1912a, 1912b, 1913, 1919), and by way of comparison, will be contrasted with, firstly, the requirements for the setting of psychoanalysis proposed by Quinodoz (1992) and secondly the tactics and techniques of supportive therapy advocated by Dewald (1994). The latter two texts are concise and articulate expositions of the issues around the requirements of the framework in contemporary psychoanalysis and supportive therapy respectively and are included for the purposes of comparison with Langs's ground rules. It is not proposed that they embody an exhaustive commentary on contemporary psychoanalysis or supportive therapy.

3.4.1 A stable, single, relatively neutral setting

This ground rule requires that the patient be seen in a single location and not in different locations at different times. This ground rule is consistently maintained over both texts. Langs (1988) adds that the setting is preferably in an entirely private office suite in a professional building. Langs (1982) adds that the office should be a single office with a private waiting room and should not be part of the therapist's house.

Langs remarks that in the ideal office setting the patient is offered a "solid and definitive physical setting for psychotherapy" (ibid. p365) which does not expose the personality of the

therapist apart from the therapist's important capacity to secure the necessary physical space for the treatment experience. Langs comments that the physical setting becomes the silent background to the relationship between therapist and patient. The importance of the consistency and neutrality of the setting is apparent in this requirement.

Quinodoz (1992) advocates that the room in which psychoanalysis takes place is to be quiet and unchanging over a long period. This position is in line with Langs's attitude regarding the single setting.

In line with the flexible approach of supportive therapy Dewald (1994) maintains that the physical setting may be variable in supportive psychotherapy. If necessary the patient may be seen in hospital if it is required that he or she be admitted. Dewald is not advocating the patient be seen in different locations as a matter of course, but simply that, if necessary, this may be permitted and is in line with the tactics of supportive psychotherapy.

3.4.2 A single fixed fee with a full sense of responsibility for attendance at all scheduled sessions on the part of both patient and therapist

This ground rule is listed as two separate ground rules in the earlier text (Langs, 1982) and the second part of the ground rule, the question of responsibility for all sessions, is not included specifically in the later text (Langs, 1988) although it is implied in some of the clinical examples given in the text. They have been collapsed into a single ground rule because of their logical compatibility and following the example of Smith (1991a) who also discusses them under a single heading (*ibid.* p185).

Langs (1982) advocates that the therapist should not involve third parties in the payment or give out accounts at the end of the month. The therapist should simply set the fee for the therapy at the beginning of therapy and then instruct the patient to calculate and pay the fees at the end of every month. According to Langs this fosters the patient's autonomy and allows the patient the opportunity to express conflicts and fantasies in this area (*ibid.*). Similarly Langs advocates that there be no exception to the rule requiring that the patient take financial responsibility for each session whether attended or not. Langs (1982) argues that failure to maintain this aspect of the ground rule will prove seductive and confusing to the patient and

will reinforce the patient's own use of pathological denial and will tend to preclude the analysis of separation anxieties and furthermore could foster "pathological symbiotic or parasitic ties" (ibid. p438). Langs adds that making exceptions to the rule requiring the patient's financial responsibility for all sessions may sometimes reinforce the patient's wish to be ill and to obtain other similarly pathologically gratifying modifications to the framework.

Freud makes no specific comment on the issue of a single fixed fee but does comment that he is not in favour of lowering his fees or of offering free therapy. Freud (1913) remarks that the value of a treatment is not enhanced if a very low fee is asked. Apart from the considerable loss of revenue if a substantial portion of the analyst's day is given over to free treatment that will lead to justifiable resentment in the analyst, he also observes that the practice is faulty on purely technical grounds in that free treatment can lead to increased resistance in patients (ibid. p132).

On the second part of the ground rule Freud (1913) is quite specific, advocating that the patient be allocated a set hour of his available working day and that consequently the patient is liable for this hour even if it is not used. Again, the reasons for this are practical but also largely technical as a way of enhancing the therapy. Freud comments that adopting a less strict approach will lead to greatly increased non-attendance on the part of patients and can lead to the experience of finding that breaks in the therapy occur just when the material promises to be important and rich in content (ibid. p127).

Freud's position is adopted also by Quinodoz (1992) who advocates that the analyst is paid by the patient who also pays for missed sessions. Quinodoz is silent as to the issue of a fixed fee and whether reductions in fees should be allowed for some patients.

Dewald (1994), in line with the more flexible structure of the treatment situation advocates flexibility about methods of payment by the patient according to the nature of the patient's personality (p 509). Although Dewald does not specifically pronounce on the issue of missed sessions or reductions in fees it is clear from the flexibility that he advocates that missed sessions would not be charged for and reductions in fees would be tolerated.

3.4.3 A specific and set time for each session, with a defined length for each session (preferably 45 or 50 minutes)

This is consistent requirement of the fixed frame according to both the earlier work (Langs, 1982) and the later work, (Langs, 1988). It is not material whether 45 minutes or 50 minutes is selected as the length of the therapy 'hour' so long as it is consistently maintained throughout the therapy (Langs, 1982). Langs remarks that the therapist should be careful to end the session on time and unless there is a dire emergency there is no justification to extend the hour. Langs does not go into detail regarding his rationale for this specific ground rule but it is part of the ritual and consistency required of the framework generally (see section 7.6.2 below). Langs indicates the importance he attaches to strict compliance with this ground rule when he remarks that any inadvertent extension to the therapy hour on the part of the therapist will be an important event which will be perceived as such by the patient and will be unconsciously commented on in the following session. He maintains that this unconscious commentary will need to be addressed before other issues are dealt with in the therapy (ibid. p449).

Freud (1912, 1913), whilst advocating that patients lease a set hour from him on a daily basis, appears to be more flexible in terms of the time constraints, pointing out that occasionally some patients need more than an hour. Freud (1913) comments:

Occasionally, too, one comes across patients to whom one must give more than the average time of one hour a day, because the best part of an hour is gone before they begin to open up and to become communicative at all. (p 128)

Quinodoz (1992) advocates that sessions have a set length of either 45 or 50 minutes and that the schedule of therapy is regular and fixed. This is completely in accord with Langs's ground rule.

Dewald (1994) on the other hand advocates complete flexibility with regard to the therapy hour proposing that sessions can be halted if patients 'feel finished' for the day. He states that sessions can be longer or briefer depending on the comfort of the patients. Dewald comments that brief sessions discourage introspection and foster conscious reporting, both of which are tactics in supportive therapy (ibid.).

3.4.4 A regular location within the therapy room and the use of the couch

This ground rule requires that the therapist and patient occupy a regular position in the therapy room and that therapy be transacted only within this configuration, that is, not outside the room or on the way to the room or with any other seating arrangement. In his earlier work Langs (1982) advocates either the use of the couch or having the patient sitting in a chair facing the therapist. This ground rule appears to have changed in his later work with Langs (1988) stating this ground rule simply as a requirement for the use of the couch. While the regular location within the room would enhance the consistency of the therapy setting, the use of the couch is specifically designed to enhance the production of the patient's unconscious, derivative material by facilitating a regression of the patient and by emphasising the different nature of the therapeutic dialogue, compared to the more normal face to face way of conducting ordinary social conversations (Langs, 1982, 1988).

On the difference between psychoanalysis and psychotherapy in regard to the use of the couch, Langs (1982) maintains that this traditional difference whereby psychotherapy patients sit and face the therapist whereas psychoanalytic patients lie on the couch is not justified as the use of the couch is beneficial in psychotherapy that occurs on a once a week or twice a week basis. Langs does however propose a consistent use of either position and if the patient proposes to change this particular position it is subject to exploration in the therapy.

Freud does not comment on the requirement of a regular location within the therapy room but remarks on his ritual use of the couch for psychoanalysis. Freud (1913) invites the patient to lie on the sofa whilst he himself sits out of the patient's line of vision. For this ground rule Freud gives both personal and technical reasons. The former being because he could not "put up with being stared at by other people for eight hours or more a day" (ibid. p134) and the latter reason being due to a wish to avoid contaminating the transference or to influence patients by his facial expressions in response to what they were telling him.

Quinodoz (1992), in line with Freud's recommendation advocates simply that the patient lies down and that the analyst sits behind him or her. While she is not explicit about the location

of the participants within the room she does advocate that the room is unchanging over a long period thus implying the need for the regular location within the room.

The use of the couch, while being almost symbolic of psychoanalysis itself (Gedo, 1995; Wolf, 1995), has not had much attention in the psychoanalytic literature (Frank, 1995; Wolf, 1995). Most commentators (Frank, 1995; Gedo, 1995; Jacobson, 1995; Lichtenberg, 1995; Wolfe, 1995) emphasise the facilitative function of the use of the couch. Frank (1995) describes the two way facilitative function eloquently.

It is axiomatic that not looking at each other frees each analytic partner. In both participants, processes of inner realization are facilitated, in one by not viewing and in the other by not being viewed. (ibid. p324)

Lichtenberg (1995) describes his experiences of the couch as an analysand and as an analyst and contends that the use of the couch is facilitative of the process of exploration in psychoanalysis but he concedes that this is not universally the case, and for some patients it can exacerbate the difficulties in analysis. Gedo (1995) emphasises the use of the couch for "transference reactions of a regressive nature" (ibid. p296). Jacobson (1995) takes the view that the use of the couch is not the *sine qua non* of psychoanalysis and that analysts are able to work more freely and effectively if they allow the patient a certain amount of latitude in respect of their use of the couch or not. Jacobson also points out that the use of the couch can present as many opportunities for resistance in analysis as does the refusal to use the couch.

Dewald (1994) on the other hand is specific about the need to minimise regression as a tactic of supportive therapy as well as the need to foster conscious reporting and to reduce the transference towards the therapist. Hence Dewald would not advocate the use of the couch in supportive therapy although he does not explicitly advocate its not being used. Dewald is also not specific about the requirement of a regular location within the therapy room.

3.4.5 The adoption of the fundamental rule of free association

This ground rule is consistently maintained by Langs across both texts. The requirement is for the patient to express whatever comes to mind by way of thoughts, feelings, and images.

It is a basic rule of psychoanalysis and is useful in allowing access to the patient's unconscious and it is an important component of the communicative approach, insofar as this approach relies heavily on the analysis of derivative material and interpretation of the patient's unconscious perception of the therapist and of the therapeutic encounter.

Langs (1982) observes that there appears to be confusion as to whether free association applies to psychotherapy with some theorists believing that it is not possible in psychotherapy but can only occur in psychoanalysis. Langs however is very clear that it is not only possible and important in psychotherapy but that the "establishment of open and unencumbered free association is an essential element of this environment and basic to insight therapy" (ibid. p454).

This rule of free association had its origins with Freud and arose as an alternative to the technique of hypnosis. In terms of this rule Freud (1912b) requires of patients in psychoanalysis that they should communicate everything that occurs to them "without criticism or selection" (p 112). Free association is such an important part of psychoanalysis that Freud refers to it as 'the fundamental rule' of psychoanalysis. Freud (1913) explains that he begins the analysis by instructing his patients to tell him what they know about themselves and by warning them that he has to know a good deal about them before he can say anything to them. Freud (ibid.) wants the patient to choose at what point he or she wishes to begin the story and consequently takes pains to allow the patient to speak first. The only exception to this however is in imparting an explanation of the fundamental rule of free association to the patient (ibid.), thus giving some indication of the importance that he gives to this rule.

Kris (1982) defines free association as a joint venture in which the part of the analyst is to contribute "guided by his own associations and formulations" with the view to enhancing the expression of the free associations of the patient (ibid. p3). Kris, in his discussion of free association and psychoanalytic psychotherapy, reminds us that free association is bound up with the other elements of analytic technique in that it is enhanced by the frequency of sessions and by the use of the couch. Free associations that emanate from a therapy setting that has the patient coming to therapy less frequently than four or five times a week and sitting

face to face with the therapist will be qualitatively different from the free associations in analysis (ibid.).

Many authors (Modell, 1988; Spruiell, 1983; Stone, 1981) believe that the fundamental rule requiring analysands to communicate everything, without any editing, is a virtually impossible task. Modell believes that for many patients the capacity to free associate only occurs towards the end of analysis, Spruiell contends that it is impossible for any length of time and Stone mentions that its obligatory character is more often than not, honoured in the breach. Casement (1990), commenting on Freud's insistence that patient's free associate in analysis, remarks that the modern tendency is to *allow* patients to free associate rather than to attempt to force them to, or to *insist* that they do.

Quinodoz (1992) does not deal with free association in her article on the setting of psychoanalysis. Despite the difficulties in carrying it out, it is an inherent part of modern psychoanalysis even if it is not always seen as being part of the setting, as such, of psychoanalysis.

Dewald (1994) stresses that in supportive psychotherapy the focus is on conscious, manifest issues and the patient is not encouraged to bring previously unconscious issues to awareness. Regression is not encouraged in supportive therapy and the therapist through his interventions and interactions, avoids regression as far as possible. Thus although Dewald (ibid.) is not explicit on this point it is clear that a more rational, reality oriented interaction with the therapist is adopted in supportive therapy. Free association is not a technique that is encouraged in supportive therapy.

3.4.6 The therapist's maintenance of free-floating attention

This ground rule is delineated in the earlier text (Langs, 1982) as "The therapist's maintenance of free-floating attention, open role and image responsiveness, and a full capacity to contain the patient's projective identifications" (p461). It has been shortened in the later text to the simple requirement on the part of the therapist to maintain evenly hovering attention (Langs, 1988). As it stands the ground rule is complex and has many implications and makes many assumptions about the practice of therapy. The ground rule is

a counterpart to the previous ground rule of the fundamental rule of free association and is complementary to it in the sense that the therapist maintains free floating attention as the patient free associates and is thus more easily able to access the patient's free associations and can consequently be more in touch with the patient's unconscious.

Langs (1982) maintains that this ground rule is an important part of the therapeutic ambience offered to the patient in that it implies an openness to both the patient's manifest and derivative material, as well as an ability to experience pressures emanating from the patient toward forcing the therapist into roles and modes of relatedness. In addition it implies the ability on the part of the therapist to metabolise projective identifications and to process these understandings into interpretations.

Freud (1912b) advocates the use of evenly suspended attention on the part of the analyst as a way of mastering the abundance of material that comes the way of the analyst if he or she should be treating more than one patient at a time. Thus this technical rule is put forward as an aid to memory and a way of avoiding the strain of attention to all that the analyst hears. But there is more to it than this and Freud (*ibid.*) asserts that the rule of giving equal notice to everything is a 'necessary counterpart' to the rule of free association. He contends that the practice consists simply in not directing one's notice to anything in particular and in maintaining the same 'evenly suspended attention' in the face of all that one hears. Freud declares that the analyst must:

...turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line, which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations. (*ibid.* p116)

Freud contends that by maintaining an evenly hovering attention, the unconscious of the analyst 'tunes in' to the unconscious of the patient and this enables the analyst to more readily reconstruct the unconscious of the patient. Thus, according to Freud, an important requirement for maintaining free-floating attention is to have had analysis oneself as a therapist in order to be able to maintain a flexible and receptive attitude to the patient with a

minimum of one's own preoccupations intruding on the material of the patient. Thus Freud (ibid.) advocates a 'psycho-analytic purification' for therapists.

Again, as with its counterpart in free association, Quinodoz (1992) does not comment specifically on this aspect of the framework of psychoanalysis. Although Quinodoz does not place this ground rule specifically within the realm of the setting, it is clearly a fundamental part of modern psychoanalysis.

Dewald (1994) also does not deal explicitly with this aspect of technique but the tactic of the therapist in focusing on manifest content in supportive therapy implicitly negates this ground rule as an important technique in supportive therapy. This contention is supported by his advocating the fostering of conscious, rational, reality based dialogue from the patient which also specifically rules out the technical concept of evenly hovering attention on the part of the therapist as it was originally intended by Freud and as it is taken up by Langs.

3.4.7 The therapist's use of appropriate silence and valid, neutral, active interventions

This ground rule has been consistently maintained by Langs (1982, 1988). Langs advocates the use of only four types of interventions, namely silence, the playback of selected derivatives, framework management and interpretations. It is this ground rule that provides the peculiar hallmark of Langs's work. Only certain types of interpretations that conform to a specific, exacting format are allowed. These are the so-called communicative, interactional interpretations that take account of three important elements. These three elements that go towards making up a valid interpretation are firstly the framework break or trigger, secondly the manifest representation, in the patient's material, of the trigger and thirdly the derivative material or encoded material. These elements are synthesised into an interpretation. All other interpretations, according to Langs do not receive validation. All other interventions, including questions, clarifications, confrontations, reflections and encouragements and other so called supportive interventions will receive derivative disconfirmation, according to Langs (1982, 1988).

Freud (1913) advocates a cautious approach to making interpretations to the patient, recommending that in the beginning it is better to adopt an approach of sympathetic

understanding to allow the transference time and opportunity to develop. Freud (ibid.) also advocates that therapists take pains to make interpretations to patients only when they are close to grasping them.

For Freud (1915b) the rule of abstinence guides therapists in their dealings with the patient and in their choice of interventions. Wishes, desires, needs and wants directed at the therapist have to be *understood* in terms of their dynamic and genetic origin rather than *gratified* by a kindly therapist. This is primarily in order that "the patient's needs and longings should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes" (ibid. p 165). Thus Freud (1919) emphasises that "Analytic treatment should be carried through, as far as is possible, under privation - in a state of abstinence" (p 162).

Quinodoz (1992) puts the requirement for analysts succinctly when she observes that for the duration of the analysis there is no 'doing' or retaliation by either of the parties. This brief facet of the setting of modern psychoanalysis covers a multitude of aspects of the relationship between analyst and patient and, insofar as it is upheld by both parties, places the emphasis squarely on the understanding and verbal interpretation of the wishes and desires to 'do' and to 'retaliate'.

For Dewald (1994) supportive therapy is the very opposite of abstinent. The therapist, in keeping with the tactics of supportive therapy, is active, verbal and gratifying of patients' needs insofar as this is professionally possible. The therapist offers advice and suggestions and provides active alternative understanding of situations and events. In addition the therapist offers prompt feedback to the patient regarding transference distortions, thus keeping to the strategy of focusing on conscious, manifest issues.

Lindon (1994) in a thought provoking paper, states his belief that the rule of abstinence was an error from the beginning and he feels that even though it distorts the analytic process it continues to this day primarily because Freud prescribed it. Lindon advocates 'optimal provision' of the patient's *needs* as opposed to gratification of the patient's *desires* and suggests that, while the *rule* of abstinence should be abolished, the *role* of abstinence should

be retained (*ibid.* p 559). Thus Lindon subsumes abstinence under the rubric of optimal provision which he defines as "any provision that, by meeting a mobilized developmental longing, facilitates the uncovering, illuminating, and transforming of the subjective experiences of the patient" (*ibid.* p 559). This is not as artful as it seems at first glance in that even clearly abstinent actions like silences, for example can be seen as provisions, under Lindon's system, if they help to uncover, illuminate or transform the subjective experiences of the patient. Lindon, following Atwood and Stolorow (1984) defines psychoanalysis in these terms, as a process, primarily utilising interpretation and leading to the uncovering, illumination, or transformation of the patient's organising principles. Lindon's tightly argued and thoughtful contribution falls down somewhat in his presentation of clinical evidence in support of his position that optimal provision can actually enhance the analysis rather than hinder it, in that the evidence is anecdotal and there is insufficient material to help the reader interpret this material. Lindon also completely ignores the contributions of Langs to this very important issue.

Grotstein (1994), in his commentary on the paper, remarks that Lindon's downplaying of the absolute importance of abstinence is symptomatic of the humanistic changes currently taking place in psychoanalysis. Grotstein places Lindon's thesis in perspective in terms of these changes which he describes as the move towards intersubjectivity, the move away from the drive theory and towards the interpersonal and the bipersonal field of analysis, an increasing emphasis on countertransference rather than simply transference and an increasing emphasis on privation, deprivation and traumata as important pathogenic components in the development of neurosis.

While Grotstein recognises the importance of Lindon's contribution he nevertheless emphasises the role of abstinence in the holding environment which is provided by the secure frame. Lindon argues that there are problems in the concretisation and ritualisation of this basic rule of abstinence, which possibly absolves some practitioners of responsibility for their rude behaviour. Grotstein, however, contends that the tenets of Langs's communicative psychotherapy offer the most formidable challenge to Lindon's thesis although he does not marshal any actual clinical evidence in his commentary.

Schachter (1994), remarking that Freud usually adopted a technical device for personal reasons and then later formulated its theoretical basis, claims that the rule of abstinence was probably designed to curb Freud's own troublesome, erotic countertransference. She maintains that:

These speculations, while having no bearing on the clinical value of abstinence and related neutrality, do emphasise the necessity to assess their utility objectively, on the basis of *clinical data*. (ibid. p709, italics added)

Schachter (ibid.) deplores the dearth of actual clinical data and the simple iteration of the value of abstinence and neutrality. She recognises the difficulties of obtaining unequivocal clinical evidence for or against the value of these two principles of psychoanalysis, citing firstly the difficulties occasioned by the fact that the two concepts are not easily defined. She ignores completely the contribution that Langs (1982, 1988) has made, firstly to the operational definition of the terms by his breaking them up into their component parts which are essentially the ground rules of therapy, and secondly, by his attempts at gathering evidence for the clinical utility of these component parts.

3.4.8 The therapist's relative anonymity

This ground rule has been consistently maintained by Langs (1982, 1988). It has at its heart the requirement that the therapist not disclose personal information about himself or herself to the patient. Langs uses the word relative to qualify the term 'anonymity' because of his recognition that something about the therapist will inevitably be revealed by his or her office, furnishings, dress and manner of speech. In this sense then total anonymity is clearly not possible. Langs (1982) comments that this ground rule not only provides the opportunity for projection by the patient but also it provides a sense of safety to the therapeutic relationship. Langs maintains that this break in the frame serves to gratify needs in the therapist and help the therapist defend against separation anxieties and the necessary separateness from the patient. In addition Langs argues that breaks in this ground rule serve to "undo any sense of depression on the therapist by serving as a manic-fusion defense" (ibid. p470).

Langs has elaborated on this ground rule to include an injunction against the therapist revealing countertransference aspects (ibid.). This aspect of the framework of therapy has recently been challenged in some psychoanalytic journals. The issue of therapist disclosure,

or countertransference disclosure has increasingly come under the spotlight in psychoanalytic circles with the current *debate* about the use and value of self disclosure emanating largely, but not exclusively, from the perspective of self psychology (see Aron, 1997; Maroda, 1991, 1997; Frank, 1997; Greenberg, 1997; Mitchell, 1997). However very little clinical evidence, along the lines of Langs's validation of therapist's interventions, emerges in this literature but it is of interest as an emerging phenomenon in line with the more humanistic and dialogical trend in modern psychotherapy and psychoanalysis (Frank, 1997; Grotstein, 1994; Maroda, 1997).

The ground rule has its roots in Freud's (1912b) admonition to analysts that they should be "opaque" to patients and "like a mirror, should show them nothing but what is shown to him." (p118). At face value Freud appears to be suggesting that analysts remain cold and aloof towards their patients but a study of Freud's actual practice reveals him to be nothing of the sort (see Ellman, 1991; Haynal, 1988; Lipton, 1977; Mogliano, 1987; Thompson, 1994 and section 3.1 above). This apparent dichotomy between aspects of Freud's theory and his actual practice has led to some theorists (Greenson, 1971; Lipton, 1977) postulating the existence of and the importance of the 'real relationship' between analyst and patient as something separate from psychoanalytic technique on the one hand and transference on the other hand. This concept of the 'real relationship' has given rise to much debate in the psychoanalytic literature, the details of which touch on many aspects relating to the debate on abstinence and gratification, and the debate on the respective value of holding and containing on the one hand and interpretation on the other. These issues are taken up again in section 7.6.2 below.

Quinodoz (1992) does not comment on this aspect of the ground rules in her article on the setting. Dewald (1994), in keeping with the supportive therapy tactic of maintaining the transference at dilute and unconscious levels, advocates that the therapist, amongst other things, offers appropriate *personal* information and opinion. Therapist anonymity is thus antithetical to supportive therapy.

3.4.9 The absence of any prior, concomitant, or post-treatment relationship between the patient and therapist, and the essential absence of physical contact

This ground rule is stated in the earlier work (Langs, 1982) but is not mentioned explicitly under the ground rules in the later work (Langs, 1988). Although not explicitly mentioned in the later work it is clearly implied in the cases and examples cited by Langs and clearly remains an important element of the ground rules for Langs. Langs (1982) argues that this ground rule serves to protect the therapeutic situation and relationship and helps to preclude a wide range of extra-therapeutic and non-therapeutic gratifications which would be inimical to the use of insight and understanding as the sole means of alleviating symptoms.

The prohibition on extra analytical relationships has its origins in Freud (1913) who asserts that special difficulties arise if the therapist has a friendship or social ties with the patient or his family (p125). But Freud appears to be looking at the issue more from the point of view of the destruction of the friendship rather than from the view of dual relationships causing insurmountable technical difficulties in the therapy. He remarks that:

The psycho-analyst who is asked to undertake the treatment of the wife or child of a friend must be prepared for it to cost him that friendship, no matter what the outcome of the treatment may be: nevertheless he must make the sacrifice if he cannot find a trustworthy substitute. (ibid. p125)

But there is also a technical disadvantage to the previous acquaintance between analyst and patient and Freud delineates the problem as a transference attitude which has already developed and which the analyst has to uncover instead of having the opportunity of observing the transference develop from the start in the new patient (ibid. p 125).

Quinodoz (1992) states the requirement simply as part of the 'refraining from doing' facet of the setting. She asserts that the analyst and patient should have no relations with each other outside of the sessions of psychoanalysis.

Dewald (1994) argues that in supportive therapy the relationship to the therapist is very different to that of exploratory therapy. The therapist is more likely to intervene outside of the therapy with other parties where the patient is unable to do so himself. The therapist is more likely to prescribe medication and attempt to be helpful in other ways. On termination

the idea of the continuity of the relationship with the patient is fostered with the patient being encouraged to return to therapy should further problems arise. Thus there is a sense of the relationship being maintained indefinitely even though the therapy might have terminated and the therapist and patient may no longer meet; the idea being that a sense of continuity with a helpful other is fostered.

3.4.10 A one to one relationship with total privacy and confidentiality

This ground rule is split up in the later work (Langs 1988). Smith (1991a) points out that although the two concepts of privacy and confidentiality have much in common there is a subtle distinction between the two in that confidentiality involves something over and above privacy. Privacy involves keeping other people out of the therapy room and ensuring that what occurs between therapist and patient is not observed or overheard by others. Confidentiality involves keeping all aspects of the therapy away from third parties and not disclosing anything about the therapy to anyone else (*ibid.*).

Langs (1982) maintains that true insight therapy is predicated on a totally private, confidential, one-to-one relationship which implies that the therapy space belongs exclusively to the patient and that no one else is permitted into that therapy space, directly or indirectly, to the greatest extent possible. Langs elaborates as follows:

This implies that actual intrusions of third parties, the offer of information to outsiders, and the acceptance of information from others, are all to be excluded. In this way, the therapist indicates to the patient that he or she is prepared to offer the safety of a totally private and confidential relationship, and that he or she is capable as well of being the sole individual who will attempt to cure the patient of emotional ills. (*ibid.* p475)

Freud is not specific on this point and one has to read between the lines in order to ascertain his approach. Freud (1913) mentions that, in the earliest days of analysis it was his custom to obtain information from outside sources regarding patients. He would then present this information to patients with the aim of helping them to resolve their symptoms. This practice would appear to be a clear breach of the ground rule requiring privacy and confidentiality. Freud mentions that this 'intellectual' knowledge on the part of the patient failed to result in the clearing up of the symptoms. It is for this reason that he shifted the focus in analysis

more to the analysis of patients' resistances to remembering, thus facilitating the patients' bringing forth of material rather than attempting to obtain it from other sources.

Quinodoz (1992) is more explicit on this question. She specifies simply that patient and analyst are alone in the room and advocates that, as part of the refraining from doing facet, the analyst refrains from contact with third parties concerning the patient, including the patient's family. In addition the analyst does not report on the patient to any third parties.

Dewald (1994) does not mention this issue explicitly as part of the tactics of supportive therapy. However in supportive therapy there is much more of a sense of the involvement in the actual affairs of the patient outside of therapy. Thus Dewald (*ibid.*) advocates intervention with third parties and people with whom the patient feels unable to maintain his interests. Clearly with this sort of intervention in supportive therapy, privacy and confidentiality have to be compromised to a large extent.

3.5 IMPLICATIONS OF BREAKS IN THE FRAMEWORK IN TERMS OF PATIENTS' MATERIAL

Breaks in the frame occur in many ways in that many actions and events in therapy have implications for various ground rules. The meaning of an event will be different for different patients depending on the break, the context and the prior experiences of the patient concerned. Langs does not systematically set out to describe the thematic material that patients will produce in response to various framework breaks. However he does discuss the kind of material that is expected under certain conditions and where certain framework breaks have occurred, leading to some clear cut propositions. In addition Langs (1988) asserts that even though the details of each break in the ground rules will shape its particular, recognisable response in the patient's thematic material, there are certain general themes that would be expected under deviant frame conditions generally and these include images of persecution, intrusion, murder, destruction and madness (*ibid.* p182).

Broadly there are three types of ground rules. Firstly there are ground rules that have to do with the fixed frame of therapy, secondly there are those that have to do with the technique of therapy and finally there are ground rules governing the relationship between therapist and

patient. Each of these types of ground rules will have distinct consequences if they are broken and they will be discussed in turn.

The first three ground rules namely the single setting, the single fixed fee with responsibility for all sessions and the specified time and duration for the therapy make up the fixed frame or setting of therapy, according to Langs. Breaks in these ground rules will lead to the patient experiencing the situation as chaotic and consequently the thematic material will indicate images of chaos. The derivative material will have chaos as a large part of the thematic make up. In addition Langs (1982) has it that any deviation in the ground rule relating to the fees will be interpreted unconsciously by the patient as a seduction (p317 & p422) or an infantilisation (p435), or as seductively controlling and unnecessarily gratifying (p438).

The ground rules relating to technical arrangements for listening to the patient (ground rules 4, 5 and 6), the use of the couch, free association and the evenly hovering attention of the therapist are for the most part geared towards obtaining maximum access to the patient's unconscious processes. Breaks in these ground rules will generally result in a paucity of such unconscious productions rather than specific themes, imagery, or derivative material.

The ground rule pertaining to the use of neutral interventions by the therapist, if not kept, is likely to evoke themes of harm, betrayal or inappropriate care in the patients' themes (Langs, 1982 p 468). In addition the lack of communicative, interactional interventions on the part of the therapist is predicted to bring forth themes of communication difficulties or breakdown in communication (Langs, 1988 p158).

The three ground rules relating to the relationship, if broken, bring forth their own different images in the patient's material. A break in the rule requiring the relative anonymity of the therapist will lead to images of seduction, dishonesty and symbiotic pressure (Langs, 1982 p472) According to Langs (1982) breaks in the ground rule relating to the one to one relationship with total privacy and confidentiality invoke images of leakage (ibid. p 365), and unfaithfulness and betrayal (ibid. p314). Breaks in the ground rule relating to the absence of a prior, concomitant or post therapy relationship will lead to images of inappropriate merger (ibid. p393).

Langs's predictions regarding the kinds of thematic material that can be expected to occur in the therapy sessions leads to fairly clear cut propositions that can be tested in the actual clinical situation. These predictions are tested in this study and reported on in section 6.14 and discussed in section 7.2 below.

3.6 RECENT CRITIQUES OF THE COMMUNICATIVE PARADIGM

Grotstein (1984), in a generally favourable review of Langs's work, concurs with the whole thrust of Langs's theoretical overhaul of the way that therapists' gain access to the patient's unconscious and says "... we have withdrawn our belief in the unconscious and merely pay lip service to it" (p6). Grotstein emphasises the relational aspect of psychotherapy and points to the value of being able to express difficult issues within the privileged confines of a safe therapeutic environment. In this context, the manifest productions of the patient are also important, not necessarily in the sense of a catharsis of previously repressed material, but more in the object relations sense of containment and metabolism (Bion, 1962) of previously unintegrated experiences. Speaking of the repetition compulsion in psychotherapy and the value of the therapeutic relationship for the metabolism of experiences, Grotstein says:

We are best able to complete an experience - and to mourn it, say good-bye to it, and to forget it - when we know that there is an object present who is attuned to us, in an empathic bond and yet separate from us, and who is sufficiently unvictimized to convince us that he or she has survived personal experiences and can pull us into our future safely. (ibid. p13)

A somewhat trite aspect of his critique of Langs is Grotstein's conceptualisation of the framework as having the potential for 'brainwashing' patients. Granted that the therapist's influence on the patient in therapy, intentional and unintentional, is well documented, the whole thrust of Langs's work is to try to identify this influence as it occurs in unintended and unconsciously intended ways, through an appreciation of the adaptive context of the therapy, and so to reduce this unintended influence through a careful consideration of what patients are actually saying in the therapy.

Perhaps a more considered criticism of Langs's framework, emanating from Grotstein (ibid.), is his concern about the potential for the communicative therapy environment to appear to be

bleak and punitive to patients experiencing the strictures of rigidly applied ground rules. Langs has criticised not only the more humanistic stance emanating from the Budapest school of psychoanalysis (see Haynall, 1988) but also the so called classical psychoanalytic stance (see Lipton, 1977) for its lack of rigour. Grotstein reminds us of the importance of play, as emphasised by Winnicott (1971), in the psychotherapy space, and suggests that the relentless maintenance of the framework is inimical to that mode of play that gives rise to imagination, innovation and symbolic transformation. Grotstein does however concede that his concerns may be obviated once the neophyte communicative analyst has completely integrated Langs's technique and given up a self consciously rigid application of the ground rules. Langs (1988) considers his method to be rigorous rather than rigid but this is a common area of criticism of the communicative methodology and it is an issue that will also be discussed in relation to the current study in section 7.6.2 below.

Gill (1984) points to Langs's confusing use of the term derivative in that Langs sometimes takes the term to mean the actual productions of the patient and at other times to mean the inferences drawn from those productions, but this seems to be a minor point in that one can work out from the context how Langs is using the word. Gill (1984) expresses his agreement with much of Langs's views but also contends that Langs, in his rigid emphasis on the ground rules of therapy remains a captive of classical psychoanalysis as described by Lipton (1977). Gill contends that conscious associations, or manifest content also deserve attention in that the patient's *explicit* references to the therapist should not simply be discounted but remain the point of departure for understanding the patient's allusions to the therapist.

Gill raises an interesting point when he asserts the difficulty of the task that Langs sets for the analyst in the requirement for "unflagging alertness to catch hidden meanings" (Gill, 1984 p411) and the vast potential for error in the communicative paradigm and the essential lack of activity that has to be maintained in order to not interfere with the patient's productions. Gill feels that this is a "persisting attempt to make the analyst a blank screen" (ibid.) and like Grotstein (1984) he balks at the potential for the therapist to come across as inhumane and uninvolved in this stance. In line with this point Gill also takes issue with Langs's use of silence as an intervention and points out that silence itself will have its own meaning for the patient and could be interpreted as avoidance or gratification or both on the part of the

therapist. Again, Gill takes issue with Langs's avoidance of questions, clarifications and confrontations, contending that in some instances they may in fact be more useful in eliciting derivative associations.

Siegelman (1990) also takes issue with Langs on the apparent bleakness of his therapeutic stance and is concerned that the therapist will come across as inhumane and as a "scientest/hypothesis tester engaged in the purely cognitive activity of searching for clues" (ibid. p181). Siegelman feels that Langs pays only 'lip service' to the important notion of *play* in the therapy space; a notion that has been emphasised by Winnicott (1971) and Milner (1987) and Siegelman quotes the latter two authors with approval and at length as a counterpoint to the ostensible lack of cheer of the Langsian secured framework.

Silverstein (1984) in an essentially uncritical review of Langs's work that simply rephrases most of the Langsian postulates about the frame⁴ contends that the rigidly maintained frame helps the patient get in touch with his or her own issues. He reminds us that silence, within the secured frame, is a powerful adaptive context that will stimulate the production of the patient's derivative material related to the patient's dependency conflicts and this derivative material can be interpreted in response to the therapist's silence because of the absence of questions on the part of the therapist.

Lothane (1985) in a review of Langs's approach, which is in agreement with most of Langs's postulates about the ground rules and framework of therapy, reminds us that many analysts, beginning with Freud, have acknowledged the potential to cause harm to patients through countertransference "but no analyst before Langs has defined the therapist as an ever-present traumatising agent, and none has made this point of view into a system, as Langs has" (p181). Lothane describes Langs's approach to the understanding of patient's material as being of great heuristic usefulness but he takes issue with the claimed certainty of the Langsian interpretive methodology. Lothane becomes entangled in an essentially irrelevant issue when he asks "In a given moment, who is the patient *really* talking about - the patient or the therapist?" (p190 italics in original). In one sense this is the crux of the matter and it cuts to the heart of the Langsian interpretive approach but, in another sense, the answer, according to

⁴ Silverstein (1984) includes, with approval, the Langsian injunction that not even a pen is to be lent to the patient in the therapy room for fear of breaking the frame (ibid. p102).

communicative theory, is simply that the patient is talking about both himself *and* the therapist at any given moment. To attempt to adopt a rigid distinction is prosaic, unnecessary and inaccurate.

Troise (1992) questions the concept of the universal framework which postulates that all patients will have similar types of reactions to the deviations in the frame and will react in similar types of ways to the secure frame. In a precursor to Bonac's (1995) ideas on the transference (see section 2.2 above) he argues that the influence of childhood trauma, carried in the unconscious, will have a bearing on the patient's selection of certain frame conditions, secure or deviant, as potential carriers of transference expression. In other words the patients will select the frame conditions as a means to act out their disturbing internalised object relations. Troise and Quinn (1991) discuss Sandler's (1976) concept of role responsiveness as a type of transference in which the patient continuously attempts to engage the therapist in a recreation of a past object relationship. Troise and Quinn (1991) emphasise that both therapist and patient attempt to impose intrapsychically based role-relationships on the other; the therapist through a mismanagement of the frame and the patient through an exploitation of this mismanagement, or, in the presence of a secure frame through an attempt at changing the ground rules. They point to the necessity of maintenance of the secure frame in order to help the therapist to understand and analyse the patient's need to evoke the role in the therapist and hence help the therapist gain insight into the patient's "object relational based psychopathology" (p184).

Despite Troise's (1992) questioning of the universal framework concept and his contention that not all patients will respond negatively to deviations in the frame, he remarks, somewhat loosely that:

There are some blatant and disruptive deviations in the standard analytic frame which will, most likely, disturb any patient regardless of whether the therapist's deviation resonates with the patient's intrapsychic concerns or not (e.g. breaches of confidentiality, extra analytic involvement between patient and analyst, departure from neutrality, etc.). (ibid. p108)

But Troise is concerned more with the occasional framework breaks that occur within the context of a generally secure frame and his point is that occasional breaches will not necessarily result in a negative perception of the event on the part of the patient and similarly

the patient's response to framework breaks will not necessarily be universal or entirely predictable but will also have something to do with their internal object relations. Troise thus leaves the possibility open for a more balanced approach to the influence of transference in the understanding of patient's productions in therapy (*ibid.*). This idea is revisited in the discussion in section 7.4 below.

CHAPTER 4

METHOD

The communicative approach calls for an examination and appraisal of the productions of patients within the context of the interactions between both participants to the therapy. This has been the most prominent and enduring contribution of the communicative approach to understanding the patient. The contextual examination of behaviour of research subjects is an approach to understanding that is also emphasised by qualitative researchers (Bogdan and Biklen 1992; Bromley, 1986; Dey, 1993; Miles and Huberman, 1994). Miles and Huberman (1994) contend that:

Most qualitative researchers believe that a person's behaviour has to be understood in a specific context, and that the context cannot be ignored or "held constant". The context can be seen as immediately relevant aspects of the situation (where the person is physically, who else is involved, what the recent history of the contact is, etc.), as well as the relevant aspects of the social system in which the person appears (a classroom, a school, a department, a company, a family, a hospital ward, a local community). Focusing solely on individual behaviour without attending to context runs the serious risk of misunderstanding the meaning of events. (p102)

Spence (1987), calling for a more appropriate metaphor and methodology for research aspects in psychoanalysis than that of the natural sciences, argues for the importance of the context of events in the therapy room. Within the qualitative approach to research generally, the communicative approach to psychotherapy takes this contextual understanding to its extreme in that Langs's methodology can be said to involve a radical approach to the contextual understanding of patients' material within the therapy session, relating virtually everything that the patient says in therapy to the therapeutic context. Therapy is not an isolated act between two people but occurs in the situation of ever widening contextual circles. The immediate context is the framework, but this occurs in the context of private practice or of a hospital setting with particular institutionalised ideas and attitudes towards psychotherapy. This setting in turn exists in the wider context of a suburb, town and country with the wider attitudes to therapy also impacting on the therapy and the therapeutic interaction. What is also apparent about the contextual approach of communicative psychotherapy is that the wider contexts, outside of this therapeutic interaction, are perhaps not adequately considered in this methodology.

The Langsian communicative methodology, in its operation as therapy and as it occurs within the therapy room can be seen as a form of participation research (Reason & Rowan, 1981) in the sense that the therapist's interpretative activity ideally proceeds according to the patient's response to the interpretations. The therapist hypothesises about the patient and intervenes on the basis of those hypotheses which are then confirmed or not confirmed by the patient's responses.¹

The present research study can be broadly conceptualised as a qualitative analysis (Miles and Huberman, 1994) of a number of texts (Kelly, 1994a, 1994b; Ricoeur, 1970, 1977, 1981a, 1981b; Spence, 1987, 1988) that have been produced in the normal course of psychotherapy. Understanding and interpretations in the form of interventions are bound up with the patient's 'self reflection' (Habermas, 1972), and confirmation of interventions or interpretations requires an examination of the patient's responses to the interventions (Langs, 1982, 1988). In the current study, the *research* takes the form of an examination of completed texts that have been produced by patients and therapists. The original texts might have been produced with some degree of collaboration between the two parties but the collaboration is limited to those two parties and the later analysis can be seen as a meta-analysis or a meta-interpretation of these original living dialogues which are now fixed in the form of transcripts.²

This study is further conceptualised as a multiple case study method (Bromley, 1986; Edwards, 1993, 1994) in the area of theory testing and specifically testing the relationship between events (Edwards, 1994) with questions asked of the data of individual cases and across all cases as a form of replication of the individual case studies (Miles and Huberman, 1994). The study can be further understood as being a type of situation analysis (Bromley,

¹ This is not to suggest that the interpretive activity of the therapist is a smooth, clearly articulated process that can be neatly divided into discrete units (see Kelly, 1994a). The process of therapy unfolds as a dialogue (Kelly, 1994a; Brice, 1993; Friedman, 1992) with the two parties to the dialogue influencing each other in a dialectical fashion and the patient in the process obtaining an understanding or enlightenment, as a form of self reflection (Habermas, 1972).

² The fact that these texts are now relatively static in the form of transcripts is not to deny the possibility of further exegesis and interpretation (Ricoeur, 1979; Spence, 1987).

1986; Swartz, 1989) whereby the circumstances of the framework of psychotherapy in a specific hospital context are examined.

Individual cases are examined for the ground rules that have been broken and the responses to those ground rules in the thematic material of the patient. The questions asked of the individual cases concern whether there is thematic material that corresponds to or can be coherently linked with these ground rule breaks. Langs's (1982, 1988) ideas of what kind of thematic material to expect are used as a starting point for this exploration but the research is not limited to this and the patient's material is further interrogated to discern other possible links and meaningful patterns in the data, partly in line with Mahrer's (1988) conceptualisation of discovery-oriented psychotherapy research. The ground rules are examined across all the cases to explore the breaks in these ground rules common to all the cases and to establish whether there is a pattern to be discerned in the material across the cases.

This study is delineated in two parts but it is essentially a single study of patient's responses to the framework breaks in a particular institutional context. The salient framework features of this particular institutional context are described in some detail in the first part of the study (Chapter 5) in order to broadly contextualise the therapy sessions that are examined in the second and main part of the study (Chapter 6).

4.1 VALIDITY OF THE RESEARCH

The concept of validity in this study refers to three distinct but interrelated issues. On the one hand there is the validity of the actual research methodology which is separate from but related to the scientific status, or scientific validity of communicative psychotherapy, and the validity of Langs's propositions and theories about the ground rules and about therapy generally. Both of the above validity issues are linked in important ways to the validity of the therapists' interpretations in the actual therapy sessions under study. Each of these issues will be examined in turn in this section but the link between them will be apparent throughout the study and the latter two issues will also be dealt with in the discussion (see section 7.2.5 below).

4.1.1 The scientific status of communicative psychotherapy

The method of understanding patients' material adopted in this study is a modified version of Langs's (1979) communicative approach to supervision and the communicative approach to understanding patient's material generally (Langs, 1982, 1988). Communicative psychotherapy is unequivocally within the psychoanalytic ambit and it is appropriate to consider the scientific implications of this modified communicative methodology in this section of the study alongside a broader conceptualisation of the scientific status of psychoanalysis generally. Freud (1938) conceived of his activities as scientific and modelled his nascent science on the natural sciences (Edelson, 1984, 1988; Grünbaum, 1984, 1993), attempting to force the hermeneutic and human science aspects into the mould of the natural sciences, the prevailing dominant paradigm of science (Habermas, 1972; Spence, 1987). Langs (1982, 1988) conceptualises communicative psychotherapy within the same boundaries as psychoanalysis (Meacci, 1992), only attempting a tightening up of certain aspects of the treatment methodology and claiming in the process a return to the earlier Freud, the Freud of the topographical theory and the Freud of the interpretation of dreams. The methodology of communicative psychotherapy is based on the methodology of the interpretation of dreams (*ibid.*) with the day residue being the equivalent of the adaptive context and the manifest and latent content of the patient's material having its equivalent in the manifest and latent dream material (Langs, 1988).

The scientific concerns of communicative therapy are a logical extension of the 'therapy as laboratory' approach that Freud espoused. Freud (1938) conceptualised his work as being, at one and the same time, both therapy and research. This research aspect of psychoanalysis has developed hand in hand with a theoretical infrastructure which has been heavily criticised by, amongst others, Popper (1972) for its lack of falsifiability and more cogently by Grünbaum (1984, 1993) for its epistemological confusion.

The issue of the scientific status of psychoanalysis is a complex one and the details of the extensive debate that has raged, almost since the inception of psychoanalysis, (Edelson, 1984, 1988; Hornstein, 1992), while important and interesting in its own right, is beyond the scope of this dissertation. Only the barest outline is possible here and it is hoped that this

simple outline does not misrepresent the intricacies of the points made by the protagonists in the debate.

Habermas (1972) contends that psychoanalysis can claim legitimation as a science and is the only tangible example of a science which incorporates 'methodical self reflection' (p214). Perhaps the most relevant aspect, for communicative psychotherapy, of Habermas's conceptualisation of psychoanalysis, is his explication of Freud's retreat from the self reflective (and according to Habermas, validly scientific in its own right) methodology of dream interpretation into an attempt at objectivity that, for Habermas, reflects a retreat into a crude positivism. Habermas reminds us that Freud's metapsychological framework was derived from the analytic situation under particular conditions of 'sheltered communication' and consequently these analytic discoveries cannot be divorced from this context, thus diminishing the usefulness of, if not entirely shutting down the possibility of, an external, empiricist examination of these assumptions (ibid.). Consequently Habermas contends that in order to effectively critique the Freudian metapsychology one has to examine it on its own terms, within the context of that privileged space made possible by psychoanalytic technique. This has implications for communicative psychotherapy with its heavy emphasis on the ground rules of therapy and the technique of therapy and also for the present study which attempts to examine some of the propositions of communicative psychotherapy, particularly those relating to the ground rules.

Spence (1987, 1988) argues that it is essential to have a reliable and valid extra-clinical access to the privileged therapy space and this can be achieved without doing violence to the narrative quality of the data and without forcing the clinical material into a positivist straightjacket. The present study is an attempt at examining a circumscribed aspect of what is occurring in the therapy space, in its own terms and in a manner which does minimum violence to that privileged space, whilst maintaining an acceptable degree of validity.

Habermas (1972) contends that Freud's 'depth hermeneutics' deals with texts which indicate 'the author's' (the patient's) self deception. For Habermas the neurotic symptoms are "the scars of a corrupt text that confronts the author as incomprehensible" and he reminds us, following Freud, that the non-pathological model for such a text is the dream. (ibid. p219).

Langs (1988) extends this conceptualisation. While Habermas has it that the interpretation of dreams is the model for the illumination of all pathologically distorted meaning structures, Langs extends this model of dream interpretation as the model for the interpretation of all communication in the therapy room (Langs, 1982; 1988), including in this extension, the patient's veridical perceptions of the therapist which are distorted through symbolisation and displacement, when they are communicated by the patient.

Habermas maintains that the disturbance of communication which is the object of psychoanalysis and at the heart of depth hermeneutics requires an interpreter, not to mediate between two people who speak different languages but instead to interpret to one person, the aspects of their language that have become foreign or alien to them. Thus for Habermas, the type of understanding in psychoanalysis or psychoanalytic hermeneutics is 'self reflection' in that there is ever present this requirement of enlightenment or understanding on the part of the patient. For Habermas this fact of self reflection can be demonstrated on the basis of Freud's technical papers which are aimed largely at this project. Thus self reflection has important consequences for the process of verification and confirmation of therapist interpretations. Habermas contends that the analytic insights possess validity and can be accepted by the analyst only after they have been communicated to, and accepted as knowledge by the analysand through this process of self reflection. This is an echo of Freud's (1937) so called 'tally argument' of verification which has received such heavy criticism from Grünbaum (1984, 1993) and upon which much of Grünbaum's criticism of Freud and psychoanalysis rests.

Spence (1987) argues that psychoanalysis, by adopting the methods and metaphor of the natural sciences (see Edelson, 1984, 1988; Grünbaum, 1984, 1986, 1993; Wallerstein, 1986b) and trying to make order out of chaos through an attempt at understanding all the undecipherables, is in effect closing down the possibilities that are promised by this once exciting method. Spence (1987, 1988) calls for a tough minded hermeneutic approach that will leave open some of the possibilities for further understanding while at the same time providing for the establishment of a system that will allow for the accumulation of rules and the accretion of methodological axioms that would guide the making of meaning and prevent an approach to interpretation wherein 'anything goes'. For Spence (1987) this means

firstly the requirement that the authors of case studies supply sufficient detail and context for the reader to follow the proceedings and the interpretative thought processes of the therapist\researcher. Freud, by plugging all the gaps in the narrative of the patient through a process of smoothing (Spence, 1987) and through attempting to justify his methodology by forcing it into the mould of the natural sciences actually shuts off the promise of further discovery in the data that he presents. According to Spence:

The longer that psychoanalysis insists on being a science, the more it will play down one of its main attractions - the search for multiple meanings and the search for decision rules to select among them. (ibid. p155)

Edelson (1984) delineates three stages of philosophical criticism of the scientific status of psychoanalysis. The first two stages of the debate, firstly that psychoanalytic concepts and terms are too vague as to admit of any serious inquiry (Nagel, 1959) and secondly that the propositions of psychoanalysis are in practice unfalsifiable (Popper, 1972) have been adequately refuted by many commentators (Edelson, 1984, 1988; Wallerstein, 1986b) and most cogently by theorists who are themselves critical of the scientific status of psychoanalysis (see Grünbaum, 1979, 1984, 1986, 1993).

The third stage of criticism of the scientific methodology of psychoanalysis comes in the formidable form of the arguments of Grünbaum (1979, 1983, 1984, 1986, 1993) whose contentions have proved to be harder to refute by those elements of the psychoanalytic community that have bothered to take note of them (see Grünbaum, 1986 and responses from 39 commentators). The gist of Grünbaum's argument is that, contrary to cherished belief, psychoanalysts cannot legitimately use the data obtained from within the psychoanalytic situation to gather support for their hypotheses. Central to Grünbaum's thesis is his contention that data from the psychoanalytic situation are irredeemably corrupted by the psychoanalyst's suggestions and selection biases (conscious or not) and the analysands' prior knowledge and preconceptions about psychoanalysis as well as the fallibility of the patients' memory and reasoning about their own experiences, thus precluding the use of the patient for verification via a form of 'tally' with the therapist's interpretations. The target of Grünbaum's formidable and incisive analysis has been wide ranging and has included the hermeneutic reformulation of psychoanalysis, the major psychoanalytic hypotheses, the theory of

repression and the theory of transference and the role of the case study method in the foundations of psychoanalysis (Grünbaum, 1993). Grünbaum's (1984) work has engendered a lively debate that has been fostered by the publication of a précis of his position, together with the invited responses from 39 other commentators (Grünbaum, 1986) and this has led to the revision of one specific, but important, aspect of his thinking regarding the lack of reliability of psychoanalytic data due to its contamination. In response to the commentary by Holt (Grünbaum, 1986), Grünbaum (1993) concedes that he will stand corrected "if future study of tape-recorded analytic sessions should turn out to be capable of disentangling contaminated data from valid data, as Holt surmises" (ibid. p276).

Grünbaum (1986, 1993) allows then for the possibility of extra clinical validation of some of the tenets of psychoanalysis. The current study attempts to assess a small corner of the communicative psychotherapy domain and attempts to use a methodology that conforms to acceptable standards of rigorous methodology.

4.1.2 Confirmation of therapist interventions

Confirmation of psychoanalytic interpretations and consequently of psychoanalytic theory is an aspect that has been critically dealt with by Grünbaum (1984, 1993), Ricoeur (1977) Edelson (1984, 1988) amongst other theorists. Communicative psychotherapy is specifically concerned with a narrower range of events to be verified in therapy than that of the aforementioned commentators, who are more concerned with a broad sweep across the realm of the verification of psychoanalytic assertions, theory and interpretations generally. Thus Ricoeur (1977), for example, essays a lengthy and detailed foray into the question of proof in Freud's writings and maintains that, although Freud conceptualised psychoanalysis as scientific he never managed to articulate fully how "its assertions are justified, how its interpretations are authenticated, how its theory is verified" (p247).

Within the confines of its specific interest in the validation of therapists' interventions, communicative psychotherapy attempts to provide a more workable, operationalised process of validation of interpretations than that suggested by Freud (1937, 1938) and articulated more comprehensively by Ricoeur (1977) but it maintains the unconscious of the patient as the final arbiter of the veracity of the therapist's interventions. Langs (1988) concedes the

importance for communicative psychotherapy of the parallel processes of decoding of patients' communications and verification of therapists' interventions. He states:

In substance, then, the communicative approach to psychoanalytic psychotherapy stands or falls on the correct decoding of the patient's encoded, or derivative, communications and on an understanding of their unconscious meanings and ramifications. For validation of correct interpretations, the approach relies on subsequent unconscious derivative communications from the patient which typically extend a correct therapeutic intervention in unique and unexpected ways. (ibid. p10)

The derivative validation required of interventions in communicative psychotherapy takes two forms, cognitive and interpersonal. Cognitive validation refers to the emergence in the patient's material of a new dimension to the patient's symptomology, while interpersonal validation refers to the emergence in the patient's material of well functioning figures, often involving an allusion to something done well and effectively. Ideally both should be present in order to validate a sound intervention (Langs, 1988, p82).

The patient's derivatives provide confirmation of the validity of the interventions or they provide a lack of such confirmation, thus opening up communicative therapy to a formal process of verifiability and falsifiability and undercutting to a large extent the charge of epistemological confusion brought by Grünbaum (1984, 1986, 1993) in relation to Freud's so-called 'tally argument' of verification. In addition communicative therapy offers predictions at various points in the therapeutic process as to the type of response that could be expected from the patient. Langs offers numerous examples of predictions of patients' responses in his seminars with neophyte therapists (Langs 1979) and in his more general texts on psychotherapy (Langs 1976, 1978b, 1982, 1988) (see section 3.5 above and section 7.2 below).

4.1.3 Validity of the research methodology

Questions of the validity of the research methodology are particularly important in this study, perhaps more so than in other qualitative approaches to psychotherapy research in that the analysis of sessions is based on Langs's theory of communicative psychotherapy which is itself, broadly speaking, under scrutiny in this study. In these circumstances one has to be particularly wary of begging the question and using the theory to justify itself (Grünbaum, 1984, 1993; Edelson, 1984, 1988; Eysenck, 1985; Popper, 1972).

Miles and Huberman (1994) note that people are "meaning finders" and have a tendency to quickly find meaning and make sense out of the most chaotic events (ibid. p245). Bromley (1986) reminds us that this tendency to impose order on chaos and to see connections, even spurious connections, between things is a fundamental human propensity and it has led to the creation of some rather dubious sciences such as palmistry and astrology (ibid. p244). This human proclivity is particularly relevant in the context of communicative psychotherapy where it is required of the researcher (or originally the therapist) to look for patterns in the patient's verbal productions and to make sense of these patterns in terms of the prevailing adaptive context of the therapy. Miles and Huberman (1994) suggest a number of tactics for drawing meanings and for verifying conclusions in the qualitative research approach generally, some of which are directly relevant in the context of this research and are examined below. Similarly Bromley (1986), observing dryly that we are probably better at identifying the biases and limitations of other people's thinking rather than our own, suggests numerous ways of checking for bias in one's inference making process and counsels vigilance against specific forms of logical fallacies in this deductive process. Edelson (1988) enumerates similar standards which should be observed by case studies in psychoanalytic literature if the latter "purports to constitute a scientific body of knowledge" (p266).

Miles and Huberman (1994) suggest a healthy scepticism when it comes to the human propensity to make sense too quickly of themes and gestalts in the data. They counsel holding off premature closure and suggest that the researcher ask whether the meaning occurs elsewhere in the data, whether it makes conceptual sense and whether there are any counter examples. They suggest that not only should the researcher look for plausibility in the explanations for the data but also lack of plausibility and the researcher should actively use the tactic of looking for negative evidence to refute constructs (ibid. p271). They remind us that the absence of negative evidence can never be decisive as a confirmatory tactic (Popper, 1972). Miles and Huberman (1994) argue that it is vital to hold on to rival hypotheses during the course of one's qualitative analysis and not to foreclose too early on these other explanatory hypotheses. They advise that it is important to hold onto several possible explanations until one of them becomes more compelling on the basis of stronger and more varied evidence and in this way avoid a possible bias (p276).

The advice of Bromley (1986), Edelson (1988), and Miles and Huberman (1994) is really a description of a mindset to be adopted by the researcher, similar to the mindset suggested by Spence (1987, 1988) for tough minded hermeneutics. This advice has to be heeded but it is not enough for the researcher to invoke one's mindset as a kind of talisman to ward off the evil eye of criticism of one's methodology. It is difficult for the researcher to specify exactly how one has been tough minded and unbiased in one's analysis and consequently one has to provide enough information for readers to partake of the decision making process and make their own decisions regarding the meaning and pattern of the events described in the research (Spence, 1987). This information has been specified in some detail in sections 4.3 and 4.4 below.

In addition to the above and in similar vein, an audit trail of the research has to be left, so that the process of the research can be followed and if necessary audited. The audit trail in this study is comprised of the setting out of the specific steps taken in the analysis of the data, consulting with colleagues and supervisors regarding the analysis of the data, and the safe keeping of raw data and original documents.

In the first part of the study (section 4.3 below) the question of researcher effect is conspicuous. Miles and Huberman (1994) describe the researcher effect simply as the effects of the researcher on the behaviour of the subjects that would not have occurred ordinarily. They delineate two reciprocal kinds of researcher effects, namely the effects of the researcher on the case and the effects of the case on the researcher. In this section of the study the first kind of researcher effect was decreased due to the fact of the researcher being part of the organisation under study. However this fact meant that the possibility of the converse form of researcher effect was simultaneously increased. The researcher, as a member of staff of the hospital, was not seen as an outsider making observations of the operation of the framework in the hospital context and consequently could be privy to more information without influencing and interfering with the data source, but simultaneously, could be said to have been too enmeshed in the hospital to retain the objectivity necessary to report faithfully on the issues relating to the ground rules. It is doubtful, however, if other research methods would have delivered more information in a cost effective way, or even

simply in a more effective way. In addition, the researcher's observations were supplemented by the interviews with therapists which formed the second part of the study and by an examination of the actual transcripts of their therapy sessions.

The texts to be examined were transcripts of audio tapes of the sessions, thus eliminating to some extent a potential bias due to the propensity of therapists to smooth over gaps in their memories of past sessions and to not recall all the details of these sessions (Smith, 1993, Spence, 1987). This is a minimum requirement of research into the process of therapy (Edwards, 1993, 1994; Gill, 1984; Grünbaum, 1993). In addition the researcher interviewed therapists individually regarding the background adaptive context of each individual session in order to obtain a thorough understanding of the breaks in the ground rules occurring in the individual sessions of therapy.

All available transcripts of sessions were used in this study which represented an attempt at a naturalistic observation of what was occurring in terms of the ground rules of therapy in the hospital context. No attempt was made to sample specific kinds of sessions or to select specific patients although it could be argued that there is a type of selection bias at the level of the individual therapists who were selecting the kinds of patients that they would record for therapy supervision and hence for the study. This selection factor does not significantly effect the research in that the sessions of therapy were being scrutinised in their entirety and subjects were, in a sense, acting as their own controls in that each transcript of a therapy sessions provided examples of ground rules being adhered to and ground rules being broken. The patients' responses to these different ground rule conditions provided the elements to be interrogated and analysed.

4.2 THE RESEARCH QUESTIONS

The three broad goals of the empirical portion of the study are firstly, to examine the actual workings of the ground rules of psychotherapy within a psychiatric context, focusing on the ground rules that are consistently broken in this context. Secondly, to examine patients' responses to the ground rules that are broken within this context. Thirdly, to broadly evaluate Langs's theoretical contribution to the practice of psychotherapy in an institutional context in South Africa.

The questions addressed by this study were:

1. What are the ground rules that are consistently broken within an institutional context?
2. What are the reasons for the breaks in the ground rules?
3. How do patients respond to these ground rule breaks both at a conscious and an unconscious level?
4. Are supportive therapeutic interventions as ineffective and detrimental as Langs claims them to be?
5. Is a rigidly maintained framework itself not problematic in a hospital context and are there not instances of patients reacting unfavourably to the strictures of a rigidly maintained framework?
6. Are there some ground rule breaks that are more favourably received by patients in a psychiatric hospital context?
7. Are patients in a psychiatric hospital context as deeply suspicious of the flexibility of supportive therapy as the Langsian communicative paradigm maintains them to be?
8. Do patients respond more favourably to a more rigidly maintained framework?

4.3 OBSERVATION OF THE WORKINGS OF THE GROUND RULES IN THE INSTITUTIONAL CONTEXT

The first part of the study consists of a delineation of the operation of the ground rules of psychotherapy as they apply generally at Lentegur psychiatric hospital. This then is the broad context of the research in that the therapy sessions took place within this hospital context. Swartz (1989) describes two traditions in the research literature relating to the social organisation of psychiatric practice, namely the macrosocial and the microsocial levels and concludes that research which links the macrosocial with the microsocial levels of analysis is important for a fuller understanding of how these institutional aspects broadly impact on the actual practice of individuals within this institutional context. The current study attempts a narrow focus, specifically on those particular aspects of the institution that affect the ground rules of psychotherapy in the institutional context. A more widely focused analysis would undoubtedly be fruitful in understanding the broader context of these institutional factors impacting on the ground rules, located as they are within the relationships of power within psychiatric and medical hierarchies. This broader analysis,

interesting and fruitful as it would be, has to remain outside the scope of this research for reasons of space and time.

4.3.1 Method of obtaining information

Observations were made by the researcher, of the procedures and administrative systems that have an impact on the psychotherapy that is performed at the outpatient department and at two inpatient therapy units at the above hospital. Simple observations were made in and around the ward with a specific focus on aspects of the administrative arrangements that would possibly have an impact on the functioning of the framework and the ground rules of therapy in those units. Aspects of any administrative matters that were initially unclear were followed up by discussions with the relevant administrative officers and clerical staff responsible for their implementation.

4.3.2 Data recording

Notes were taken of these observations, discussions and interviews. For the level of analysis of the data required by this particular study it was not felt to be appropriate to record conversations or ward rounds using an audio tape. This does open the researcher up to a charge of biased selection of the material but the data that is reported in this section is accessible to any casual observer or visitor to the wards in question. It is of the order of common knowledge within this type of context and is not at the level of penetration requiring any specific justification in terms of the data analysis. The data in this section becomes more meaningful when it is combined with the responses to these framework conditions that are provided by patients in the following section.

4.3.3 My role in the institution

These observations were undertaken over a period of two years while I worked and supervised in the above three units from August 1995 to July 1997. Although I have worked in the hospital context for a considerably longer period and have been interested in researching therapy in this context (Rees, 1993), my interest in this particular aspect of psychotherapy was sparked by sustained exposure to the work of Langs just prior to this period. This constituted the beginnings of a curiosity about the functioning of the ground rules of therapy and the difficulties of maintaining a secure frame in this institutional context

(Rees, 1995a). This aspect of Langs's work, together with his methodology for understanding what patients seem to be saying about these various aspects of the damaged frame in their productions in therapy, seemed to be an extremely pertinent aspect of therapy to research in the hospital context.

In one of the therapy units I attended ward rounds and other ward meetings as a full member of the multidisciplinary team and took part in the activities of the ward, seeing patients for individual therapy, running groups and supervising intern psychologists. In the other therapy unit, which was run along very similar lines, my role consisted more in attending ward rounds and the supervision of intern psychologists. I also saw individual outpatients for psychotherapy.

4.3.4 Interviews with therapists

The above observations were supplemented by an examination of the actual practice of therapy on the part of six therapists who worked at Lentegur Hospital in the above three units (part 4.2 below). The therapists were interviewed regarding the workings of the ground rules of therapy in respect of actual sessions of therapy (see Appendix 1) and their actual therapy sessions were scrutinised for ground rule breaks, as part of the second part of the research. An account was developed (Chapter 5 below) of the workings of the ground rules of psychotherapy at Lentegur hospital on the basis of these observations, interviews, and examination of the framework breaks in actual sessions of therapy.

4.4 THE STUDY OF PATIENTS' RESPONSES TO THE INSTITUTIONAL FRAMEWORK

The main part of the study comprises an examination and analysis of individual patients' responses to the framework breaks that applied to each individual patient. Not all of the framework breaks that are in operation generally in the institution apply to every individual patient. Each case is examined individually in order to ascertain which ground rules are broken and which remain in force in that particular session of therapy. Therapists were interviewed to establish which ground rules were operating with regard to each session of therapy. The interviews were based on Langs's (1982, 1988) delineation of the ground rules (Chapter 3 above). The interviews were undertaken using a semi-structured format, using a

set of questions (see Appendix 1) as a basis for the interview. Notes were taken by the researcher of the therapists' responses to the questions during the interviews.

4.4.1 Selection of participants for the study

No specific selection criteria were used for obtaining participants in the study. All of the therapists working in the three units concerned were asked to participate in the research. All agreed to supply material for the study when requested. Participants were required to supply a transcript of an audio taped session of therapy and to agree to be interviewed regarding the ground rules pertaining to the particular session under scrutiny and the operation of the ground rules generally in the units. No specific session was requested in terms of whether the session was in the beginning, middle or end phase of the therapy. Participants were told that the research involved a study of the framework of therapy as it operated in the hospital context and that the researcher was interested in examining the patient's unconscious responses to these various framework conditions. Six of the 12 sessions examined were originally produced as transcripts of audio taped sessions for supervision and thus were not produced specifically for the study. No attempt was made to select patients for the study in terms of their diagnostic categories and pathology, and a conscious decision was made to simply accept whatever patients were being seen by therapists for psychotherapy in this institutional context.

4.4.2 Selection of sessions for analysis

In total, transcripts of 12 audio taped sessions of psychotherapy were examined and analysed. Six therapists were originally interviewed for the study but the therapy sessions of two therapists could not be used due to poor quality of the audio tapes and had to be discarded. The six sessions of therapy obtained from the four remaining therapists were supplemented by six audio taped sessions of the researcher's therapy with two separate patients.

It was felt to be important to supplement the six sessions of therapy obtained from the other therapists with six sessions of therapy from the researchers' own work, making a total of 12 sessions for analysis. This was done in order to increase the variation in the type of therapy sessions obtained. It was considered that using therapy material from patients seen by the researcher would not involve a research bias, as the nature of this part of the study involved

predominately a scrutiny of the patient's material, specifically the patient's unconscious perception of the breaks in the ground rules. It was felt that this additional material would enhance the research as the focus of this section of the study was on the patient's narrative as obtained from transcripts of audio taped sessions of therapy and not on the therapist. In the past, a serious criticism of the communicative approach in general and Langs's work in particular has been that it does not use the work of experienced clinicians in the case study material that is published (Gill, 1984; Rees, 1995a; Smith, 1991a). Langs in particular declines to report on his own work, claiming not scientific expedience, but simply that he is reluctant to violate the privacy and confidentiality of his patients (Gill, 1984). Langs reports then only on work that he has supervised, which, almost by definition, is more likely to be of an inferior quality, in terms of communicative psychotherapy methods, than his own work, and not very elucidating as a comprehensive example of sound communicative technique.

In addition, as a further source of variation in the research and as a form of participation research (Reason & Rowan, 1981) it had been hoped to use the ongoing work of some of the participating therapists over a number of sessions whilst they were being supervised in the techniques of communicative psychotherapy with due regard for the importance of the framework. However this was not possible because of difficulties in obtaining consecutive sessions of therapy from the therapists. Thus it was felt that by using the researcher's own work, which involved a tightening up of the ground rules of therapy over the five sessions, an important variation in the data would be obtained. It was felt that a substantial difference in the patient's responses could possibly be discerned over these five sessions of therapy and these changes in patient's responses could be examined for their relation to the changing framework conditions over these sessions.

4.4.3 Selection of material for study

The study of psychotherapy poses a large problem for researchers. Access to that intimate space that constitutes psychotherapy is extremely difficult without interfering in some way with that process. Investigating with accuracy and validity the process of patients' responses to the ground rules of therapy is especially difficult without somehow contributing to the ground rule breaks. Obtaining audio tapes of sessions of therapy, whilst essential in any research on the process of psychotherapy (Gill, 1984; Smith, 1993b; Spence, 1987), is

acutely ironic in this context because it is a blatant break of the ground rule requiring privacy and confidentiality and a violation of the sanctity of the therapy that is the whole thrust of the principles behind the communicative approach to therapy. Adopting this procedure was justified on the grounds that the making of audio tapes was, for the most part, occurring for the purposes of supervision, thus this ground rule was in any event being broken in this context. It was felt to be extremely important to obtain material that was an accurate record of what was occurring in the therapy sessions.³ This was in order to obviate the fundamental problem of inadequate therapist recall of actual events in the therapy session as well as providing a more substantial base of evidence for the research (Spence, 1987; Smith, 1993b).

The patients themselves were not interviewed and questioned as to their perceptions regarding the framework. The researcher, following the communicative approach to understanding patient's material, was interested in the *unconscious* attitudes of patients to these important events in the therapy. Interviews with patients on the subject would obviously provide an excellent access to their conscious attitudes and perceptions but the thrust of this study was towards an understanding of the patients' unconscious responses as a type of depth hermeneutics (Habermas, 1972; Ricoeur, 1970). Kelly (1994b) puts the point succinctly when he states that:

If we think that the subjects who are the object of our investigation are finally the ones to whom we are to return our interpretations in order to establish their veracity, I believe we reduce our attempts at understanding to the most banal and superficial level. (ibid. p5)

Langs (1982, 1988) maintains that even if patients give their conscious agreement to our interpretations, they consciously assent to our interventions and consciously go along with our ground rule breaking actions, their unconscious, derivative material has to be read for the

³ Gill (1984) expresses surprise at Langs's injunctions against the use of audio recording of sessions of therapy for research purposes, particularly in view of Langs's stated concerns with an empirical validation of his postulates about therapy. Gill feels that this issue is not negotiable. Lubin (1984) points out that Langs does in fact sanction the use of taping of sessions for research purposes, provided that it is considered a crucial adaptive context and that it is eventually rectified within the therapeutic relationship (ibid. p424). Langs's current research activities involve audio recording of sessions of therapy for research purposes (see Langs & Badalamenti, 1992a, 1992b; Langs, Badalamenti & Cramer, 1992).

truth about this superficial acquiescence. The return to the patient for confirmation then, for Langs, is at a different level, in that the derivative material, the latent message below the manifest, surface content invariably contains clear signs of a negative reaction to the breaks in the frame (*ibid.*).

4.4.4 Patients' consent

Like the issue of the intrusion into the therapy session by the use of audio taped material, the issue of the use of patients' material for the purposes of training and study is a thorny one. Patients in the hospital context give their written consent to their material being used for the purposes of training and study and it was felt that this constituted the necessary consent for the use of the therapy material for this study which is essentially a form of supervision. The question of obtaining prior, specific consent from each individual patient, on the part of the researcher, was weighed up in terms of the increased likelihood of the interference this would have had on the process of the therapy in general as well as the increased interference specifically on the study.

While the decision was taken to proceed with the study on the basis of the implicit consent given by the patients, this was not taken lightly and it remains a theoretical and practical problem in research of this nature. A judgement has to be made in every case on the basis of the degree of exposure of patients' material, the merits of the research in potentially improving the therapy of current and future patients and the potential for adding another element of intrusiveness into the therapy and an added distortion into the research. There are no easy answers to this question.

Names and some of the more obvious identifying details of patients, which were not relevant to the questions at hand in the study, were changed or left out in order to conceal as far as possible the identities of patients. In addition names of particular wards have also been changed as an additional attempt at concealing patients' identities.

4.4.5 Langs's method for deciphering patients' material

Langs (1988) considers that the communicative approach, through its relentless and rigorous focus on the unconscious has developed a methodology that is "faithful to Freud's original

goal, which was to offer a cure for madness based on insight into truly unconscious factors." (p10).

The methodology summarised here is adapted from Langs (1988). Langs has developed his ideas considerably over the three decades that he has been writing on the subject of psychotherapy but this work (*ibid.*) contains the most comprehensive and up to date account of his 'hermeneutic' methodology for understanding and decoding patients' material from sessions of psychotherapy. Later works focus firstly on working with larger groups of people outside of the therapy room in a class room context (Langs, 1993) and in a further development, apply a quantitative and mathematical approach to psychotherapy research. (Badalamenti & Langs, 1992; Langs & Badalamenti, 1992a, 1992b; Langs, Badalamenti & Cramer, 1992).

Langs's method of analysis of patients' material has been developed specifically for the purpose of understanding the material within the session and is designed to help the therapist make the most appropriate interactional interventions within the sessions, in light of the patients' material, while the material is being produced in the session (Langs, 1982, 1988). In line with this usage, Langs (1979) has also utilised his system of understanding the patient's material as a means of supervision. Langs's therapeutic and supervision system has been adapted here as a hermeneutic research method to understand the patient's material in response to framework breaks in the institutional context by examining transcripts of audio taped sessions.

Langs's method for decoding material is used for both psychoanalysis and for psychotherapy. Langs makes no distinction between the two in terms of the method for decoding. The method is also used in understanding material from patients where there is no secure frame operating, such as in mental health clinics and in hospitals (Langs, 1988).

At the heart of Langs's system for decoding material is the proposition that the patient's narratives and comments about outside events should always be attended to for possible unconscious perceptions concerning the therapeutic interaction. Langs (1988) concedes that "on very rare occasions a highly significant outside trauma such as the death of an important

family member may evoke a significant measure of derivative expression from the patient" (p7). But, he adds the rider that even in these situations it is important to examine how the outside experience is used to represent issues within the therapeutic interaction in an unconscious manner.

All of the circumstances around the therapy have to be considered as interventions on the part of the therapist because, according to Langs, the patient understands all of them in terms of the therapist's involvement in them (ibid. p15). Thus even though the therapist might not be aware of, for example, the inappropriate dealings that a bookings clerk or receptionist might have with the patient prior to a session, this inappropriate interaction will be understood by the patient's deep unconscious system as having occurred with the tacit approval of the therapist.

The patient's verbal productions in the therapy sessions can be derivative or non-derivative. The latter are characterised by an absence of disguised or encoded meaning, although they may have implications which are accessible from the surface. Non-derivative material takes the form of intellectualisations, generalisations, non-specific comments, direct references to the therapist, efforts at analysis and other types of speculation on the part of the patient. They are messages of the *conscious* system even though some of the implications are outside of awareness (ibid. p19).

Derivative material on the other hand is made up of narratives or images and they take the form of stories, myths, descriptions of recent or past events, plays, movies, dreams and other material where imagery is prominent. Smith (1991a) contends that derivative material is specific, concrete and easily visualised and it describes other people or situations, not the therapist. In addition derivative material tends to be discontinuous and involves many changes of subject. The connection between the use of the fundamental rule of free association as a technique and the obtaining of derivative material is clear (see section 3.4.5). Derivative messages make use of the mechanisms of displacement and symbolisation. Understanding or decoding this derivative material involves reversing the processes of displacement and symbolisation. Displacement and symbolisation are terms that are usually associated with unconscious defences and this is important in that Langs considers the

patient's veridical perception of the therapist to be so anxiety provoking as to be forced to remain in the deep unconscious system and to only see the light of day in distorted form, by undergoing these defensive transformations.

Similarly the patient's material can only be comprehensively understood in terms of the activities of the therapist. Patient's material on its own, without this knowledge of the context is meaningless, or one dimensional at best. Langs contends that:

An encoded message is an adaptive response to a stimulus or trigger. It is the product of an interactional experience and can be understood only in light of a specific stimulus and the interactional context that has provoked it. (ibid. p22)

Thus the derivative is actually defined in terms of the trigger or adaptive context. Conversely, where an extended narrative does not reveal an encoded perception of a therapist in light of his or her interventions, the material must be considered to be non derivative. Langs argues that there has to be a perception of an intervention by the therapist for something to qualify as derivative material (ibid.).

According to Langs, verbal material from patients can be divided up into four levels of meaning, each interacting with the other levels. At the first level is the surface or manifest content. The second level is the implications of this manifest content which might not be immediately apparent to the subject but which will be readily recognised when pointed out. The third level is the more disguised unconscious fantasies and memories implied by the material. This third level implies meaning in terms of the subject's psyche which requires intrapsychic decoding and a fair amount of skill and knowledge of psychoanalytic theory. Finally the fourth level of meaning is the understanding of the material that relates it to the interventions of the therapist and which can be termed interactional meaning and which requires interactional decoding. It is this fourth level of meaning which is of particular interest to Langs and to the communicative approach to understanding patients' material. It is this fourth level of meaning which, in its *systematic* delineation and deciphering takes the communicative approach beyond psychoanalysis (ibid.).

Langs maintains that it is important to isolate every single image in the patient's material and attempt to decode its meanings in the light of the adaptive contexts at hand (ibid. p68). The therapist should consider every image from the patient as a conveyor of a valid encoded perception of the actual implications of the therapist's efforts before concluding that such material contains some other form of expression. Whenever the patient tells a story, recalls a memory or a dream that does not deal directly with the therapist and therapeutic situation, there is a strong likelihood that the material is encoded and that the encoding involves accurate unconscious perceptions of the meanings of the therapist's efforts (ibid. p56). On the other hand where there is much by way of ruminations, intellectualisations and non narrative material, Langs feels that there is little likelihood of the material being encoded perceptions. Langs remarks that nevertheless, even with this non narrative material the major themes should be identified, because they could involve general perceptions of the therapist's endeavours (ibid. p56).

Decoding involves reversing the action of symbolisation and displacement. The decoding procedure involves first identifying, in the manifest story, the theme that has been displaced from the initial context, which is the trigger or the adaptive context. The main themes are lifted from the manifest material and each separate element is identified and isolated. The therapist then attempts to discover an activated trigger with implications related to these themes. The themes are then read in terms of that trigger. The key to decoding, according to Langs, is the discovery of a level of meaning that is shared by both manifest and latent images (ibid. p57).

In the context of the actual therapy sessions when the therapist is having to think and respond rapidly, Langs contends that the therapist has to continually ask "What intervention, having what implications did I make, such that this particular narrative or image is a valid, encoded perception of myself?" (ibid. p55). Thus Langs advises that, in principal, every image in the patient's associations should be tentatively accepted as some type of perception of the therapist, until proven otherwise.

4.4.6 Detailed procedure for the analysis of sessions

4.4.6.1 Therapist interviews

The therapists were interviewed in order to establish the adaptive contexts, or triggers for each session and in order to obtain the background context of therapist issues regarding the therapy. A set of questions based loosely on Langs's (1982, 1988) ground rules for therapy was assembled by the researcher (Appendix 1) and was used to provide the backbone of a semi-structured interview. Therapists were asked to elaborate on points that were not clear from their initial responses.

4.4.6.2 Therapists' interventions

The therapists' interventions in the therapy sessions were identified from the transcripts of the sessions. Langs (1988) asserts that only four kinds of interventions are legitimate and these are interpretations, silences, playback of derivatives and framework management. Scrutiny of the actual sessions in this study revealed eight other types of interventions, namely patient management, reflections, encouragement, suggestions, advice, questions, clarifications and confrontations, giving a total of 12 types of interventions. These interventions were counted as a measure of the kind of activities that therapists were engaged in. Thus a predominance of questions (see especially Appendix 2: Mary session 1 and Appendix 12: Nerina session 3) was used as an indication that the therapist was being fairly active in the therapeutic dialogue and not allowing the patient the space to free associate.

The number of words by the therapist and by the patient in each session was added up and compared. This count also provided some measure of the degree to which therapists were allowing patients to free associate in the sessions and a rough measure of the degree of therapist intrusion into patients' material (see section 3.4.5 above).

4.4.6.3 Abstraction of thematic material

The patient's thematic material provided the primary raw data of the study in that, according to the theory of communicative psychotherapy this material embodies the patient's unconscious commentary on the activities and lack of activity of the therapist. This thematic material was abstracted by the researcher from a close reading of the transcripts of the sessions. This involved simply setting out what the patient had said in general terms, in the

order in which it was said, and removing some of the irrelevant detail. Thus, for example, if the patient spoke about being angry with her husband for talking about her behind her back and this was followed by her stating that her brother had been particularly helpful to her when she needed help, two separate themes would be stated as "I am angry with someone for talking behind my back" and "someone has been particularly helpful to me". Thus the substance of what the patient was saying was extracted from the transcript, whilst eliminating some of the extraneous detail or 'noise' (Kvale, 1983) from the material. There are risks involved in this process of cleaning up the material and fixing it into themes and these risks entail the possibility of a distortion of conceivably important aspects of the material as well as the possibility of a biased selection. In order to counteract as far as possible these potential distortions, several sessions were examined by a colleague in order to audit the process of analysis of the sessions. In addition several vignettes involving verbatim material taken from the sessions, are quoted at length throughout the text but especially in section 7.2 where the patients' responses to breaks in the ground rules are specifically discussed.

Although most of the breaks in the ground rules occurred outside of the sessions, and most of the therapists' activities in the sessions consisted of a bland, unobtrusive, reflecting back of the patient's material together with encouragements to the patient to continue speaking (see Appendices 2-13) it was decided to demonstrate any possible interplay of therapist and patient material by including some of the more animated therapist interventions with the patient's thematic material. Thus the therapist's interpretations, clarifications, confrontations and any other ostensibly intrusive therapist interventions were juxtaposed with the patient's thematic material by placing these interventions in the context of where they occurred in this thematic material in the actual therapy sessions (see appendices 2-13).

4.4.6.4 Manifest representations of the adaptive contexts

The manifest representations of the adaptive contexts were extracted from the transcripts of the therapy sessions. A manifest representation of the adaptive context is a specific reference made by the patient, in an undisguised manner, to a specific aspect of the framework or to the therapist's interventions (Langs, 1988). Thus, for example if the patient has been kept waiting by a tardy therapist for a lengthy period of time before the session and the patient refers, in the therapy session, to being in a hurry, or makes some reference to time then this

could be construed as a reference to the adaptive context of being kept waiting. It is 'manifest' in the sense that it is a direct, if fleeting, reference to this adaptive context. Identification of these manifest allusions to the ground rule breaks are important preliminary steps in the decoding process in that they lend credence to the 'latent' material that is embedded in them. The latent material is a fuller more richly textured, although unconscious, commentary on this adaptive context (Langs, 1982, 1988; Smith, 1991a).

Not all sessions that contain ground rule breaks include these manifest allusions to the ground rule breaks that form such an important part of the decoding process. Following Langs's procedure for interpretation of sessions, if there was no manifest representation of the adaptive contexts then thematic material that appeared to coalesce strongly and obviously with an adaptive context was documented. According to Langs (1988) this is technically one of the most crucial aspects to the understanding of patients' material (p52). Langs has it that identification of the activated adaptive context is essential to understand the patient's unconscious material and the therapist has to search the patient's material for allusions, both direct and indirect, to these interventions. Ideally there would be direct or manifest representation of the ground rule break, however indirect or derivative allusions could also be acceptable provided that they are clear. Langs contends that they must be sufficiently clear so that an informed observer could make an educated guess as to the intervention involved. Thus any direct mention of the therapist's silence, frame management efforts, as well as any allusion to the setting or other aspects of the conditions of treatment, should be recognised as a manifest representation of the trigger (*ibid.* p53).

4.4.6.5 Type of communicative field

The type of communicative field in each session was identified and recorded. Langs describes the communicative field as an amalgamation of the communication between therapist and patient which receives input from, and relies on the communicative attempts of both parties. For Langs (1982) there are three types of communicators corresponding to three types of communicative fields, namely Type A, Type B and Type C fields.

The Type A field is characterised by a communicative style in which symbolism and illusion play a central role and in which the patient communicates analysable derivatives. This field

requires a secure framework and a therapist who is capable of understanding and interpreting this kind of material from the patient (ibid. p747).

The Type B field is characterised by efforts at the discharge of the build up of disturbing internal stimuli and not through the communication of symbolic and derivative material. Projective identification and action-discharge are prominent in this type of communicative field. However, Langs comments that despite this lack, it is possible to use interactional interpretations in this communicative field (ibid. p747).

The Type C field, on the other hand, describes a situation where the essential meaning and relationship links between analyst and patient are broken and verbalisations are apparently designed to destroy meaning and communication between the parties. This field is designed then to create barriers to "underlying catastrophic truths" (ibid. p748). This type of communicative field occurs not only when patient's are uncooperative and silent but also when their verbal material is intended to obscure rather than communicate. Langs (1982) comments that such material is characterised by the absence of a meaningful adaptive context and the lack of analysable derivatives. Langs observes that it is not uncommon for patients employing this mode to interact with therapists who make extensive use of psychoanalytic clichés thus creating a "therapeutic interaction falsely identified as viable analytic work, while its primarily dynamic function falls within the Type C communicative mode" (ibid. p748).

4.4.6.6 Mode of relatedness

Langs (1982, 1988) contends that the patient's material typically contains allusions to various types of interpersonal relationships and these allusions invariably characterise the patient's unconscious perceptions of the therapeutic relationship. These unconscious allusions are particularly important after the therapist has made an intervention as they are indicative of the patient's perceptions of the intervention and contain meanings that are beyond the awareness of both parties to the therapy. Langs (ibid.) enumerates five possible types of relatedness between patient and therapist namely, healthy therapeutic symbiosis, pathological symbiosis, healthy autism, pathological autism, and parasitism. Each mode of relatedness is characterised by typical themes and images in the patient's material.

Healthy therapeutic symbiosis, which is the most appropriate mode of relationship for therapy, according to Langs, can only obtain when the ideal conditions of treatment obtain (ibid. p160). Healthy symbiosis is represented in the patient's material by images of appropriate intimacy and caring.

Similarly pathological symbiosis involves the therapist obtaining excessive gratification in relation to the patient. Pathological symbiosis is illustrated by themes of destructive forms of care (ibid. p161).

Healthy autism, generates images of withdrawal and isolation that are positively toned and occur at moments in the therapy where no interventions on the part of the therapist are called for and the most appropriate response is silence. Langs describes these sections of the therapy "as moments of rest, private but creative interludes, and constructive periods of lying fallow" (ibid. p162).

Pathological autism on the other hand, involves isolation as a form of defensive and inappropriate withdrawal. It is characterised by images of inappropriate abandonment or absence of others at a time of need. According to Langs this form of relatedness occurs in therapy when the therapist fails to intervene in response to material that calls for an active intervention, such as an interactional interpretation or a framework management intervention.

Finally parasitism, which for Langs (ibid.) is always pathological, is characterised by images of, for example, exploitation, harm and abuse. Langs maintains that these images are a feature of, and a response to, all the therapist's non-validated interventions but are especially prominent when therapist's errors are self-serving and openly hurtful to the patient (ibid. p163).

Each session was examined, according to the Langsian criteria mentioned above, for the predominant mode of relatedness expressed in the patients' thematic material. This was then recorded by the researcher.

4.4.6.7 Mode of cure

The patients' thematic references to their perception of the mode of cure of the therapy was documented. Langs maintains that the mode of cure may stem from either true interactional insight into unconscious meaning, or via relief through 'action discharge and merger'. The former representation of the mode of cure is the desired form in therapy in that communicative psychotherapy is aimed at an interactional insight into unconscious processes, and this would be represented by thematic material alluding to constructive solutions to problems, to the patient being understood, and to handling situations constructively and well. The action discharge mode of cure on the other hand involves the opposite kinds of thematic material and is also represented by allusions to maladaptive forms of action, allusions to addictive forms of behaviour such as alcoholism and drug addiction and references to affairs or other actions that are in some way destructive or dishonest.

4.4.6.8 The central pathological figure

The patients' perception of the central pathological figure in the sessions was identified and recorded in the analysis. The central pathological figure relates to the unconscious perception on the part of the patient as to where the main locus of pathology lies, with the therapist or therapeutic framework on the one hand or with the patient on the other hand. The patient's verbal productions and thematic material reflect this perception. Langs (1988) remarks that when the therapeutic frame is secured, it is a reflection of the soundness of the therapeutic hold and a reflection of the soundness of the therapist's functioning generally and this essential condition enables the patient's pathology to be highlighted in the session. The opposite of this also applies in that if the framework is not secured, it is a reflection of the absence of this containing hold and the patient's difficulties and pathology are forced into the background. Consequently, in these latter conditions, the thrust of the patient's derivative material largely reflects a concern for and a preoccupation with the therapist and the therapeutic frame. Langs (1982) argues that the therapist must identify at any one moment, whose psychopathology the patient is working over at an unconscious level. Langs concedes that "while all of the patient's associations meaningfully reflect aspects of his or her own inner world" (ibid. p657), at any given moment the greater meaning in his or her material may apply to the therapist and this has to be assessed by the therapist.

4.4.6.9 Dynamics and genetics

Dynamics refers to the patient's intrapsychic conflicts whilst genetics involves the early life experiences that have contributed to the patient's symptomology. These two psychoanalytic concepts retain their importance in the communicative psychotherapy methodology. Langs maintains that both areas should be included in interpretations to the patient when appropriate reference has been made in the patient's material (Langs, 1988 p164). The patients' references to dynamic and genetic material in the session were noted.

4.4.6.10 Summary of the process of the decoding of thematic material

The procedure for decoding the patient's material is a slightly modified version of Langs's methodology presented in section 4.2.5 above. It must be recalled that Langs has formulated his method mainly in order to help the practising therapist understand the patient's material and intervene on the basis of this understanding, in the therapy context. It has been modified slightly for use as a research methodology. The decoding of the patient's material involved several steps that, although presented successively did not necessarily follow a linear path in the actual analysis of the sessions (see Addison, 1989; Kelly, 1994a).

For each session the adaptive context was noted and recorded on the basis of the interviews with the therapists. In addition the patients' files were consulted for additional relevant background information. The patient's background history and the therapist's general comments about the patient and the session were noted. The implications of the adaptive contexts were formulated in terms of the possible meanings these could have for the patient and the transcript of the session was carefully read with these possible implications in mind.

The manifest representations in the actual sessions of these aforementioned adaptive contexts were noted and recorded. This represents an important first step in the decoding of patient's material. The thematic material was lifted from the transcripts and was examined for possible links to the activated adaptive context by examining the material for a level of meaning that is shared by both the adaptive context and the themes.⁴ The links between

⁴ As will be appreciated, a certain amount of creativity is required in this step and it is difficult to describe this creative process in more detail other than to say that the coherence of the resulting narrative (Spence, 1987) will be the test of the success of this creativity.

these two elements were then explicated and explored for other links and for possible meanings in relation to the patient's unconscious perception of the therapist. This explicated meaning was then further scrutinised for possible other competing meanings that might have been antithetical to the communicative paradigm and these meanings were noted and recorded.

The patient's references to dynamic and genetic material were abstracted from the transcript of the session and noted. A brief assessment was made of the type of communicative field, the mode of relatedness, the mode of cure and the central pathological figure in each session of therapy. All of the above information was integrated with the analysis mentioned in the previous paragraph and a synopsis of the session was written (see Appendices 2 -13 and Chapter six).

4.4.7 General account of patients' responses to the ground rules across sessions

The patients' responses to breaks in the ground rules were summarised and integrated in a summary account of each individual session. The responses of patients across sessions were noted and integrated into a general account of patients' responses to breaks in the ground rules across all sessions of the study.

In this general account each individual ground rule was examined across the 12 sessions of therapy in order to establish the consistency of patients' responses to the ground rules. The predicted responses to the breaks in the ground rules in terms of the patients' thematic material were noted as were the instances where this predicted response did not occur in response to a clearly documented ground rule break. In addition the sessions were carefully examined to ascertain if thematic material occurred where predicted not to occur. Those sessions where a specific ground rule break did not occur were carefully examined to ascertain that there was an absence of material that would normally be associated with the presence of a ground rule break.

This integrated general account is presented in section 6.14 and specifically discussed in section 7.2. The wider implications of these results are discussed in the rest of Chapter 7.

CHAPTER 5

THE STATE OF THE FRAMEWORK IN THE INSTITUTIONAL CONTEXT

Section 5.1 describes the institution briefly and section 5.2 traces the broader institutional factors that impact on actual therapy practice and that result in ground rule violations in this context. Section 5.3 briefly examines the feasibility of maintaining each individual ground rule in the face of the institutional factors mentioned in 5.2. The actual ground rule breaks observed in the study and the impact that these ground rule breaks have on the individual patients is described in Chapter 6.

5.1 THE INSTITUTION

Lentegeur psychiatric hospital is a large state owned hospital operating in Mitchell's Plain, an apartheid era dormitory suburb originally set aside as a residential area for 'coloureds'. Since its inception the hospital has been fully multiracial in terms of the staffing as well as the patients seen. In practice however, because of its location, the patients have been predominantly 'coloured' with an ever increasing number of African patients being admitted.

The hospital caters for 390 psychiatric inpatients and 800 mentally handicapped residents of the care and rehabilitation centre. In addition a large number of psychiatric outpatients are seen regularly for follow up at the outpatient department (O.P.D.). The psychiatric inpatients are organised into sixteen wards. The hospital employs a large complement of psychiatrists, psychiatric registrars, medical officers, clinical psychologists, psychology interns, social workers, occupational therapists and psychiatric nursing staff, all working in integrated multi-disciplinary teams.

Although all wards are covered by a multi-disciplinary team, psychotherapy activity tends to be centred around the child and family unit, the adolescent unit, the two adult therapy units as well as the large outpatient department. This study focused on adult patients seen at the outpatient department (O.P.D.) and at two adult inpatient therapy wards which will be called Ward X and Ward Y for reasons of confidentiality. During the period that the study was undertaken, the hospital, like most hospitals in the financially beleaguered provincial health department was under enormous pressure through the scarcity of resources and drastic

measures had to be implemented by management in order to keep the organisation operating within budget. One of these measures included the closing down, or the amalgamation of certain wards and, as it happened, Ward X and Ward Y were amalgamated during the observation period, impacting negatively on the framework of psychotherapy of one of the patients in the study in particular (See Appendix 2 and section 6.2 below). Apart from the specific impact on this patient there is no doubt that the general financial malaise suffered by the hospital impacted broadly on all of the patients, leading as it did to large numbers of experienced staff leaving the service and creating general conditions of uncertainty and insecurity amongst those who remained.

5.2 INSTITUTIONAL FACTORS IMPACTING ON THE FRAMEWORK

5.2.1 Handing over patients for therapy

The most common, severe framework break in this sample is one where patients are handed over for therapy to other therapists, mainly because their therapists have been transferred to other wards, or because they have left the service. This compromise to the secure frame involved nearly all of the sessions in the survey, the exception being the session with Shariah (see Appendix 13). With Mary session 1 (Appendix 2) and Valery session 1 (Appendix 7) we can observe the immediate effects of this handing over for therapy in that this had been accomplished just prior to the actual session, with varying degrees of skill and sensitivity. In the case of the other sessions the effects of the handing over for therapy are not as immediate as the handing over had occurred some time previously.

This lack of continuity is such an obviously severe break in the ground rules of therapy that it is not specified separately by Langs, but it is implied in virtually every ground rule and seems to be at the centre of the whole concept of the framework of psychotherapy. The importance of the continuity of the therapeutic relationship is so essential to the stable, containing relationship that there is almost no need to delineate a separate ground rule prohibiting therapists from transferring patients to other therapists without a very sound reason. Langs, writing mainly from the perspective of private practice, where such an event is presumably quite rare, does not discuss the issue directly but alludes to it in some of the

rare examples he gives regarding clinic patients (see Langs, 1979).¹ This issue is discussed further in terms of the way that it impacts on individual patients in the institution in section 7.6.1 below.

5.2.2 Ward outings and socialising with patients

One of the institutional factors that affects a number of ground rules is the practice of taking patients out on therapeutic ward outings. This is a common practice of the therapeutic units at Lentegur hospital with at least one therapeutic outing taking place each year. All staff, including therapists, are expected to accompany the patients on these outings. This clearly constitutes a major breach of the ground rules of a secure frame in that during the outing there is the expectation that patients and therapists will socialise. It is not only when such breaks actually occur that leads to the ground rules of therapy being broken but it is more a question of the philosophy that encourages such events to take place. This philosophy towards socialising with patients outside of therapy hours occurs chiefly in the ward context and while its immediate impact is confined to that context the ramifications are perhaps wider and permeate throughout the institution as a kind of dismissive attitude to the importance of maintaining clear cut boundaries to the therapy.

This philosophy which neglects, or plays down the importance of the boundaries and the framework of therapy results not only in ward outings but in ward events such as joint staff and patient meetings and social gatherings in order to, for example, celebrate a patient's birthday on the ward. This was a common occurrence in the ward where Shariah and Mary received therapy. In some wards considerable pressure is brought to bear on therapists, particularly novice therapists to participate in these types of events. While this philosophy is generally not completely at odds with the philosophy of supportive therapy (Dewald, 1994) it can be readily seen to be inimical to secure frame therapy in that it has the effect of breaking

¹ Langs (1982) does prescribe a situation where patients should be referred on for therapy to another practitioner and this is primarily on occasions, generally during the initial session where the therapist discovers a break in the framework which is so severe as to be not rectifiable. In these situations Langs maintains that the patient's derivative material will point to a termination as the only possible alternative for the therapist (ibid. p 400) and this must be interpreted and acted on by the therapist. Langs calls this type of therapy *unrectifiable framework-deviation termination therapy*.

down the boundaries between therapy and ordinary social relationships. A large part of the pressure for these events to occur seems to come mainly from the non-psychology staff on the wards in this institution. Most psychologists generally tend to be more uncomfortable with these types of gatherings, even if they cannot articulate exactly their reasons for this discomfort.²

5.2.3 The use of clerks to book appointments and to assess patients for fees

Government regulations stipulate that fees are charged for services at a set rate at state psychiatric hospitals. However, reductions in these fees may be applied for by patients who do not earn sufficient income. Clerks are allocated to do the job of collecting the fees and of assessing patients for lowered tariffs. The patients' financial details are noted in the files, which also contain the private and confidential information regarding their therapy. Clerks have complete and regular access to these files in order to do their job. Patients are required to report to the reception prior to their therapy sessions and the files are then drawn from the strongroom by the clerks at this point. Clerks make administrative entries into these confidential files and it is not unusual for a confidential file to be open on the reception counter while the patient deals with the reception clerk. Assessing the patient for fees involves asking many questions regarding the level of financial resources and income of the patient and occasionally the financial assets of the patient.

Outpatient therapists have to make use of a bookings clerk in order to book appointments for patients, while the therapists are in session. Therapists in this institution do not make use of telephone answering machines which would record messages for them and allow them to directly contact the patients wishing to make appointments, thus eliminating a source of leakage in the therapy. The use of the bookings clerk to make appointments for patients and the heavy load of new patients needing appointments in the outpatient context impacts on the ground rule requiring a set time for sessions. The busy therapists rely on the bookings clerk to make appointments for them while they are in sessions and these open slots in the therapists' diaries are then quickly filled in by a clerk trying to accommodate the many

² Unfortunately these observations were not fully assessed by means of an actual scientific survey and have to be presented here, for what they are worth, as general impressions.

patients needing appointments. This means that patients struggle to obtain consistent times for their appointments. This factor was clearly operative in the sessions with Lala (see Appendix 9) who was not able to book her normal time at the end of her twice monthly session and had to book whatever time was available to her.

Patients arriving for therapy at O.P.D. are required to report to the reception desk, where they place their appointment cards in a box and wait to be called for their appointments. The clerks at O.P.D. retrieve the patient's file from the strongroom and take the files to the person whom the patient is due to see. The patients then wait in the waiting area until called for their appointments. Interactions occur among patients and between patients and staff. Sometimes these interactions are highly inappropriate and it is conceivable that they do not even come to the attention of the therapist even if they do intrude somehow into the therapy space. One such example of an inappropriate interaction between clerical staff and a patient involved a receptionist at one of the units making a patient a cup of coffee when he arrived a few minutes early for his appointment. This gesture, on its own, would appear to be harmless enough, but it illustrates the type of interactions that can occur with or without the knowledge of therapists.

Interactions that intruded into the therapy were recorded in two out of the 12 sessions examined in this research. One of these interactions, with a clerk (see Appendix 8 and section 6.8 below) was a highly inappropriate and damaging comment that the patient was to be referred to another clinic in the near future. This interaction had powerful repercussions in terms of the patient's derivative material and is fully discussed in sections 6.8 and 7.6.1 below. The use of clerks is a clear breach of the ground rule requiring a one to one relationship with privacy and confidentiality and this breach seems to be entrenched in the institutional context.

5.2.4 The multi-disciplinary team approach

This treatment approach is ingrained in the psychiatric hospital context in South Africa. It has its impact mainly on the treatment of *inpatients* where team meetings and ward rounds are held on a regular basis to discuss individual patients and their issues. Thus, in this therapy ward setting, the team replaces the individual therapist in that everything that is disclosed by

the patient is expected to be shared with the multi-disciplinary team responsible for treating the patient. This clearly violates the ground rule requirement of a one to one relationship with privacy and confidentiality. In an *outpatient* setting the impact is less pronounced with patients who are not on medication enjoying a one to one relationship with their therapists. Outpatients who are on medication are of course then seen additionally by the medical officer at O.P.D. and hence are not in a one to one therapeutic relationship.

5.2.4.1 Ward rounds and cardex rounds

The ward rounds are for the formal presentation of new patients, by their case managers, to the rest of the team, and for the review of progress of other patients who have already been presented in previous ward rounds. These activities are the hallmark of the multi-disciplinary team approach in that they are occasions for the all important discussions to take place regarding the difficulties with particular patients and the progress, or lack of it, with individual patients. They are opportunities for discussion and interdisciplinary sharing of information, resources and ideas. They also constitute, obviously, occasions when patients are actively discussed while they are not present, and even, on occasion, while they are. The latter occurs when patients have been assessed for treatment and are then presented in the ward round by their case managers, to the other members of the team. On these occasions the patients are called into the assembly of team members and asked questions about aspects of their psychiatric history or presenting problem that might have been unclear in the presentation. In addition there is a brief daily meeting (the cardex round) where the report of the night staff on each of the patients is read out briefly and case managers comment on their activities and progress with the patients. All of the inpatient units at the hospital employ this practice, thus rendering the ground rule requiring a one to one relationship with privacy and confidentiality almost meaningless in the context of the *inpatient* therapy unit.

5.2.4.2 Assessment of patients for treatment

As part of the multi-disciplinary team approach in the inpatient units, individual patients are assigned case managers. The case managers comprise all the members of the multi-disciplinary team, including the members who do psychotherapy with the patients, and their initial task is to thoroughly interview and assess the patients across a broad range of parameters relating to all aspects of their psychiatric, social, occupational and emotional

functioning. This information is gleaned over a relatively short period of time in order to make diagnostic and management decisions as rapidly as possible. Consequently the person doing the intake assessment is obliged to engage in a fairly intensive interview process that, by definition, involves many questions being asked of the patient. The mode of relating to patients throughout this assessment process is one of benign interrogation and the question is whether a case manager is able to move successfully from that mode of being with a patient to the mode of a relatively passive exploratory therapist demanded by the communicative approach to psychotherapy. The question is whether this initial contact with the patient constitutes an 'unrectifiable framework deviation' (Langs, 1982) that can only be corrected by termination of the therapy and referral on to another therapist for exploratory therapy should this form of therapy be indicated. This issue is discussed in section 7.6.1 below in relation to the material from the actual sessions.

5.2.5 Prescription of medication

Patients seen for therapy in an institutional context are, almost by definition, likely to be more disturbed than those seen in private practice. Consequently they are more likely to be on medication and hence seen on a regular basis by one of the medical staff, concomitant to their psychotherapy appointments. This dual relationship impacts on the framework in that it is a clear deviation from the requirement of a one to one relationship with privacy and confidentiality. The doctors prescribing the medication are obliged to assess the patients and to consult with the therapists, or at the very least, peruse the files for the therapeutic progress on a regular basis making further inroads into the requirement of privacy and confidentiality.

5.2.6 Common waiting rooms

Entrenched in most institutions is the use of common waiting rooms. The very size of institutions and the large numbers of people who work and are treated in them would appear to necessitate this deviation from the ground rule requiring privacy and confidentiality. Patients can contrive to avoid some of the main problems brought about by this arrangement by planning to arrive just prior to their appointments, provided that they have a fixed appointment. Patients are given fixed appointments for psychotherapy but the practice is different if they are required to see medical personnel at O.P.D.. In the latter case the patients are simply given a morning appointment or an afternoon appointment time. They

are thus instructed to arrive at 08h00 or at 14h00 and are then expected to wait, in and around the waiting area, until they are seen by the busy medical practitioner. Thus the waiting area and corridors in O.P.D. are filled with lines of people waiting patiently to see the medical officers or psychiatric registrars and occasionally also the psychologist. Occasionally a disturbance is caused in these waiting areas by a particularly agitated new patient who has not yet been assessed or sedated, causing further distress to the psychotherapy patients already affected by the stigma of attending a psychiatric hospital.

5.2.7 Note taking, files, and access to files

Therapists working in the institutional context are expected, as an administrative requirement of the hospital, to record their therapeutic activities and progress notes in the patient's hospital folders. The files are accessible to all other team members and to administrative personnel.

Therapists in the hospital context often keep more detailed notes of their therapy cases in private files containing process notes of the therapy and consequently these files contain a record of the more sensitive information pertaining to the patient. These notes are then kept in the office of the therapist concerned. Blander information and notes regarding the progress of therapy are recorded in the official file, thus preventing the more blatant leakage of information that patients feel particularly sensitive about and specifically do not wish to be disclosed to other people or recorded in the file. This practice does not solve the problem of the break in the ground rule requiring privacy and confidentiality for the therapy but it does help to prevent some of the more blatant exposure of sensitive patient material.

5.2.8 Concurrent group therapy and family therapy

Within the inpatient ward context, therapists conducting individual psychotherapy are expected also to run groups for patients on the ward. Support groups are one of the main forms of treatment for patients in the inpatient therapy units at Lentegur hospital and patients in these units generally have group therapy twice a week. Groups are run by the therapists on the ward, on a rotational basis and, because of the shortage of therapy staff generally, this means in practice that therapists are seeing their inpatients for individual therapy whilst seeing them concurrently for group therapy. This is a contravention of the

ground rule requiring therapists to not have concomitant relationships with their patients. Two of the patients in the sample were exposed to their individual therapists in a group therapy context. Shariah's therapist was facilitating her support group concomitantly with the individual therapy and Mary's therapist had previously facilitated a group attended by her. This is a very common ground rule violation for therapists working in the inpatient therapy units at the hospital simply because of the lack of therapy staff to run groups and to do individual therapy.

The issue of concurrent family therapy is somewhat different in that it does not occur to the same extent as does concurrent group therapy in the inpatient units. While group therapy is an integral part of the programme in the therapy unit, family therapy is more a matter of therapists' choice in that families are not automatically seen for therapy in the adult inpatient ward setting. The situation is different in the adolescent inpatient unit where families are seen as a matter of course and therapists are more often placed in a quandary with regard to whether or not to refer on for family therapy or to see the families themselves. This potential ground rule deviation applies to outpatients as well as inpatients. In this study one therapist engaged in a joint and concomitant session of family therapy with a patient, once only, at the request of the psychiatrist handing the patient over for therapy. The therapist then resolved not to repeat the process with this particular patient, feeling that it would not be appropriate with her. However this resolution was not conveyed to the patient (see Appendix 10 and section 6.10 below).

5.2.9 The hospital training function

The hospital has as one of its major functions the training of various categories of professionals from nursing staff to occupational therapists, psychology interns and psychiatric registrars. This inevitably results in something of a compromised frame in that therapists have to revolve through their placements, resulting in large numbers of patients being handed over for therapy at the end of the trainee's placement in that particular ward. For psychology interns at Lentegour this change in placements occurs every four months. Thus for their patients it entails, at best, a move to another setting after a period of four months and, at worst and certainly at the end of the internship year, it necessitates being handed over for therapy to an entirely new therapist. Being handed over for therapy to a new

therapist is something that all of the patients in the sample experienced, apart from Shariah (see Appendices 2 - 13). The issue of the continuity of therapy is discussed more fully in section 7.6.1 below.

Being in training inevitably has a severe impact on the ground rule requiring a set time for the therapy in that therapists who move to different units after a period of time, as part of their training have to slot their patients into times that are available to the therapists in the new units. Therapy times invariably clash with the ward timetables in the new units necessitating a change in appointment times for the patient.

Apart from the impact that the training function has on the continuity of the therapy which is a serious framework break, pervading a number of ground rules of therapy, an important source of framework breaks for patients of therapists in training is the requirement that the therapy be supervised. Again this provides an obvious leak in the therapy, compromising the ground rule requiring privacy and confidentiality.

The issue of whether or not it is necessary for a patient to know about a ground rule break for it to actually constitute a ground rule break is a difficult one and it is not discussed by Langs specifically. There are examples in the communicative psychotherapy literature of therapists attributing patients' derivative responses to actual breaks in the ground rules that patient's apparently did not know about but about which they nevertheless appeared to exhibit some unconscious knowledge, through their derivative material. Thus Smith (1991a) gives the example of a therapy session that is surreptitiously recorded and of the patient somehow, unconsciously detecting the presence of the tape recorder (*ibid.* p183). In the same section Smith also quotes Langs as having communicated a similar experience to him with a patient apparently *unconsciously* knowing about a ground rule break and demonstrating this knowledge through a clear derivative message. Thus while the patient might not be overtly aware of the ground rule break of being supervised, there is evidence to suggest that these types of framework breaks might still be impacting on patients.

5.2.10 Intrusions into the therapy space

Intrusions into the therapy space at Lentegeur hospital take different forms. Noise from the large aeroplanes coming in to land at Cape Town airport, situated upwind from the hospital can be a minor but persistent source of intrusion and irritation in the winter months which bring the north westerly wind and ensure that the hospital is directly below the flight path of these noisy behemoths. The telephonic interruptions, largely as a result of the lack of adequate secretarial support, are more serious intrusions into the therapy space and were noted in the session with Nerina (Appendix 12). Still more blatant interruptions to the therapy come from colleagues and patients wandering in to the therapy room. No such incident was recorded in the sessions under scrutiny in this study but all therapists working in a hospital context have experience of this form of intrusion in one form or another. In this study, intrusions into the therapy room by other people were permitted by Monica's therapist, Grace's therapist, and Nerina's therapist. All of these intrusions had repercussions that were evident in the material from these sessions (see section 7.2.2).

5.2.11 The fees policy of the hospital

In the hospital context it is not possible to have a single fixed fee in that patients are assessed for their therapy, by the tariff clerk, on the basis of their income, with those patients earning less, paying less for their therapy than those earning more. Thus in the hospital context the therapist is not required to have any part in the financial arrangements of the patient's therapy other than to ensure that patients report to the reception clerk in order to be tarified for therapy when and if they are seen as outpatients. Inpatients who are seen by their therapists for therapy are charged a flat rate whether they have psychotherapy or not.

Whether the situation pertaining in the hospital context consists of a break in the ground rules or not is thus debatable. At one level it is not a break in the ground rules in that patients, once assessed for their income levels by the finance clerk, are charged at a set rate, and this rate remains in force pending a major change in their financial status, whereupon they may theoretically apply for a reduction in the rate at which they pay for therapy. Consequently these patients have the opportunity to have their rates reduced even if this does not occur very often in practice. At another level patients are being charged at a different rate from some of their peers and this would seem to constitute a break in ground rule 2 with its

requirement of a single fixed fee. However judging from the implications to a modification in this ground rule, envisioned by Langs (1982, 1988) of pathological gratification, indulgence, and seduction it seems clear that, in order for a break in this ground rule to occur it would have to involve a patient actually asking for, and receiving a reduction in the initial fee charged. This did not occur with any of the patients in the study.

Another anomaly in the hospital context relating to this ground rule is that patients pay the same monthly rate for their psychotherapy regardless of how many therapy sessions they attend. Thus patients who only attend once a month or once every two weeks will pay the same monthly fee as those patients who see psychologists on a weekly basis or even twice a week. This strange situation seems hard to justify on logical grounds but it is fortuitously helpful in keeping hospital therapy on the right side of the requirements for the secure frame of therapy in that it technically means that patients have financial responsibility for all of the sessions in a given month, whether they attend or not.

5.2.12 Attitudes to psychotherapy within the institution

This point is harder to make and harder to lead evidence for in that the evidence that is at hand is of a diffuse, oblique nature and involves such indirect evidence as institutional attitudes to the profession that provides the psychotherapy, comparatively cheaper charges to patients for the services rendered by psychologists compared to their medical colleagues, and an institutionalised ignorance of and lack of concern for the boundary and framework issues that would appear to be important for psychotherapy.

In this institutional context psychotherapy is generally provided by psychologists. Hospital psychologists are essentially civil servants, paid by the state and psychologists do not appear to be particularly valued across the civil service generally, compared to their medical colleagues, if one takes as a yardstick salaries and career prospects to measure how the different professions are valued. Psychologists salaries do not match those of their medical colleagues, despite the matching number of years of training, and they do not have opportunities for advancement, both within their specific occupational class and within the institution generally. Specific examples of this salary and occupational class differential are that psychologists do not receive the overtime payment that is paid to their medical

colleagues; psychologists' promotional prospects are dependent on the actual availability of senior posts, unlike their medical colleagues who enjoy automatic promotion right through to the rank of principal medical officer, in what is known in the civil service as a rank promotion as opposed to a post promotion. Furthermore medical officers can ultimately advance in the institution to become the administrative heads of these institutions. This possibility is afforded only to medical practitioners and dentists, with other occupational classes in the civil service, even with the same number of years of training, not being permitted this opportunity. All of this is an obvious indication of the way that the civil service administration of South Africa has valued in the past, and currently values the skills and services of psychologists in comparison to their medical colleagues.

The hospital also serves as a training institution for psychiatric registrars and the psychologists largely provide the bulk of the registrars' training in psychotherapy. Ironically the psychotherapy skills of their psychiatric colleagues are, upon registration, automatically more highly valued and rewarded by the medical aid industry in South Africa than that of psychologists. The recommended tariff of fees for psychotherapy is considerably higher for psychiatrists than it is for psychologists (Representative Association of Medical Schemes, circular to all medical schemes, December 1995). In addition the medical aid fund reimbursement for psychotherapy provided by a psychologist is generally capped at a specific amount per annum whilst the reimbursement for psychotherapy provided by psychiatrists generally remains unlimited.

Patients in this hospital context pay the same monthly rate for their psychotherapy regardless of how many therapy sessions they attend. Thus patients who see psychologists four times a month on a weekly basis, or even eight times a month on a twice a week basis, will pay the same monthly fee as those who consult a psychologist only once a month (see section 5.2.11 above). This fee structure is in contrast to the tariff structure regarding fees charged to patients who consult medical officers in the hospital context. In this situation patients are charged a fee for every consultation with a medical officer, regardless of how many times they consult the medical officer. To put this situation in perspective, the monthly fee for psychotherapy is the equal to twice the once off fee for consulting a medical officer. This gives a clear indication of the relative value, assigned by the institution, of the different

services being offered by psychologists and medical officers and of the comparative value of psychotherapy as opposed to consultations with medical officers.

In this particular institutional context, informally at the level of anecdote, it would appear that psychotherapy is not very highly regarded as a powerful technique that has powerful effects and possibly also powerful 'side effects'. The reasons for this problem are multifaceted and stem largely from ignorance of psychotherapy and from confusion between counselling and psychotherapy on the one hand and confusion between supportive therapy and exploratory therapy on the other hand. These attitudes towards psychotherapy can perhaps be illustrated by the explanation given to the researcher by a psychiatric colleague, some years ago for, what was on his part, a particularly inappropriate referral for psychotherapy. This colleague's somewhat embarrassed, it must be said in his favour, explanation, for this referral, was that the patient was in his office at O.P.D. and she seemed to be talking too much, and on this basis he deemed that she needed psychotherapy and referred her on. This kind of unthinking and inappropriate referral for psychotherapy for other than sound reasons betrays an offhand, somewhat flippant attitude to the value of psychotherapy in this institutional context.

In addition to the above anecdotal evidence, the ignorance about boundary and framework issues in psychotherapy in the institutional context masks also an attitude to psychotherapy that requires exploration. This issue, insofar as it pertains to the question of socialising with patients has already been examined in section 5.2.2 above. It applies also in another particularly disturbing trend in that there is a great deal of pressure placed on psychologists to offer fellow staff members psychotherapy if needed. Thus, frequent explanations have had to be given at regular intervals by the head of the psychology department to the nursing management structures as to why psychologists are not available to see fellow staff members for psychotherapy. Invariably referrals for psychotherapy emanating from the staff clinic continue to be received by the psychologist at O.P.D. The professional nurses making the referrals have difficulty in comprehending the ethical, and it must be said, efficacy problems, with seeing a fellow member of staff for psychotherapy. There appears to be a great deal of scepticism about the particular brand of psychotherapy that necessitates staff members, who require to be seen, and who are not on a medical aid, to travel the long distances to the

outpatient departments of one of the other psychiatric hospitals in order to simply have, what for all intents and purposes, would seem to be simply a type of conversation with a kindly person. This scepticism towards efforts to maintain these important boundaries would seem to be particularly in evidence because of the practice of allowing this type of serious boundary break to occur in the past in this particular institutional context.

The point of the matter though, is that psychotherapy, for whatever historical and other reasons, is not very highly regarded in this particular institutional context. A great deal of the blame for this state of affairs must lie with those who have been practising it and undoubtedly with the compromised way that it has been practised in this context. It would appear that much work remains to be done to educate the other professions regarding some of these issues around exactly what psychotherapy is and around the reasons and value of the ground rules of psychotherapy. It would also seem that there is much ignorance among the other professions regarding the differences between counselling and psychotherapy and the differences between supportive and exploratory psychotherapy and here too much education of the referral sources and of the other professions appears to be needed.

5.3 THE OPERATION OF THE FRAMEWORK IN THE INSTITUTION

In general there are two types of framework breaks that occur in an institutional context. The first kind is one that is, in a sense, structural, over which the therapist has no control and which can be described as part of the institutional arrangements. These framework breaks are as a result of the way that administrative affairs are structured in the institution and include the necessity for keeping patient's files in a central area, a shared waiting room for all patients and administrative arrangements for charging fees and for collecting payment for therapy. The second type of framework break occurs more as a matter of choice on the part of the therapist and would be dependent on the therapist's approach to therapy in general and the framework in particular. Thus some therapists might, as a matter of technique, adopt a more self disclosing manner with patients or, might not be comfortable with the use of the couch, or with the use of free association in therapy. The two types of framework breaks interact to a certain extent in that the structures laid down by the institution have an impact on the practice of the professionals who work there and the technical needs of the

professionals could have an impact on changing the structures of the institutions (see Hoag, 1992).

This division of framework breaks in the institutional setting coincides, to some extent, with the division that is made by Langs (1988) between the fixed frame and the more fluid frame. For Langs the fixed frame consists of the single setting, a single and fixed fee and a specified time and duration for each session. The more fluid frame consists of the use of the couch, the adoption of the fundamental rule of free association, evenly hovering attention of the therapist, the use of neutral interventions, the relative anonymity of the therapist, total privacy with a one-to-one relationship and total confidentiality.

In the institution, as has been indicated in the section above, some aspects of the frame are structurally impaired because of the set bureaucratic requirements of the institution, but a surprising number of ground rules are not inherently or inevitably compromised by this context and they remain a matter of choice for therapists. This is particularly surprising because of the broad range of institutional impingements mentioned in the previous section, but closer scrutiny reveals that most of these impingements impact mainly on the ground rule requiring a one to one relationship with privacy and confidentiality. Other institutional impingements impact mainly on therapy offered in the context of the inpatient therapy unit, leaving the possibility for outpatient therapy of a substantially secure frame variety. All of the ground rules will be briefly examined in turn from the perspective of the possibility of their being upheld in this institutional context.

5.3.1 The setting

For the most part the hospital is able to provide a stable, single setting for its patients. The difficulty occurs when the therapist is in training and as part of the training is required to move to another unit which then necessitates the patient having to follow the therapist in moving to another office (see section 5.2.9). For therapists who are not in training a stable, single setting is quite feasible in the institutional setting and the majority of therapists in the study managed to attain this ideal.

5.3.2 The fee

In the institutional context patients generally pay lower fees for psychotherapy than they would if they consulted private practitioners. However once the fee has been set it is generally not reduced and this fact, together with the anomalous situation regarding the payment of fees whether patients attend therapy or not (see section 5.2.11) means that patients are largely adhering to this ground rule in this context.

5.3.3 The time and duration of sessions

There is no inherent reason for this ground rule not to be implemented in the institutional context. Two factors which possibly work against this ground rule in the institutional context are the fact of therapists being in training (see section 5.2.9) and the use of bookings clerks (see section 5.2.3). These factors are not insurmountable and with some effort on the part of the therapist it is entirely feasible that this ground rule can be maintained in this context and in fact the majority of therapists in the study managed to maintain this ground rule without any difficulty.

5.3.4 The location

There is no intrinsic reason for therapists to break this ground rule in the institutional context. While the ground rule of a regular location is adhered to, the use of the couch is generally felt by the therapists to be not appropriate in this context. Therapists without exception, in this study, sit in chairs facing their patients. However this approach would seem to be entirely adequate for maintaining this ground rule (see Langs, 1982 and section 3.4.4).

5.3.5 Free association

In the institutional context the adoption of the fundamental rule of free association is a matter of choice on the part of the therapist and there are no inherent reasons for this ground rule not to be maintained by therapists in this context. The therapists in the study, while not inevitably subscribing to the importance of free association as such, felt that it was important to give the patients space to talk about what was important to them and thus to keep interruptions to a minimum and to refrain from introducing elements into the therapy that emanated from the therapist. This goes some way to explaining the ubiquitous use of reflections and clarifications in the therapy (see Appendices 2 - 13). On one level these

interventions serve as a way of unobtrusively echoing what patients are saying while at the same time affirming what has been said and encouraging the patient to continue. This issue is discussed further in section 7.5 below.

5.3.6 The therapist's listening

An important requirement for maintaining free-floating attention is to have had analysis oneself as a therapist³ and thus to be able to maintain a flexible and receptive attitude to the patient with a minimum of one's own preoccupations as a therapist which would intrude on the material of the patient. Although all of the therapists had undergone therapy as part of their training and some had had additional therapy subsequent to their training, none had actually had psychoanalysis. Technically then, none of the therapists at Lentegur met this strict requirement for maintaining free floating attention although in the context of Langs's (1982, 1988) work as a whole this is not a material or insurmountable violation of the ground rule (see section 3.4.6). Clearly there is no intrinsic reason for this ground rule not to be adhered to in the institutional context.

5.3.7 Neutral interventions

Langs advocates the use of only four types of interventions, namely silence, the playback of selected derivatives, framework management, and interpretations. Other interventions are eschewed by this method and it is advocated that therapy takes place under conditions of abstinence (see section 3.4.7).

The communicative interpretation should only occur when three ingredients are present and it is structured in a specific way, containing three specific elements (Langs, 1982, 1988; Smith, 1991a). A correct communicative intervention requires the presence in the patient's material of the representation of the adaptive context (or trigger), a rich sequence of derivative material, and an indicator (the patient's affective response to the trigger) and all three of these elements are synthesised in the therapist's interpretation (see section 7.4.1). It is clear that in order to use this kind of interpretation one has to be very familiar with the theory of communicative psychotherapy and skilled in its practice. None of the therapists in the hospital filled these criteria.

³ In Freud's terms this requirement is to have had 'purification' by psychoanalysis.

Despite the lack of skilled and well trained proponents of the Langsian communicative technique of therapy, it is clear that there is no actual institutional impediment to the maintenance of this ground rule. Maintaining this ground rule would require the proper training and supervision of therapists, but there is nothing about the institution as such that prevents this from occurring.

5.3.8 Anonymity

As with many of the other ground rules there is no inherent reason for therapists not to maintain this particular ground rule and it remains a matter of choice whether therapists actually disclose information about themselves to patients and exactly what sort of information is disclosed to patients within the context of the therapy sessions. Within the milieu therapy wards pressure exists to adopt a more social stance towards patients (see section 5.2.2) particularly with regard to attendance at ward outings and social gatherings. This pressure to maintain this social stance to patients could conceivably be resisted by therapists in the therapy ward context with a more articulate argument for maintaining therapeutic boundaries with their psychotherapy patients. In the outpatient context therapist anonymity is entirely possible and is generally upheld.

5.3.9 Extra therapy relationships

In the main, the maintenance of this ground rule is largely dependent on the therapist concerned. It is generally a matter of choice as to whether the therapist insists on a firmly bounded therapy relationship or not. The specific institutional impact on this ground rule comes in the form of the dual therapy relationships that are forced on therapists in the therapy wards where the therapists on the ward are also expected to run groups (see section 5.2.8). Whether these are simply 'technical' violations of the ground rule and not substantial or material violations has to be left to the analysis of the patients' responses for a decision (see section 7.2.8 below) but the fact remains that this is a common situation in the therapy units at this hospital. However, therapists working at O.P.D. do not have the pressure of this dual therapy relationship and hence for them it is entirely and completely possible to maintain this ground rule at the level that is consistent with their approach to therapy.

5.3.10 Privacy and confidentiality

In contrast to all of the above ground rules, the institutional setting, by its very nature, severely compromises the privacy and confidentiality of the psychotherapy conducted within its confines. This expectation was borne out in this study in that all twelve sessions were conducted under conditions of compromised privacy and confidentiality (see Chapter 6).

The inpatient therapy ward involves, of necessity, a severe compromise to privacy and confidentiality by virtue of the milieu therapy and the team approach to treatment that is adopted. On the wards, patients are assigned a case manager and are then thoroughly interviewed and assessed. Their details are presented by their case managers to the rest of the team in the ward round. Invariably the patients are called in to the ward round and briefly interviewed by members of the multi-disciplinary team. In the ward context there are various formalised occasions for this sharing of information about patients (see section 5.2.4.1).

Even patients who are seen on an outpatient basis have their privacy and confidentiality compromised to some extent through the system of note taking and the necessity for keeping files which are accessible to other team members and even to the administrative staff on the units. Similarly outpatients are obliged to use common waiting rooms and have to report to the reception clerk on arrival and have the finance clerk assess them for fees. Furthermore, if they require medication, they are seen by the medical officer or psychiatric registrar in addition to their therapist.

Another compromise to the privacy and confidentiality of the therapy sessions in this study was the fact that all of the sessions were audio taped in order to facilitate accurate analysis in the research. The very fact that transcripts were made of the audio tapes and that they were analysed and used in the study provides a possible compromise to the ground rule of privacy and confidentiality even if patients are not aware of this fact (see section 5.2.9).

5.4 CONCLUDING COMMENT

The institutional impingements on the therapy space at Lentegur hospital are many and varied and appear at first glance to provide an insurmountable obstacle to the performance of

therapy of a secure frame variety in this context. They appear to cut off any possibility of conducting uncontaminated exploratory therapy. Closer scrutiny reveals that the majority of these impingements have to do with the ground rule relating to the requirement for a one to one relationship with absolute privacy and confidentiality which appears to be almost impossible in this institutional context. Other ground rule breaks examined in this context are more easily upheld by therapists, should they have the desire to do so and given adequate training and supervision. The actual impact on the patients of these various types of ground rule breaks, in terms of their responses, are noted in Chapter 6 and these responses are discussed in Chapter 7.

CHAPTER 6

PATIENTS' RESPONSES TO THE INSTITUTIONAL FRAMEWORK BREAKS

This chapter provides a synopsis of each of the 12 sessions of therapy, preceded by a summary of the ground rules that are broken in those sessions. Section 6.14, the final section in this chapter, provides a summary of the ground rule breaks across all sessions, together with a summary of the thematic material in the sessions that conforms to the expectations of communicative psychotherapy regarding these ground rule breaks.

The synopses of the sessions set out below should be read in conjunction with the appendices relating to each session and with the discussion in the following chapter where the results are more fully elaborated and discussed. The numbered themes referred to throughout this chapter are to be found in the appendix corresponding to each session. These appendices also contain background information on the patients, the background adaptive contexts, triggers from within the sessions, a summary of therapist interventions and therapist issues, together with a full list of numbered themes from the transcripts of the sessions. In addition each appendix contains a structured analysis of the patient's material consisting of the delineation of the manifest representation of the adaptive contexts and the researcher's assessment of the type of communicative field, the mode of relatedness, the mode of cure, the dynamics and genetics, and the central pathological figure.¹

The opening invitation to the patient to speak is reproduced in the synopsis of each session below, together with the ratio of therapist words to patient words in the session, as well as the number of questions as a proportion of the therapist responses. These measures give an idea of the ratio of the therapist to patient verbalisations and are a crude measure of the extent that therapists allow patients to free associate. They serve to illustrate some important differences between the sessions.

It must be emphasised that the reading given to these sessions in the synopses presented below relates mainly to the interactional component of the patients' narratives. This is not to deny the importance of the manifest content of this material, or the importance of the

¹ The meaning of these terms and the rationale behind their assessment is given in section 4.4.6.

intrapsychic elements of the patients productions in therapy which are less emphasised in these synopses. It is simply an attempt at emphasis for reasons of exposition of the important and neglected interactional elements of the patients' communications in therapy.

6.1 MARY: SUMMARY OF GROUND RULES BROKEN AND RECTIFIED

A serious problem at the beginning of this patient's therapy is, firstly, the handing over of the patient for therapy and, secondly, the chaos surrounding this handing over for therapy. This chaotic handing over (see Appendix 2, adaptive contexts) meant that the patient saw three different therapists, in three different offices over a short period of time, clearly violating ground rules 1 and 3. These important framework violations were tightened over the five sessions of therapy studied here but the chaos surrounding the initial stages of the therapy could not be undone. The patient's thematic material would be expected then to reflect this chaotic handing over in themes of chaos over the first few sessions of the therapy.

Ground rule 2, requiring a single fixed fee was clearly violated over sessions 3, 4, and 5 with this patient not being assessed for outpatient fees by the tariff clerk. This ground rule could be said to have been maintained over the first two sessions because of the all inclusive nature of the fees charged to inpatients. It would be expected that this would be reflected in the patient's material in terms of themes about money and irresponsibility about finances in the later sessions of the therapy. In addition themes of seduction, infantilisation and unnecessary gratification could be expected from later sessions.

Although the couch was not used in the sessions, the patient was provided with a regular location in the therapy room. Therapist and patient occupied the same positions in the therapy room over the course of the therapy, providing the consistency required by ground rule 4.

The excessive use of questions in session 1 constituted a clear violation of the ground rules requiring the adoption of the fundamental rule of free association (ground rule 5), the evenly hovering attention of the therapist (ground rule 6) and the use of neutral interventions (ground rule 7). The practice of asking many questions was dropped from sessions 2 to 5 allowing the patient more space to produce material of a derivative nature and allowing for

the free association of the patient and the evenly hovering attention of the therapist over these later sessions. Breaking ground rules 4, 5 and 6 would be expected to result in a poverty of derivative material and consequently diminished access to the patient's unconscious material could be expected. An improvement in the quality of the derivative material could be expected over the later sessions following the tightening up of these three ground rules.

Strictly speaking the therapist breaks ground rule 7, the requirement for using neutral interventions, throughout the five sessions in that he does not utilise sound interactional, communicative interventions according to Langs's (1982, 1988) strict requirements. It would be predicted then that images and themes of someone not being heard, and of communication breakdowns would emerge in the material over these sessions.

The therapist maintained relative anonymity over the five sessions of therapy. This met the requirement of ground rule 8 over the course of the therapy. To the extent that this ground rule is broken one could expect material relating to seduction, dishonesty and symbiotic pressure to emerge in the thematic material of the patient.

The patient's taking part in groups run by the therapist, prior to the individual therapy, is a partial breaking of ground rule 9, requiring the absence of any prior, concomitant or post therapy relationship. It is impossible to rectify a ground rule break of this nature as, clearly, once a relationship has been established it cannot be undone in the sense that it cannot be interpreted away or rectified other than to refer the patient on to another therapist who has not had this relationship with the patient. It was considered that, as the prior relationship was neutral and therapeutic, the impact would be considerably less than that of other kinds of prior relationships with patients. Themes of incest or inappropriate merger could be expected with the break in this ground rule.

The most common ground rule that is broken in session 1 is the ground rule relating to the requirement of a one to one relationship with privacy and confidentiality (ground rule 10). Thus the referral on for therapy, seeing another professional on the ward for medication, being assessed and presented to the ward round, being discussed in the cardex round and having a file on the patient kept in the nursing station all constitute breaks in this ground rule.

All these aspects of this ground rule violation were tightened up over the five sessions but, just prior to her discharge, the patient was used by a nursing student as the subject of her oral examination. In addition, an important break in this ground rule continued throughout the therapy with the taping of sessions continuing right through to session 5. The lack of privacy in the waiting room area became apparent when it was noticed that prior to session 3 the patient was accosted by one of her fellow patients who had not yet been discharged from the ward and who sat down and spoke to her whilst she was sitting in the waiting area prior to her session. The break in this important ground rule could be expected to produce themes of leakage, unfaithfulness and betrayal over all five sessions.

6.2 SYNOPSIS OF SESSION: MARY SESSION 1

Quantitative data relating to words and questions in session

No. words therapist	2389	47.8%
No. words patient	2610	52.2%
No. words total	4999	100.0%

Total questions	53	59.6%
Total therapist responses	89	100.0%

Therapist's opening invitation to the patient to speak

T Perhaps you can start by telling me about some of the problems you had when you came in.

The main themes of the patient's material revolve around the chaos that her husband causes with his drinking and the stress and anxiety that this brings to her, together with the dreadful insecurity that she had felt, due to her feeling of being abandoned and unloved by her mother. These two themes are repeated throughout the session in many contexts and represent the clearest articulations of the patient's deep unconscious concerns with the adaptive context of being "abandoned" by her previous therapist and of the chaos surrounding the handing over of her case to her new therapist.

It would appear from the patient's material that the most important adaptive context was the fact of her being handed over for therapy. This is a very important break in the frame for the patient and she refers to it many times in the session mainly in regard to her mother and also

in regard to her husband. This is clearly represented by the themes of abandonment (themes 4, 9, 11, 14, 16, 20 and 32) and of looking for love and care (themes 24, 26 and 35).

These manifest representations of the main adaptive context occur early in the session but are virtually ignored by the therapist. There is an attempt on his part to make the link when he remarks "I don't know but I can guess that it happens even now today that sometimes you feel unwanted. Sometimes with your husband or even here" (p 3 par. 2). However, according to communicative theory, this is not a sound interpretation which would require the pointing out of the adaptive context, the derivative material, and the bridging theme, together with the patient's symptoms, in combination in the interpretation.

Related to the above theme of abandonment however is the general adaptive context of the chaotic managing of the handing over of the patient for therapy and she seems to be making a strong commentary on this fact through the derivative material relating to themes of chaos and irresponsibility (themes 1, 15, 18, 23, 25 and 33). Again this is not picked up by the therapist in the session.

The therapist reverts to asking many irrelevant questions, evidently with the aim of obtaining information about the patient for the purpose of making an assessment for therapy but also with the aim of calming the patient and avoiding a breakdown in the session. Part of the reason for this was a feeling that the patient was perhaps not suitable for psychotherapy of an exploratory nature and that she would have to be handled in a supportive manner. The therapist felt cautious about the patient and about her state of mind, but during the session began to feel more at ease with her ability to handle exploratory therapy and decided during the session to offer her this mode of therapy. However the effect of the excessive use of questions, (53 responses out of a total of 89), had an impact on the therapy, causing the patient to move away from a symbolic mode of communication into a more factual, manifest level, mode of communication. Thus the mode of relatedness on the part of the therapist in this session would be judged to be 'autistic' (Langs, 1982) due to his shutting down the symbolic communications of the patient. Only one interpretation is made in the session but the interpretation does not deal with the interactional nature of the material and verges on a confrontation of the patient's avoidant defensive behaviour.

There were two main opportunities for intervention and for offering a sound communicative based interpretation, one near the beginning of the session where the derivatives coalesced around the important adaptive context of the patient abandoned by her mother and her husband and she wept at the memory. There was a clear link to the therapy with the obvious importance of the adaptive context of the transfer of the patient from therapist to therapist. The other opportunity for a sound intervention occurred near the end of the session where the issue of the patient leaving her husband came up. This is a clear reference to her intention to leave therapy if the therapist does not improve his functioning. Neither opportunity for interpretation was taken by the therapist

In session 1, with the chaos surrounding the handing over of the patient for therapy, one can expect themes of chaos in the patients material. There are decidedly themes of irresponsibility and chaos (themes 1, 15, 18, 23, 25 and 33). The fact of being handed over for therapy by her original therapist results in themes of abandonment, rejection and lack of love (themes 4, 9, 11, 14, 16, 20 and 32) and themes of looking for love and care (themes 24, 26 and 35).

The lack of communicative interventions linking this thematic material with the adaptive context on the part of the therapist leads to the patient producing themes of someone who makes her feel that she is the problem and that she is mad (themes 2, 3, 19, 21 and 34). In addition there is the important theme of inability to get through to someone (theme 17), which according to Langs is an indication of the patient's perception of a lack of proper listening, that is, communicative interactional listening, in the session.

The themes of anxiety and fear and avoidance of things (themes 8, 9, 26, 27, 28 and 30), themes of difficulty in being oneself (themes 12, 13 and 29) and themes of lack of energy and powerlessness (themes 22 and 35) are, on one level, an indication of the patient being able to access material relating to her own symptoms as a result of the containment brought about by the relative tightening up of the frame during the session. It is significant that much of this material appears later on in the session. These themes can also be seen, at another level, as a commentary by the patient on the therapist's lack of decisive interpretative action

in the session as well as lack of decisive action in the ward context generally in that the therapist is seen as allowing the chaotic situation pertaining to her handing over for therapy to occur in the ward. These themes represent models of rectification for the therapist (Langs, 1982, 1988). It is as if the patient is telling the therapist in an unconscious way to "be yourself, don't be anxious and afraid and avoidant, become more energetic and powerful".

The themes of envy (themes 29 and 31) and of having to share someone (theme 5) can be related to the therapist being the facilitator of the group that the patient attended, on the ward, prior to the individual sessions but also more broadly to the theme of having been abandoned by her previous therapist.

In general all of the major ground rule breaks appear in some way to have been commented on by the patient in an unconscious thematic way except for the obvious break in ground rule 10, requiring a one to one relationship with privacy and confidentiality. The expectation here would be to have thematic material around leakage, unfaithfulness and betrayal.

6.3 SYNOPSIS OF SESSION: MARY SESSION 2

Quantitative data relating to words and questions in session

No. words therapist	1419	42.5%
No. words patient	1918	57.5%
No. words total	3337	100.0%

Total questions	5	10.6%
Total therapist responses	47	100.0%

Therapist's opening invitation to the patient to speak

- T You knew about this session didn't you? I think I said last week that we were having a session today.
- P No.
- T Oh.
- P Maybe I forgot I don't know.
- T All right, anyway. Anything you want to bring up, to talk about?

In session 2 the patient is still on the ward and is on the verge of being discharged. Although the framework has been tightened to some extent, there is still the element of the chaotic take-over from the previous therapist, together with the rest of the chaotic ward framework at play in the patient's material. This has not been interpreted and hence not been adequately

resolved and the patient is unconsciously aware of the continuing, inadequately resolved chaotic situation and refers to someone being irresponsible and chaotic (themes, 1, 7, 10 and 17). There is the faint promise of change on the part of the therapist but the patient does not believe it (theme 2) and neither does she believe that things will improve (theme 11). The patient perceives that if things were not so chaotic they would be quite pleasant (themes 6 and 9) and she would like to convince the therapist to get help for the situation (theme 8) and unless this happens she would like to terminate the relationship with the therapist (themes 3 and 4).

The patient moves onto her perception of the hopelessness of the situation (theme 13) and of her rage and frustration at being out of control (themes 14 and 15). She realises that the chaotic framework is the norm (theme 17) and how there is a complete lack of awareness of its effects on people (theme 18) and of how she herself is deteriorating (theme 19).

The patient has cut herself off from her feelings as a way of defending herself in the past and this is also how she is handling the current situation in the therapy and in the ward (themes 20, 21, 22, 23, 24 and 27). The patient's interpersonal and ontological insecurity emerge again in this session through themes of pessimism about good things continuing (theme 26), of separateness from other people and insecurity around them (themes 29 and 30) but the genetic components of this insecurity are exacerbated by the lack of a secure holding in the therapy. Finally the patient indirectly remarks on the therapist's lack of clear communicative interactional interventions by the thematic material relating to someone not understanding her or telling her about her behaviour (themes 28 and 31) and the theme of someone not talking but of fighting and arguing (theme 5) and the theme of keeping something to herself because of shame (theme 12). Carried over from the previous session, and related to the lack of interactional, communicative interventions (in the sense that the therapist is not incorporating the context or the triggers into his interventions) is the patient's unconscious perception of being blamed by the therapist's purely intrapsychic or intrapersonal as opposed to interpersonal, formulations and interventions. This is represented in the patient's themes of being blamed (themes 16 and 17), situated as it is, immediately after the therapist's intervention in (3-8).

6.4 SYNOPSIS OF SESSION: MARY SESSION 3

Quantitative data relating to words and questions in session

No. words therapist	1315	43.0%
No. words patient	1745	57.0%
No. words total	3060	100.0%

Total questions	6	16.6%
Total therapist responses	36	100.0%

Therapist's opening invitation to the patient to speak

T Okay lets start.

The patient has been discharged from hospital and is now attending therapy on an outpatient basis. The chaotic framework situation in the ward has been left behind although it has not been interpreted or dealt with in any other way in the sessions. The patient was interviewed by a nursing student, as part of the latter's oral examination prior to her discharge (see Appendix 4, adaptive contexts). The ground rules for the therapy have not been spelled out although the patient now has a set and regular time for sessions, and a set and regular place for the therapy. The question of the fee for her outpatient therapy has not been discussed with her.

The patient begins the session by reporting that things are going better in her interaction with her husband but she fears a relapse (themes 1, 2 and 3). Her husband appears to be trying hard to give up drinking but she can sense that he might still be drinking (theme 1). This can also be seen as derivative material relating to the chaotic framework which seems to be improving but of which there is no guarantee that it has improved or that it will remain at the improved level.

The question of payment for therapy comes up in a derivative form in the therapy with the patient's unconscious preoccupation with money (themes 5, 7 and 8). She has now been discharged from the hospital but there is no negotiation around her fee for her outpatient therapy. The patient is wanting to avoid this reality together with other unpleasant realities. She remarks that she is wanting to avoid all unpleasant subjects and this is a consistent theme in the session (themes 5, 9, 10, 11, 17 and 20) in line with her avoidant defensive style.

The patient has no energy (themes 8, 9 and 19) and wants to be alone (themes 12, 13, 15, 16, 17 and 22). While this is part of her symptomology it is also a derivative commentary on the intrusions prior to the session by the second patient. This intrusion is a break in the patient's right to privacy and confidentiality.

Linked to the above themes is the feeling that the patient is having to be for other people and can not be herself (themes 14, 21, 22 and 24) to such an extent that she can't remember what it is that she really wants and who she in fact really is. Although this is a problem of long standing which is dynamically and genetically connected to her poorly developed sense of self, it is triggered to a certain extent by the unempathic type of intrusive question posed by the therapist asking why she does not want to go back to work (see Appendix 4) and the fact of being used by the nursing student in her oral examination.

The patient is finding it an effort to come to the therapy session (manifestly stated near the beginning of the session) mainly because she is having to repeat herself (theme 18) and is hence not being heard. This is a commentary on the lack of communicative, interactional interpretations in the sessions and a specific commentary on the fact that the therapist does not appear to be actually listening to the patient's unconscious communications.

Although there is no sign of interactional, communicative interpretations, and notwithstanding the intrusive question mentioned above, the therapist continues to improve his functioning in the session with fewer intrusive questions and more clarifications and interpretations, although mainly on a manifest level. This improved functioning of the therapist and of the framework has led to a shift of emphasis, with the patient moving from complaining about the behaviour of others, to her looking at her own issues, particularly her difficulties in relationships and her avoidance of unpleasant reality.

The patient mentions her fear of a terrible feeling that she does not seem to be able to articulate very well but she describes it as a feeling that she would like to do away with herself (theme 20). In line with the tightening up of the framework in this therapy this is

conceivably an indication of the beginnings of the patient's 'secure frame anxiety' (Langs, 1982).

6.5 SYNOPSIS OF SESSION: MARY SESSION 4

Quantitative data relating to words and questions in session

No. words therapist	1070	19.6%
No. words patient	4391	80.4%
No. words total	5462	100.0%

Total questions	5	11.6%
Total therapist responses	43	100.0%

Therapist's opening invitation to the patient to speak

T Okay what would you like to talk about today?

The patient arrives at the session with an entourage consisting of her husband and children and they proceed to play outside the therapy room, noisily chasing after the family pet. The patient launches into the session with gusto and makes good use of the time to talk about meaningful material. There is an extended narrative about events in the recent past (before her admission to hospital) that have clearly troubled her since their occurrence and which clearly need to be related to a sympathetic listener. This is material and detail that has not come up before and it is a sign of the patient's deepening trust in the therapist and in the therapy process which is mainly a function of the tightening up of the framework of the therapy.

In addition to the surface material which needs to be sympathetically heard by the therapist there is a large amount of derivative material which is also a function of the tightening up of the frame, specifically ground rules 4, 5 and 6. Not surprisingly, given the background adaptive contexts that have not been interpreted and the degree of chaos in the handing over process, the patient still appears to be struggling to some extent with a lack of security in the therapy and this is articulated in themes of not being able to trust someone (themes 5, 6, 7, 18 and 32). She talks of being undefended (theme 10), unsupported (theme 15), neglected (theme 17) and not understood (themes 40 and 41). There are also themes of being blamed for something (themes 11, 13, 14, 26, 30, 31 and 37) and of being labelled mad (themes 14, 31, 33 and 34) which are in line with the non-interactional nature of the therapist's

interventions which place the focus squarely in the intrapsychic rather than the interpersonal realm, which in a sense places the focus of enquiry and scrutiny, and hence the 'blame', purely on the patient. In addition the patient appears to be aware, at a deep unconscious level, of the financial irresponsibility of the therapist in not discussing the fees for therapy and not arranging for fees to be paid by her and produces themes of financial irresponsibility generally, and specifically themes of someone not paying important debts (theme 20), of someone squandering a windfall (theme 22), of not asking someone what he has done with the money because she is afraid to find out (theme 23), and of simply handing over responsibility for the finances to someone although she is disturbed by it (theme 24).

There are several indicators of the patient's 'disturbance' in her manifest reference to her getting out of control and fighting with people (themes 3, 4, 7, 9, 15, 27 and 28) and again in her material relating to her avoidance of issues that are painful or disturbing to her (themes 23, 43, 44, 45 and 46). In the light of all the ingredients for a communicative interpretation, namely the manifest reference to an adaptive context, derivative material relating to that adaptive context and indicators of the patient's disturbance, it is imperative for the therapist to provide an interpretation combining these elements. The lack of an appropriate intervention appears to be unconsciously noted by the patient in her derivative material relating to the communication breakdowns of not speaking to someone, not being understood and of not hearing someone (themes 21, 45 and 46)

There is derivative material that indicates the patient's concerns with the leakage from the one to one therapeutic relationship in her themes of people talking about her (themes 34, 37 and 38). Not surprisingly the patient produces themes of feeling angry and frustrated (themes 16, 29 and 35) and of being made a fool of and of wanting to be alone (theme 39).

6.6 SYNOPSIS OF SESSION: MARY SESSION 5

Quantitative data relating to words and questions in session

No. words therapist	1061	25.4%
No. words patient	3116	74.6%
No. words total	4177	100.0%

Total questions	3	6.8%
Total therapist responses	44	100.0%

Therapist's opening invitation to the patient to speak

The patient simply starts the session.

In this session the framework of therapy has been tightened considerably. However the therapist has not been using interactional, communicative interventions to interpret the patient's productions in the therapy to date and consequently the patient's unconscious concerns around abandonment, as indicated by the derivative material from previous sessions have not been fully addressed. Even though the chaos around the handing over of her therapy might have been reversed and the therapy space might have become more orderly, there is still the *potential* for abandonment by her current therapist in line with her previous experiences in therapy.

Two aspects of the frame that have not been tightened up in this session are firstly, the ground rule relating to fees and, secondly, the ground rule relating to privacy and confidentiality. In the former case the situation has worsened from previous sessions in that the patient has not been assessed for fees since becoming an outpatient. In the latter case the ground rule relating to privacy and confidentiality has not been fully tightened up in that the therapy sessions are still being recorded.

While there are four main triggers or adaptive contexts operating in this session, the framework of the therapy has been tightened up to a considerable degree in comparison to the chaos surrounding her referral and this allows for the patient's production of a considerable amount of derivative material, relating to three of these four triggers, in the session. There are no manifest representations of the adaptive contexts of the session but the thematic material as a whole points to these adaptive contexts operating in this session.

There are three main types of themes discernible in the session. Firstly there are themes relating to trust and not being able to trust people, secondly there are themes relating to abandonment and rejection and to fear of abandonment and rejection and lack of acceptance, and thirdly there are themes relating to problems in communicating with someone and not getting through to someone. This thematic material has clear links to the above triggers.

The patient starts the session with thematic material relating to issues of fear of abuse and harm coming to her children (themes 1, 3, 4, 5, 6, 8, 13 and 14). This is echoed in other themes of her sister having been sexually abused as a child and of her own close encounter with an abuser (themes 7, 10, 11 and 16), and in a theme of covering up for wrong doers and of innocent people getting hurt (theme 15) and finally in a theme of being abused but not wanting to retaliate (theme 26). This gives an indication of the patient's view of the therapy that she is receiving at this time, particularly the 'free therapy' that she is currently receiving. It is seen as potentially abusive and dangerous.

The other major theme occurring in this session has to do with abandonment in general, and this general theme takes many specific forms in the session. The patient speaks of her realisation of having to let go of someone (theme 2) and of someone growing away from her (theme 17) and of being alone and lonely (theme 18), jealous (theme 24), and of someone deserting her or of being inconsistent in their relating to her (themes 19, 20, 21, 23, 27 and 38). In a more subtle variation of this theme of abandonment, the patient speaks about being uncomfortable around women and of women making her feel anxious and not good enough (themes 29, 30, 31 and 32) and of someone expecting too much from her and not accepting her (themes 33 and 34). This is followed by more distinct material relating to someone preferring other people to her (theme 35 and 39) and by her talking about being angry because she has allowed other people to become important to her (theme 37). It seems clear from the variety and quantity of this material relating to abandonment that the patient is still, at some level, attempting to deal with her abandonment by the previous therapist and with the subsequent potential for abandonment by her current therapist.

Finally the patient's unconscious response to the lack of communicative interventions is apparent in the thematic material relating to communication difficulties. She gives an indication of her unconscious awareness that her deepest fears and concerns are not being heard or properly understood by the therapist when she speaks of not being able to tell someone something important (themes 9 and 22). In a comment perhaps on her potential to use projective identification as a mode of communication by impact she speaks of wanting people to feel like she does (theme 25). In an oblique commentary on her own avoidant defensive style, as well as perhaps on her perception of the therapist's intrusive style in the

session, the patient talks about remembering painful things because of being reminded by what someone else has said (theme 12).

6.7 VALERY: SESSION 1

6.7.1 Summary of ground rules broken

This patient is handed over for therapy, as with the previous case, but there is a difference in the manner in which this handing over takes place. With the current patient the process is more orderly and takes place in an attempt to provide her with ongoing continuity of therapy. It is a consequence of her previous therapist having left the service and the therapist at O.P.D., knowing that he too would be leaving the unit in the near future, attempting to find a more permanent therapist for the patient. The patient is introduced briefly to the therapist and a set time and place is arranged for the therapy, her fees having been previously arranged at the beginning of her previous therapy. However, despite these efforts, there is confusion around her initial hour when the patient phones in to cancel her initial appointment (see Appendix 7). Thus although ground rules 1 and 2 have been complied with in this initial session, it has to be conceded that ground rule 3, the specified time of the session has been broken for this session.

Ground rule 4 is also complied with, in that the patient and therapist retain the same fixed position in the therapy room although the patient does not make use of the couch. Ground rules 5 and 6 are substantially complied with by the therapist allowing the patient to free associate and by the therapist attempting to maintain an evenly hovering attention. Strictly speaking the provisions of ground rule 7 are not complied with, in that, although the interventions of the therapist are neutral, they do not conform to Langs's (1982, 1988) strict requirements. The therapist retains anonymity and there is no prior or concomitant relationship thus complying with ground rules 8 and 9. However ground rule 10, relating to privacy and confidentiality is severely compromised in several ways in this therapy, as is the case with all the sessions examined in this study.

In summary, in this session it is clear that ground rules 3, 7 and 10 are compromised. The other ground rules, namely 1, 2, 4, 5, 6, 8 and 9 are maintained, to a large extent in this session of therapy. In response to these adaptive contexts one could expect then, in this

session of therapy to have themes of chaos (ground rule 3), themes of someone not being heard, or of communication difficulties (ground rule 7) and themes of leakage, unfaithfulness and betrayal (ground rule 10).

6.7.2 Synopsis of session: Valery session 1

Quantitative data relating to words and questions in session

No. words therapist	1113	20.5%
No. words patient	4324	79.5%
No. words total	5437	100.0%

Total questions	16	30.8%
Total therapist responses	52	100.0%

Therapist's opening invitation to the patient to speak

T Okay what's been happening? Lets just hear about it from your side.

The patient has been handed over for therapy and has been sent from O.P.D. to another building for therapy. Things have been fairly chaotic in the setting up of the first appointment, with a number of misunderstandings resulting in her eventually being seen fifteen minutes late on her originally designated day for therapy despite that day being changed. The patient immediately reflects this in her thematic material, speaking about someone being sent away for punishment (theme 4) and things becoming chaotic because of this (theme 5, reflected later in themes 36, 40 and 42) and a subsequent lack of understanding (theme 6). The patient goes on to speak of not being supported (themes 7, 8, 20 and 35) and of being alone with someone else just giving out rules and making her do the talking (themes 7 and 24) and of people becoming like strangers (themes 7 and 8). The patient remarks that she is doing everything in her power to keep things together but to her dismay she has discovered that someone close to her drinks (theme 9) and in addition this person does wrong by robbing people and absconding (themes 3, 9, 10, 11, 16, 25, 37, 40, 41 and 48), a reference perhaps also to the chaos in her therapy and the absconding of her previous therapist. This perception is reinforced by the themes of someone neglecting their duties (themes 34, 35, 38 and 44).

Later in the session the patient seems to be taking a more positive view of the session when she refers to themes of someone improving in how they are compared to how they were

before (themes 15 and 29), a theme of being grateful to someone who is firm but kind (theme 17) and a theme of developing more trust in someone (theme 18). The patient refers also to being helped (themes 12 and 13). The patient goes on to talk about how she has made an effort to laugh even though she is depressed (theme 14) and how she wants everyone to be happy (theme 21), which seems to have a kind of superficial ring to it as a type of positive thinking attitude that will mask some of the real issues, possibly portending the later unmasking in future sessions of more material relating to depression.

Apart from the background adaptive contexts there are two triggers that operate in the session itself. The main trigger appears to be the therapist not making any interactional, communicative interventions in the session and this is reflected in the patient's derivative material having to do with the communication difficulties in that someone makes her do all the talking (themes 7 and 24) and themes regarding the lack of talking and the violence which is occurring in its place (themes 18, 26, 27, 43, 46 and 47). The second trigger, the taping of the session does not appear to receive any specific clear derivative comment from the patient.

6.8 MONICA: SESSION 8

6.8.1 Summary of ground rules broken

The most important compromise to the ground rules is the encounter that the patient has, prior to the session examined here, wherein she is informed by one of the reception clerks that she will have to attend an outlying clinic in future and will no longer be able to attend at O.P.D., as a result of the restructuring at O.P.D.. This, combined with the patient's history of being transferred on for therapy, and combined with her knowledge of her therapist's pending move to another unit, must obviously have had a very detrimental effect on her perception of the containing function of this therapy. This ground rule break of the potential loss of her therapist is of such a nature that it virtually pervades all of the ground rules. One would expect then to encounter themes of abandonment and rejection and loss, in abundance, in the patient's material.

Therapy with Monica involves a single setting, a set fee, and a specified time and duration for each session. Ground rules 1, 2 and 3 are thus complied with. While the therapist does

not make use of the couch in therapy, both participants occupy a fixed location in the therapy room, thus largely fulfilling the requirements of ground rule 4.

The therapist allows the patient the opportunity to talk about her issues and is reasonably open and receptive to them although she does not, strictly speaking, employ free association and an evenly hovering attention. Ground rules 5 and 6 are thus adequately complied with.

Ground rule 7 is problematic in that the therapist's interventions are not always neutral, given her well considered concerns about the patient's current boyfriend. The interventions also do not comply with the strict requirements of the communicative approach. It can be said then that ground rule 7 is not fulfilled in this therapy and one can expect themes of not being heard or of communication breakdowns, reflecting this non compliance with this ground rule.

The therapist remains relatively anonymous in the therapy and there is an absence of any prior or concomitant therapy relationship. It was felt that the brief encounter between therapist and patient in the ward context, eight months prior to the therapy, which involved the therapist assessing the patient for the ward programme, was not a consequential break in ground rule 9. The therapist had questioned the patient on this point, at the beginning of the therapy, but the patient's conscious response had been that she did not recall the fact that she had been interviewed by the therapist at that time, as there had been so many people who had interviewed her. Ground rules 8 and 9 are considered to be substantially complied with.

Ground rule 10 is however, like all of the therapy sessions examined in this study, severely compromised in many different ways (see appendix 8 and sections 5.2.10 and 7.2.2). This could be expected to lead to themes of leakage, unfaithfulness or betrayal.

6.8.2 Synopsis of session: Monica session 8

Quantitative data relating to words and questions in session

No. words therapist	1630	21.2%
No. words patient	6047	78.8%
No. words total	7677	100.0%

Total questions	32	37.6%
Total therapist responses	85	100.0%

Therapist's opening invitation to the patient to speak

The patient starts the session by saying that she has a cold and the session follows on from there. Usually the therapist begins the session by asking the patient how she is.

The patient's major preoccupation in the session appears to be with being abandoned, rejected or not being involved with someone (themes 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 21 and 44). This can be linked to the theme of her needing someone to be close to (themes 32, 33, 37 and 38). These themes can be directly related to her hearing about the impending abandonment by her therapist. This adaptive context is actually represented manifestly by the patient near the end of the session lending further credence to its importance for the patient and for understanding and decoding the unconscious communications from the patient's material.

The other manifest representation of the adaptive context is the patient's reference generally to being in therapy and being on medication, throwing some light on the thematic material of someone abusing her or damaging her (themes 17, 18, 19, 23, 24, 25 and 41), of being controlled or interfered with (themes 28, 31, 40, 50, 51, 52 and 53), of wanting to avoid a relationship with someone (themes 26, 27, 28, 29 and 46) and of taking in something bad or damaging or of being spoiled (themes 34, 45, 47 and 49). At first glance this would appear to be a contradiction of the feeling of being abandoned but it can be explained by the patient's unconscious recognition of her need for the right kind of relationship, a healthy therapeutic symbiosis within a secure frame.

The above material is not decoded by the therapist in the session leading the patient to bring up thematic material of someone not wanting to talk about a topic or of not listening to her (themes 8, 17 and 23). This in turn leads to the themes of her symptoms of her feeling helpless, powerless and lacking in energy (themes 1, 16, 40, 41, 43 and 48). There is also a link here with the theme of having to work hard at something (themes 20, 34, 35 and 36), although this linkage is perhaps more tenuous.

Finally there is the thematic material relating to leakage from therapy, or trying to keep someone out (themes 22, 30 and 39). This can be related to the adaptive contexts of being

supervised and of having the session taped, as well as the concurrent session with the medical officer and of the patient's boyfriend coming into one of the previous sessions.

In addition to the adaptive contexts that are operative at the beginning of the session there is a clear trigger that appears to operate within the session. Most of the therapist's interventions are neutral; questions, encouragement to continue speaking, or reflections. In addition the therapist occasionally clarifies things for the patient. Only one interpretation is made within the session. The interpretation (see Appendix 8) is a kind of positive encouragement to the patient, telling her that there is more to her than the sad grieving part and that underneath the sadness is someone with a lot of energy and love and things to give. Although the patient agrees with this consciously, the comment definitely does not receive the more important unconscious validation from the patient who, after saying that this is true immediately speaks about how she is "very gullible to believe people" and recalls the "car incident" which is an example of her believing someone who was nice to her but who did not have her interests at heart and she talks about how she has to be careful because men are cruel and are not always what they seem to be. Given the context of the session and the adaptive context operating at the time of the therapist's apparent pending abandonment of the patient this would have undoubtedly exacerbated the patient's suspicion of the positive comment from the therapist. This point is more fully elaborated in section 7.2.5 where the issue of validation of interventions is discussed.

At the end of the session, at the patient's request, the therapist clarifies for the patient that she is not to be transferred on to another therapist but will have the opportunity of remaining in therapy if she so wishes, when the therapist moves on to another ward. This is clearly a very reassuring offer for the patient and she responds to it with a wealth of material, even though the session is at an end, a clear indication of her relief at this offer.

6.9 LALA: SESSION 4

6.9.1 Summary of ground rules broken

The therapy complies with ground rule 1 requiring a single setting. Ground rule 2 is substantially complied with, although unlike the other patients who are assuming financial responsibility for all sessions whether attended or not, Lala believes that she is paying only

for the sessions that she attends. Ground rule 3 is compromised because the sessions do not take place at a set time on a set day. This is because the patient attends every second week, makes her appointments with the bookings clerk and sometimes encounters difficulty in obtaining appointments. The sessions are however, over a set duration of time, thus partially meeting the requirements of ground rule 3.

As with all the other sessions, the therapist does not make use of the couch in therapy but both participants occupy a fixed location in the therapy room, thus largely fulfilling the requirements of ground rule 4.

The therapist allows the patient the space to talk about her issues and is reasonably open and receptive to them although she does not, strictly speaking, employ free association and an evenly hovering attention. Ground rules 5 and 6 are thus adequately complied with.

Ground rules 8 and 9 are complied with in this session but ground rules 7 and 10 are both compromised. Ground rule 7 is broken in that the therapist does not use communicative interactional interpretations. Ground rule 10, relating to privacy and confidentiality, is severely compromised in many ways in this therapy, as with all of the other sessions examined in this study. Themes of not being heard and of communication breakdowns can be expected as can themes of leakage, betrayal and unfaithfulness.

In summary then, ground rules 1, 2, 4, 5, 6, 8 and 9 are substantially complied with. On the other hand ground rules 3, 7 and 10 are not complied with in this therapy session. Pervading all of the ground rules and the whole of the therapy, however, is the most important adaptive context (Appendix 9 adaptive context 6) which is that there is the possibility of the therapy being terminated due to the therapist being transferred to another ward at the end of her placement in her current unit and the patient's knowledge of this possibility. This adaptive context has such severe implications for the therapy as to undermine all of the ground rules listed above.

6.9.2 Synopsis of session: Lala session 4

Quantitative data relating to words and questions in session

No. words therapist	1033	19.3%

No. words patient	4314	80.7%
No. words total	5347	100.0%
Total questions	44	44.9%
Total therapist responses	98	100.0%

Therapist's opening invitation to the patient to speak

T How are things with you?

Despite the adaptive contexts there are many positive elements in the session. The therapist clarifies many issues for the patient at one level, even though she does not allude to material at the interactional, communicative level. There are positively toned themes in the session and the patient raises these when she speaks of having answers to questions and of having learned things (themes 8, 10 and 12) and of being encouraged to study further (theme 11) and later on of being comfortable talking to someone (theme 37).

The session starts with the therapist asking the patient how things are with her. The patient replies that she has started a casual job. The therapist expresses interest and asks a few questions and the patient remarks that she was reluctant to work there because it involved family. This is clearly an important issue for the patient, she has had a history of sexual abuse at the hands of a family member and this has not yet been opened up in her current therapy. Instead of picking up on the patient's reluctance to work with family members and other latent issues around crossing of boundaries and dual relationships with people (theme 1, repeated later in the session as themes 51 and 52), the therapist focuses on the details of the manifest content of what the patient is saying and asks two questions at the manifest level, namely "What kind of factory?" (1-11) and "Are you working as a machinist?" (1-13). This sets the tone for the session that follows and the patient is soon raising themes of boring, mundane work (themes 2 and 7 and repeated later in themes 31 and 32) and of not much communication with other people (themes 4, 5 and 9 which are repeated later in the session in themes 26, 27, 34, 36 and 37). The above thematic material seems also to be a reference to the mundane level of the therapist's inquiry and a reference to the manifest level of the therapy generally. Later in the session the patient raises themes of superficial conversations with people (themes 33, 38, and 45) and of someone not being real with her (theme 39) and of putting off talking to her (themes 43 and 44).

The patient refers to the adaptive context of the uncertainty around the therapy and whether it will endure (Appendix 9, adaptive contexts 4 and 6) when she raises themes of ambivalence around relations with her (themes 23, 24, 25 and 49). Her unconscious perception of the therapist's apparent ambivalence about the relationship with her is also alluded to in her thematic material around someone trying to put her off therapy (themes 15, 17, 19 and 20) and around the theme of someone thinking that money might be more important than her health (theme 18) counterpoised with themes of someone encouraging her to come to therapy (themes 16 and 21).

Despite the therapist's best efforts, the session ends on an ominous note. At the end of the session the therapist tries to sum up by giving the patient some brief feedback of her impressions of her in the session. This feedback not only does not receive derivative confirmation but seems to receive strong derivative disconfirmation in that the material from the patient immediately following indicates that the therapist's perceptions are erroneous (see section 7.2.5 below where this issue is fully discussed).

6.10 GRACE: SESSION 8

6.10.1 Summary of ground rules broken

Two factors stand out about this therapy, both having an important impact on the framework of the therapy. Firstly, the therapist was persuaded to join the psychiatric registrar at O.P.D. in a joint session of family therapy with the patient and her two sons, prior to her taking over the therapy. This family therapy occurred only once and the therapist resolved not to undertake any further sessions, but this intention was not communicated to the patient. Consequently the possibility of further sessions of family therapy, as far as the patient is concerned, have not been ruled out. Secondly, the therapist had moved from a more supportive therapeutic stance towards the patient to a more exploratory approach to the therapy, also without interpretation or explanation to the patient. This essentially involved a more passive, listening approach to the therapy, according to the therapist. These two factors, particularly the former, clearly have a pervasive impact on the framework.

Apart from the above two factors this therapy attempts to conform to the rest of the ground rules. The exceptions being ground rule 10, relating to privacy and confidentiality which is severely compromised in many ways in the sessions, ground rule 7 which does not conform to the strict requirements of the communicative approach and to a certain extent ground rule 4 where the therapist does not make use of the couch but maintains a fixed position in the room.

6.10.2 Synopsis of session: Grace session 8

Quantitative data relating to words and questions in session

No. words therapist	896	24.1%
No. words patient	2821	75.9%
No. words total	3717	100.0%

Total questions	30	51.7%
Total therapist responses	58	100.0%

Therapist's opening invitation to the patient to speak

T How have things been going?

The most striking themes of the session relate to the patient feeling that someone has violently forced themselves on her (themes 7, 12, 15, 29, 34, 35 and 49) and that someone is trying to mould her (themes 10, 12, 16 and 35) and that she is adamant that she does not wish to be moulded or treated like a child (themes 10, 11, 17, 19, 41, 42, 43, 44 and 51). This would appear to be a reference to the adaptive contexts of the joint session of family therapy and the potential for further sessions of family therapy involving the therapist and the referring registrar.

The patient is concerned at a deep unconscious level with a perceived change in the relationship with the therapist and communicates this concern with derivative material of someone becoming more aggressive together with derivative material of having been more pleasantly involved with someone in the past than is currently the case (themes 2, 3, 5, 9 and 14). The therapist has moved from being supportive to adopting a more passive exploratory stance and the patient is perceiving this to be a more aggressive, menacing, and unfriendly stance. The tape recorder is an additional variable for the patient to cope with in this particular session. The possibility of another family session has not been ruled out for the

future. This, combined with the therapist appearing to be different in the session, clarifies to a large extent why these issues appear to be more prominent in this particular session. The therapist, by adopting a more passive, exploratory approach is allowing more of the patient's unconscious concerns to come out in the therapy, which by definition would have been more stifled in previous supportive sessions (see section 7.2.3 below) but it would also seem that, in the execution of the exploratory stance, the therapist is appearing, to the patient, to be more aggressive.

The patient also appears to be unconsciously concerned with leakage from the therapy, indicated by her theme of something not being confined to just the two people (theme 40) and her themes of defending herself against slander and of people talking about her (themes 23, 24, 25, 26, 27, 28 and 32) and of not knowing who she can trust to talk to (theme 53). This would be predicted to be a major contextual issue for this patient given that no less than seven adaptive contexts (1, 2, 4, 5, 6, 7, and 8, see Appendix 10) could be said to have leakage and lack of privacy and lack of confidentiality as part of the underlying issues.

The patient seems to be concerned that she is not being heard by the therapist or believed (theme 24) or understood and accepted (themes 18 and 46), and that her therapist does not admit to things or own up to them when she is wrong, even when the patient confronts her with the evidence (theme 31). She is experiencing things that she can't seem to tell her therapist (theme 45). She is saying that the therapist seems to think that her way is the only right way (theme 47) and that she can't seem to tell the therapist this because she will get violent with her (theme 48). She is threatening to give up therapy (themes 17, 27 and 36), if the therapist doesn't damage her so much that she will have to be admitted to a psychiatric hospital (themes 49 and 51). At one level the patient appears to be in tune with the therapist's unspoken concerns about her needing hospitalisation (see Appendix 10). The patient feels that she is not coping (themes 1, 6, 20, 21, 22 and 33) and remarks that things are deteriorating (themes 4 and 15). The above material calls for a clear and concise interpretation along communicative, interactional lines in order to contain the patient, to prevent further deterioration, to reassure the patient regarding her unconscious concerns about being moulded and to prevent her imminent dropping out of therapy.

6.11 GRACE SESSION 9

6.11.1 Summary of ground rules broken

The summary of ground rules pertaining to the previous session (delineated in section 6.10.1 above) applies equally to this session (see Appendices 10 and 11). None of the adaptive contexts have been addressed in the session to date and accordingly they are perceived to be still operating.

6.11.2 Synopsis of session: Grace session 9

Quantitative data relating to words and questions in session

No. words therapist	593	24.3%
No. words patient	1845	75.7%
No. words total	2438	100.0%

Total questions	14	41.2%
Total therapist responses	34	100.0%

Therapist's opening invitation to the patient to speak

T How have things been for you?

This session comes across generally as a truncated version of the previous session with very few new themes emerging and many of the themes from the previous session being repeated. In addition this session is a good deal shorter than the previous session with a total word count of 2438 compared to the total of 3717 from the previous session. In the current session Grace still finds herself in her dreadful predicament. She finds herself in the middle of, and pulled in two directions by, on the one hand her two adult sons who have rejected her religion and embraced Christianity, and on the other hand, the remainder of her extended family who demand that she now shun her two children on religious grounds; that she have nothing further to do with them whatsoever. As a way out of this dilemma the patient's previous therapist had attempted family therapy and had involved the current therapist in the attempt. The family therapy had not been officially terminated (see Appendix 10) and the potential for it to occur again was there in the session. In the previous session the patient had appeared to perceive this unconsciously as an aggressive infringement on her autonomy and had articulated this perception of the therapy in an unconscious way through her conspicuous derivative material of being aggressively moulded.

The patient reports themes of hopelessness (theme 9) and of wanting to avoid her problems by sleeping and hoping that they will go away on their own (themes 2, 8 and 10). In this session the fact remains that things have not changed and she is still caught in her difficult situation (theme 11). The patient returns to the theme from the previous session of tension in a relationship (theme 7) and of her having to take shelter (themes 1 and 5) from someone who is aggressive towards her (themes 5 and 6) and who has changed from how they were previously (theme 4).

In addition the patient talks about people not being available to talk to her when she needs them (themes 12 and 18). More at a symbolic, derivative level the patient talks about eating without gaining nourishment (themes 14 and 15) which can be metaphorically linked to the therapeutic feeding or lack of it going on in the session. But in contrast to this the patient also talks about someone catching on fast and being helpful to her by getting her out of herself and taking her with him (theme 17), which can be understood as perhaps a more positive indication of the sort of help that she is getting in the session.

6.12 NERINA: SESSION 3

6.12.1 Summary of ground rules broken

Nerina's current therapist is her fourth therapist in a short space of time. She has been handed over for therapy so often that it seems to be not accurate to talk about a single setting for the therapy, but the current therapist complies with ground rule 1 and sees her in a single setting and has done so for the three sessions of her therapy so far. She has been tarified for her therapy and pays a reduced fee but it is a constant fee, thus meeting to a large extent the requirements of ground rule 2. She does not have a specified time of day, or day of the week for each session but is seen at approximately weekly intervals, when a booking can be obtained for her. Thus ground rule 3 is not complied with. The duration of the sessions is however constant.

The therapist does not make use of the couch but occupies a constant location within the room as does the patient, thus substantially complying with ground rule 4. Ground rules 5 and 6, requiring the use of free association and the evenly hovering attention of the therapist are for the most part not complied with in the session. Similarly, as with all the sessions in

this study, ground rule 7, requiring the use of neutral, communicative, interactional interventions is not complied with.

Ground rules 8 and 9 requiring the relative anonymity of the therapist and the absence of a prior or concomitant relationship are complied with by the therapist. However ground rule 10 requiring privacy and confidentiality is severely compromised in a number of ways in this therapy.

In summary, ground rules 3, 5, 6, 7 and 10 are unequivocally compromised. Ground rules 8 and 9 are unequivocally maintained. Whilst there is some doubt around ground rule 1, ground rules 2 and 4 seem to be substantially maintained. With this configuration of breaks in the ground rules one could expect a paucity of unconscious material due mainly to the breaks in ground rules 5 and 6. One could also expect themes relating to breaks in ground rules 3, 7 and 10 which would involve themes of chaos, themes of lack of communication and breaks in communication and themes of leakage, betrayal and unfaithfulness respectively.

6.12.2 Synopsis of session: Nerina session 3

Quantitative data relating to words and questions in session

No. words therapist	1268	44.3%
No. words patient	1597	55.7%
No. words total	2865	100.0%

Total questions	56	50.9%
Total therapist responses	110	100.0%

Therapist's opening invitation to the patient to speak

T You're not feeling very well today?

There is a fair amount of resistance evident in this session with the patient showing some reluctance to use the session in order to talk about her difficulties. This is not surprising given the significant frame deviations that have occurred and especially the fact that the patient has had no fewer than four primary therapists in the space of the previous two months, as well as one other person whom she has to consult for medication on a regular

basis. Consequently it is hardly surprising that the patient appears to be reluctant to open up and to talk freely about her difficulties to her current therapist.

The lack of derivative material is exacerbated by the excessive use of questions by the therapist and by the inability of the therapist to address the more prominent frame work breaks leading to the patient's gross behavioural resistance. The therapist also exacerbates the situation by encouraging the patient to bring to the session, notes which the patient has made regarding her feelings and this error is further compounded by the therapist accepting these instead of asking the patient to read them or talk about them. The latter course of action would bring these notes into the realm of the therapy session as material from the patient to be analysed and understood by therapist and patient together, rather than as something that is handed over to the therapist to peruse and understand on her own.

In terms of the thematic material, the patient's most important unconscious preoccupation appears to relate to her fear of expressing herself and of saying what she thinks, for fear of upsetting the therapist and of provoking rejection and abandonment (themes 3, 6, 7, 8, 9, 13, 14, 16, 17 and 18). This is not surprising given the fact that the patient would have perceived her previous therapist's handing her over for therapy as, at some level, an abandonment, no matter how the actual handing over had been rationalised to her

In addition, the patient appears to be concerned with her not being allowed to help someone (themes 1, 2, 4, 5 and 19), and has related concerns with someone saying horrible things about someone else (theme 10) and themes of someone spreading destructive lies about someone else (theme 11). This would appear to pertain also to the therapy situation in that the therapist was responsible for not allowing the patient's lover into the second session after she had been allowed into the first session and after previous therapists had in fact expressly invited her into the sessions (see appendix 12). Theoretically there should be a fair amount of unconscious validation for the action of excluding the patient's lover from the sessions but this does not appear to be entirely the case in this instance with the material seeming to possibly also suggest some negative views on the exclusion. This material is however not rich in derivative properties and is more at a conscious level, produced in response to questioning

from the therapist. Themes 10 and 11 also relate to the issue of the lack of privacy and confidentiality in the session with their subject matter being related to destructive lies.

There are instances in the session of advice giving and of the therapist making use of suggestion and other techniques of a supportive nature (asking the patient to bring notes to the session) which cannot be fully assessed in terms of the communicative paradigm because of the paucity of derivative material in the session. The therapist operates in this session purely on a manifest level with no thought for unconscious processes, and for the patient's quite understandable, interactional resistance. The result is a very impoverished session from the communicative point of view. However, there are still indications from the patient of what is unconsciously of concern to her about the therapeutic frame and of why she appears to be reluctant to use the time to speak about her concerns. An understanding of the patient's material in interactional, communicative terms is still possible despite the lack of abundant derivative material.

6.13 SHARIAH: SESSION 4

6.13.1 Summary of ground rules broken

Shariah's therapist, with her explicit supportive approach to therapy, manages to break virtually all of the communicative ground rules of therapy. The exceptions being compliance to some extent with ground rules 1, 2 and 4.

Although she is seen for her individual therapy in a single setting, seemingly complying with ground rule 1, in a sense there cannot be said to be a single setting for the therapy because the patient is also seen in a group context by her therapist concomitantly to the individual therapy. Because the patient is an inpatient, the charges for her therapy are not itemised separately on her account and are included in the total amount that she is billed for her stay in the hospital. Thus ground rule 2 is to some extent compromised. The patient does not have a set time or day for the therapy, clearly violating ground rule 3.

Her therapist does not make use of the couch but Shariah occupies a set location in the room when she is undergoing individual therapy, thus to a large extent complying with ground rule 4. However the therapist has also had conversations with her outside of the therapy room

and in the corridor on the way to the therapy room which would compromise ground rule 4 to some extent.

Ground rules 5, 6 and 7 are unequivocally violated by the supportive therapy. The therapist has disclosed personal information about herself and her personal circumstances to the patient, violating ground rule 8. Similarly it is hard to argue for the absence of a concomitant therapy relationship between therapist and patient given the nature of the therapy and the fact that concomitant group therapy is occurring, as are ward outings and social gatherings on the ward involving therapists and patients thus violating ground rule 9. As with virtually all of the other sessions in the study, ground rule 10 requiring a one to one relationship with privacy and confidentiality is severely compromised in many different ways in this therapy. The patient is seen for therapy in a ward context, has been assessed by her therapist and presented in the ward round, has notes kept on file which are accessible to other team members and is seen for medication by the psychiatric registrar on the ward.

Given that virtually all of the ground rules are broken in this session it would be expected that the patient's thematic material would reflect themes of seduction, themes of chaos, themes of harm or inappropriate care, themes of leakage unfaithfulness or betrayal, and themes of incest or inappropriate merger. In addition, given that the ground rules relating to access to the patient's unconscious (ground rules 4, 5 and 6) are broken one can expect a paucity of good, clear, derivative material generally. The lack of appropriate communicative interactional interventions would be expected to lead to themes of not being heard or of breakdowns in communication.

6.13.2 Synopsis of session: Shariah session 4

Quantitative data relating to words and questions in session

No. words therapist	1707	48.5%
No. words patient	1810	51.5%
No. words total	3517	100.0%

Total questions	41	43.2%
Total therapist responses	95	100.0%

Therapist's opening invitation to the patient to speak

T What is it that you would like to talk about today?

This session is noteworthy for its focus on purely manifest conscious material and its lack of attention to any derivative, latent material. The session has many features of a typical session of supportive therapy (Dewald, 1994). It is apparent in the session that the therapist is very active and talks almost as much as the patient (1707 words compared to 1810 words for the patient). The therapist does not leave any room for silences of any kind, and everything is dealt with on a manifest level with no delving into the patient's unconscious. The therapist asks many questions and reflects back many times for the patient, and also clarifies some things for the patient. This is a typical session of supportive therapy of the kind that occurs at Lentegeur hospital generally (Rees, 1993). The therapist has the patient's interest at heart generally and knows that it would be best for her to get a stable job, and to become more emotionally stable and then to get a place of her own to stay, and then, when things are going well, to look towards getting custody of her child. Towards this end the therapist refers the patient to the child and family unit to have her son attended to because he has suffered sexual abuse and, in addition, she refers the patient to the local Muslim agency for counselling on specifically religious issues. Furthermore, the therapist suggests a joint session of therapy with the patient's mother.

The patient responds to these legitimate supportive therapy techniques (see Dewald, 1994) with thematic material reflecting neglect and lack of proper care (themes 3, 4, 5, 6, 8, 12, 30, 31, 37 and 38), themes of being prevented from doing what she needs to do (themes 5, 11, 28 and 32), themes of chaos (theme 9), of being confused (theme 34) of being controlled (themes 21 and 22) and themes of someone being aggressive towards her and taking advantage of her (themes 18, 20, 33) and in addition a theme of someone who has abused someone sexually denying that he has abused (theme 7).

The patient responds to the lack of interactional communicative interventions and the lack of proper listening with themes of not being able to express herself (theme 16) of people taking advantage of her because she can't talk for herself (theme 20) and of someone trying to control the way that she is thinking and not allowing her to speak and telling her that she is stupid (themes 21 and 22)

All in all, within its context, this appears to be a useful session of supportive therapy and not all of the material is negatively toned, although it must be noted that the therapist does actually attempt to encourage a positive response from the patient (see Appendix 13) by, for example telling the patient "You fend for yourself. You stand up for yourself. And you are feeling very proud about that. That's very positive, that's good." This encouragement from the therapist elicits comments from the patient that she is communicating better and always smiling (theme 23), that she used to be a loner and now spends time with people (theme 24), that she doesn't care what people say about her (theme 25), that it was a good idea to come for help (theme 26) and that she feels as if she has improved and is handling herself better (theme 27). All of this is in direct response to the therapist's prompt. Given that derivative material is more likely to be related to unconscious processes, this conscious, material produced in response to the therapist's comment is of less value for understanding the patient's unconscious processes than the material that emerges more spontaneously from the patient and which can be taken as derivative material (see section 4.4.5).

There is one part in the session where the therapist confronts the patient about her anxiety (see Appendix 13) and the patient's latent response is informative, as is the difference between the manifest and latent responses. The patient initially laughs, says that she wants to be helped and then goes on to talk about the occupational therapist teaching them positive thinking and self assurance and then switches in a derivative way to how her mother argues with her and she then tells her mother "Mommy can't do this, Mommy can't say that to me" (see Appendix 13). This is perhaps one of the few derivative moments in this highly manifest session, but it is a significant communication and the patient seems to be saying this a few paragraphs later when she states, ostensibly about her interaction with her mother, but at another level, also about the therapist "I got the message over, you can take it or leave it". This pithy statement from the patient could well serve as a general comment on the session as a whole, given that the therapist in this case is very much not taking the unconscious 'message' from the patient.

6.14 SUMMARY OF GROUND RULE BREAKS ACROSS CASES AND RELATED THEMATIC MATERIAL

The ground rules breaks are summarised in this section and the expected, matching thematic material is presented together with these ground rule breaks. Where there is a lack of predicted, matching thematic material this is noted. These results are more fully elaborated and discussed in section 7.2 below.

6.14.1 The setting

Each of the twelve sessions examined was conducted technically in its own single setting in that the offices used for the therapy were constant for each therapist patient dyad. However, given the chaos surrounding the referral of Mary (Appendix 2), it is doubtful that one can talk meaningfully of a single setting for the first session of her therapy. Thus ground rule 1 is maintained in all of the sessions apart from Mary session 1.

Thematic material relating to chaos is greatly in evidence in Mary session 1 with themes relating to chaos and irresponsibility (themes 1, 15, 18, 23, 25, and 33) fairly prominent in this session, as is to be expected. This type of thematic material does not occur in the other sessions of therapy apart from sessions with Valery (themes 5, 36, 40 and 42) and Shariah (themes 9 and 34) which also have thematic material relating to chaos and confusion. The presence of this type of thematic material in therapy with Valery and Shariah is explainable by the break in ground rule 3 which applies specifically to these sessions also (see 6.14.3 below). The lack of this type of thematic material in all of the other sessions in the study is in line with expectations.

The predictions and expectations of communicative psychotherapy regarding thematic material in response to breaks in this ground rule are strongly supported in this study. There is strong evidence of patients' unconscious commentary relating to chaotic conditions and confusion if a consistent setting is not provided.

6.14.2 The fee

All of the sessions from the patients in the sample, with the exception of sessions 3, 4 and 5 with Mary, involved patients being tarified in accordance with the hospital regulations and

paying a set monthly fee for therapy, regardless of the number of sessions attended during the month thus substantially complying with ground rule 2. Mary on the other hand was not tariffed for her outpatient therapy and consequently was receiving free therapy for sessions 3, 4, and 5 thus breaching ground rule 2. Shariah was receiving a form of free therapy in that, as an inpatient, in accordance with hospital regulations her fee for therapy formed part of her total account and was not itemised separately.

Thematic material relating to money matters occurs in Mary session 3, (themes 5, 7 and 8), and themes of a lack of financial responsibility are prominent in Mary session 4 (themes 20, 22, and 24). Themes of sexual abuse are prominent in Mary session 5 (themes 7, 10, 11 and 16). These themes also occur to some extent in the session with Shariah where there is an allusion to sexual abuse (theme 7) and an allusion to someone's financial needs being met but not their emotional needs (themes 8 and 30).

It seems clear from the above material that if patients receive therapy that they are not charged for then this is unconsciously perceived by them as dangerous and is unconsciously equated with a form of sexual abuse on the part of the therapist. This perception of dangerous sexual abuse does not appear in the sessions with the patients who are paying for their therapy and who are responsible for all sessions of therapy whether attended or not. This would seem to be clear and unequivocal evidence in support of the communicative psychotherapy prediction that free psychotherapy is perceived by patients as dangerous and seductive and as having unconscious thematic affinity with sexual abuse.

6.14.3 The time and duration of sessions

Six out of the twelve sessions examined met the requirement of the fixed frame for a set time and standardised duration of the sessions. Of the six sessions that did not meet the requirement, three (Mary sessions one and two and Valery session one) were temporary chaotic aberrations that were then rectified (see Appendices 2, 3, and 6), and future sessions with these patients then met this requirement. The other three exceptions, sessions with Lala (Appendix 9), Nerina (Appendix 12), and Shariah (Appendix 13) were not held on a consistent day and time and continued in this fashion for future sessions. The sessions with Lala and Nerina, while they did not meet the requirement for a *set time* for the sessions, did

however meet the requirement in terms of the *defined length* of the sessions, in that sessions were invariably a set duration of 50 minutes. Shariah on the other hand was seen on different days and at different times and in addition would occasionally be seen for sessions of less than the full defined length.

Themes of chaos and confusion are notable in Mary session 1 and in therapy with Valery and Shariah, as would be expected (see section 6.14.1 above). This thematic material is not evident in the sessions with Lala and Nerina as would partially be predicted by the fact that this ground rule is only partly broken in these sessions. Following expectations, thematic material of this nature does not appear in the other sessions examined in this study.

From the evidence in this study presented here there is support for the prediction that patients will be unconsciously perturbed by breaks in the ground rule requiring a set time and a set length of the sessions and will respond to this break with derivative material reflecting themes of chaos and confusion.

6.14.4 The location

In this study none of the sessions was conducted using a couch and all of the sessions were conducted in a regular location within the room, with the therapist sitting opposite the patient thus to a large extent meeting the requirements of ground rule 4.

The consistency of the location would add to the sense of containment and security of the patient and lack of consistency in this regard would be predicted to lead to thematic material of confusion, chaos and insecurity generally. The use of the couch would be predicted to enhance the production of derivative communication from the patients. Not using the couch would result in a corresponding impoverishment of the derivative communication (see section 4.4.5), rather than result in actual derivatives corresponding to any specific theme. Consequently it is not possible to comment on the validity or otherwise of this prediction of communicative psychotherapy.

6.14.5 Free association

None of the sessions examined in the survey involved therapists that employed this technique fully and completely. Some of the sessions managed to approximate the requirements to a greater degree than others. With the therapy of Mary, over the five sessions the therapist came closer to this requirement in the later sessions, allowing the patient more opportunity to talk about what came to mind. This is in contrast to the earlier sessions when the therapist appeared to be talking almost as much as the patient and was using many questions. However, on the basis of the crude measures of number of questions and the ratio of therapist words to patient words in the sessions, it was deemed that this ground rule was substantially maintained in all of the sessions apart from three sessions, namely Mary session 1, and the sessions with Shariah and Nerina. The consequences of this break in the framework, as with the previous ground rule break mentioned in 6.14.4, are that the derivative material would tend to be lacking and impoverished in the sessions that did not employ free association as fully as other sessions (see section 4.4.5). This prediction was supported in the study with Nerina and Shariah particularly showing a lack of derivative material and Mary demonstrating less derivative material in session 1 than later sessions where free association was employed more clearly by her therapist.

6.14.6 Free floating attention

This rule is the therapist's counterpart of the above ground rule requiring the employment of free association. As with the section above, this ground rule was deemed to have been substantially violated with Mary session 1 and with Nerina and Shariah and to have been maintained, on the whole in all the other sessions. Breaks in this ground rule result in a paucity of derivative material in these sessions rather than with specific thematic material. This prediction appears to be supported in this study in that these three sessions demonstrate the most impoverished derivative material in relation to the other sessions where the ground rule is more adequately maintained (see section 6.14.5).

6.14.7 Neutral interventions

Out of the 791 total therapist responses over the 12 sessions in the study (see section 5.2.7) there were no playbacks of selected derivatives and no framework management responses on the part of the therapists. There was a total of six silences and only 11 interpretations out of

a possible 791 therapist responses. Of these 11 interpretations that were made by the therapists not one met the requirement for a valid communicative interpretation (Langs, 1982, 1988; Smith, 1991a). Interventions on the part of the therapists tended mainly to be questions (38.6%), reflections (27.4%), encouragement to speak (11.3%) and clarifications (12.8%). Appendices 2 - 13 give the individual totals of interventions for each session.

To the extent that this ground rule is not being maintained it is predicted that images and thematic material of communication breakdowns and communication difficulties would be prominent in the material. In addition, to the extent that the patient is not actually being heard in an interactional way by the therapist there is the potential for the patient, at an unconscious level, to feel blamed or accused or made out to be the problem by the therapist.

In Mary session 1 there are themes of someone who makes her feel that she is the problem and that she is mad (themes 2, 3, 19, 21, 34) and there is a theme of an inability to get through to someone (theme 17). This trend continues in later sessions. In Mary session 2 there are themes of being blamed (themes 16 and 17) and themes of someone not understanding her and not telling her about her behaviour (themes 28 and 31). In Mary session 3 there is a theme of having to repeat herself (theme 18) and a theme of someone seeing a problem in her (theme 23). In Mary session 4 there are themes of being blamed for something (themes 11, 13, 14, 26, 30, 31, and 37) and themes of a lack of communication or of not speaking to someone and of not hearing someone (themes 21, 45, and 46). Finally, in Mary session 5, there are themes of not being able to tell someone something important (themes 9 and 22).

In the session with Valery there are themes of someone pushing her away and of having a bad attitude to people and not letting people talk (themes 19, 26, 27, 43, 46 and 47). In addition there is a theme of not understanding someone like before (theme 6) and themes of someone making her do all the talking (themes 7 and 24).

In Grace session 8 there are themes of someone not understanding her or accepting her or believing her (18, 24, 31, 45, 46, 47 and 48). In addition there is the theme of keeping quiet

just to keep the peace (theme 50). In Grace session 9 this trend continues with themes of not having someone to talk to (themes 12 and 18).

In the session with Lala there are themes of not communicating with other people, not wanting to contact them or visit them (themes 4, 5, 9, 26, 27, 34, 36, 37 and 57). Additionally there are themes of someone having short superficial conversations with her, of not being real and of putting off talking to her (themes 33, 38, 39, 43, 44, 45 and 47).

In the session with Monica there are themes of someone not hearing her or of avoiding discussing something (themes 8, 17 and 23).

In the twelfth session (Mary session 5) there is also evidence of communication difficulties but this is slightly more equivocal in that this session also shows evidence of enhanced communication (see section 7.2.4). This more equivocal evidence from this session would be expected in that this session, out of all the sessions in the study came closest to the communicative psychotherapy ideal of interactional understanding and interventions, although the interactional interventions did not meet the requirements of the communicative methodology.

In eleven out of the twelve sessions which have not employed communicative interventions there is clear evidence of thematic material relating to communication difficulties or of a breakdown in communication as would be predicted by the Langsian communicative methodology. In the twelfth session, which employs this methodology partially there is some evidence of thematic material of this nature but it is countered by evidence of its opposite, that is, of enhanced communication. This evidence as a whole in this study is supportive of the communicative prediction in this regard. However it would require more evidence of a positive nature in order to be unequivocally supportive of these communicative predictions. Thus what is required for the strong unequivocal support of this prediction is more sessions utilising sound communicative interventions which concomitantly demonstrate an absence of thematic material relating to communication difficulties.

6.14.8 Anonymity

All of the therapists, with the exception of Shariah's therapist maintained their relative anonymity with no self disclosure to patients. Shariah's therapist on the other hand adopted a more open approach to her patient as a matter of technique (Dewald, 1994) disclosing information about herself which was solicited by the patient.

Therapist self disclosure is predicted to result in derivative material relating to seduction, dishonesty, and symbiotic pressures. Themes of sexual abuse appear in the material from Shariah's session (themes 5 and 7) and in Mary session 5 (themes 7, 10, 11, and 16). This derivative material of sexual abuse has a thematic affinity to seduction although it is not the exact equivalent. This thematic material has been discussed in relation to free therapy in section 6.14.2 above.

Themes of interactional pressure (themes 7, 10, 11 and 16) appear in the session with Monica (see section 6.8.2 above). In line with expectations, other sessions in the study do not contain material of this nature. Thus the evidence regarding this prediction would appear to be inconclusive but weakly supportive of the communicative psychotherapy predictions (see section 7.2.7 below)

6.14.9 Extra therapy relationships

All of the sessions examined by the study were conducted by therapists who technically maintained this ground rule with no therapist having any prior or concomitant relationship with their patients and no physical contact between therapists and patients. None of the therapists planned to have a post therapy relationship with their patients either. However, extra therapy contact did occur in the case of Shariah who was seen for therapy as an inpatient and her therapist had frequent brief contact with her in the confines of the ward but outside of the therapy room. In addition, it could also be said that, because both Shariah's and Mary's therapists were responsible for running groups on the wards that were attended by both patients, there existed a prior therapeutic relationship, in the case of Mary and a concurrent therapeutic relationship, in the case of Shariah. While this is technically a break in the ground rule it can also be argued that the relationship remained a neutral, therapy relationship throughout the group therapy and consequently it would have had less of an

impact on the individual therapy than other kinds of prior or concurrent relationships between patient and therapist. Similarly, Monica was interviewed by her therapist, in the inpatient ward context, some eight months prior to her therapy and again this was considered to be more of a technical break in the ground rule rather than any consequential break in that the contact was purely in the context of work on the ward, was relatively brief and was purely work related.

The thematic meaning link with this ground rule break is one of inappropriate merger. No sessions in the study showed clear, unequivocal evidence of this kind of derivative material. Consequently it must be said that the evidence is not conclusive regarding this prediction of communicative psychotherapy. However it can be argued that there is some thematic affinity between derivative material relating to seduction and relating to inappropriate merger and there is a case for a combination of these two ground rules. This issue is further discussed in section 7.2.8 below.

6.14.10 Privacy and confidentiality

All of the patients in the study experienced therapy where this ground rule was severely compromised in many different ways. As all of the patients in this study had very clear, unequivocal breaks in this ground rule the expectation would be that all of the sessions would show unambiguous evidence of thematic material relating to unfaithfulness, betrayal and more concretely, leakage (Langs, 1982). Only four of the sessions had themes that could obviously be linked to this ground rule.

Grace showed themes of something not being confined to two people (theme 40) and themes of having to defend herself against slander and of people talking about her (themes 23, 24, 25, 26, 27, 28 and 32) and of not knowing who she could trust to talk to (theme 53). The session with Monica had themes of leakage or trying to keep someone out (themes 22, 30, 39). Nerina presented themes of someone saying horrible things about someone else (theme 10) and of someone spreading destructive lies about someone else (theme 11). Mary session 4 had themes of someone talking about her (34, 37 and 38). Despite the abundance of ways that this ground rule is broken in all of the sessions in the study the other eight sessions did not appear to show evidence of thematic material that could be linked to this ground rule

break. This lack of clearly related thematic material in eight of the sessions, under these circumstances of clear deviations to the ground rule requiring a one to one relationship with privacy and confidentiality, is not predicted and it remains to be properly understood and explained. The issue is further discussed in section 7.2.2 below.

6.14.11 Concluding comment

Trying to isolate particular ground rules or particular aspects of the framework and matching them with derivative material is a potentially self defeating exercise. Some of the meanings inherent in a particular ground rule break can be applied to several other ground rules, thus making it difficult to simply postulate a one to one correspondence between a particular ground rule and a particular element of derivative material. In this study this applied to aspects of the ground rules relating to free therapy, therapist anonymity, and relationships with the patient outside of the therapy space. All of these breaks in the frame have similar elements of a 'gift' to the patient which could have been unconsciously perceived as seductive and potentially dangerous. This point is discussed further in section 7.2 below, where these results are more fully elaborated and discussed.

In this study strong evidence is demonstrated for the communicative psychotherapy propositions regarding ground rules 1 and 2 relating to a consistent setting and the fee of psychotherapy. Support of a slightly weaker but nevertheless substantial nature is exhibited for the predictions applicable to ground rules 3, 5, and 7 relating to the duration of the session, the rule of free association, and the therapist's use of neutral interventions. Similarly there appears to be support for the predictions regarding ground rule 6, the ground rule requiring the therapist's use of free floating attention.

The evidence regarding ground rules 8 and 9 relating to therapists' anonymity and lack of extra therapy relationships respectively, would appear to be inconclusive but weakly supportive of the communicative psychotherapy predictions. These two ground rules are discussed in sections 7.2.7 and 7.2.8 respectively.

There does not appear to be any evidence to confirm or to disconfirm ground rule 4, the ground rule requiring the use of the couch and the regular location within the therapy room.

The reason for this is that all of the therapist's used a regular location within the room and none of the therapists in the study used the couch. In addition it is not easy to find derivative material that would relate specifically to requirement of a regular location within the room that would not also implicate the ground rule requiring a regular setting for therapy. Furthermore the use of the couch is a particular part of the ground rule designed more for the enhancement of the patient's production of derivatives rather than one that is likely to bring about specific derivative material that would correspond to this part of the ground rule not being maintained.

The evidence in this study does not seem to support the predictions regarding ground rule 10 relating to the requirement of a one to one relationship with privacy and confidentiality. Only some of the sessions show evidence of material that is unequivocally related to the break in this ground rule whereas all of the sessions demonstrate clear breaks in this ground rule. This surprising result is discussed in section 7.2.2 below.

All of these results are discussed and elaborated on in section 7.2 below. The implications for therapy in the institutional context and the wider issues raised in the study are discussed in the rest of Chapter 7.

CHAPTER 7

DISCUSSION

7.1 THE SCIENTIFIC CONCERNS OF COMMUNICATIVE PSYCHOTHERAPY

One of the most impressive things about the communicative methodology is its broad scientific approach. Smith (1991a) argues for cautious optimism regarding the scientific stature of the communicative methodology as opposed to the broader psychoanalytic methodology which he regards as being irreparably flawed (*ibid.* p242). Langs's methodology is concerned with the systematic verification of therapist interventions through a careful scrutiny of the patient's productions following an intervention. In addition the methodology allows for predictions about patients' potential responses to breaks in the ground rules of therapy and sets out a specific operationalised system for analysis of these observations of patients' responses which allows for the falsifiability of these predictions as well as their verification. Most importantly, these predictions are not centred on the broad and epistemologically contaminated issue of patient cure, which Grünbaum (1984, 1986) has cogently argued, through his analysis of the 'tally argument', is irretrievably contaminated. The Langsian predictions relate specifically to patients' responses to therapists' interventions, to the specific ground rule breaks, and to the framework conditions generally. These particular facets of communicative psychotherapy allow it to refute some of the criticism levelled at psychoanalysis in general, specifically that its propositions are so vague as to render them meaningless (Nagel, 1959), that its propositions are unfalsifiable (Popper, 1972) and that its use of the so-called 'tally argument' to verify the therapist's interpretations is untenable (Grünbaum, 1984, 1986, 1993). The crux of Grünbaum's argument is that psychoanalysts cannot legitimately use the data obtained from within the psychoanalytic situation to gather support for their hypotheses. Central to Grünbaum's thesis is his contention that data from the psychoanalytic situation are irredeemably corrupted by the psychoanalyst's suggestions and selection biases, whether or not these are conscious, and the analysands' prior knowledge and preconceptions about psychoanalysis as well as the fallibility of the patients' memory and reasoning about their own experiences. For Grünbaum this precludes the use of the patient for verification via a form of 'tally' with the therapist's interpretations. Langs's methodology circumvents Grünbaum's accusations in that there is a specific method for verification of the therapist's interventions which does not rely on the

patient's conscious assent or conscious response and neither does it rely on anything as broad and difficult to define and prove as the patient's cure. Langs (1982, 1988), advocates two forms of validation of interpretations. In addition to the more common form of cognitive validation of interpretations which would be the patient's production of additional material, or of a reorganisation on the part of the patient of the material so that it yields new meaning, Langs also advocates validation in the interactional sphere. This interactional form of validation requires reports of positive introjects on the part of the patient which would take the form of the patient reporting in terms of some positive helpful or constructive outside figure or else of the patient reporting on some positive attribute of his or her own. Thus Langs's form of validation of interpretations is much more able to withstand the criticism emanating from Grünbaum regarding the psychoanalytic validation of interpretations (see Chapter 4 and section 7.2.5 below)

Despite the fact that Langs is concerned with gathering evidence for his many propositions about therapy and attempts to set out conditions for the verification of these propositions, there appear to be instances where Langs seems to allow his *methodology* to escape the rigours of close scrutiny. For example one of Langs's most basic premises is that if there are framework breaks then patients will comment on these breaks in derivative fashion. However Langs also contends that if the breaks are so bad that they are unrectifiable then the patient will not respond in a derivative way at all but will be locked into a Type C communicative mode, which is essentially a 'non communicative' mode of relating that is intended to seal off the dangerous or catastrophic reality. Thus the patient will be non communicative, relatively silent and there will be a paucity or complete absence of derivative material, making it difficult to unravel or decode the patient's commentary on the framework breaks because in effect there is no commentary. At first glance this would seem to be an instance of begging the question, or using the conclusion as evidence for itself but Langs's observation about this is, in itself, also a prediction. This prediction is to a certain extent borne out in the study by the experiences with Shariah (see section 6.13.2 and Appendix 13) and especially with Nerina (see section 6.12.2 and Appendix 12) where both these patients experienced a compromised framework with many breaks in the ground rules and both responded to their respective therapists' supportive therapy efforts with relatively impoverished material. This was especially the case with Nerina whose therapist

experienced her as being extremely frustrating and was exasperated by her extreme lack of material in the session. These sessions can be compared to Grace session 8 (see Appendix 10 and section 6.10) where the therapist found surprising material emerging after changing to an exploratory mode of therapy from a supportive mode.

Langs (1982) does indicate what sort of framework deviations count as being unrectifiable. He calls this type of work with patients 'framework deviation termination therapy'. But the example he gives (*ibid.* p361) does not seem to be of this variety in that the ground rule deviations given in this example would seem to be fairly easy to rectify relating as they do to delays in the start time of the therapy, a mix up over an office, the use of an inappropriate office and the use of a crowded waiting room. Langs does point to some gaps in his research when he concedes that more research needs to be done on this issue as to whether severe framework breaks create a set of conditions that impede meaningful communication from patients (*ibid.* p362). However even in therapy situations which involve severe framework deviations it remains possible to use the patient's material to garner an understanding of how the patient is perceiving the situation and to act on the basis of this understanding in order to correct the situation, either through the rectification of the ground rule breaks or through referring the patient to another therapist. There seem to be two separate issues here. The first point is that certain framework conditions are simply unrectifiable and would require referral onwards. The second point is that certain framework conditions are so severely damaged as to preclude any meaningful derivative material emerging. Thus, for example seeing a patient for therapy who was concomitantly in another relationship to one (for example a work colleague) would not be rectifiable other than through termination of the therapy, but the derivative material would not necessarily be obscured by this deviation. On the other hand certain conditions could conceivably prevail in a particular therapy which would make it extremely difficult for the patient to feel secure and safe enough to produce material in the session. Alternatively certain conditions in the therapy could prevail which would actively discourage the patient from producing derivative material, for example certain supportive therapy techniques which actively focus on conscious manifest material (see section 3.3) and thus would make it difficult to interpret the unconscious perceptions of the patient. This would not necessarily be unrectifiable in the sense that the techniques could be changed by the therapist to ones that are more appropriate to the patient's production of

this sort of material (as for example with Grace session 8). This issue is further discussed in section 7.2.3 and section 7.2.4 below.

Langs (1982, 1988) is wary of claiming absolute validity for his formulations about any particular patient until they receive derivative validity. Thus Langs contends that interpretations based on these formulations must be made to the patient and then validated by the patient's responses, after the intervention, in order to confirm the original formulation. This highlights the importance of the validation of interventions for communicative psychotherapy, an issue which will be discussed also in section 7.2.5 below. However, even if Langs's formulations and predictions do receive derivative validation in accordance with the methodology, this does not place them in the realm of concrete fact and absolute certainty. Ultimately the inferences drawn from this derivative validation remain at the level of judgements and no amount of massing of derivative validation will elevate them to the status of incontrovertible fact. Smith (1991a) advocates adopting a strategy of 'strong inference' in order to falsify any particular hypothesis in relation to other rival hypotheses, thus keeping alive the possibility that the current hypothesis might itself eventually be falsified in relation to another stronger hypothesis.

This emphasises the hermeneutic aspect of Langs's methodology in the sense that there is, and will surely always be, a degree of ambiguity about the meaning of any material (Spence, 1987, 1988, 1994) that is read in response to breaks in the ground rules. In adopting Langs's methodology, this ambiguity should be creatively exploited to add a richness to the patient's account and the meaning possibilities of any particular piece of material should not be prematurely closed off in a futile attempt at grasping for a specific kind of scientific rigour. This means, at a practical level, keeping in mind other possibilities for the meaning of the data and other explanations for the material produced, and essentially keeping in mind instances which might falsify the hypotheses at hand.

In the communicative approach it is important to examine sessions as a whole in order to assess the security of the framework. Trying to isolate particular ground rules or particular aspects of the framework, and matching them with derivative material is potentially a self defeating exercise. This is particularly so in relation to the ground rules regarding access to

the patient's unconscious, ground rules 4, 5 and 6 which have reference to the use of the couch, the use of free association, and the use of free floating attention. Breaks in these ground rules are predicted to result in impoverished derivative material rather than specific thematic material and yet there are ways in which these ground rules could possibly be broken which would result in specific thematic material. Thus a break in ground rule 4 concomitant to the patient being moved around the therapist's office in an inconsistent manner would be predicted to produce derivative material relating to chaotic conditions and to confusion, but this would be similar to the thematic material expected from sessions which were not conducted in a regular and consistent location. Similarly a break in ground rule 6 which resulted say in the therapist intruding on the patient's material in one form or another, would be predicted to produce thematic material relating to this intrusion. Thus the thematic material from the patient has to be carefully examined in a qualitative way in relation to the material as a whole. This is undertaken in section 7.2 below.

Something that needs to be heavily emphasised in any discussion of the communicative listening process is that the added interactional dimension, which Langs reads into the patient's productions and that he brings to his interpretation of the patient's material, is a dimension of understanding which is in *addition* to the specific manifest content and to the manifestation of the patient's psychic reality and internal object relations. These three levels of meaning in the patient's productions are not mutually exclusive and they can fruitfully be seen as complementing each other. Clearly these three levels of meaning, operating simultaneously, generate a complexity which threatens to overburden the novice therapist and even experienced therapists who are new to this method (see Gill, 1984). This complexity leads to some of the difficulty in adopting this methodology but at the same time it introduces a subtlety and nuanced understanding that would appear to be particularly valuable in any therapy context. This issue of the overdetermination of derivative material is more fully discussed in section 7.3 below.

7.2 THE VERACITY OF COMMUNICATIVE PSYCHOTHERAPY EXPECTATIONS REGARDING PATIENTS' RESPONSES TO THE GROUND RULE BREAKS

This section contains a careful examination and evaluation of the results reported in section 6.14. This evaluation is more widely discussed in sections 7.3 to 7.6.

Eight broad areas relating to Langs's propositions, predictions, and expectations about patients' responses to framework breaks in psychotherapy are examined below. These eight areas coincide roughly with the ground rules of psychotherapy, with three of the ground rules, namely ground rules 4, 5, and 6 (relating to enhanced access to the patient's unconscious) being combined and treated under one heading in this discussion. Langs's predictions in these areas are not actually set out as predictions in the true sense of the word but are delineated in his work as examples of the types of responses that might be expected from patients' following breaks in the ground rules (see section 3.5 above). There is no easy matching of responses to predictions and the concept of a thematic affinity is important here (see section 4.2.6.10 above) in that the types of responses to the breaks in the ground rules have to make sense in terms of the shared meaning of ground rule break and response.

7.2.1 Reduced fees for therapy

In the hospital context the therapist does not have control over this ground rule and patients are charged a reduced fee depending on their incomes. However the fees charged to patients are generally constant and the patient has responsibility for the monthly fee regardless of sessions missed (see section 5.2.2 above). In this study, sessions 3, 4 and 5 with Mary were the only sessions not conforming to this arrangement (see section 6.1 above and Appendix 4). In the case of Shariah who is receiving her therapy as an inpatient and consequently is not receiving an actual account for her psychotherapy as such, but is paying an all inclusive tariff for her stay on the ward, there is a sense that she is receiving free therapy. Consequently her therapy can be seen as contravening this ground rule.

Lala on the other hand erroneously assumed that she was being charged on a weekly basis and consequently requested to come to therapy only every second week in order to save on the costs of the therapy and this request was granted by her therapist (see section 6.9 above and Appendix 9).

The patients' thematic material reflects this difference in framework conditions. While one cannot say that the thematic material from the other eight sessions reflects an acceptance of this financial arrangement, there does not appear to be any thematic material that expresses

or indicates an unconscious concern with this ground rule on the part of the other patients. However, themes from Mary's later sessions (see sections 6.4, 6.5 and 6.6 above) and from Lala's session (section 6.9 above) reflect some unconscious preoccupation and lack of preoccupation with this issue in important ways. Langs (1982) predicts that a lack of adherence to this ground rule would result in derivative material relating to seduction (*ibid.* p317 & p422), infantilisation (*ibid.* p435), controlling, or inappropriate and unnecessarily gratifying relationships (*ibid.* p438). With Mary, in session 3 (section 6.4) the question of payment for therapy comes up in a derivative form in her unconscious preoccupation with money (themes 5, 7 and 8). Mary has at this point been discharged from the hospital but there is no negotiation around the fee for her outpatient therapy and she is consequently receiving free therapy. In session 4 (section 6.5) she appears to be aware, at a deep unconscious level, of the financial irresponsibility of the therapist in not discussing the fees for therapy and not arranging for fees to be paid by her and she produces derivative material of her husband being very irresponsible and not paying the mortgage bond (theme 20) and squandering his severance pay (theme 22). She remarks that this issue remains unspoken in that she and her husband do not talk to each other (theme 21), she does not ask because she is afraid to find out (theme 23) and she just accepts things and has handed over financial responsibility to him (theme 24). Similarly with the therapist, the issue remains unspoken because she is afraid to find out and has handed over responsibility to the therapist for the financial arrangements even though they are disturbing to her at some level.

In session 5 (section 6.6 above) the communicative implications of this lapse on the part of the therapist seem to become more explicit. The patient starts the session with thematic material relating to issues of fear of abuse and harm coming to her children (themes 1, 3, 4, 5, 6, 8, 13 and 14). This is echoed in other themes of her sister having been sexually abused as a child and of her own close encounter with an abuser (themes 7, 10, 11 and 16), and in a theme of covering up for wrong doers and of innocent people getting hurt (theme 15) and finally in a theme of being abused but not wanting to retaliate (theme 26). This would seem to give an indication of her view of the therapy that she is receiving at this time, particularly the 'free therapy' that she is currently receiving. It is seen as seductive, abusive and potentially dangerous.

Unlike the other patients in this study, Lala assumes that she is paying for only the sessions that she attends (see Appendix 9 and section 6.9.1 above). This would be much like the system operating generally in private practice in this country in that most therapists do not insist that patients take responsibility for sessions not attended if reasonable notice is given (Rees, 1995a). She shows some specific preoccupation with this aspect of the therapy in her material around the theme of someone thinking that money might be more important than her health (theme 18). This comment can seemingly be related to her aunt (to whom it is indeed manifestly related) but it can also be read as a commentary on the therapist who is allowing her to neglect her therapy by condoning her coming only once every two weeks for therapy, and is also perhaps a commentary on her own giving of priority to money rather than health.

Lala's relatively mild commentary on this ground rule break is in line with the degree of the framework break in comparison to both Mary and Shariah. With Mary the ground rule had been clearly broken and she had, by session 3, perceived that her therapy was being offered free of charge and had consequently produced more obvious thematic material relating to this ground rule break. With Shariah the ground rule is perhaps more ambiguously broken in the sense that she is not being charged specifically for therapy in that she is receiving it as an inpatient (see section 5.2.11 above) and there is some degree of material relating to sexual abuse. Lala's material is also in line with all the other sessions in the study where the patients' perception was that they had to assume financial responsibility for the therapy, whether attended or not, and their sessions reflected this in an absence of material that could be thematically linked to this ground rule break thus providing a combination of both negative and positive confirmation of the association of the predicted thematic material with the ground rule break. Adding further weight to this interpretation of the patient's perception of this ground rule break, and an important component to the discussion, is the fact that Lala has experienced sexual abuse as a prominent aspect of her history (see Appendix 9) and hence has it within her 'repertoire' to produce material of this nature in the session. One view of the matter could be that she does not experience her therapy as abusive enough to bring up thematic material related to this aspect of her history, an issue which will be discussed more fully below (see section 7.4.2).

7.2.2 Privacy and confidentiality

Strictly speaking, all twelve of the sessions in the study involved a compromise to the ground rule requiring privacy and confidentiality. One would expect then a surfeit of thematic material relating to this ground rule. According to Langs (1982) breaks in the ground rule relating to the one to one relationship with total privacy and confidentiality invoke images of leakage (*ibid.* p365), unfaithfulness, and betrayal (*ibid.* p314). Surprisingly only four of the sessions, namely Grace (section 6.10), Monica (section 6.8.2), Nerina (section 6.12.2), and Mary session 4 (section 6.5) had themes that could obviously be linked to breaks in this ground rule.

Closer examination reveals that what is different about these sessions with Monica, Grace, and Nerina is that there were specific intrusions into the therapy on the part of other people (see Appendices 8, 10, and 12) with the potential for these intrusions to occur again. Similarly with Mary there occurs the specific intrusion of the nursing student using her for her practical examination purposes immediately prior to Mary's discharge from the hospital. These intrusions were in addition to the standard breaks in privacy and confidentiality reported by all the other therapists (see Appendices 2 -13).

It is not surprising then that these four sessions had prominent thematic material relating to this break in the frame. This is particularly so with Grace session 8, given that no less than seven adaptive contexts (1, 2, 4, 5, 6, 7, and 8, see section 6.10 and Appendix 10) could be said to have lack of privacy and lack of confidentiality as part of the underlying issues.

With Grace the intrusion involved an actual joint session of family therapy with another therapist. The involvement of this other therapist as well as the involvement of her two sons in her therapy could be seen as quite significant intrusions into her privacy and into the confidentiality of the therapy sessions. The patient appears to be unconsciously concerned with leakage from the therapy, indicated by her theme of something not being confined to just the two people (theme 40) and her themes of defending herself against slander and of people talking about her (themes 23, 24, 25, 26, 27, 28 and 32) and of not knowing who she can trust to talk to (theme 53). This strong thematic material from the patient supports the contention that this attempt at family therapy is seen by the patient as a violation of her

privacy and confidentiality and that she seems to be distinctly concerned with this violation in an unconscious way.

Monica was faced with two intrusions into the therapy space (see Appendix 8), namely her male friend's actual participation in part of a session and the more symbolic but perhaps more invasive intrusion of the reception clerk's erroneous information regarding the patient's pending transfer to another clinic. The session with Monica had themes of leakage or trying to keep someone out (themes 22, 30, 39). These themes were not as prominent in her session as were themes of abandonment and rejection (see Appendix 8 and section 6.8.2 above), giving some weight to the idea that the content of the intrusion by the reception clerk was more devastating to the patient than the simple fact of the intrusion.

Nerina (see section 6.12.2) presents a paucity of derivative material generally and in response to the break in this ground rule generates meagre themes of someone saying horrible things about someone else (theme 10) and themes of someone spreading destructive lies about someone else (theme 11). With Nerina the intrusion into the session occurred in the first session of therapy with her current therapist, in that the therapist allowed Nerina's lover into the therapy room, as had been the practice with Nerina's previous therapists (see Appendix 12). The therapist discontinued this practice in subsequent sessions. Although she did not allow this to happen again, the ground rule of a one to one relationship with total privacy and confidentiality was not actually spelt out and rectified in a communicative manner as a direct response to the patient's derivative material, as would be required by the communicative methodology.¹

In therapy with Shariah (see section 6.13 above) there is the possibility of an intrusion, with her therapist suggesting that her mother come in to see a separate therapist, not the current therapist (Appendix 13, trigger no 4). While this produces the conscious response from the patient, that her mother would not come in due to pressure of her work commitments, it does not specifically produce negative derivative material which is clearly and obviously

¹ Langs (1982, 1988) provides numerous examples of correct communicative interpretations. Section 7.4.1 below provides an example of a correct communicative interpretation as it would relate to a session in this study.

identifiable with this particular trigger. The only specific thematic material in regard to privacy and confidentiality is Shariah's comment that she does not care what people say about her (theme 25). This appears to have been produced almost as a conscious identification with the perceived desires of the therapist, coming as it does after the intervention of the therapist praising her for her progress (see section 6.13.2 above).

In therapy with Mary there occurs an invasion of her privacy and confidentiality in that she is interviewed by a nursing student, in front of several examiners, as part of the latter's examination just prior to Mary's discharge. Although this is not an actual invasion into the therapy space itself, it is a clear invasion into her treatment and in a sense it could be said to concretely and physically embody for her the reality of the compromised state of this particular ground rule. Mary produces thematic material in session 4 of someone talking about her (themes 34, 37 and 38).

The six other sessions in the study, although providing evidence of compromises to the ground rule requiring a one to one relationship with total privacy and confidentiality, do not appear to show any thematic material relating specifically to this topic. A brief recapitulation of the breaks in this particular ground rule as it relates to the other sessions examined in this study is in order here. All of the patients in the study were assessed for medication by the medical practitioners assigned to their units and continued to see them for medication on a regular ongoing basis. All of the patients had folders kept on them by their therapists, updated regularly and kept in places accessible to other professionals and clerical staff. All of the patients (apart from Mary and Shariah) shared a common waiting room and reported to the reception desk at O.P.D. prior to the sessions. All of the patients had their therapy sessions audio recorded. These adaptive contexts, in combination if not in isolation, would seem to add up to a serious break in the ground rule requiring privacy and confidentiality and the lack of thematic material reflecting this is a noteworthy if puzzling omission from the other sessions in the study.

Two reasons for this paucity of thematic material relating specifically to this ground rule break with the other sessions seem apparent. The evidence from this study seems to suggest that patients are much more concerned with the threat posed by actual physical intrusions

into the therapy space, in the form of other people such as therapists, staff members and other family members than with breaks in the ground rule that do not involve such intrusions on the part of other people. Thus the sessions producing the most material relating to this ground rule came in direct proportion to the degree of actual physical intrusion into the therapy space, ranging from a large amount of thematic material for Grace through some material for Monica and Mary and still less for Nerina and with only the hint of specific material from Shariah. No specific material in regard to this ground rule break could be found in the thematic material from the other sessions. Thus it would appear that the violations to this ground rule that involve actual physical intrusions by other people appear to be of much more concern to patients and will invariably produce an unconscious response, while other violations to this ground rule are more easily tolerated because somehow they are not as intrusive. Thus the actual physical presence of other people seems to be an important issue in this ground rule and this makes sense in terms of the general thrust of communicative psychotherapy in that it is based on the premise of unconscious perception in an interpersonal context (see Chapter 2). The very basis of unconscious perception or unconscious meaning analysis (Dorpat and Miller, 1992, 1994) is that it occurs in relation to other people and has to occur at an unconscious level because of the significance and importance that other people hold in general for humans. Putting the point simply and plainly and obviously simplistically, someone is more likely to show an unconscious concern, and need to resort to an unconscious perception, in relation to an interaction with another person (whoever that person might be) than in relation to an inanimate object say, or to an animal or plant for example. Other human beings appear to be immensely significant for us, so much so that we need to sometimes defend ourselves against our perceptions of them and force these perceptions into our unconscious. That the defence mechanisms are inextricably bound up with the unconscious is a verity that has been observed almost since the beginnings of psychoanalysis (Freud, 1915b).

Related to this point is the fact that the other breaks in this particular ground rule involved other people but not in a concrete, immediate and 'embodied' form, but were simply a potential, as it were, for other people to be involved. Thus, for example, having a file kept on a patient with confidential notes that could potentially be read by someone else, is a break in the ground rule for the patient but it is not quite of the same magnitude for this patient as,

say, coming across someone actually reading this file. The latter break in the ground rule would surely result in more obvious thematic material relating to this break than the former. Hence it seems to be logical that the breaks in this ground rule that actually involve the physical, personal intrusions will attract the more obvious commentary in the derivative material of patients.

The second reason would appear to relate to Langs's (1988) observation that patients seem to be more concerned unconsciously with deviations to the frame that are under the control of the therapist and that are within the power of the therapist to manipulate. Langs contends that this 'deviant frame' therapy can be useful in its own right as a fairly effective treatment modality provided that the therapist has no choice in the matter but to deviate from the optimal framework conditions. Langs is more sceptical about the effects of deviations in private practice situations where therapists would arguably deviate more out of choice than necessity (*ibid.* p144). Thus aspects of the fixed frame that therapists cannot do anything about, but which are inherent in doing therapy in a hospital context, and aspects which therapists would conceivably wish to eradicate but cannot, would possibly not receive the same degree of negative derivative material from patients. This hypothesis clearly has important implications for the possibility of doing therapy in a hospital context with its compromised framework conditions generally (see chapter 5). Given that some ground rule breaks will inevitably be occurring in this context, even if drastic steps are taken to tighten up the framework conditions in the institution, then it is of consequence that therapy of value (in terms of the communicative methodology) can be conducted in this context. This issue is more fully discussed in relation to deviant frame conditions generally in section 7.6.2 below. However in relation to this ground rule specifically, which is pervasively broken in the institutional context, it would seem from the above evidence that the way in which this specific ground rule is broken in a structural, and hence 'difficult to change' way, is not as damaging to the patient as the way in which the ground rule is broken in a non-structural, and hence 'simpler to change' way. This has the implication then that this ground rule can be tightened up as far as possible, with meaningful consequences for the therapy and the patient. The way in which this ground rule is perhaps more structurally embedded may not be as detrimental to the therapy or the patient given that it does not involve the seemingly all important involvement of people in the form of the direct intrusion of other people into the

therapy space. This would clearly need further investigation in this specific therapeutic context.

The other possibility in regard to this seeming lack of response from patients to this clear ground rule break, is that patients are presumably more concerned with the more serious adaptive contexts which relate to them, and less concerned with the adaptive contexts which could be said to be relatively more trivial. Thus a hierarchy of adaptive contexts is postulated with the more serious adaptive contexts occupying the patient's unconscious more prominently than ones that are less serious. Thus theoretically, patients would focus on the less serious breaks in the ground rules when the more serious ones have been tightened up and addressed. This assumption goes some way to accounting for the lack of derivative material in this regard in the first few sessions with Mary (see sections 6.1, 6.2, 6.3, 6.4 and 6.5). Mary was faced with a tightening framework over the five sessions, with the exception of the ground rule regarding privacy and confidentiality, but did not appear to be commenting derivatively on this particular ground rule until session 4 when the rest of this very compromised framework had been tightened up to a large extent. A fairly simple way to test this hypothesis against the one mentioned in the previous paragraph would be to simply analyse more sessions where the framework was well maintained and secure, apart from one or two seemingly minor structural breaks relating to the ground rule requiring privacy and confidentiality, such as files being kept on patients. This would help to determine the extent of the patients' concerns with this ground rule break, given the security of the other sectors of the framework.

Another aspect of this issue is that patients would be predicted to produce material relating to the ground rule that is of particular concern at that point in time. Thus with Grace this was one of the most significant ground rules to be broken. Consequently this could be predicted to be a major contextual issue for Grace given that no less than seven adaptive contexts (1, 2, 4, 5, 6, 7, and 8, see Appendix 10) could be said to have leakage and lack of privacy and lack of confidentiality as part of the underlying issues. A brief reiteration of these ground rule breaks is in order here. Grace was seen with her two sons for a session of family therapy by her therapist together with another therapist and this family therapy had not officially been terminated and as far as the patient was aware, could occur again at any time. Similarly the

patient was seen concurrently for medication by the referring doctor at O.P.D. The patient reports to the reception desk prior to her appointment and waits in the reception area along with many other patients prior to her appointment. In addition the therapy is audio recorded, supervised and the patient has a confidential file kept on her at the reception area at O.P.D. This ground rule break is then bound to have repercussions in the unconscious productions of the patient given the sheer number of times and manner of times that it is broken.

7.2.3 Techniques for accessing the unconscious

Ground rules 4, 5 and 6 are intended to facilitate access to the patients' unconscious. The non observance of these ground rules then, is predicted to have the effect that the material from the patient will be more impoverished in terms of derivative material.

The sessions with Shariah (section 6.13.2) and Nerina (section 6.12.2) provide a good example of how supportive therapy approaches with a very active therapist, adopting a deliberate strategy of not focusing on unconscious issues, and attempting to keep the focus on conscious material (Dewald, 1994) can succeed in precisely those terms and block much unconscious, latent, derivative material. This is a specific tactic of supportive therapy (Dewald, 1994) and insofar as these supportive therapy techniques are employed in therapy with Shariah and Nerina the tactic is seen to be effective in that both these sessions are characterised by a paucity of unconscious derivative material. One cannot, in a study of this nature separate out entirely the twin elements of, on the one hand patient propensity for adopting a relatively untalkative stance in the therapy and, on the other hand, therapist technique; both of which will play a part in the amount of the patient's unconscious productions in the therapy. Langs (1988) maintains that there is no such thing as a 'bad' patient, only inappropriate therapist techniques and interventions that lead to what appears to be a lack of co-operation on the part of the patient. There is surely a great deal of truth in this assertion as would seem to be in evidence in the sessions with Nerina and Shariah. On the other hand Langs also describes a category of patient that does not communicate in a derivative manner, the so-called "nontransformers" who "...only rarely report out from the deep unconscious system by conveying transformed or encoded associations" (ibid. p28). Thus Langs recognises the interplay between therapist technique and patient disposition in the ultimate determination of the amount and quality of interaction between therapist and

patient, but Langs emphasises the importance of refining the therapist's technique in order to ensure that this does not play a prominent role in the problems with communication experienced in the therapy room.

Using techniques that block off unconscious communication is not necessarily a fault in that it is conceivable that with certain kinds of patients this would be a legitimate tactic, and this point would be vigorously argued by Dewald (1994) and other theorists (see section 3.3), but it does indicate just how effective this technique is in blocking 'the message' from the patient's unconscious. It indicates how it is possible to block patients' unconscious communications and goes some way to explaining how the session with Grace (section 6.10.2 above) could suddenly produce material of a surprising nature if the patient was given more scope in the session to free associate and to explore issues generally. Grace's therapist changed from a deliberately supportive approach to a more passive exploratory approach (see section 6.10 and Appendix 10) and was surprised by the content of the important material, at both a manifest and a latent content level, that emerged from the sessions following this change in approach. Thus subsequent to her changing from a supportive to an exploratory approach Grace's therapist learned of a significant relationship that Grace was conducting with a man. This is obviously important at the level of manifest content in that this particular person represented a great deal of problems for Grace. More importantly at the level of latent content and derivative material, this person seemed to embody, at the symbolic, level many of the framework issues that were of great concern to Grace. When the therapy was changed to exploratory therapy she was allowed the scope to produce material about being aggressively moulded and abused. With Grace the question as to why she seems to be more concerned in this particular session with the issues of being moulded and of someone having changed to become more menacing, has to be addressed. We don't have a record of previous sessions and we don't know exactly what transpired there but we do know that these previous adaptive contexts (Appendix 10) are still operating in this session, and the patient, for whatever reason, has responded to them in a very clear way, albeit in a derivative way using latent, unconscious messages and it seems clear that this material needs to be taken account of in this session. Langs (1988) argues that the prevailing adaptive contexts can be invoked at any time by the patient and he states that once a third party has been introduced into the therapeutic space then he or she is always there (*ibid.* p95).

Intuitively this would appear to be correct in that, if one applies this to the concrete example of Grace, the fact of her having had family therapy and thereby having had introduced, not one other person, but three other people, into the therapy space is not something that can simply be undone by interpretation. The damage to the secure frame is done and the best that the therapist can do is, in response to the patient's unconscious derivative material, attempt to rectify the situation by firstly interpreting the patient's concerns in relation to the framework break and then ensure that the break will not occur again. But even these measures will not completely repair the damaged frame and there will surely remain a residual area of distrust on the part of the patient. How much more of a residual area of uncertainty will remain, in the mind of the patient if the issue is not addressed via an interpretation of the patient's concerns and if the framework is not rectified in response to these unconscious concerns? This non rectification of earlier framework breaks is a feature of the therapy with Grace as with all the other sessions in the therapy.

Grace's particular dilemma and the mode of therapy (family therapy) chosen to address it initially by her original therapist in conjunction with her current therapist would seem to impose a tremendous pressure on the patient to resolve her dilemma in a particular way and it is understandable that she could perceive this pressure as an aggressive moulding. With Grace, there is also the sense that the therapist has only recently moved to a more exploratory mode of therapy from previously being in a more supportive mode. Exploratory therapy is, by its very nature and as its name implies, more likely to allow the patient more opportunity to explore unconscious issues than is supportive therapy (Dewald, 1994; Rockland, 1989; Wolberg, 1967) and hence this form of therapy, with its relatively more passive therapist, provides more opportunity for the patient to say things, and concomitantly, for the therapist to hear what the patient is saying at a latent level. The specific content of Grace's extremely interesting derivative material is discussed in the appropriate sections (see section 7.2.4 and especially section 7.3) but the point being made in this section is that it is likely she was able to produce this valuable material which could be interpreted in this manner, as a result of the shift in stance of the therapist.

Similarly in therapy with Shariah the therapist deliberately adopts a more supportive approach (see section 6.13.2) and Shariah responds to a prompt by the therapist by

consciously reporting a positive message of everything being fine now that she is on the ward and learning positive thinking and self assurance. This could at one level be taken as disconfirming evidence of the communicative hypotheses regarding communicative interactional interventions in that it could be seen as a partial confirmation (see section 7.2.5) of the validity of the preceding intervention which was not a valid communicative interactional intervention. However the material has to be seen in context and it has to be seen as a whole, and it must be remembered that this particular piece of material from the patient does not conform to the requirements of derivative material (see section 4.4.5 above).

It also seems clear that this positive response from the patient in response to a positive prompt from the therapist is a simple glossing over of the nature of the patient's problems in that this is the same patient who has had several failed marriages and who is not in a position to care adequately for herself, let alone take custody of her child, which she so desperately wishes to do. This aspect of focusing on the positive in Shariah's session could also perhaps be described as avoidant, and as not dealing significantly with the patient's actual internal issues in any real way, but more importantly for this study can also be seen as blocking the production of derivative material which would help to understand the interaction between therapist and patient. However even in these circumstances of a deliberate attempt at adopting a supportive approach to the patient, with a specific focus on the patient's conscious and manifest productions and with a deliberate strategy of attempting to elicit some positive aspects of the patient's existence, the underlying latent content still emerges in this session and thematic material emerges of neglect and lack of proper care (themes 3, 4, 5, 6, 8, 12, 30, 31, 37 and 38), together with themes of being prevented from doing what she needs to do (themes 5, 11, 28 and 32), themes of chaos (theme 9), of being confused (theme 34) of being controlled (themes 21 and 22) and themes of someone being aggressive towards her and taking advantage of her (themes 18, 20, 33) and in addition a theme of someone who has abused someone sexually, denying it (theme 7). Shariah responds to the lack of interactional communicative interventions and the lack of proper listening with themes of not being able to express herself (theme 16) of people taking advantage of her because she can't talk for herself (theme 20) and of someone trying to control the way that she is thinking and not allowing her to speak and telling her that she is stupid (themes 21 and 22). Thus despite the therapist's eliciting a positive, conscious response from the patient in

one part of the session the rest of the thematic material in the session, inadvertently but no less significantly, is perhaps a more realistic depiction of her unconscious perception of the therapeutic interaction. Thus the supportive approach with Shariah, while attempting to keep the material on a conscious level, does not actually succeed in completely obscuring her unconscious perception of the framework. This is an important finding in terms of the issues raised in section 7.1 about the ability of deviant frame therapy to yield up information about the patient's unconscious perception of the therapy situation.

7.2.4 The lack of communicative interactional interventions

The communicative approach to psychotherapy moves decisively away from a 'one person psychology' ² with its heavy emphasis on the intrapsychic, to focus squarely on the interaction between therapist and patient. More importantly it provides the methodology to carefully scrutinise this interaction. In addition to this well defined 'listening' methodology communicative psychotherapy delineates specific interventions which are allowed by the therapist.

None of the sessions under scrutiny employed Langs's listening method adequately to comprehend and respond to the patient's unconscious communications in an interactional communicative manner. Langs (1988) maintains that the absence of these kinds of interventions will be noticed by the patient unconsciously and will be commented on by the patient derivatively. This derivative material will take the form of themes relating to the absence of communication, or to closed communication, or to not being properly understood or other kinds of communication difficulties. Langs remarks that "the patient's material will contain allusions to the openness of communication under secure frame conditions and to impairments when deviations are present" (ibid. p158). Langs also contends that when

² The terms 'one person psychology' and 'two person psychology' are roughly equivalent to the terms 'intrapsychic model' and 'interactional model' (see Gill, 1996). These concepts are fully discussed by Gill (ibid.) and a number of other theorists in a recent special issue of the journal *Psychoanalytic Inquiry* titled "Interaction: Reflections on one- or- two person psychology" (see Bornstein, 1996; Mitchell, 1988). Although a 'one person' model has traditionally been associated with the Freudian model it has to be said that Freud's (1912b) seminal idea regarding the therapist's unconscious acting as a 'receiver' for the transmissions of the patient (see section 3.4.6) has given rise to modern elaborations in psychoanalysis along the lines of the importance of the counter transference and projective identification for understanding patients' material and, more broadly, the recent preoccupation with intersubjectivity and interactional dynamics in psychoanalysis and psychotherapy generally.

patients allude to not being heard or understood or to other types of communicative difficulties in their thematic material, the therapist should examine his or her recent interventions for error (ibid.).

This prediction of communicative psychotherapy was borne out to a large extent by the study with this kind of thematic material appearing unequivocally in 11 out of the 12 sessions. The exception to this being Mary session five (Appendix 6), which, out of all of the sessions in the study is perhaps the session³ that is most involved with unconscious communications and an attempt at unconscious listening to the patient. Hence Mary session 5 could be predicted to be the one session out of the twelve that might elicit less of this type of thematic material from the patient. While Mary session 5 produced no specific thematic material relating to communication difficulties as such, the session still managed to produce themes of the patient not being able to talk about things (themes 9 and 22) and this is in line with expectations in that the session was not conducted under secure frame conditions and the therapist was not using the communicative interpretive methodology in an adequate manner. However, what makes the evidence from this session slightly more equivocal is that there are also themes of being able to talk to her children (theme 3) and of doing things with her friend and talking about everything to her (theme 21), thus showing evidence of some positive communicative properties of the session (see Appendix 6 and section 6.6 above).

Some of the more conspicuous examples of thematic material from the other eleven sessions which illustrate the lack of communicative interventions were as follows. In Mary session 1 (Appendix 2) there is a theme of not being able to tell someone how she feels (theme 17) and prominent themes of someone making her feel that she is the problem and that she is mad (themes 2, 3, 19, 21 and 34). This trend continues in later sessions with Mary session 2 (Appendix 3) evincing themes of not talking but of fighting and arguing (theme 5), themes of being blamed (themes 16 and 17) and themes of someone not understanding her (theme 28) and of not telling her about her behaviour (theme 31). In Mary session 3 (Appendix 4) there are similar themes of having to repeat herself (theme 18) and of someone seeing a problem in

³ This session also appears to have the most secure frame *despite* the lack of actual communicative interventions within that session. Section 7.4.1 below discusses the non validation of the transference type interventions which were made in this session.

her (theme 23) and in Mary session 4 (Appendix 5) there are prominent themes of people not speaking to each other (theme 21) and of not hearing what someone has said (themes 45 and 46).

Valery session 1 (Appendix 7) shows evidence of very conspicuous themes of communication problems. She speaks of someone being oppositional and not listening (theme 19), of not being able to talk about her needs (theme 20), of someone being pushed away by someone (theme 26), of someone not giving people a chance to talk and of not wanting to hear what they say (theme 27), of not being able to talk to someone without them becoming irritable and getting into a rage (theme 43), and of someone using violence instead of encouraging people to talk (themes 46 and 47).

Grace session 8 (Appendix 10) exhibits much derivative material relating to communication difficulties. She speaks of someone not understanding and accepting what she needs (theme 18), of being tired of defending herself and of being blamed for what she has not done (theme 24), of continuously having to defend herself (theme 25), and of people not admitting to things when she confronts them with what they have done (theme 31). Communication difficulties are also at issue in the following vignette from the latter half of the session. At that point in the therapy the patient had been complaining about someone trying to mould her and dictate to her and the therapist was dealing with this on a manifest level, as had been the case throughout the therapy.

Clinical vignette: Grace session 8

T And you don't need someone to dictate to you.

P To dictate to me because I know what is right and what is wrong. And I'm going through things that he can't even imagine what goes through your mind at home. I can't tell him that

T Uhmhmn.

P I mean will he understand? Will he accept it or will it be like your past life is interfering now and I don't want to know nothing about this and I don't want to know nothing about that.

T It sounds like it's not a two way relationship. It sounds like what he says...

P It's a one way - his way - cause he's the man- his way is right. A woman's got no say. She's just a woman and that's that. I don't know in what land he's living - maybe in one of those far away places where a woman has to crawl when a man comes in.

T Have you been able to tell him all of this?

P I can't cause he gets physical.

T So there's the fear that he will hurt you.

P Exactly. I mean he's done it once and I said never ever will he do it again cause I'm not ending up in a psychiatric hospital every time you want to work on my nerves.

T So it sounds like you've had to put up with a lot of his abuse?

P Yes you keep quiet and you don't answer and you just take it in what he says to keep the peace.

This trend of bringing up communication difficulties is continued in the next session with Grace (Appendix 11) where themes of not having someone to talk to emerge (themes 12 and 18), although this type of thematic material is less prominent in this session than in the previous session. In the vignette above the patient appears to be concerned with communication difficulties that are bound up with her partner's aggressive attempt at moulding her and at forcing his understanding on her, which have implications for how the patient is perceiving therapy generally at that point (see section 6.10 above).

Therapy with Lala (Appendix 9) produced its share of prominent themes of communication difficulties mainly revolving around the issue of the quality of the communication being superficial and the talk being about superficial things (themes 33, 38, 39 and 45) and about her being the one who does all the talking and the other person wanting to wait until later or wait until next week (theme 43). There are also themes about an inconsistency and ambivalence in whether or not there will be a conversation. Thus the patient speaks about someone who can't seem to decide on a relationship with her and tries to force her to be intimate after previously rejecting her (themes 24, 25 and 26), and about someone who does not say a lot when the time actually comes to talk (theme 44). The patient complains about being punished for talking (themes 41 and 42), and earlier on in the session she speaks about not communicating much with other people (theme 4), and about just sitting around not actually talking to anyone (theme 9). Clearly the communication difficulties that the patient alludes to in the thematic material are related to broader issues than simply the lack of interactional communicative listening. These broader issues involve also the important aspects of what exactly is *not* being heard by the therapist, namely that the patient is uncertain about her future in the therapy and she is perceiving the therapist as being particularly ambivalent in the therapy about her relationship with the patient. This perceived ambivalence is surely playing a large role in inhibiting the patient's communications to the therapist. What is important to note here is that this unconscious perception on the part of

the patient is an accurate perception of what is occurring in the therapy. The therapist has indicated that she will probably need to terminate after a few months when she moves to another unit, she has allowed therapy to take place every second week instead of weekly and she does ask somewhat irrelevant questions about the manifest content of the patient's material. All of this is quite rightly perceived by the patient as an ambivalence about therapy and a 'talk about superficial things'. Thus the talk about communication difficulties in response to the lack of communicative interventions is also bound up with the patient's wider perception of the therapy and therapist and bound up with and coloured by her past history and current relationships (see section 4.5 above). This would apply to all the other sessions and not only to this session but the example is more obvious in the case of Lala.

Therapy with Monica (Appendix 8) demonstrates some of the themes of communication difficulties which are also linked to the broader therapy issues, particularly her perception of her pending abandonment by the therapist. She talks about not having someone to talk to when she gets lonely (theme 6), and about someone not wanting to talk about the issue of leaving, out of fear (theme 8), about someone damaging her and not wanting to listen (theme 17), and about someone abusing her and not wanting to listen to her when she tells them off, and accusing her of being mad when she does this (theme 23).

Finally, therapy with Shariah (Appendix 13) illustrates communication difficulties in her theme of not being able to express herself very well (theme 15) and in a series of themes around not being allowed to talk for herself (themes 20, 21 and 22) which are reproduced here in a vignette from near the middle of the session.

Clinical vignette: Shariah session 4

T Tell me something Shariah...about the past. You've mentioned this to me before that you are trying your best to forget the past. What is it about the past that you want to forget? What specifically?

P It is everybody that is so - looking down on me..... against me. I'm a person that can't retaliate..... I can't talk for myself man, that kind of thing. Now people will take advantage of that. I do everything people say. Like a robot. I mean it affects you all the time.

T And you would respond before by just keeping quite.

P Then it bottles up in my chest - then I just burst.

T When you say you just burst - what do you mean?

- P Shaking and crying loudly, throw things around, mostly cry.....I blame my mommy for all this. She always wants to control the way I'm thinking, even when we have a conversation in the family and I like, say something - then she'll say "Shariah keep quiet." They always say that I'm dumb and I'm stupid.
- T So what you are saying is that Mother always put you down, you've developed a...
- P Negative complex. And she's still doing it. (Pause)
- T You mentioned building your self esteem on the ward.
- P Ja.
- T You've learned to take control of a volatile situation.
- P
- T It seems to me that before you would respond by keeping quiet until it comes to a point where you can't keep quiet, then you burst out crying, become angry and throw things around. It seems from what you are saying that yes, you go home and they are still the same, but that you are handling the situation differently.
- P
- T You fend for yourself. You stand up for yourself?
- P Yes (laughs).
- T And you're feeling very proud about it.
- P Smiles.
- T That's very positive, that's good.
- P I hope it will keep on like this...something to build on.
- T So that is something that you intend working on.
- P Ja.
- T Okay.
- P I'm even communicating better, I'm always smiling. (laughs). Before I was always such a sour face.
- T Why do you think its, that you...
- P It's just that I get hold of myself man, now my whole face will light, you can see I'm always sitting with the other patients. Before I was an introvert. I used to just be by myself. But I made up my mind I'm not going to always sit alone. I won't go through life like that.

The above vignette also illustrates the self consciously supportive nature of therapist's interventions in this session in that she attempts to tease out the patient's positive perception of herself and the positive aspects of her stay on the ward. There is no attempt to understand and interpret the interactional nature of the patient's productions or the aspects of the patient's unconscious that are being revealed in the session. The patient responds to this coaxing by obligingly presenting material of this positive nature, even remarking on a conscious level that she is communicating better and always smiling. But the derivative material, the latent message, which is there to be read, is of a poor communication between therapist and patient. The patient remarks "I can't talk for myself man, that kind of thing. Now people will take advantage of that. I do everything people say. Like a robot. I mean it affects you all the

time" perhaps revealing that at some level she is also doing what the therapist asks, like a robot and not talking for herself. In addition, further on in the session the patient says revealingly, ostensibly about her mother, "She always wants to control the way I'm thinking, even when we have a conversation in the family and I like, say something - then she'll say 'Shariah keep quiet' They always say that I'm dumb and I'm stupid." The therapist, instead of listening to the latent message here, immediately changes the topic to focus on something positive that the patient has said previously. The therapist's change of topic at this point in the therapy could possibly be seen as being motivated, at one level, by a feeling of discomfort with the topic being addressed by the patient. Thus the intervention can be seen as unconsciously intended by the therapist to cut off any further unconscious communication on the part of the patient about this issue which could also be seen as a dangerous issue for the therapist, touching as it does on the area of the therapist's control of what the patient is thinking. Poignantly and perhaps appropriately the patient points out that her mother (and at another level her therapist) "is still doing it" even though she has pointed it out. It must again be emphasised that there is no denying the reality of the patient's difficulties with her mother and there is no doubting the patient's perception of her mother as being controlling of her. What is of particular interest in this study and in the communicative approach generally is the additional interactional layer of understanding that this commentary provides on what is happening between therapist and patient and how this derivative material coincides with the therapist's clear attempt, as a tactic of therapy, to shut the patient up at an unconscious level and to not hear the patient's communications at this unconscious level.⁴ What is also of interest for this section of the study is that the patient's material coincides with what is predicted by communicative methodology in that there is unambiguous material from the patient of communication difficulties and this coincides with the lack of communicative, interactional interventions in the therapy.

In most of the sessions above the communication difficulties are bound up with how the patients' are perceiving therapy generally. Grace perceives herself as being aggressively moulded and her perceived communication difficulties in the therapy reflect this aggressive lack of understanding. Lala complains about someone having short superficial conversations

⁴ This approach to therapy was being followed by the therapist at a conscious level and the attempt to keep therapy conscious is an actual strategy of supportive therapy (Dewald, 1994)

with her and about someone being ambivalent as to whether they actually want to have a conversation with her, as does Monica, reflecting the peculiar circumstances of uncertainty about the future that both these patients find themselves in regarding their therapy with the same therapist. Shariah's thematic unconscious commentary about her communication difficulties with her therapist, on the other hand, reflects the broader picture of the therapist not listening to her unconscious communications and attempting to control her. All of this is an indication of the impossibility of making simple one to one correlation between the ground rule breaks and the productions of the patients in the therapy room. Clearly the derivative commentary that patients make about a break in any one particular ground rule is bound up, not only with the manifest content of the material, and hence is clearly related to what is actually happening in their lives outside of the therapy room, but the patients' perception about a particular break is also bound up with the rest of the ground rule breaks within that therapy dyad. Thus a lack of communicative, interactional interventions in any particular session is predicted to produce latent content relating to a lack of communication or communication difficulties. But this latent content will be embedded not only in the manifest content, which will be manifestly about the patient's life, relationship and existence outside of the therapy room but also embedded in the patient's broader perception of the therapist generally and hence will be embedded in the thematic material relating to other framework breaks as is clearly illustrated in the material above relating to communication difficulties. All of this points to the necessity for understanding each patient's material as a whole and to the necessity for not focusing specifically and solely on any one particular ground rule in a simplistic way, and to the exclusion of the others, a point which was also made in section 7.1 above.

7.2.5 Validation of therapists' interventions

The question as to how the analyst knows whether a construction or interpretation is accurate or not brings psychoanalysis up against philosophy of science issues and up against the formidable arguments of Grünbaum (1984) as they apply to psychoanalysis. Many theorists believe, following Freud's handling of the topic, that the interaction between analyst and patient is the ground upon which the interpretation is judged for its accuracy. There is a process of validation that occurs in the therapy in which the interpretations are judged by their effect on the patient and by the subsequent interactions between therapist and patient.

Thus it is not simply a case of whether the interpretations accord with the patient or whether or not the patient consciously and expressly agrees with them that imparts validity to them.

For Freud (1937) a simple agreement or disagreement on the part of the patient is inadequate, other evidence is needed and it often comes in the form of an exclamation of surprise on the part of the patient or an analogous association subsequent to the interpretation. Freud also observes that in patients showing a negative therapeutic reaction, confirmation of the correctness of the interpretation can even come from an aggravation of their symptoms or of their general condition. For Freud a construction has power and achieves the same therapeutic result for the patient if it produces the assured conviction of its truth in the patient. Grünbaum dubs this 'the tally argument' and makes much of its epistemological deficits (see Chapter 4).

The question of the validation of interpretations has occupied many theorists and therapists since Freud and it continues to occupy them. In terms of validation of interpretations in the clinical setting Kernberg (1994), following Freud, contends that:

...a shift in the affective response, in the behavioural aspects of the dominant object relation, and a corresponding deepening of the communication of the patient's subjective experience may be considered validating criteria for the appropriateness of the interpretive intervention. (ibid. p1195)

In a similar vein Malan (1979) regards the deepening of rapport between therapist and patient, in combination with direct confirmation of the intervention by the patient, as been essential for validation of the therapist's interventions. Malan maintains that the therapist can use the moment to moment fluctuations in rapport as a gauge of the appropriateness and correctness of the therapist's interventions (ibid. p20).

Winnicott on the other hand tended to downplay the role of interpretations in therapy (James, 1985; Rees, 1995b) and he remarked that he interpreted in order to show the limits of his understanding. Winnicott had a horror of 'clever' interpretations and he felt that the 'cleverness' and understanding should come from the patient. Winnicott advocated a show of therapeutic naïveté on the part of the therapist, even while maintaining an understanding of

the patient's dynamics, thereby leaving space for the analysand to create the understanding (Winnicott, 1971, 1972).

Langs (1982, 1988), in addition to the more common form of cognitive validation of interpretations also advocates validation in the interactional sphere. Cognitive validation occurs by virtue of reports by the patient of additional material of an especially meaningful nature or else of a reorganisation by the patient of the material so that it yields new meaning. The interactional form of validation on the other hand is a type of validation that has been specifically emphasised and developed by communicative psychotherapy. It requires reports of positive introjects on the part of the patient which would take the form of the patient reporting in terms of some positive helpful or constructive outside figure or else of the patient reporting on some positive attribute of his or her own. Thus the patient's productions immediately following an interpretation have to be carefully examined for validation of the therapist's intervention. It is noteworthy that Langs's form of validation of interpretations is much more able to withstand the criticism emanating from Grünbaum regarding the psychoanalytic validation of interpretations (see Chapter 4) in that it is not bound up with the necessity for a kind of 'tally' with what is real in the patient, and neither is it dependent on some form of cure of the patient. Communicative validation of interventions is circumscribed and limited to an assumed event, the introjection of a quality or aspects of a quality of the therapist, by the patient. This event is assumed to have occurred only if specifically reported on by the patient within the interaction between therapist and patient, in a derivative form having specific positive qualities.

Over the twelve sessions of therapy examined in this study, none of the therapists' interventions received derivative validation from the patients in terms of Langs's criteria for validation of interventions. Conversely, apart from not receiving validation many of the interventions received active disconfirmation from the patients' derivative material. Some of the more prominent disconfirmations will be set out below.

At the end of the session with Lala (section 6.9. 2 above and Appendix 9) the therapist tries to sum up by giving the patient some brief feedback of her impressions of her in the session. This feedback not only does not receive derivative confirmation but quite clearly receives

strong derivative disconfirmation. It is instructive to repeat the sequence of the material here.

Clinical Vignette: Lala session 4.

T *Mhmmn. My impressions of you today...you seemed um, I'm not sure how to describe it, but you have a bit more energy today than when I've seen you previously.*

P (laughs).

T *And obviously there's changes, and there are still a lot of things in your life that are affecting you quite deeply. And I think hearing from your mother this week was quite something.*

P Ja...

T I can feel that.

P Like I want to show it, but...

T No, I can understand that. And we haven't spoken about that a lot but I know...

P But otherwise my work, there we are.....And then I've started getting agitated because I know that most of the stuff that comes through, like I don't always see what is wrong...and it goes to the next person, but I can see some of this stuff is totally wrong. Or sometimes when you're finished you have to loosen the stitches of whatever's wrong and then they send it back and then it's still wrong. And then the other girl said to me that she told the lady that it's wrong. So I said, but there's something you have to learn, you can never teach an older person. Older people don't want to be taught, like they're going to tell you I've been doing this my whole life so you're not going to tell them how to do it.

T

P And then they are wrong, but ...I'd rather just leave them, leave the old people alone, because they are stubborn. "You are a lightie you don't know anything."

T It's difficult to work like that.

P Ja, it is. And like then I bring the stuff and I tell someone else, why don't you go tell that person, since you are more on the same level.

T Mhmmn.

P But otherwise I won't bother with them. Because then you only come down to an argument. So I just leave it.

T Well I wish you good luck.

The intervention, highlighted in italics in the vignette above is the therapist's attempt to summarise her impressions of the patient in the session. This type of intervention has no place in the communicative repertoire of interventions and it emerges as a combination of a confrontation, a clarification, a reflection, and an interpretation. Although the patient laughs and assents at a conscious level to the intervention, the derivative material from the patient immediately following the intervention indicates that the therapist's interventions are clearly perceived as erroneous. What follows is a remarkable sequence that almost seems as if the patient has read a textbook on Langs and is parodying his approach. The patient immediately

launches into a monologue, apparently utterly unrelated to the discussion immediately preceding this. In Smiths (1991a) terms it conforms to most of the requirements of derivative material, in that it is specific, concrete, easily visualised, does not manifestly refer to the therapy situation and is discontinuous with what came before it (ibid. p136). It appears to be the clearest most unambiguous derivative material in the session (see section 4.4.5 above). In this monologue the patient speaks about things that are "totally wrong" and that have to have the "stitches loosened" and to be sent back to be redone, a clear, derivative, non validation of the therapist's efforts. In this sequence the patient also appears to signal her intention to leave therapy if the "older people" don't learn and if things don't change.

Another implication of the above material is to do with the patient's avoidance of feelings. The therapist draws attention to the patient's feelings about her mother which are not expressed in the session and her sadness is palpable to the therapist. As the therapist draws attention to this, the patient, for defensive reasons, moves away from this immediately and talks in derivative fashion about her mother being one of the old people who won't learn and who will subsequently be left because she won't learn. This is also a possible implication of the communication from the patient. She displaces not only her feelings about her therapist but also her feelings about her mother onto the thoughts about the older workers at the factory. In the displacement she also does not wish to face up to leaving her mother, and it is thus a displacement of feelings from the therapist as well as her mother. This discussion also raises the issue of transference and the communicative approach to transference which will be more fully dealt with in section 7.4.3 below.

Therapy with Monica (see section 6.8 and Appendix 8), like the majority of sessions in this study is mainly on a manifest level and, in keeping with this form of doing therapy, her therapist focuses on the manifest content and interprets at that level. Two examples from this therapy illustrate the non validation of these manifest interventions.

Clinical Vignette: Monica session 8

Responding to the patient's complaints about her boyfriend's attempt at control of her, the therapist remarks:

T I'm sure he does because everything that you've described to me about him is him trying to control you.

P Yes he wants to control me.

T If somebody is trying to control you, you are going to feel powerless. You ...because everywhere you turn there's another wall which you hit against.

P Mhmmn. It's true.

T And when you came in the room now, when you started talking in this session, that was the feeling I got from you, that you felt powerless, and helpless and that the world was impacting on you in a negative way and you couldn't do anything about it.

P I always feel that feeling. I must be honest. I felt a lot like that in the last year. I've got no power. Whatever I do I can't go forward. You know that is something that I must work on is my powerlessness and also I'm very unsure about myself as a person. That was my problem when I came to hospital. They found that I was - I didn't cope with that problem. Obviously something in me from the past. And my self image and my self esteem and that was very low and they worked on that and I still feel that it's not very stable. I still feel very small sometimes, I still feel not worthy of happiness. And I think maybe I don't look nice today. I might have nice clothes on but I don't feel as if I look good. Michael reinforces all the negative thoughts I have about myself in my subconscious. He will also reinforce, bring it to the fore and work on it. Then when I wake up in the morning I don't feel happy. I feel ugly.

T What are the kinds of things that make you feel more powerful?

P I'll tell you this much. If I was more emotionally, and I mean my emotional state was more secured. If I wasn't seeing a psychologist and I wasn't being on medication....it feels almost as if I'm not right man. That would make me feel more happy. If I'm a secure person, I feel good about myself, I feel positive about what life holds for me, things like that, that would make me feel more powerful.

T So for you, seeing a psychologist and taking medication is an indication that you're not good enough, that there's something wrong.

The patient assents to the therapist's intervention by agreeing consciously to what she has said, but the derivative material that follows points to her feelings of shame and inferiority at the negative things that she *perceives* to have been "reinforced" ' about her. It is a form of narcissistic injury (Bacal & Newman, 1990; Chessick, 1985; Kohut, 1971, 1972; Wolf, 1988) that she experiences by having her weakness exposed in therapy and she likens it to having her negative thoughts reinforced. The therapist, by commenting on how the patient has come across to her in the vignette above has "reinforced" the patient's negative view of herself, according to this specific unconscious commentary by the patient.

A second vignette from later on in the same session illustrates more vividly, an intervention at the manifest level that does not receive derivative validation and more than this, receives clear derivative disconfirmation from the patient.

Clinical vignette: Monica session 8.

T There is a lot of sadness in you and a lot of unhappiness. I agree with that. Um... I think sometimes when things are feeling really bad, its easier to say "I'm

completely a sad person, and that's all that I am." And I don't think that's true. I think you are very sad, and there are parts of you that are still grieving deeply. But I don't think that that's all there is. I think there's someone with quite a lot of energy, and love, and things to give...

P I would love to think of myself like that. I think I am someone to give a lot. There's a lot of goodness in me. I've got a good nature. And I wish that this overwhelming sadness and unhappiness doesn't overpower who I am. You know...people can see the sadness in me more so than who I am. That's what I notice. They pick up the sad and miserable person in me and I think we must address the fact that I feel that people see through me. Because I'm vulnerable and very gullible to believe people. I did mention to you about the car incident. Another example of a vulnerable me. Allowing me to feel very nice towards an individual who is nice to me, and I believed him. And I could actually have a situation where I could become very much involved in somebody and I could actually make a big mistake. You know it's a very crucial time now in my life. I must be very careful. I know I'm very vulnerable I can make a big mistake. And men are cruel. They're not always what you think they are, not all, some of them. And um..

In this vignette the patient exhibits her suspicions of the therapist's positive commentary on her and her description of her as someone who has something to give. She likens this intervention to the car incident wherein she was gullible and taken in by someone. In view of the prevailing adaptive context to this session where the patient believes that the therapist is about to terminate with her and which has not been addressed by the therapist at this point, it is not surprising that the patient will demonstrate suspicion of such a positive intervention of this nature.

Another example, taken this time from therapy with Mary is illustrative of an intervention that does not receive derivative validation.

Clinical Vignette: Mary session 2

T That's the part that's worrying you is that you're not in control of yourself. It sounds like you've been knocked around by his problems and issues and you're feeling an overwhelming anger and overwhelming feelings that are hard to even understand.

P Yes and the fact that when I get like this...everyone looks at me and criticises me. I am the one who gets hysterical, who fights, who doesn't care and who throws things around. They don't understand that its the only way that I can... that I can demonstrate what I feel. (weeps).

T It feels like people are criticising you for being angry. They think that you are wrong.

P It's the way my mother feels. She says that I must just accept. My husband is not the only man who drinks. I must just try to be quiet but it is difficult. Its easy for other people to say if they haven't experienced these things. I am the person who worries about whether he will lose his job, whether we will lose the house...the children.

Maybe the fact that this hasn't yet happened....I'm making myself sick over it, working myself up. (weeps).

T It feels like people, like your mother are a bit critical, they don't seem to understand what you're having to go through and your fears and how desperate you feel sometimes. You could lose your house. It sounds like its the feeling of fear that you are feeling sometimes, you have nothing to hold onto, nothing that is stable.

P ...Mmmhm

T And when you feel that, when that happens, you want to try to attack your husband, you want to try to get him a certain way, to get him right. It feels like you're a bit out of control.

P He does not seem to be aware of what he is doing to me and the children.

This vignette demonstrates that the patient's perception of the therapist's interventions is that she feels unconsciously criticised by the therapist and perceives his interventions as blaming her for not accepting the situation. The patient remarks that her husband is not aware of what he is doing to the children but this is also an oblique reference to the therapist not being aware of what he is doing to the patient in the sense that he is also "blaming" her and "criticising" her at one level by not perceiving and interpreting the interactional nature of the patient's material. It seems clear from the above material that the therapist's interpretations do meet the criteria of a deepening rapport (Malan, 1979) and of a deepening communication (Kernberg, 1994) but still do not meet the more exacting requirements of the communicative methodology.

While there are many instances of disconfirmation of interventions in this study, coinciding with the lack of adequate communicative interventions and thus partial support for the communicative method of validating interventions, further material is clearly needed in order to draw adequate conclusions about this method of validating interventions. Thus there clearly needs to be a study that involves examination of sessions that actually incorporate sound, well constructed and well executed communicative interpretations that are well validated, using the communicative methodology.

7.2.6 The set time and defined length of sessions

This requirement of the fixed frame appears to be widely advocated and adhered to in the context of psychoanalysis and exploratory therapy but in the realm of supportive therapy it would not be strictly adhered to, as a deliberate tactic (see section 3.4.3 above). It would appear that even Jungian analysts who generally support a much more flexible approach to

the framework of psychotherapy keep to this requirement. Thus Hillman (1983) reports that he adheres to the set hour as a deliberate strategy. Lacan (1977) on the other hand avoids the ritualisation of technique (see Forrester, 1990; Macey, 1988) and consequently advocates sessions of variable length. The issue of the ritualisation of technique and its implications for the enhancement or hindering of therapy will be discussed in section 7.6.2 below.

Six out of the twelve sessions examined met the requirements of a set time and standardised duration of the sessions. Of the six sessions that did not meet the requirement, three sessions, Mary session one (Appendix 2) and session two (Appendix 3) and Valery session one (Appendix 7) were temporary, chaotic aberrations that were then rectified and future sessions with these patients then met this requirement. The other three exceptions, sessions with Lala, Nerina and Shariah were not held on a consistent day and time and continued in this fashion for future sessions (see section 5.2.3 above). Lala was being seen every second week and the therapist could not give her the same appointment time at the end of every session but instead she was required to make an appointment with the booking clerk after each session (see Appendix 9). Nerina was seen at approximately weekly intervals when a booking could be obtained for her (see Appendix 12). Shariah was seen on different days and at different times and, in addition, would occasionally be seen for sessions of less than the full defined length thus not fulfilling any of the requirements of ground rule 3 (see Appendix 13). Sessions with Mary, Valery, Lala and Nerina were invariably a set duration of 50 minutes, thus meeting the requirements in terms of the defined length of the sessions and hence partially met the demands of ground rule 3.

Although this ground rule cannot be separated out entirely from the other ground rules of the fixed frame there are aspects to its not being kept that have definite *sequelae* in the patient's thematic material. According to Langs (1982) themes of chaos could be expected to emerge in the patient's thematic material as a derivative response to this break in the ground rule (p457).

With Mary themes of chaos are a prominent feature of the first two sessions of therapy, (see Appendices 2 and 3 and sections 6.2 and 6.3). These themes of chaos largely disappear in the subsequent sessions as this requirement of the frame is fulfilled in sessions 3, 4 and 5 (see

Appendices 4, 5 and 6 and sections 6.4, 6.5 and 6.6). This would be in line with expectations and predictions of the communicative approach. Similarly with Valery (see Appendix 7 and section 6.7) there are themes of chaos in line with the chaos surrounding her attempted change in the time of her first appointment (Appendix 7 adaptive contexts 3 and 4). Again, with Shariah (see Appendix 13 and section 6.13), in line with expectations, there are themes of chaos or being confused (themes 9 and 34).

With Nerina, in the paucity of derivative material, there are no obvious themes of chaos that can be related back to this ground rule (see section 6.12). However two explanations could be offered for this apparent failure to meet this particular expectation. Firstly there is a paucity of thematic and derivative material generally and a fairly active therapist. Secondly, what little derivative or thematic material there is, is taken up with the more prominent framework issues related to continuity of therapy. Given the fact that the patient is in therapy with her fourth primary therapist in a matter of months (see Appendix 12) this adaptive context would be predicted to be more prominent than the relatively minor one of not being allocated the same time for her session every week.

With Lala there is similarly no thematic or derivative material depicting themes of chaos that can be linked to this ground rule break as would be predicted by Langs. However the patient is seen at the same time of day for her appointments, even though they are not on the same day of the week and are not on a regular weekly basis. Similarly the sessions endure for the regular defined length of time, thus to some extent meeting the requirements of this ground rule.

The rest of the sessions of therapy, as would be expected, do not produce themes of chaos or derivative material relating to chaos (see Appendices 2 - 13). This conforms to communicative therapy predictions about this ground rule.

7.2.7 Therapist self disclosure

Both this ground rule break and the one following (see section 7.2.8 below) are extremely difficult to evaluate because the so called breaks are not unequivocal and there is also some corresponding ambiguity about the thematic material that is evidence for it. As is readily

apparent, both of these ground rules have to do specifically with the patient's relationship with the therapist.

Of the twelve sessions of therapy examined here, no overt therapist self disclosure occurred in the sessions and only one session, namely Shariah (see appendix 13 and 6.13) involved a therapist who had disclosed personal information to the patient about herself at some point prior to the session examined here. Langs (1982) predicts that this kind of disclosure would result in the patient producing derivative material relating to seduction, dishonesty and symbiotic pressures (*ibid.* p472). Very little of this type of thematic material is clearly discernible in the sessions under study. The exceptions are sessions with Shariah, Mary and to a lesser extent, Monica.

Shariah's session, which would be expected to exhibit material of this nature produces references to her son's sexual abuse and specifically themes of someone denying their part in sexual abuse or of avoiding someone who had been abused (Appendix 13 themes 5 and 7). While sexual abuse does not equate, strictly speaking, to seduction there is a clear thematic affinity. In addition, there is also reference to sexual abuse in the material of Mary's session 5 (see Appendix 6 and section 6.6) in which there is no disclosure of therapist material. However, in Mary's case there is a break in the very similar ground rule requiring no previous contact between therapist and patient and this could account for this material (see section 7.2.8 below).

The other two types of derivative material, namely interpersonal dishonesty and symbiotic pressure, which could be thematically linked to the break in the ground rule are also not conclusively found in the patient's material in this study. Themes of dishonesty in interpersonal relationships are not clearly discernible from any of the sessions (see Appendices 2 - 13). Themes of symbiotic pressure are slightly more ambiguously represented in some of the thematic material. Symbiotic pressure, would be pressure to be joined, inappropriately, in a 'merged' relationship with someone and this inappropriateness together with the elements of harm and dishonesty connoted by the concept of seduction, provides the thematic link with the self disclosure which according to Langs is always

inappropriate and contains some seductive countertransference elements (Langs, 1982, 1988).

Monica (Appendix 8) produces themes of being controlled or interfered with and specifically alludes to the coercion of being forced to be involved with someone that she is ambivalent about involvement with (theme 31). In addition she produces themes of not being allowed the freedom to feel what she wants to feel about another person (theme 40), of being controlled all her life (theme 50), of not being allowed to make her own mistakes (theme 52) and of people taking away her independence and making her feel powerless (theme 53). In all of this thematic material however the element of subtle dishonesty and seductiveness seems to be largely missing. This would be an important meaning link with the underlying countertransference issues that Langs postulates to underlie inappropriate therapist disclosure (Langs, 1982; 1988; Cartwright, 1997). The underlying message from the thematic material above is one of coercion through force rather than subtle dishonesty and seduction. This is even more the case with the thematic material of Grace (Section 6.10 above) in that there is much evidence of coercion but it is evidence of a forceful aggressive coercion and not of a subtle, dishonest coercion towards symbiosis which would be implied by the concept of a seduction.

This issue remains largely inconclusive in this particular study but it perhaps shows some degree of support for Langs's expectation in that not one of the twelve sessions shows any evidence of therapist self disclosure *within the session*, and concurrently there is no evidence of this type of expected material in eight of the twelve sessions, only mildly linked evidence in three sessions, namely Mary, Shariah and Monica. However, in one session studied, namely Shariah, there was *previous* self disclosure on the part of the therapist and one would have perhaps expected stronger evidence in the patient's material to be thematically linked to this. This current study indicates that there is a case to be made for a combination of the ground rule requiring no therapist self disclosure, with the following ground rule (section 7.2.8 below) requiring no extra therapy contact, in that their meanings are so similar, and the thematic material seems to be so similar, particularly in the subtle ways that it is evinced in this study.

7.2.8 Prior or concomitant relationships

Three of the therapists had some degree of prior or concomitant contact with their patients (see Appendices 2, 8 and 13) but all three of these contacts occurred within the work context and were work related. For this reason these contacts must be regarded as less of a deviation than, for example, contacts outside of the work situation or social contacts of varying degrees of intensity.

Both Shariah's and Mary's therapists were facilitators of groups on the ward in which their patients participated (see Appendices 2 and 13). In the case of Mary this group participation was prior to her going into individual therapy (see Appendix 2) and in the case of Shariah participation in the group was prior to, as well as concomitant to, individual therapy (see Appendix 13). In the case of Monica, her therapist had interviewed her some eight months prior to her being seen as an outpatient (see Appendix 8). This had been a one off, intake assessment and according to her therapist, Monica had no conscious recall of it, saying that she had been interviewed many times, by many people, in the course of her referral and admission to the ward, at that time.

In line with his formulations generally about ground rule breaks, Langs (1982, 1988) contends that if there has been prior contact with the patient then this will be reflected in the derivative material. Langs (1982) suggests that the thematic meaning link with this ground rule break is one of inappropriate merger (p 393). It will be readily seen that this meaning link is very similar to the one of seduction, dishonesty and symbiotic pressure mentioned above as a thematic link to the ground rule break of therapist disclosure (see section 7.2.7). It will be obvious that there are clear affinities in these two ground rules and consequently it is not surprising that there are similarities in the unconscious meaning that patients could be expected to ascribe to breaks in these two ground rules in that both ground rule breaks imply a breaking of the boundaries between the therapy relationship and other kinds of relationships.

It will have been noted that it is Shariah, Mary and Monica who are mentioned in the previous section as having derivative material that comes closest to a thematic affinity with the previous ground rule break, although only Shariah had actually experienced the ground

rule break. All three are implicated in this current ground rule break. This seems to point to the need to view these two particular ground rules in combination because of their similar meaning and similar structure, affecting as they both do, the boundaries of the therapeutic relationship and creating a specific breakdown in the separation between social discourse and therapeutic discourse.⁵ If these two ground rules are handled together for purposes of deciphering patient's material then it becomes clearer that patients have responded to the breaks in a way that conforms to Langs's expectations.

7.2.9 Concluding comments

As was concluded in section 6.14.11 there is strong evidence for the communicative psychotherapy propositions regarding ground rules 1 and 2 relating to a consistent setting and the fee of psychotherapy. Support of a substantial nature is exhibited for the predictions applicable to ground rules 3, 5, and 7 relating to the duration of the session, the rule of free association, and the therapist's use of neutral interventions. Similarly there is support for the predictions regarding ground rule 6, the ground rule requiring the therapist's use of free floating attention. The evaluation of the data in section 7.2 served to strengthen this support for the predictions of communicative psychotherapy in regard to these ground rules.

The evidence regarding ground rules 8 and 9 relating to therapists' anonymity and lack of extra therapy relationships respectively is much stronger if these two ground rules are dealt with in combination. This would seem to be a logical step and would seem to be strongly suggested by the arguments advanced in sections 7.2.7 and 7.2.8 above.

At first glance the evidence in this study does not seem to support the predictions regarding ground rule 10, relating to the requirement of a one to one relationship with privacy and confidentiality, in that only some of the sessions show evidence of material that is unequivocally related to the break in this ground rule whereas all of the sessions demonstrate clear breaks in this ground rule. However closer examination of the evidence reveals that

⁵ In a sense all of the ground rules are designed to enhance the separation between therapeutic discourse and social discourse in that the framework has this as one of its main functions (see sections 1.1, 3.2 and 3.4 above). Therapeutic discourse would be described as embodying qualities of seriousness and profoundness and as not being bound by the rules of politeness and social etiquette as would social discourse. This issue is discussed in section 7.6.2 below.

there are important differences in the manner of the breaking of the ground rule in those cases that demonstrate unequivocal evidence for a link between the patient's unconscious concern and the break in the ground rule. The evidence in this study indicates that those sessions that exhibit this ground rule break embodied in the form of a personal intrusion into the session are likely to show evidence for the patient's unconscious concerns for this break and vice versa. Thus those sessions which do not show such an intrusion in the form of a person actually intruding into the session are not likely to show this evidence of the patient's unconscious concern for the break.

7.3 TRAUMA IN THE THERAPY ROOM

Communicative psychotherapy provides an important perspective on the debate around the revival of the seduction theory or the trauma theory of neurosis (see section 2.3 above). The bare elements of the debate could be said to centre around Freud's original discovery of psychic reality and his subsequent downplaying of the actual events that might have occurred in the patient's early history. The other side of the polemic centres on the recent revival of the theory of the importance of traumatic events in the aetiology of neurosis (Davies, 1996; Harris, 1996; Masson, 1984; Miller, 1983, 1984).

Stated simply and perhaps simplistically, when patients talk about childhood neglect, deprivation and traumatic events, Freud would hear and understand these productions of the patient in the sense of their psychical verity which might or might not coincide exactly with historical truth. In contradistinction to this view, theorists who wish to revive the seduction or trauma theory would be more inclined to hear and deal with these productions as reflecting actual occurrences in their patient's lives. Langs on the other hand would be more disposed to listen to the productions primarily as a commentary, largely on the therapy and on the therapist and only secondarily in terms of the psychic reality and actual reality (see section 2.3 above). As is readily apparent, these perspectives are not mutually exclusive and can fruitfully be seen as complementary to one another.

In the hospital context it would appear that all three of these perspectives are important in the understanding of patients' productions in therapy. Although none of the patients in this study had experienced recent trauma, many patients in the hospital context have been traumatised

to some extent, both recently and in the past. These negative experiences cannot simply be ignored or glossed over and the patients need to be able to talk about these events to a sympathetic, understanding person. This almost goes without saying, but as the current study indicates, in the hospital context the manifest content of patients' productions generally take precedence (see Chapter 5 and Appendices 2 - 13) in the sense that this manifest content is responded to by the therapists at the expense of the other two perspectives. However, even with patients in the hospital context the two other dimensions of patients' experiences and the corresponding, underlying dimensions of their productions in therapy cannot be ignored.

In addition to the perspectives of psychic reality and material reality, the communicative perspective of Langs provides an additional, interactional dimension to the understanding of what patients in the institutional context are telling us about their experiences. There are instances, from all of the sessions in the study, of this interrelationship of the three dimensions of patients' productions but an illustration from the therapy with Grace is particularly instructive, revealing as it does the full depth of the material, psychic and interactional dimensions to her productions in therapy (see Appendix 10 and section 6.10 above).

Grace finds herself in an extremely difficult predicament. Her two adult sons have rejected her religion and embraced Christianity. The remainder of her extended family demand that she now shun her two children on religious grounds; that she have nothing further to do with them whatsoever. The patient's predicament also poses a challenge to those who would attempt to help her. As a therapist, the immediate question of how to help her deal with such a dilemma is prominent. Family therapy might seem to be a simple solution, attempting a compromise between the parties. Although this sounds like the logical and indeed the fairest and most liberal solution, it is not a neutral solution and, in a sense, it does violence to the patient. It violates her independence and attempts to push her towards a compromise solution of living amicably with her sons. It forces her to have contact with them and spikes her on one of the sharp horns of her dilemma, leaving her to face the wrath of her extended family and her religion. The patient's previous therapist attempted family therapy and involved the current therapist in the attempt and the family therapy had not been officially terminated (see Appendix 10 adaptive context). The patient perceives this unconsciously to

be an aggressive infringement on her autonomy and articulates this perception of the therapy in an unconscious way through her conspicuous derivative material of being aggressively moulded.

In this session it is notable how many times the patient uses the third person when she appears on the surface to mean to be using the second person. This lends a strange quality to some of her utterances which appear to be aimed directly at the therapist although ostensibly they are about a third party. A vignette from the session illustrates this.

Clinical vignette: Grace session 8

T This relationship has been going on for a while now?

P For a while. It is the type of person, um... so much different from those years. It's now the type of person that um...I'm the macho man and as the time goes by you learn their ways um I'm a macho man, you do what I tell you to do. You can only go where I say you can go. I'm like a piece of clay he wants to mould, the way he wants to. I cannot have myself moulded because I've got my own things to deal with.

T It sounds like you resent the fact that he's trying to mould you. And you've been moulded all your life by your husband.

P I've been moulded all my life and so far and no further. So now I'm a person of my own. I do my own thinking and all that. At least I'm trying to do the best what I can after all these downfalls and things. *Here you come and you just want to sort of mould me and you can't get me the way you want me so you want to use violence on me.* I cannot afford that. I can't. And my family would never allow that he should use violence on me they will not. I mean we've got our differences about the children and things like that, but as far as those things as violence - somebody being aggressive towards me, violent towards me- they will not stand for it because I'm their only sister I've got nine brothers.

The section above in italics is a conspicuous example of this peculiar manner of speech on the part of the patient. Further brief examples of this particular manner of speech from the session⁶ are:

1. "This is the way I am instead of trying to mould me the way you want me to be. I can't be the way you want me to be." (3-1)
2. "Why get so aggressive - just because you can't mould me the way you want to." (7-1)
3. "So you can't come now and disrupt that for me." (8-13)

⁶ The page and paragraph numbers from the original transcripts are given in brackets.

4. "But you can't expect to take me like a piece of clay and if I want the point to come out I'll pull it and it must be there because I want it like that. I'm not prepared to be moulded all over. I'm too old for that." (9-1)

This way of expressing herself lends weight to the assumption that although the patient is ostensibly talking about her lover, at some level she is also directing these comments at the therapist and at the frame more generally and is objecting in a most strenuous way to her perception of being coerced into doing something, or of being moulded by the treatment. It must be stressed that there is no doubting the reality aspect of the patient's material. She is facing a difficult relationship and no doubt has faced actual difficulties in her relationships with others in the past and this needs to be addressed in her therapy if the treatment is to be complete. There is also no doubting the importance of the patient's psychic reality, the reality of her internalised object relations as this is played out in the way that she interacts with people and especially the way that she perceives people, including the therapist. But this aspect cannot be addressed at the expense of her perception of, and her commentary on, the therapy specifically. Indeed it is intricately bound up with her perception of the therapy and the therapist. However, her valid commentary on the therapy, based on the veridical perceptions of the breaks in the frame needs to be addressed and distinguished from what she is bringing to the situation. Her unconscious supervision of the therapist and the therapy situation needs to be heard and understood by the therapist before the therapy can proceed fruitfully.

Ultimately there is no neat solution to this patient's problem. All that a therapist can do is to *be* with the patient in her terrible agony of indecision, to help her to find some strength in herself to face the dreadful predicament, and to hope that by being there for her, by listening to her in as neutral, and at the same time as caring and understanding a manner as possible, the patient will be able to call on her inner resources to find her own way through her awful dilemma. It seems clear from what this patient is telling us, that anything other than this, whether it is in the name of supportive therapy or family therapy is experienced as an aggressive moulding of the patient.

Therapy with Mary (sections 6.2 and 6.3 and Appendices 2 and 3) is also illustrative of this point. Mary is undoubtedly experiencing a tremendous amount of difficulty in her relationship with her husband. Her husband in all likelihood is a source of great trauma for her. She remarks that he is irresponsible and chaotic and he does abuse her dependence on him by having affairs and coming home intoxicated. Similarly she recalls that her early relationship with her mother was characterised by abandonment and neglect. This is undoubtedly also, at some level, a source of trauma for her, contributing to her current difficulties. However, the conditions prevailing in the therapy at that time bring these particular issues out in the therapy at that particular point and it is important for the therapist to heed the patient's message about these conditions of the therapy. As these chaotic therapy conditions subside (see sections 6.4, 6.5 and 6.6 and Appendices 4, 5 and 6) so too does the prominence of Mary's productions in therapy relating to the chaotic husband and the abandoning, rejecting mother. This is not to say that her perceptions of her mother and her husband are not important. They clearly are, but her underlying perceptions of the therapy are equally important and need to be addressed first in order to give her the space to explore what is really at the heart of her problem. Concentrating on the manifest content of what she is saying is understanding only one aspect of what she is communicating. Rushing in to do marital therapy, as an option on the basis of a large part of the manifest content of the first session relating to her husband, would be largely missing the primary point about what she is actually communicating in that first session.

Therapy with Monica (see section 6.8 above) perhaps provides the clearest illustration of the point about the need to take into consideration the patients' interactional commentary on the therapy without hastening headlong into dealing with the manifest material. This has already been discussed at some length under section 7.2.5 above but it is useful to briefly look at the material in this context. Monica (see Appendix 8) comes into the session having learnt the devastating 'fact' from a clerk that she will have to give up her therapy in the very near future. This is in addition to her expectations of possible termination in her therapy by her current therapist because of the latter's imminent move to another unit and in addition to her previous experience of 'abandonment' by her former therapist on the completion of the latter's training. Monica's knowledge of this pending abandonment is not brought up at the beginning of the session and consequently her erroneous fear of being abandoned by her

current therapist is not cleared up early in the session. Monica, not surprisingly, spends a good deal of time in the session complaining about her abandonment and rejection in the past and her pending abandonment in the near future by her best friend. Clearly her manifest preoccupations in the session are a commentary on what is extremely important to her, but is below the surface of her consciousness. This latent preoccupation clearly needs to be addressed by the therapist. To be side-tracked at this point in the therapy by comforting the patient about her experiences of loss in the past and her pending loss of her friend is to miss the point quite badly about what kind of distress is actually being communicated in the therapy and what its source actually is. She has indeed lost her fiancé in a car accident and she *is* losing her friend who is moving away to get married but, more importantly, at this point in her life she assumes that she is about to lose her therapist and in a seemingly quite arbitrary and callous fashion. Not surprisingly she is suspicious of the therapist's attempts at an interpretation at a manifest level and this is illustrated by the vignette from the session quoted in section 7.2.5 above, which does not receive derivative validation and in fact receives quite clear derivative disconfirmation.

It is also instructive to examine what occurs towards the end of the session when the patient refers to this issue directly and the therapist addresses the issue by offering her the opportunity to continue with the therapy. This is not a framework rectification as set out by the communicative methodology and accordingly it does not receive direct and clear derivative validation. Although the patient very clearly would like to continue with the therapy there is a degree of ambivalence in that she sees it as somehow an indication of her need. The patient initially sees it negatively as a message from the therapist that she needs therapy, but there is also clearly a degree of relief on her part that she is not being 'abandoned' and she launches into a section of dialogue where her relief, although not stated directly, is tangible. The following brief vignette illustrates this.

Clinical Vignette: Monica session 8

- T Its time for us to stop now.
P Okay.
T So I'll see you next week.
P Ja, and what about the sessions for...like how long...I don't know if I qualify with the situation in front here with regards to going to other clinics or something like that.

- T Okay...No I was actually going to talk to you about this next week, but let's talk briefly about it now. I am actually going to be able to carry through a couple of people when I move to ward X.
- P Oh.
- T And I was going to ask you whether you would like to carry on after the end of May, since I'm only here until the end of May.
- P End of May.
- T At Outpatients.
- P Oh here, and then you move to another ward.
- T Ja, then I move to ward X. So I would be able to carry on with you there.
- P So I would need more sessions then, with you? That is how you see....
- T It's something that you need to think about. I certainly think that you are one of the people I see who I feel would benefit from longer term work. And as I said before, it's not to do with me thinking that you are so 'sick' that you need more work. It's more to do with the fact that you would...benefit most from that kind of long term work.
- P Okay.
- T Obviously it's your choice. It's up to you, as to whether you want to carry on.
- P Therapy, you mean.
- T Mhmmn.
- P No, I think I need to work through some more things. That's also what I was told, that I need to work a lot on my self image as a person more so. And what I want to give into the world because I'm not sure if my individuality is certain. That's why I'm so uncertain when I go out into the real world. I think I should work on that.
- T Mhmmn.
- P I'm not exactly sure who I am. I've been kind of toppled over because of Michael's death and that's why I'm struggling because my foundation I had, my false foundation I had was taken away from me. With Michael. So I have to deal with me now there's no Michael.
- T Okay, well you can think about it and we can talk about it more next week - your carrying on.
- P Okay thanks Tessa.
- T All right, take care.
- P I will then see you what date?
- T Same time next week, the 15th

In this vignette the therapist is closing off the session when the patient brings up the issue of her continuing in therapy, in the light of what she has heard from the clerk at the front desk. After the therapist informs her that it will be possible to continue, the patient launches into a description of the core of her problem as she sees it, which is the issue of her self, or her "individuality" and building this up. She admits to having had a "false foundation" based on her relationship with her fiancé which was taken away from her and she is expressing the need to build up her self, to be more self reliant, as it were. In a similar way her relationship with her therapist had seemed to be a false foundation, and there is also the sense that she needs to build up her self in order to overcome the false foundation of reliance on therapy but

the important point here is that she appears to be greatly relieved by the news that she is to continue in the therapy and the threat of the loss of the therapy played a prominent part in her 'selection' of this particular manifest content of the session relating to her loss and abandonment.

7.4 TRANSFERENCE

Langs (1982) plays down the traditional view of transference and at the same time he has a high regard for the importance of the non-transferential, veridical aspect of the patient's commentary on the therapeutic interaction. Langs (1982) asserts that a very large portion of this commentary is non-transference and is an unconscious, and more often than not accurate, perception of the therapist and the therapeutic interaction. For Langs it is all too easy for defensive therapists to ignore the patient's real perceptions of the interactions in the bipersonal field and to explain these often uncomfortable perceptions as having genetic antecedents. This concept of the accurate, if unconscious perception of the therapist or the therapy is at the very heart of the communicative approach to therapy. Langs (1984) remarks that the use of his model may well render obsolete the term transference and its converse nontransference. This is a point that is taken up with some enthusiasm by Smith (1991a, 1993a) and other theorists (Szasz, 1981) who have also questioned the usefulness and the theoretical underpinnings of transference (see section 2.2 above). This is an extremely heretical position in the field of psychoanalysis as transference has come to be regarded as the most important and useful concept in psychoanalysis and is, in a sense, definitive of psychoanalysis (Person, Hagelin & Fonagy, 1993). Szasz (1981) argues somewhat polemically that the concept of transference has served a very useful defensive function to analysts and its very existence arose from a defensive need of therapists. This position would serve to place the communicative paradigm at odds with virtually every other school of psychoanalysis where transference, in some form or another is of fundamental importance to the therapy. However if one looks at Langs's opus as a whole one can see that he is not dispensing with the historical, genetic factors in the development of neurosis but is rather, through his emphasis on the ground rules, saying that the iatrogenic syndromes and symptoms caused by the deviant frame and the therapist's countertransferential input into the bipersonal field have to be analysed first, before one can validly focus on material that appears to reflect transference distortions (Langs, 1979, 1981, 1982, 1993).

7.4.1 The interpretation of transference material

Conventional wisdom in psychoanalysis has it that transference should not be interpreted too early. For example, Wolf (1988) following Kohut (1971) and Freud (1914) maintains that transference should only be interpreted when it has become a resistance through the patient's lack of co-operation following non-fulfillment of the transference wishes.⁷ Wolf explains that this is because it would, amongst other things, sound like a prohibition to the patient and it would inhibit him from pursuing that avenue of thought. Transference interpretations are powerful interpretations and can be taken as injunctions to the patient not to talk about those matters. In a broad sense, all of the interpretations that are made by a communicative analyst are transference interpretations in that they relate everything that the patient says back to the therapist or to the therapy frame.⁸ One has to be cautious then about making these kinds of interpretations early on in the therapy because they can come across to the patient as an injunction not to speak about these things; in effect an injunction to not speak about anything, because everything is related back to the therapist as a form of transference. Therapy with Mary illustrates the dangers of these early transference interpretations, but it must be remembered that Langs (1982, 1988) advocates a certain technique in making communicative interpretations and this therapy does not comply with these recommendations. An example of an erroneous type of transference interpretation together with the *sequelae* that demonstrates a drying up of the patient's derivative material comes from the following vignette taken from therapy with Mary session 5. The drying up of the patient's material comes perhaps as a consequence of the patient seeing this interpretation as an indication from the therapist that she is doing something wrong, that she should not be thinking these things and that the therapist has perhaps caught her out and pointed out something wrong that she is doing. This is then, in a sense a kind of injunction (Wolf, 1988) not to talk about these matters. The vignette comes near the end of what the therapist rated as a good session of therapy from the point of view that the patient had seemed to be using

⁷ This position can be contrasted to that of Gill (1982) who advocates that transference be interpreted from the beginning of treatment.

⁸ Transference interpretations are essentially interpretations that illustrate to patients how they are transferring feelings, thoughts, and affections from other people, essentially other significant people from the patients' past, onto the form of the therapist (see Person et al, 1993). Although transference involves a transfer by the patient of feelings onto the therapist, transferred essentially from people in the patient's past, it is possible to extend this concept to incorporate the transfer of feelings from people in the current life of the patient.

the therapy well to explore many issues regarding her dependency needs and her fears and anxieties in interpersonal situations (see Appendix 6 and section 6.6 above).

Clinical Vignette: Mary session 5.

T Yes, but it feels as if they don't accept you always. You feel as if men accept you more easily and with women there might be a chance of an argument.

P You know, and then on the other hand it feels like it might be because of that relationship that I had with my mother. You know, I never felt easy in her company. She always expected that I must be someone else and she, I don't think she liked it herself. She would always say that I am anxious and withdrawn, and um, I was never like the others that people like because they were more spontaneous. Um but I felt that I was more acceptable if I was somebody else. You know, it is difficult for me to explain.

T Mhhmn.

P And I felt that she never accepted me for the person that I really am. Because my sisters had a stronger will than me. They, you know, if we were together then automatically you would see them and I would be in the background, and this is why my parents actually liked them. But if they look at me then I am like the person who is scared of everything, at the age of six or seven a person who used to still wet herself, you know and I can't understand why I always had that feeling. Sighs.... You know if I think back on those days, because it is not something that I forget easily, then I try to think why was I like that.... why? Why was it difficult for me to trust other people or to be with other people? I can't ever get an answer to that. But the fear that I will be left with other people, or if I went to crèche then I am always the one that will give her problems. And then it is easy to send the other children with someone but I am the one that does not want to go because I am scared of the person, um, you know, that anxious feeling. Sighs. Even when I think about it, it makes me tired.

T Mhhmn.

P You know, I can't understand that I am so, I don't know what to say...sighs.

T You feel that your mother won't be there for you. Its a feeling that if she takes you somewhere she won't come to fetch you or if you come home one day then she won't be there. Or if you arrive somewhere the people who you are supposed to see won't be there. Its a feeling that people are going to let you down.

P You know, I can't even say what it is what gave me that feeling that my mother is going to leave me and never come back and fetch me....

T Yes its a feeling that you get every now and then with your girl friend and with your husband and with other people. One day they just won't be there for you. If you get attached to someone they are going to let you down and leave you. One day they just won't be there for you. *And its also a feeling that your therapist is also going to let you down and leave you. It feels that it happens at all levels and in all cases.*

P You know on the other hand then I feel angry with myself to let people become important for me. You know. I will just want to have nothing to do with people. And, how come I get easily hurt about things that other people just accept easily?

T Mhhmn.

P Sighs. I don't know. The fact that I always had the feeling that my mother is going to abandon me, I think I am now still angry with my mother. I get that feeling

towards her, if she invites me then I feel that she is feeling guilty and I choose not to go to her. Oh!. sighs.

T Mhhmn.

P I don't know what happened between my mother and I. You know that sighs

T It feels that something happened that you can't remember, something happened to make you feel that.

P I don't know what happened. You know I feel that she loves my other brothers and sisters more than she loves me, because I am maybe not...

T It feels as if she has more time for other people and that happens also in general. It feels like you husband and friend, they have more time for other people. *It feels like all the people your mother, your husband, your friend and even perhaps your therapist, they all seem to have more time for other people.*

P Oh Dr, I, I, don't understand myself.

T Yes it feels as if you don't understand yourself but it seems like you are trying to understand what happened. You are trying hard to understand yourself now, and it is not an easy thing. It is not an easy thing to sort out all of these things especially if you have such strong feelings about things.

P Sighs....

T But it is not an easy thing to sort these things out.

P But I don't know what is wrong with me. Sighs

The sections highlighted in italics in the above vignette represent attempts on the part of the therapist to relate the patient's material back to the underlying issue of abandonment by her previous therapist and a consequent fear of being abandoned by her current therapist. While the idea behind the interpretations appears to have validity in terms of the therapist's communicative, interactional understanding of the patient's material, the interpretations fail from a point of view of their technical execution. From the communicative, interactional perspective they fail in that they do not combine the essential elements of the communicative interpretations. The interpretations, as they stand could be seen by the patient as the therapist 'reading her mind' as it were, in that there is very little linking of the essential components of the interpretation. In the vignette above this failure of the interpretation is reflected in the patient's flow of material seeming to dry up at that point and in a lack of derivative validation for the interpretation. The intervention also seemed to have the effect of inhibiting the patient in that her productions seemed to dry up after her anguished cry that she does not understand herself and her comment that she does not "know what is wrong with me". The rest of the session produced no new material and ended on a slightly strained note with the patient sitting in what seemed to be an awkward silence.

In the communicative psychotherapy paradigm, virtually all of the interpretations could be described as, at some level, transference interpretations in that they are being related back to the therapeutic situation.⁹ But it is the way in which the communicative interpretation is structured that would make it different from the type of transference interpretation that Wolf (1988) and Kohut (1971, 1972, 1977) are referring to when they remark that transference interpretations are taken as an injunction to the patient not to talk about these types of things. The communicative interpretation can only occur when three ingredients are present in the patient's material and it is structured in a specific way, containing a synthesis of these three specific elements (Langs, 1982, 1988; Smith, 1991a). A communicative intervention requires the presence in the patient's material of the representation of the adaptive context (or trigger), a rich sequence of derivative material, and an indicator (the patient's affective response to the trigger). Thus in the above vignette the *indicator* is represented by the patient's talk about being tired, not being able to understand herself or remember what it is that gave her the feeling that her mother would not come back for her. The *trigger* is represented by the loss of the patient's original therapist when the patient was referred on for therapy by this therapist (see Appendix 6, adaptive contexts). There is rich *derivative material* which coalesces around this trigger in that the patient talks about her parents preferring her siblings to her, her difficulty in trusting people and the feeling that she will be abandoned or that her mother will leave her and not come back for her. The therapist has to synthesise these three elements, firstly the adaptive context, secondly the patient's manifest representation of the adaptive context and finally the unconscious implications in terms of the latent meaning for the patient of this manifest content. Thus a correct interpretation of the material from the above vignette should possibly read as follows:

T It is difficult for you to understand your feelings and it makes you tired when you try, but it is a feeling of having trouble trusting people and feeling secure in relation to other people. You have had experiences of being let down badly by other people, in the past as a young child and in the present, including on this ward when your previous therapist referred you on for therapy when she left the ward and this has

⁹ This view of transference, derived mainly from a Kleinian perspective (see Klein, 1952; Rosenfeld, 1965) is not without its detractors and, for example, Sandler, Dare and Holder (1973) argue that it is important to differentiate transference from non-transference elements rather than to label all elements from the patient transference. Similarly Baranger (1993) argues that "if we regard everything as transference, we in fact lose sight of transference" (ibid. p21).

brought home to you these feelings of anxiety and fear of not being able to trust people that you are talking about.

This kind of synthesised interpretation would be predicted, by the communicative method, to obtain the requisite derivative confirmation from the patient. It seems apparent that the elements of this interpretation, synthesised as they are in this way by linking the patient's current symptoms and interpersonal difficulties, firstly with their developmental and genetic origins in her perception of her childhood experience of parental neglect and abandonment, and secondly with the all important re-experiencing of this neglect and abandonment in the context of her current treatment in the institutional context, could serve as a particularly containing intervention for the patient. It seems apparent that this interpretation would go some way to rectifying some of the damage caused by the patient being handed over for therapy in the chaotic way that it occurred (see Appendix 2 adaptive context) in that the interpretation would make clear to the patient the therapist's recognition of the pain and difficulty that this handing over caused to the patient, even if this pain was not consciously expressed by the patient. The interpretation would at the same time implicitly signal the therapist's intention not to repeat such an experience for the patient and this in itself would provide an important containing element for the patient. In addition the interpretation would illustrate to the patient that the therapist has some understanding of her condition and situation. The interpretation would hold out the promise of helping the patient to gain some insight into how her pathology has developed and how it is maintained, while simultaneously auguring a therapeutic environment that would not needlessly and erroneously repeat the neurotogenic and traumatogenic situations and would thus hold out the promise of laying bare for understanding and interpretation the pathogenic elements of the patient's neurosis that are brought to the therapy situation by herself in the form of her transference.

The interpretation actually given in the session seemed to inhibit the patient from talking about these issues in line with Wolf's (1988) concept of the transference interpretation serving as an injunction to patients to stop speaking about a particular topic. What is at issue here is the question of the composition and timing of transference interpretations and the necessity of communicative psychotherapists to utilise transference interpretations early in the therapy because of the paucity of interventions allowed by this communicative psychotherapy technique.

The interpretation given to Mary in the vignette above, apart from being incorrect in terms of the communicative methodology would also be open to question in terms of the timing. Baranger (1993) reminds us of the need to interpret at the point of urgency, "the moment in the session when something is about to emerge into the analysand's consciousness" (ibid. p20). She points out that the analyst withholds many things that are understood by him or her until the 'point of urgency' is worked out and understood. Similarly Baranger remarks that a comprehensive interpretation is not normally given in the beginning of the session because of its blocking or inhibiting effect and in addition because it would come across as unconvincing to the patient. Interpretations that are appropriate at the beginning of the session are ones that deal with the clearing away of obstacles to dialogue and the opening up of communication. From the communicative psychotherapy perspective, with its strict rules regarding the construction of interpretations, the closest intervention to these kinds of interpretations would be the 'playing back of selected derivatives' as a way of attempting to elicit clearer material from the patient. The issue of the paucity of acceptable communicative interventions is discussed further in section 7.5 below.

Freud (1937) believed that no harm would come about if once in a while a therapist made an error in interpretation. It would simply be a waste of time and would possibly delay the process of therapy. Freud remarks that the mistake can be admitted to the patient at some future time without any great sacrifice in the therapist's authority. This could be accomplished if some opportunity arose in the therapy and new material came to light which enabled the therapist to correct his error and make a better interpretation. In Freud's work maintaining the authority of the therapist remains of paramount importance. In contrast to this approach Greenacre (1975, 1981) emphasises the importance of the unravelling together with the patient, the important life experiences and the importance of the relationship with the patient. She emphasises that this working relationship, together with the analyst's responsiveness, concern, lack of authoritarian approach and fidelity to their mutual work is even more important than the precision of the interpretations. This formulation is acknowledged by many analysts with varying degrees of emphasis. Brenman (1980) observes that "Analysis does not answer historical questions but provides the security to explore them" (ibid. p54). Winnicott's (1965, 1971) emphasis on the importance of the

relationship with the patient in therapy is well documented (James, 1985; Rees, 1995b). Winnicott tended to downplay the role of interpretations in therapy and he remarked that he interpreted in order to show the limits of his understanding. As mentioned previously, Winnicott had a horror of clever interpretations and he felt that the cleverness and the understanding should come from the patient. James (1985) comments that Winnicott was against an intrusive, invasive, meddlesome style of doing therapy that the French called "terrorism by interpretation" (ibid.). Similarly self psychologists (Chessick, 1985; Kohut, 1971, 1972; Wolf, 1988) are concerned with patients' sensitivities to interpretations generally, particularly narcissistic patients' sensitivities to interpretations and within this paradigm there is a greater emphasis on the relationship and the manner of interpretation than on strict accuracy of the interpretation. This is not to say that accurate interpretations are not important to self psychologists but simply that the therapeutic ambience is seen as more important if the interpretation is to be accepted in the first place (Wolf, 1988, p100). This point is discussed further in section 7.6.2 below.

The issue of the effect on patients of incorrect interpretations is discussed by Kumin (1989) who reminds us that because interpretations are conjectures about the unconscious, only the patient's response to the interpretation can confirm or fail to confirm them and in addition the very fact of being suppositions will mean that interpretations will frequently be incorrect. While Kumin's paper specifically concerns interpretations, his treatment of the topic can be applied to interventions generally and can be broadened to a consideration of the patient's responses to the framework of psychotherapy generally. Kumin maintains that the patient's reactions to incorrect interpretations mimics on the one hand past affective responses to previous relationship failures and on the other hand past defensive reactions to these failures. These reactions can also be an important source of information to the therapist regarding the patient's level of integration. Kumin observes that:

To the patient, the incorrect interpretation feels like the return of the repressed, projected into the analytic situation. The well-integrated patient feels as though the analyst has dropped the ball; the poorly integrated patient feels as though he himself has been dropped. (ibid. p142)

Kumin discusses the various types of incorrect interpretation and the steps to be taken to redress the effects of these incorrect interpretations, contending that incorrect interpretations

in themselves are not necessarily catastrophic for the therapy. Despite this line of argument Kumin clearly recognises the importance of correct interpretations in the context of a secure therapeutic framework (ibid.).

7.4.2 Direct references to the therapist

Paradoxically, one of the few types of patient's utterance that is considered by Langs not to be transference discourse, is the patient's direct reference to the therapist. Langs (1982, 1988) makes the point that it is generally erroneous to consider direct and conscious expressions about the therapist as transference examples. These types of expressions do not have the unconscious, derivative quality that would be demanded of an expression of transference. Thus if a patient discloses to the therapist directly and consciously, any strong emotion felt about the therapist, it does not automatically imply a transference expression and on the contrary it is more likely to have as its referent some other person or entity. On the other hand derivative material, expressed in the context of an activated adaptive context which has manifest representations, is more likely to be considered by Langs to be transference in its broad sense, that is, to be related to the therapist. Langs (1982) states:

Transference expressions are not to be equated with manifest associations and reactions to the therapist. These responses are actually poor carriers of unconscious fantasy constellations and often serve primarily defensive rather than revealing functions. In a sense, every association from the patient pertains on some level to the therapeutic relationship. (ibid. p536)

Langs (1982) describes two types of transference and sets these two types of transference apart from non-transference. Pervading all three of these concepts is the concept of unconscious perception (see Chapter 2). For Langs transference is divided into classical transference and interactional transference. The former version of the concept is broadly similar to the Freudian notion of transference and can be seen as the patient's inappropriate transfer of feelings, thoughts and responses onto the therapist that rightly belong to figures from the patient's past. Langs remarks, in a slightly confusing addition to his description of this form of transference, that the patient's transference responses do not arise *de nova* but always constitute *maladaptive* responses to the therapist's attitudes and interventions. This is similar to the concept of the patient's responses to the therapist's interventions that constitutes non-transference, but the key difference is the fact of the patient's response being

maladaptive in the case of transference and an understandable, adaptive response in the case of non-transference which involves the patient's veridical perception of the therapist's transgressions in the framework of the therapy.

The interactional transference on the other hand involves inappropriate interactional pressure by the patient onto the therapist through projective identification or interactional projection. Langs comments that these are maladaptive responses to a sound intervention context provided by the therapist. Langs concedes that this type of transference, like the classical kind mentioned above, derives from earlier relationships and has a clear genetic dimension and in addition displacement plays a role in its expression. Langs makes the distinction because of the form that this type of transference takes and because of the form of self scrutiny that the therapist has to indulge in, in order to separate out the primary origin of this form of transference. That is whether the interactional pressure from the patient is in response to an interactional pressure originating from the therapist, in which case it has to be labelled non-transference; or whether the interactional pressure arises "primarily from pathological unconscious fantasy constellations that prompt the patient to create such pressures mainly because of his or her own inner needs" (ibid. p536), in which case it has to be labelled interactional transference.

As will be readily apparent from the foregoing, in the communicative paradigm, transference can emerge only within the context of a secure frame when the therapist has intervened correctly. In this instance the patient, without external justification in the behaviour of the therapist, displaces onto the therapist the underlying fantasy distorted from earlier relationships. Langs emphasises that it is an *unconscious* fantasy and experience of a pathogenic nature that is at the heart of transference. He argues that "a constellation from an earlier figure is displaced onto the therapist, but then usually (because of defensive need) finds representation in some further displaced form" (ibid. p532). It is this defensive need on the part of the patient that keeps the transference material unconscious, through the mechanism of displacement.

Reactions in the form of derivative material on the part of the patient to the therapist's erroneous interventions, and to the breaks in the ground rules, are not taken as expressions of

transference. Langs delineates these responses as nontransference and they are based on the patient's veridical, if unconscious, perception of the therapist. Thus Langs uses the terms nontransference and transference in the broad sense, the former term referring to "all sound and valid" responses (ibid. p504) on the part of the patient to the therapist's framework breaks, and the latter term referring to the patient's inappropriate responses to the therapist's valid interventions and sound framework maintenance. Langs emphasises that both nontransference and transference have genetic components and both of them involve responses that derive partly from early relationships.

There is room in Langs's complex idea of transference for Freud's concept of the overdetermination of symptoms as is illustrated by the case of Lala (Appendix 9 and section 6.9 and see section 7.2.5 above). The therapist acts in a manner that is, for the patient, at some level, reminiscent of her mother. The patient is unconsciously preoccupied in the session with the actions and interventions of the therapist in that there are many ground rule breaks in the session. The therapist has acted in many ways like the patient's mother specifically in the therapy in her lack of engagement with the patient. The patient produces material in the session that is displaced from the therapist and from the patient's mother, onto the 'older workers' who won't learn and who will be deserted. The therapist intervenes, near the end of the session at a manifest level, commenting about the importance of the patient's mother and the patient responds by talking in an indirect and derivative fashion about her fellow workers who do things erroneously but cannot be told or corrected and so just have to be ignored and ultimately left. This, according to communicative theory is on the one hand a specific and clear disconfirmation of the therapist's intervention and on the other hand it is a prognosis on the part of the patient of what will happen in the therapy to the therapist, if the therapist does not learn, but it also relates to the patient's mother in that the same fate of rejection will await her. A multi-layered understanding of the patient's productions as they pertain simultaneously to current figures, figures from the patient's past, and to the therapist is required of the therapist, similar to Malan's (1979) 'triangle of person'.¹⁰ Malan's 'triangle of person' involves an understanding of the patient's affective links between three key elements, namely 'parent', 'other' and 'therapist' and requires the therapist to make the links between the patient's feelings directed towards each of these elements.

¹⁰ Malan (1979) acknowledges that this concept originates in Menninger's concept of the triangle of insight (ibid. p80).

One possible way to interpret this multi-levelled understanding of the material is to keep the interpretations initially at the manifest level of the patient's mother by relating back the fate of the patient's older colleagues to the possible fate of rejection that awaits the patient's mother and only at a later stage relating the material back to the therapist when the patient is more appropriately engaged in the therapy. This would be in line with the injunction to delay transference interpretations and to exercise caution in making these transference interpretations and hence would conform to the general requirement by some commentators (Freud, 1914; Kohut, 1971, 1977; Wolf, 1988) to be cautious about interpretations involving transference in the initial stages of the therapy. However this approach would not be approved of if one was adopting a strict communicative approach to psychotherapy which has specific guidelines for the construction of interpretations and discourages interpretations at a manifest level. This issue is further addressed in section 7.5 below.

Spence's (1982, 1987, 1988, 1994) hermeneutic approach to the understanding of material in the therapy situation emphasises this multifaceted exegesis of the patient's productions and he deplores the premature closing down of the possibilities of explication of patient material. The simple and perhaps automatic translation of everything the patient says back to the therapist would be construed by him as a shutting down of the possibilities for a creative understanding of the patient's material. Similarly Baranger (1993) remarks that analytic listening is primarily defined by its attempt at listening to the unconscious but the concept of the unconscious is itself not a 'thing' to be emptied by the process of psychoanalysis and neither is it a sense or meaning that simply and arbitrarily underlies what the patient says in a hidden way. Baranger (1993) declares that:

The analyst listens to something other than what he is being told. To imagine that he seeks a latent content that exists behind the manifest content would be to reify something dynamic. The listening of the analyst consists in decentring the patient's discourse, stripping it down in order to find a new centre, which at this moment is the unconscious. (ibid. p20)

Baranger is making the important point that one cannot seek the unconscious content of the patient's productions in a perfunctory translation of manifest into latent content but that the unconscious content of the patient's productions is alive, dynamic, and elusive and has to be

sought in the patient's material as a whole. Relentlessly relating everything back to the therapist and the therapy situation would be an example of a reification of a dynamic concept. Langs could be accused of relentlessly relating everything that the patient says, back to the therapist in a mechanical and prosaic manner, a manner which destroys some of the richness of the patient's material. This point is implicitly recognised by Langs (1979, 1982, 1988) in his concept of transversal communications, which are defined as "associations from the patient that bridge and simultaneously express, both fantasy and reality, transference and nontransference, unconscious perception and distortion, truth and falsehood, self and object" (Langs, 1982 p746). Langs's recognition of this point is also demonstrated by his creative interpretations in his published clinical material. However this remains a problem for therapists new to the field who are attempting to deal with the complexities of the unconscious and unconscious communication and who have a need for some form of sureness and certainty in their understanding and interpretation of patient's material.

7.4.3 Breaks in the frame as hooks for the transference

Could it be that patients bring past pathogenic issues to the therapy room and actually need the mild breaks in the frame to attach these issues to in order that they might be brought up and discussed in a relatively safe containing environment? Troise (1992) argues that the patient will respond to whatever framework conditions are on hand and will use these conditions in order to bring out their internalised object relations thus attempting to evoke a response in the therapist (Sandler, 1976) and to compulsively repeat a past event in order to deal with it (Freud, 1914). Is it possible that, in addition to an empathic, understanding therapist, the patient needs to connect to some aspect of the frame, whether secure or broken in order to delve into traumatic material? This, at first glance, would seem to be an apology for careless frame maintenance on the part of the therapist, in that, if this contention is true, then it could be claimed that it does not matter if the therapist maintains the frame or not as, whatever happens in this regard, the patient will be able to use the ground rule break to comment, unconsciously, on some aspect of their problem that the framework break is reminiscent of.

While this contention is conjecture, it does seem to be one of the implications of communicative theory in general and frame theory in particular. Lala's case (see Appendix 9

and section 6.9 above) seems to be instructive in this regard in that her childhood experiences of sexual abuse had not yet been mentioned in her current therapy. Somehow it would appear that the conditions for bringing out this important aspect of her history were not favourable in that the adaptive contexts that she responded to in the therapy were related more to her perception of an uninvolved therapist rather than an abusive, seductive one. Thus Lala's therapist asked questions of the material on a manifest level, allowed her to come to therapy every second week, and perhaps most tellingly had mentioned that she was at some stage going to be moving on to another unit and that there was a possibility of termination when that occurred. Given this evidence it is not surprising that the framework break that connected to the patient's transference issues was the break relating to her perception of a therapist who was focusing on superficial issues and was not really relating to her and would possibly abandon her, rather than a therapist who was abusive. This is very clearly reflected in the patient's thematic material. This seems to be very clear evidence for the value of the patient as an unconscious supervisor of the therapist through decoding of the derivative material.

Similarly Nerina's sexual abuse (see Appendix 12) does not come out in the session because of the circumstances of the therapy session itself. Despite (or perhaps because of) all the therapist's probing and questioning, the patient is not able to actually use the session because of a combination of the framework breaks and the therapist's lack of an interactional understanding of what is being communicated by the patient. The therapist operates in this session purely on a manifest level with no thought for unconscious processes, and for the patient's interactional resistance. The session is very impoverished from the communicative point of view. There are instances in the session of advice giving and of the therapist making use of suggestion and other techniques of a supportive nature. However, there are still indications from the patient of what is unconsciously of concern to her about the therapeutic frame and of why she appears to be reluctant to use the time to speak about her concerns. An understanding of the patient's material in interactional, communicative terms is still possible despite the lack of abundant derivative material and if this interactional understanding had been utilised by the therapist this would have been helpful in allaying some of the patient's quite understandable interactional concerns within the actual session (see section 6.12.2).

This point also ties in with Winnicott's idea of the 'good enough' therapist and the patient's need to experience a failure on the part of the therapist before being able to 'use' the therapist in a constructive way in the therapy (Winnicott, 1972). Winnicott emphasises the importance of the therapist's inevitable failures of provision. This allows the patient to 'hate' the therapist and hence ultimately to begin to 'use' the therapist in the therapy situation. The inevitable failure of the therapist and the subsequent hate in the transference is different from the patient's original early experiences of environmental failure of provision in that the latter was out of the infant's omnipotent control and hence was not able to be overcome by the infant; whereas the 'advantage' to the patient of encountering or recreating a similar sort of environmental failure in the therapy is that it is possible to bring the experience within the patient's control and thus have a different outcome to the earlier environmental failure.

In this regard Winnicott (1972) observes that regression in therapy can be in the service of the ego if it is engaged by the analyst, and if the patient manages to bring extreme reactions to therapeutic failures under his or her omnipotent control. The key to this process is the eventual control and management by the patient of his or her projections and introjections. For Winnicott, in the developmental process in infancy this omnipotent control and aggression against the object, followed by the survival of the object, leads to the beginnings of the process of separation from objects and of object use. The ability to use an object implies a greater degree of ego strength and ego integration. However this change does not come about automatically by the maturational process alone and it requires the facilitating environment of the 'good enough mother'. If this has not been provided in the critical early period, leading to crucial, pathogenic deprivations for the child, then the facilitating environment of the 'good enough' therapist is required.

The use by the patient of the therapist's inevitable failures of provision and indeed the almost setting up of the therapist to fail in this way in order to engineer a situation which can be 'used' by the patient has an echo in the later writings of Kohut (1977) and other self psychologists (Bacal and Newman, 1990; Stolorow, Brandchaft and Atwood, 1987; Wolf, 1988) who talk about the transmuting internalisations which come about after the inevitable failures of empathy. Bacal and Newman (1990) contend that the establishment of the 'self object' relationship in therapy and the repeated re-establishment of this relationship following

disruptions associated with inevitable frustrations on the part of the therapist, strengthens the patient's self. They add that it is important not to react with defensiveness or indifference in the face of patient's attacks or demands following these frustrations (ibid. p258).

This concept of use of the analyst also has echoes in and elements of the classical Freudian notion of the compulsion to repeat in the transference the repressed traumatic event or events. Barranger, Barranger and Mom (1988) summarise Freud's views in this regard as the attempt on the part of the ego, which experienced the original trauma passively, to repeat a weakened version of the trauma, in order to be able to direct its course actively in order to gain mastery over the original events through this activity. This point is also taken up by Neubauer (1994) in relation to the concept of displacement, a concept which is of particular interest to communicative psychotherapists (see section 2.1) in that it is central to the concept of unconscious perception.

Neubauer (1994) discusses the origin of defence mechanisms by Anna Freud and observes that the term displacement was not included in her original list of ten defences although it was included in a later work (Freud and Sandler, 1985) as a defence mechanism linked to primary process functioning. Neubauer observes that displacement is a mechanism employed by many other defence mechanisms and has a different role from other defences in that while "*most defence mechanisms restrain drive derivatives, displacement places them where ego mastery over them may be obtained*" (ibid. p108 italics in original). Neubauer argues that it is this property of displacement which sets it off from other defence mechanisms. Thus the mechanism of displacement transfers conflicts to symbolic objects where these conflicts can be more easily dealt with. Unlike the other defence mechanisms which repress the conflict and hence place it outside of the control of the subject, displacement allows the subject to experiment with the conflicts and obtain mastery over them at a symbolic level initially. Thus one can speculate about the patient's original conflicts, the genetic material, being hooked up by issues in relation to the framework of therapy and being displaced onto outside objects in order to be dealt with in therapy, initially in a symbolic and hence safe way. Thus, for example in the case of Mary who in session 5 (see section 6.6 above) is dealing with genetic issues along the lines of her dialectical fears of abandonment and engulfment, has experienced abandonment recently in her therapy and

unconsciously fears this experience could occur again. Mary manages to bring up this material in a symbolic and displaced manner in relation to her friend whom she fears will abandon her. It seems clear that the therapist needs, at some stage, to incorporate all of these elements into the interpretation in order to deal with the issues at all three levels, namely the manifest, the intrapsychic and the interactional. Dealing with the issues at these three levels will surely make the patient feel more understood and hence more supported than simply dealing with the material at, say, a manifest level, or simply attempting an interactional interpretation without incorporating the manifest and the intrapsychic levels of understanding.

Winnicott is clear that therapy is not simply a matter of providing a corrective emotional experience (Alexander, 1961), or a more optimal environment which may have been absent in early life. He emphasises that analysts do not set out to provide a corrective emotional experience in the transference in that transference comes about through unconscious processes regardless of the intentions of the analyst. Winnicott reiterates that even if the analytic experience is a corrective one, it is not enough and what is ultimately needed is for the patient to develop the capacity to 'use' the analyst. Winnicott's dismissal of Alexander's concept of a corrective emotional experience in therapy is echoed by Wolf (1988) who disapproves of the notion of the therapist playing a specific role towards the patient. Wolf argues that it is not particularly helpful for patients to learn that other people, including their therapist, can react differently to how their parents acted, as patients have already learned this before coming into therapy. Wolf contends that:

On the contrary, the analysand's experiencing the analyst as, at times, just as unempathic, or inappropriate, that is, just as deficient in providing needed selfobject responses as the parental selfobject was during early development, often leads to the kind of transference disruption that allows a real working-through process to occur. (ibid. p135)

Wolf continues that the regression inherent in analysis, and affecting both parties, leads not only to idealising transferences which place the therapist in an ideal parental role but also revive the *therapist's* need for an idealisable selfobject and this resultant high regard for the patient can act as a stimulus which encourages the patient to live up to his or her potential. But this is a long way from the 'studied attitudes' and surrogate parenting on the part of the

therapist that is implied by Alexander's concept of the corrective emotional experience (ibid.).

Grotstein (1994) comments on the similarities between Alexander's 'corrective emotional experience' and Lindon's (1994) concept of 'optimal provisions' in therapy. Grotstein contends that Alexander's ideas in this regard, emerging as they did in the mid 1950's came too soon and were rejected and discarded by a psychoanalytic community within which the humanistic trend had not yet taken hold. Grotstein continues that the current humanistic trend in psychoanalysis provides a more fertile ground for the sort of ideas propounded by amongst others Ferenczi, Winnicott, Alexander, and currently by the self psychology movement in psychoanalysis, and specifically the concept of the value of 'optimal provision' propounded by Lindon (1994).

Lindon advocates 'optimal provision' of the patient's *needs* as opposed to gratification of the patient's *desires* and suggests that, while the *rule* of abstinence should be abolished, the *role* of abstinence should be retained (ibid. p 559 and see section 3.4.7 above). Thus Lindon subsumes abstinence under the rubric of optimal provision which he defines as "any provision that, by meeting a mobilised developmental longing, facilitates the uncovering, illuminating, and transforming of the subjective experiences of the patient" (ibid. p 559). Even clearly abstinent actions like silences in response to questions or requests from patients, for example, can be seen as provisions, under Lindon's system, if they help to uncover, illuminate or transform the subjective experiences of the patient. Thus the controversial communicative practice of using 'silence' as an intervention (see Gill, 1984) has some unintentional theoretical support and justification from Lindon's argument.

Grotstein (1994) in his commentary on Lindon's (1994) paper on the value of gratification and provision in psychotherapy remarks that Lindon's thesis "is representative of the winds of change that are confronting psychoanalysis from many angles" (p596). He places Lindon's thesis in perspective in terms of these changes which he describes as the move towards intersubjectivity, the move away from the drive theory and towards the interpersonal and the bipersonal field of analysis, an increasing emphasis on countertransference rather than simply transference and an increasing emphasis on privation, deprivation and traumata as important

pathogenic components in the development of neurosis. For Grotstein (1994) this new trend in psychoanalysis is represented by the concept of the patient as a valued partner in the analysis of the patient's material rather than as someone of whom the therapist has to suspiciously prevent from gratifying themselves at the expense of their therapy. He puts this view succinctly by saying that "It is as if patients can now be honored guests rather than instinctually driven suspects" (ibid. p596). But Grotstein is wary of dismissing the concept of abstinence even though it appears to have become ritualised over time and seems to have lost its meaning (see section 3.4.7) and he argues convincingly for what he terms the "dual track theorem" (ibid. p603) which includes the rule of abstinence in a dialectic mode with provision and which allows for the optimal provision of patient's needs along with the analysis of their desires. Grotstein puts the position eloquently:

The field of abstinence is the veritable "darkroom" whose very darkness is mandatory for the development of the negatives from the patient's internal world. Perhaps one could also say that, whereas abstinence is in the foreground of the analytic field, the provisions that Lindon suggests belong in the necessary but less mentioned aspects of the background. (ibid. p600)

At first glance it appears difficult to imagine, from the communicative psychotherapy perspective, what patients have to talk about if there is a perfectly secured frame. The answer to this, according to Langs is that the patient's intrapsychic issues are then brought to the foreground and highlighted in the material and it is only under these secure frame conditions that the therapist can be confident of being able to ascribe everything the patient says in therapy to the patient's psychopathology. Occasionally patients also develop, under conditions of a secure frame, what Langs (1982, 1988) terms, 'secure frame anxiety' and this manifests in their material as negative imagery, particularly a form of death anxiety (see section 7.6). Bonac's attempt at explaining this secure frame anxiety in terms of prior experiences (see section 2.2 above) has interesting possibilities but it could not be examined in this study, largely due to the lack of a completely secure frame in any of the sessions.

Langs seems to be saying that the frame is universal and will have universal consequences in terms of the patient's derivative response to the breaks. But the meaning of a break in the frame will be different from person to person (Siegelman, 1990; Troise, 1992) and this

meaning will in large part be dependent on the prior experience of a patient, their internal object relations (Joseph, 1985; Klein, 1952).

Langs (1982) contends that under secure frame conditions generally, when patients become stirred up by outside events, or outside figures, they create framework issues with the therapist in order to obtain an intervention and then the therapist responds by maintaining the frame and interpreting the resultant derivative material from the patient. This derivative material allows the therapist to help the patient understand aspects of himself or herself by synthesising his or her responses to the therapist, to the outside event or person and to the pertinent aspects of the patient's neurosis that have been mobilised by these intra-therapy and extra-therapy events. It is in this way that communicative therapy makes conscious pertinent aspects of the patient's neurosis in each interpretation. Langs (1982) remarks:

Thus an interpretation is an effort to explain the unconscious basis of a therapeutic context (a manifestation of the patient's Neurosis) by identifying the intervention context to which it is related and the derivative complex of which it is a part, and that clarifies its unconscious dynamic and genetic basis. (ibid. p645)

Each interpretation works as a kind of mini-analysis with this combination of elements, and in this way Langs avoids the charge of an empty, 'here and now' type of psychology with no adequate conception of developmental psychology and psychopathology (Smith, 1991a; Troise, 1992). It is precisely the concept of transference, in the classical sense of the term, that rescues the Langsian paradigm from the fallacy of cutting itself off from the past and cutting itself off from an adequate conception of how people come to develop neuroses and from the error of a confused and an even less adequate notion of what it is that they are doing in therapy to heal themselves (see Bonac, 1995 and section 2.2 above).

It would seem that there are, and will always be, breaks in the ideal framework even in the best run therapies. Psychotherapy seems to virtually have built into it the concept of inevitable failure in some small way, simply by virtue of the fact that the person providing the therapy is human. While making this point does not imply that therapists should be lax about maintaining the ground rules of therapy and does not suggest that therapists should be satisfied with a policy of 'anything goes' in the framework, it does perhaps mean that the inevitable framework breaks that will occur in the best run therapies will not be totally

detrimental for the therapy. Apart from providing opportunities for rectification of the framework in a sound and therapeutic manner thus providing the mainstay of the therapeutic process (Smith, 1991a), these framework breaks will perhaps also provide the therapist with opportunities for observing aspects of the patients functioning in response to these framework breaks in line with Kumin's (1989) creative and novel handling of the issue of incorrect interpretations (see section 7.4.1) and will provide the patient with opportunities for re-experiencing failures and for dealing with these failures within an environment maximally attuned to helping them to integrate the current experiences with those of the past (Freud, 1914; Neubauer, 1994; Sandler, 1976; Winnicott, 1978; Wolf, 1988). This has obvious implications for the possibility of doing therapy in an institutional context with its structural pressures on the framework and these points will also be taken up again in section 7.6.2 below.

7.5 THE LIMITATIONS OF LANGS'S REPERTOIRE OF INTERVENTIONS

Langs's radical approach to limiting the number of legitimate therapeutic interventions is a source of possible confusion for neophyte therapists. Langs (1982) advocates the use of only four interventions in therapy, namely silence, the rectification of framework deviations, the playback of selective derivatives, and interpretations (which encompasses the two other interventions that Langs allowed in previous works, namely: reconstructions and the metabolisation of projective identifications). All other non interpretive interventions such as questions, clarifications, confrontations, requests for more information, expressions of sympathy and reassurance, and so on, are illegitimate and are deviations from the secure frame, according to Langs (1982).

It is easy to misinterpret Langs in this instance and to read into his work a rigidity and proscription that is potentially dangerous for the continuation of the therapy. This is potentially a very bleak therapeutic environment which Langs would prefer to describe as rigorous rather than rigid. Lipton (1977) and Gill (1984) take issue with Langs on the potential aridity of this therapy environment from the perspective of the patient, pointing out the dangers inherent in the use of silence as an intervention. Lipton argues that silence should mean only that the therapist is listening and not that it is being employed as an intervention (*ibid.*). Gill concurs with this, arguing that the silence, in itself, will have a

meaning for the patient and will generate reactions which will in themselves require further examination. Gill continuing along this theme, argues that Langs's passive and silent response to the patient's efforts and requests to modify the frame, will in itself be experienced by the patient as a kind of avoidance, or gratification on the part of the therapist. Thus, for example a patient might make a statement about the therapist or about her or his perception of the therapist, and if this observation is met with silence it could be taken by the patient as tacit agreement on the part of the therapist with what has been observed. Silence as a response could also possibly be seen as avoidance of the subject on the part of the therapist, a form of defensive self gratification. Although this particular issue was not addressed in the current study, specifically because of the lack of such responses on the part of the therapists, Gill's point would seem to make intuitive sense, particularly for the kinds of patients that have been labelled as narcissistic by self psychologists (see Kohut, 1971, 1972, 1977; Wolf, 1988). Wolf maintains that narcissistic patients, if they perceive themselves to have been slighted, tend towards a grandiosity that protects them from the painful perception of this slight. This tendency to grandiosity, serving as it does a defensive function compounds the interpersonal misperception in the therapy space (*ibid.*).

Communicative therapists, it would appear, have to interpret early in therapy in order to maintain the holding environment, or else they run the risk of saying nothing, and not maintaining a containing presence and a holding environment for the patient.¹¹ And yet one has to be sparing about making transference interpretations (see section 7.4.1), or any kind of interpretations for that matter, because relentlessly and continuously relating everything the patient says back to the therapist will potentially be a harrowing experience for therapist and patient, dramatic in its intensity and particularly startling for patients. It is perhaps partially this sort of intensity that Strachey (1934) had in mind when he spoke about the patient and analyst needing to withdraw, after a sound interpretation, into therapy of a less intense nature. The admonition to tread warily around transference interpretations in the beginning of therapy is of necessity ignored by communicative therapists because of the general lack of

¹¹ Raney (1984) observes that students of the communicative technique, some with many years of experience in other techniques, report a curious inhibition and tendency towards long silences in the therapy sessions, even when there are, as is later observed in supervision, many opportunities for valid communicative interventions.

permissible interventions. The fact that there are no other available legitimate interventions will mean that communicative therapists will use interpretations early in the therapy. All interpretations are ultimately transference interpretations in this paradigm. Similarly Winnicott's warning about too much interpretation too soon (Rees, 1995b; Winnicott, 1972, 1978) would necessarily be ignored if the only available interventions, apart from interpretations, are silence and framework rectification.

Gill (1984) takes issue with Langs specifically for the disallowing of other kinds of interventions that would enable the therapist to explore the patient's conscious thoughts and ideas about possible adaptive contexts, say for example, in relation to some stereotyped attitude on the part of the patient. Gill puts it thus:

An effort to gain access to such ideas by questions, clarifications, confrontations, and other such devices may well lead to better results than will a silent wait for encoded derivatives of the patient's experience. The silence is easily experienced as a sullen complaint that the patient is not offering usable material. (ibid. p406)

Grotstein (1984) addresses a related problem in his discussion of Langs's eschewing of the interpretation of manifest content in therapy. Grotstein points to the necessity, for the patient, of having what is said 'vouchsafed' by the therapist and in this way feeling validated and confirmed as a person, an important part of the healing process that has also been emphasised by self psychologists (Kohut, 1971, 1977; Wolf, 1988). Similarly Grotstein (1984), following Winnicott, remarks on the issue of not going beyond the patient's level of readiness to absorb the interpretation and he identifies a potential source of difficulty in the makeup of the communicative psychotherapy interpretation in that it will potentially appear to the patient as being too clever (James, 1985; Rees, 1995b). In fairness to Langs, it must be said that his communicative interpretations are much more explicit and incorporate the elements of the patient's manifest content more fully than Grotstein (1984) gives him credit for (in his example), and hence would be less open to Grotstein's charge of invoking envy in the patient towards the therapist's ability to concoct brilliant and incomprehensible (to the patient) interpretations.

Freud (1913) emphasises the importance of waiting for a proper rapport or positive transference to develop with the patient before making interpretations. Freud puts it thus:

It remains the first aim of the treatment to attach him to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was accustomed to be treated with affection. It is certainly possible to forfeit this first success if from the start one takes up any standpoint other than one of sympathetic understanding. (ibid. p139).

Freud seems to be saying that one has to initially draw the patient into coming to therapy by sympathetic understanding and that the transference, which is an important component of Freud's methodology, will develop from this beginning. Without becoming enmeshed in the voluminous debate around transference, the working relationship or working alliance and the existence of the real relationship between patient and analyst, it is apparent that Freud is acknowledging, and this would seem to be common sense, that at the very least, there has to exist some kind of harmony or unity of purpose between therapist and patient if therapy is to proceed at all.

This presents a methodological and technical problem for novice communicative therapists. Part of showing ones concern and sympathetic understanding of a patient is to ask questions sympathetically regarding aspects of the patient's story that are not clear or that require amplification. Failure to do this could come across as lack of interest. However, in Langs's methodology, the nearest thing to a question that is allowed is the playing back of selected derivatives, when an adaptive context is not clear to the therapist. Langs (1979) remarks that active questioning has the disadvantage of moving the patient to the surface of his or her thoughts, puts the emphasis on manifest content and prevents derivative communication. Langs's disenchantment with questions extends to the issue of whether or not to take a detailed history prior to beginning the therapy and he argues that it is not necessary and on the contrary he contends that "the pursuit of such historical facts creates a type of bipersonal field in which symbolic communication and illusion are impaired" (ibid. p113).

There is no doubt that arbitrary questions represent the agenda of the person asking the question rather than the person free associating. Thus questions such as "tell me about your mother?", or "tell me about your childhood?", asked at any arbitrary moment in the therapy is

more an indication of what is seen as important by the therapist asking the question than what is necessarily going on with the patient. Similarly relentless questioning of a patient can defeat the object of trying to obtain derivative material, or an insight into the patient's unconscious processes, and sometimes may even defeat the object of obtaining any information, conscious or unconscious from patients. Silverstein (1984) reminds us that questions convey a lack of neutrality towards the material, that they can be used manipulatively by redirecting the flow of the patient's material, and that they direct attention away from the latent material. An example from therapy with Nerina (Appendix 12) is illustrative of questioning that detracts from the potential of the therapy to deliver up derivative material.

Clinical Vignette: Nerina session 3

- P Probably she would just say that she would not take me there.
 T So she wouldn't help you?
 P No..... I don't think so.
 T Perhaps if she is very angry she wouldn't want to help you.
 P
 T And then what would happen?
 P I'd probably just take it to work and he would fetch it there.
 T And how would that be? Would that be okay?
 P Nods.....
 T How has work been?
 P It's been okay, we just have a lot of pressure coming up next week.
 T So last week and this week was fine?
 P Nods.....
 T Nerina it is important to let Z know how you feel, its hard to do.
 P Nods.
 T Maybe that's something we can talk about here, why its hard to do.
 P I don't like speaking to her because then she gets upset.
 T And if she gets upset then what might happen?
 P She gets very upset and sarcastic with me and I think she will then leave me.
 T If you upset her too much...
 P Yes

It must be emphasised that there is an interactional element to this difficulty in obtaining material from the patient (see section 6.12 above). The patient has had experiences of previous therapists 'abandoning' her and for this and other reasons provides a daunting challenge to the therapist to penetrate and understand her resistance to the therapy and to make sense of what little material is available in the session. At the same time the therapist contributes to the malaise that is the therapy at this point, largely as a result of trying too hard

to obtain conscious information. The vignette illustrates the intrusive nature of questions and their potential for blocking derivative material from the patient. Other clear examples of this potential of questions to prevent derivative material from emerging are to be found in nearly all of the sessions examined in this study but perhaps particularly at the beginning of the session with Lala (see section 6.2) and also with Mary session 1 (see section 6.9). Lala's therapist, at the very beginning of the session, steered the patient's narrative firmly into the manifest mode by asking direct questions about where the patient was working and what sort of work she was doing. Consequently the patient's subsequent derivative complaint about superficial conversations was understandable and predictable. Mary's therapist used many questions in this first session of therapy partly as a strategy of avoiding a regression on the part of what was perceived to be a disturbed patient.

However, in psychotherapy not all questions are necessarily of an intrusive nature. What is it that defines a question? A question is simply a request for information and, in certain contexts, a quizzical look, a raised eyebrow, or even sometimes a kind of grunt,¹² is a question. The 'playing back of selective derivatives' as a specific technique which is sanctioned by Langs, is a request for information and hence a form of question which does not interfere with the patient's process. However, whether one can make such a sharp distinction between interventions is at issue here. For example if a patient brings up the death of his or her father in therapy and does not say anything more about it and the therapist feels that it would be important to know about this, it is a simple matter to make a brief intervention, or rather to comment about the fact that the patient has merely mentioned it without going into any great detail. This intervention is partially a question (one wants more information) partially an interpretation (it is in the form of a comment about the patient's lack of elaboration) partially a clarification (one is partially clarifying something for the patient about his or her lack of expression of feelings) and partially a playing back of selected derivatives. The point is that there is no clear cut distinction between interventions, which necessarily, occasionally blend into one another. To labour the point, having an injunction against questions in therapy carries the danger of misunderstanding on the part of inexperienced therapists. Neophyte communicative therapists will have the tendency of

¹² Regarding the use of non-verbal communication in analysis, Forrester (1990) comments astutely "Indeed, there is no doubt that analysts have converted the grunt into a delicate and nuanced instrument of communication" (ibid. p173).

adopting the rule about questions and not asking them, rather than entering into the spirit of the Langsian injunction which is to not intrude oneself onto the patient's flow of associations by asking intrusive questions and to remain neutral with respect to the material that is brought to therapy by the patient.¹³

Dorpat (1984b) in a review of the sparse literature on the use of questions as a psychoanalytic and psychotherapeutic technique, remarks that there have been no systematic studies of the frequency with which questions are used as an intervention but concludes, from his reading of the literature and from his informal study of the therapists that he has supervised, that questions are the most commonly used intervention in psychoanalysis and psychoanalytic psychotherapy. It is of note that Dorpat's speculation about the frequency of questions in relation to other interventions was borne out by the current study in that questions constituted by far the most frequent intervention (see section 6.14 above). Dorpat concurs with Langs and maintains that all questions tend to have a stifling effect on the patient's capacities for free association and symbolic communication, and shift the patient's attention from aspects of their story that they consider to be important onto issues that the therapist queries. Dorpat maintains that "questioning serves as a convenient means by which therapists can exert some control over the experience, communication and responses of the patient" (ibid. p70). He gives the example from his own earlier work of how the specific technique of questioning was used by him in one particular session as an unconscious device designed to reverse the patient's regression in the therapy, to block her disturbing mode of communication, and to substitute a more rational mode of discourse (ibid.). This example of the specific use of questions as a method for regulating the patient's type of communication and for preventing a regression in the therapy is echoed in Mary session 1 (see Appendix 2 and section 6.2) where the therapist employed many questions in the session in an attempt to keep the patient's discourse at a surface level, which was prompted by a concern that the patient was not suitable for an exploratory mode of therapy and would regress if offered this mode.

A relentless focus on underlying unconscious material creates an intensity in the therapeutic situation that is potentially dangerous. Langs (1984) concedes that this is perceived as

¹³ It is clear that this neutrality with respect to the material from the patient is a prerequisite for conducting psychoanalysis or exploratory therapy, although a case could be made for a lack of neutrality in supportive therapy (see Dewald, 1994).

dangerous by therapists as well as patients and that this is why mutative interpretations (Strachey, 1934) and correct well timed interpretations are so seldom made, and when they are made, are likely to be followed by interpretive work that is of a lesser standard (Langs, 1984). Material is unconscious for a reason and the relentless exposure of this unconscious material in a therapy session is going to be a harrowing experience for therapist and patient, particularly in the beginning stages of therapy. Focusing occasionally on manifest issues in a sympathetic way could also be seen as diluting the dangerous intensity in the therapeutic setting. The occasional sympathetically understanding murmur or even comment or question, following some disclosures by a patient, should not necessarily be seen as a frame-deviant, non-neutral focusing on manifest content, they are part of what 'oils the machine' of therapy, as it were, in that they can be used to decrease the intensity of the therapy experience where considered necessary. However it would appear to be important for the therapist to be fully aware of the capacity of these interventions, namely questions, clarifications and comments, to dilute the intensity of the therapeutic interaction. It would be important then for therapists to use the property of these interventions rationally and sparingly and with complete awareness as to the reasons for their use at any particular moment in the therapy.

7.6 THE HOLDING AND CONTAINING FUNCTION OF THE SECURE FRAME

The ground rules of therapy are designed to provide stability and continuity for patients in order that their neuroses may be laid bare and examined against this backdrop of stability (Langs, 1982, 1988). This well secured framework provides a 'holding' relationship (Winnicott, 1956, 1971, 1972, 1978) and a 'containment' (Bion, 1959, 1962) for the patient. For Winnicott the concept of holding describes a parental, caretaking function and this caretaking function serves as an analogy for the therapy attitude. While Winnicott seems to confine the focus of the holding to specific ontological or existential fears in the infant and the patient, holding would also have a broader function and could be seen as containing any powerful affect. The patient (or infant) sees in the face of the therapist (or mother) the calm stillness that he or she needs to become more in touch with, and to develop his or her own calm centre. This is more than simply a form of imitation but involves introjection and identification in that the patient/infant introjects an aspect of the therapist/mother. The concept of holding is similar to the concept of the 'container' in the therapeutic relationship.

Although the concept of the container has been used by Bion in a more technical sense (Bion, 1959, 1962), in its less technical sense it implies the conveying (not necessarily in a verbal manner) by the therapist that the patient's deepest fears have been understood and they have not damaged or frightened the therapist. The therapist has experienced something of the patient's deepest fears, he has survived this experience and he is still available to the patient. The patient, through a process of identification and introjection can take in some of this attitude. Modell (1976) describes research carried out in London during the second world war that showed that infants remained calm and were less affected emotionally by the externally dangerous situations if their mothers remained calm. On the other hand caregivers who showed their fear affected the children negatively regardless of the extent of the actual danger. It is almost as if children need to read the situation from what is reflected in the face of the caregiver. This is, in itself, unremarkable but spelled out in simple terms it does mean that if a therapist is uncontained then he or she will have difficulty in meeting the needs for containment of his or her patients. The ground rules of therapy provide then a necessary, but perhaps not entirely sufficient, structure for the containment of the patient and also for the therapist.

'Containing' also has the implication of being a kind of repository for the patient's overwhelming feelings and it is more in this sense that it is used by Bion (1962). Britton (1992) describes the 'container' aspect of the container/contained as being similar to a sanctuary, being in a safe place or inside something good and he likens this to Winnicott's idea of being held in therapy (p103). He maintains that "the analytic situation could be described as endeavouring to provide both of these - a bounded world (the container) where meaning can be found (the contained)" (p104). While Bion believes there is a need for a 'containing' function in therapy he also gives examples of patients in analysis who cannot tolerate the containment and, due to their primary aggression and envy, attempt to destroy the containment that is provided by the therapist (Bion, 1959).

It is on this point that Bion, Winnicott, and Langs seem to part ways, seeing fundamentally different concepts of aggression and different reasons for the 'attacks' on the therapist and the therapy. Following Klein, Bion (1959) sees this aggression as primary, and the early use of

projective identification as the prototype of an aggressive object relation. For Bion this has its equivalent in the patient's attack on the calm stillness of the therapist.

Winnicott (1971, 1978) on the other hand sees the aggression as a therapeutically useful sign of the ability of the patient to begin to 'use' the therapist. Modell (1976) following Winnicott maintains for example that the narcissistic patient's rage in the transference at the analyst's failures, real or imagined, comes as a therapeutically necessary development and replacement for their lack of affective response in the transference (*ibid.*). Thus for Winnicott the patient's ability to experience and express rage and any other strong affect is a sound development and can be used in the transference.

Bion's observations of the patient's attacks on the 'calm stillness' of the analyst has its equivalent in Langs's concept of the attacks by certain patients on the secure frame. Langs (1982) maintains that the secure frame can be threatening because it limits the patient's opportunities for flight, denial and defensiveness and these limits bring them up against the limits of life itself thus leading to the experience of death anxiety in relation to the secure frame. Smith (1991a) explains this concept of secure frame anxiety cogently and succinctly:

Although this phenomenon is not yet well understood, a plausible explanation seems to be that the secure frame universally symbolizes the limitations of human existence, the inexorable constraints of time and death imposed by nature which throw us back on an awareness of our own fragile mortality. In Jaspers's (1986) terminology the secure frame provides a 'limit situation', an experience of finality which if accepted honestly rather than denied, can have a tremendously constructive existential impact. (*ibid.* p189)

As a way of avoiding this confrontation with the existence of the ultimate reality and ultimate finality of death, patients are tempted into relating to the therapist and the therapy frame in ways that would help them deny their dread. Breaks in the ground rules of therapy and in the framework then become small but important triumphs, but ultimately futile triumphs, against this dreadful and painful realisation of the reality of death. Langs (1982, 1988) points out that the threatening aspects of the secure framework also apply to therapists and there are many countertransferential reasons for therapists attempting to deviate from the secure frame.

For Langs (1982, 1988) then the secure frame is the only means through which therapy of a profound and durable nature can occur. It provides the background of stability and continuity against which the patient's problems can be safely and successfully explored. One of the greatest threats to this stability and continuity is clearly the actual premature termination of the therapy or the handing over of the therapy on the part of the therapist, for whatever reason.

7.6.1 The continuity of the therapeutic relationship

Nearly all of the patients in the current survey were handed over for therapy at some point or another. The only exception to this was Shariah (Appendix 13). This handing over was accomplished with varying degrees of sensitivity and adroitness on the part of the therapists. This common hazard for patients at Lentegeur hospital needs to be understood in terms of the effect it has them. Therapy with Monica (Appendix 8 and section 6.8) was instructive in this regard. Monica had been handed over for therapy previously, to her current therapist, and was facing the possibility of being handed over again on the completion of the latter's training placement. This eventuality was brought home to the patient suddenly and prematurely and, as it turned out, erroneously, by an encounter with the reception clerk prior to the session. The threat to the continuity of her therapy clearly and dramatically coloured her productions in the therapy session, leading her to be preoccupied with themes of abandonment, rejection and being not involved with someone (themes 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 21, and 44). Monica was not able to actually raise the issue directly and consciously for the major part of the session but at the end of the session there was a direct allusion, on her part, to this important break in the frame. This manifest allusion lends strong support, according to the theory of communicative psychotherapy (see Langs, 1982, 1988 and see section 4.4.6.4 above), to the interpretation of the foregoing thematic material, as having direct relevance to the patient's perception of the therapist's pending abandonment and rejection of her. It would be very easy, as a therapist, to get caught up with this manifest material and to offer a kind of grief therapy approach to the patient, whilst missing the clear and legitimate underlying concern of the patient. One of the therapist's interpretations in the session deals with this material in this fashion (see Appendix 8 and section 7.2.5 above) when the therapist comments on the patient's positive qualities. While the therapist's comment might be true in itself it clearly misses the most important element of

what the patient is actually communicating to the therapist. In accord with communicative psychotherapy predictions, the therapist's intervention receives very specific, unequivocal derivative disconfirmation from the patient (see section 7.2.5 above).

In the institutional context the question of handing over patients for therapy is also particularly relevant when it comes to deciding on the best course of action in the context of the therapy ward with its requirements for the taking of the patients' detailed history and the presentation of their cases in the ward round. Given this requirement, and given that exploratory therapy is indicated for a particular patient, is it better to have the patient handed over for this exploratory psychotherapy by the person who does the original assessment for treatment, or should the person who laboriously takes this detailed history continue with the exploratory therapy? This study cannot answer this question in any definitive way but it does point to some of the issues around the problem and gives an indication of a solution. Langs argues for the continuity of the therapist, and with good reason, but he is clearly not referring to the sustained, detailed inquiry that characterises the psychiatric history taking in the institutional context. This type of interrogation involves many and varied questions and sets the tone for the subsequent relationship with the patient, making it difficult to adopt a more passive, exploratory stance towards the patient at a later stage. Langs (1979) recognises the detrimental effect that the process of taking a history has on a patient's subsequent therapy (if conducted by the person taking the history) in that he considers that a particular type of bipersonal field is created in which symbolic communication and illusions are impaired (*ibid.* p112). The paucity of derivative material with Shariah (Appendix 13 and section 6.13 above) gives some weight to this. Shariah's therapist, as well as being the person who took a detailed history, subsequently continued to see her for therapy and decided to adopt a supportive mode of therapy, finding it more appropriate in the circumstances.

Nerina (Appendix 12 and section 6.12 above) on the other hand had not been formally assessed by her current therapist but had previously been handed over for therapy *four* times. When her current therapist adopted a more supportive role, without listening to the interactional aspects of the patient's productions, she was not in a position to comprehend or interpret the patient's gross behavioural and communicative resistance at an interactional level, and the result was an impoverished session, painfully difficult for the therapist (see

vignette in section 7.5 above). Adopting a more exploratory approach and paying some attention to the interactional nature of the patient's communications would have gone some way in alleviating the therapist's feelings of frustration in the session at the patient's apparent reluctance to use therapy, and would have gone a long way to opening up avenues of understanding into what the patient was in fact communicating in the session, even in her limited and impoverished way.

Sessions with Mary are also of interest in this context. Mary (Appendix 2) was handed over for therapy twice, in chaotic circumstances on the ward. The therapist, after initially being very active and asking many questions in the first session, attempted to adopt a more passive, exploratory approach endeavouring to listen to the patient's unconscious material. This resulted in a richer account from the patient with more meaningful derivative material even though the therapist's understanding was not communicated to the patient in clear, accurate, communicative interventions. The production of derivative material improved over the five sessions examined here as a function of the improvement of the framework of therapy. It would appear then that, in these circumstances it is important to adopt a stance towards the patient which would enable one to 'hear' what is being communicated. In addition it would appear that if the more active initial assessment, as occurs in the institutional context, leads to the therapist's difficulty with adopting a more passive, listening approach to the patient then the patient should be referred on for therapy to a new therapist who would be able to adopt this listening approach. Thus it would appear that it would be more appropriate for therapists to not themselves take a detailed psychiatric history from patient's. If this detailed psychiatric history is required, as for example in the ward context, then it would seem that it would be more appropriate to separate this task from the task of doing exploratory therapy with the patient, if the latter is indicated for the patient.

7.6.2 The rigid maintenance of the ground rules of therapy

Langs himself points out that both Freud and Winnicott were preoccupied with the setting or the frame of therapy and advocated certain rules to achieve this holding environment and yet paradoxically, both Freud and Winnicott deviated considerably from these established rules in their actual *practice* (Haynal, 1988; Lipton, 1977; Mogliano, 1987; Siegelman, 1984; Thompson, 1994). Freud (1913) is at pains to indicate that his recommendations to

physicians are just that, *recommendations*, and they are not absolute rules that have to be followed in a mechanical fashion. He states:

The extraordinary diversity of the psychical constellations concerned, the plasticity of all mental processes and the wealth of determining factors oppose any mechanisation of the technique; and they bring it about that a course of action that is as a rule justified may at times prove ineffective, whilst one that is usually mistaken may once in a while lead to the desired end. These circumstances, however, do not prevent us from laying down a procedure for the physician which is effective on the average. (ibid. p123)

Freud and Winnicott had the strength and the wisdom to rely on their intuition and to bend the rules when the situation demanded it.¹⁴ The neophyte therapist or one new to the communicative paradigm could mistakenly be too rigid in the interpretation of Langs's injunctions regarding interventions (see Grotstein, 1984 and also section 7.5 above). The consequences, particularly if this occurs early in the therapy, before a proper working relationship has been established, are that the patient will not complete the therapy and will drop out of the treatment because of the perceived aridity of the therapeutic environment. This would seem to apply particularly to patients who have been diagnosed as having a narcissistic personality disorder or narcissistic personality traits (Chessick, 1985; Kohut, 1972, 1977; Wolf, 1988) who would be predicted to be much more sensitive to an austere therapeutic environment constituted by a therapist maintaining a rigidly secure frame. Wolf (1988) remarks that these patients who experience their analysts as uncaring will drop out of treatment. Lindon's (1994) point about the value of 'optimal provisions' (see section 3.4.7 and section 7.4.3 above) would be particularly applicable with regard to these kinds of patients. Chessick (1985) contends that:

The analytic ambience, based on the therapist's reasonable, humane, tactful, nonhumiliating attitude, facilitates the process of psychoanalysis and psychoanalytic psychotherapy and has a soothing effect that can also be interpreted. (ibid. p192)

Thus the correct ambience can highlight the patient's need for soothing and for gratification and this can in turn be interpreted. Chessick (1985) makes the point that 'interpretation' rather than 'gratification' is the rule in analysis. However Chessick observes that occasionally, what he terms a 'reluctant compliance' with patient demands is necessary to avoid a cold,

¹⁴ The communicative methodology quite rightly requires that one looks for the validation or non-validation of one's interventions in the form of the patient's derivative material following any such framework deviations.

critical, unaccepting ambience which will disrupt the treatment of patients, especially patients suffering from 'preoedipal' disorders, and will result in an iatrogenic narcissistic withdrawal on the part of these patients (ibid. p191). The issue, as summarised by Chessick, is really whether the 'classical' psychoanalytic stance interferes with the analytic process through fostering a non-responsiveness on the part of these therapists or, on the other hand, whether the empathic stance of self psychologists interferes with the analysis through a contamination of the transference. Wolf (1988) in an attempt at reconciliation of various approaches to the question of therapeutic ambience, contends that the issue has more to do with values of the therapist than actual theories. This certainly appears to have some element of truth when one examines Langs's acknowledgement of the need to occasionally gratify the needs and demands of some of the more severely disturbed patients.

Langs acknowledges that there are times when it is necessary to temporarily modify the ground rules but these are exceptional circumstances with severely disordered patients almost exclusively and they occur in the context of a well secured frame which has been extensively tested out by the patient. Langs (1978b), in a passage reminiscent of the work of Winnicott, has it that:

....under rare circumstances, such as those seen with patients who have experienced early life-threatening traumas, the patient may regress to the point where he works through his suicidal and homicidal fantasies and impulses, and inherently demands of the analyst specific and limited modifications in the framework. These parameters appear to be sought as a means of concretely conveying to the patient the analyst's deep commitment to his survival, thereby enabling the analysand to modify his malignant and destructive introjects and to work toward a reintegration of his personality. Such emergency modifications of the framework should be minimal, should be extremely rare, and should be comprehensible in terms of the severe psychopathology and traumatization of the patient; they should, in addition, be rectified and analyzed with the patient as soon as he begins to emerge from his severely regressed state. (p303)

Langs (1982) is clearly aware that certain kinds of patients cannot use the rigidity of the framework but he remains insistent that the secure framework should in all instances be attempted and only after this approach has clearly not worked can a reluctant decision be made to alter the minimum specific ground rules in the face of insistent manifest demands on the part of a severely disordered patient. Langs insists that the alteration to the ground rules should be supplemented by interpretive work that reveals the 'destructive' nature of the compromise to the ground rules. Ultimately the aim is to institute a rectification of the break

in the ground rules if the patient's derivative material permits (*ibid.* p712). Langs is emphatic that the best approach to patients, even severely disordered patients, is adherence to the ground rules to the greatest extent possible and these should be altered only with great reluctance in the face of unmistakable evidence of the patient's flight from therapy.

Smith (1991a) concedes that there are certain patients who cannot benefit from the communicative approach. These so-called frame-sensitive patients are usually those who have been subjected to severe trauma in early life. Smith (1991a) remarks that one of the reasons that Langs has given up his private practice in favour of full time research is to "create new and benign forms of psychotherapy appropriate for the treatment of frame-sensitive patients" (p190).

Baranger (1993) makes the point that listening to manifest content has more to do with counselling than to do with psychoanalysis or communicative psychotherapy. Langs also emphasises that this form of listening has its place and that counselling situations exist and are useful. It might be added, particularly so in the institutional context. Langs (1988) distinguishes counselling from psychotherapy and this distinction, based as it is on the distinction between manifest and latent content is clearly important with certain kinds of patients, particularly those who have recently been exposed to severe trauma, such as for example being recently raped. These patients are in need of much more validation of their manifest productions (Miller, 1981, 1983, 1984; Davies, 1996) than can possibly be provided by exploratory psychotherapy or psychoanalysis and consequently they would need to receive counselling related specifically to the recent severely traumatic events that have been experienced by them (Rees, 1994). In the current study none of the patients fitted this specific criterion of needing to be referred for counselling because of the occurrence of recent severely traumatic events (see Appendices 2-13 background information, and section 4.4 above).

Knowledge of the rules regarding the provision of a secure framework is necessary for the containment in therapy but is not sufficient. Something more is needed and, as Winnicott has argued, the security provided by this framework is not simply a function of the physical arrangements but is mainly provided by the psychological containment in the form of the

presence of the well functioning therapist, analogous to the child in the presence of the mother (Winnicott, 1972; Rees, 1995b). It is not simply a matter of a therapist mastering some techniques and applying them relentlessly that will provide a safe containing environment for therapy, it is a more important matter of the therapist himself having grown sufficiently, or being sufficiently, strong to provide the containment for therapy and this is perhaps partially what Freud (1912b) meant when he advocated 'psycho-analytic purification' for potential psychoanalysts. Romanyshyn (September 1995, personal communication) puts the point succinctly thus: "To be a therapist one must be a character and one must have character". There is a sense in which being a character and having character is intricately related to having ego strength; the sort of ego strength that would go a long way to providing the introjectable human qualities (Langs, 1982, 1988) that are so necessary for cure in the therapy room; the sort of ego strength that would enable the therapist to be calmly aware of his or her own countertransference issues and to not allow them to intrude into the therapy space unduly, and when they do intrude to be able to rectify the intrusion and to learn from the patient's unconscious supervision (Casement, 1985, 1990) without burdening the patient with his or her own problems; the sort of ego strength that would allow the therapist to provide the containment (Bion, 1959, 1962) for the patient in the form of being able to listen to the patient's deepest fears without being overwhelmed by these fears (Model, 1976), to understand and withstand the patient's aggressive attacks without needing to retaliate (Winnicott, 1972) and to allow the patient's subsequent 'use' of the therapist (Winnicott, 1956, 1971, 1972). This point is recognised by Langs (1978b) and Smith (1991a) but is not sufficiently stressed by them. It is something that needs to be laboured because of the potential for misunderstanding on the part of neophyte therapists that strict adherence to the clearly defined ground rules is providing all that is necessary by way of introjectable qualities in the therapy room.

There is the sense then that it is not the actual ground rules that are imperative but the response on the part of the therapist to the impingements to the frame and the way the therapist attempts to maintain the frame in the face of those impingements that will bring out his or her introjectable human qualities. It seems clear from the evidence discussed in section 7.2.2 which deals with the important ground rule relating to privacy and confidentiality that if the modifications to the frame are proposed by the therapist,

countertransferentially, for defensive or other purposes, then the damage to the therapy will be far greater than if the ground rule deviations are beyond the control of the therapist and are objectionable to him or her. Given that the maintenance of this specific ground rule is the most problematic in the institutional context (see section 5.3) then this is an important finding for the possibility of doing useful therapy in the institutional context. This line of thinking would see functional therapy being practised in an institutional context if the therapist had the right attitude to the framework of therapy, despite the institutional deviations to the ground rules. How the therapist responds to the framework deviations are more important in this sense then, than what the deviations actually are. Langs (1988) discusses this issue in terms of his proposition that the deviations to the framework are an expression of the psychopathology of the therapist, which expressions then become the central issue for the patient. Clearly then if the therapist is opposed to the deviation to the framework, and the deviation is something that is being imposed on the therapist and the therapy by, say, the unyielding administrative requirements of the institution, then this cannot be seen as an expression of the therapist's pathology and will be of less concern to the patient unconsciously than if the deviation had been initiated by the therapist for selfish or for countertransference reasons (ibid. p146).

An important feature of the communicative approach to therapy is its built in consideration for the patient. If the therapist is listening well to the patient and respecting the patient's unconscious perception of the therapy and doing something about these perceptions, then this is profoundly respectful of the patient. It is this profound respect for the patient that is implied by a secure frame, and by the therapist's attempts to maintain this secure frame that provides the introjectable qualities in the therapy, not the actualities of whether or not there have been deviations. It is not the rigidity of the secure frame, the iron clad security of an absolutely secure frame that is so important but the way the therapist goes about handling the *inevitable* impingements to this framework that provides a model of sanity and a containing presence to the patient. If the therapist, firmly, politely, and sensitively declines the request for a modification to the frame then this is, at the very least, in behavioural terms a model for the patient's healthy future behaviour and in psychoanalytic terms the therapist provides a strong and firm figure with which the patient can identify. Over the course of the therapy the strength of this 'good object' in the form of the therapist is able to be introjected by the

patient. Examples of the introjection of and identification with the well functioning therapist were not readily apparent in the current study but a specific example, provided for purposes of illustration only, is given from similar circumstances to those pertaining to this study. In this example taken from a previous work (Rees, 1996) it is illustrated how the patients' circumstances could be used as a defensive manoeuvre to avoid looking at issues in themselves, to unconsciously sabotage the therapy or to force the therapist into a gratifying but untherapeutic position in relation to themselves. It was observed that, in this regard hospital outpatients are no different from other patients, even if their strategies may sometimes differ. In this instance it was found that consistent maintenance of the framework of therapy on the part of the therapist provided the patient with introjectable qualities that were useful in dealing with the issues in her own life. The example concerned a young married woman with two young children who was literally being driven psychotic by her husband (who refused to come in for therapy) and who somehow found a way to stand up to his impossible behaviour through an identification with the therapist. This process of identification was helped by the therapist being a model of consistency within the context of the frame of therapy but without being rigid and inflexible. The frame of therapy was tested many times by the patient who initially had some trouble relating to a relatively passive therapist in the face of the chaos that her life had become and the relatively active role that her husband seemed to be playing in maintaining this chaotic state. She came late once, arrived once on the wrong day, stayed away from therapy for three weeks and on one occasion arrived for therapy with a young active child, pleading the lack of a baby sitter. These disruptions to therapy were dealt with in a sympathetic way without resorting to interpretations and without resorting to breaking the frame in order to accommodate her. It was simply pointed out to her how they were actually harmful to her therapy and thus to herself in the long run. She was able to integrate this stance on the part of the therapist with her therapy, in a way that enabled her to adopt a similar firm, consistent attitude to her husband forcing him to look at his own behaviour and its impact on their lives with the result that he sought therapy of his own. There are similarities to therapy with Mary (see Appendices 2-6 and sections 6.2 - 6.6) but also, important differences in that, in Mary's therapy the chaos around the framework was initially caused by the therapists involved and the tightening up of the framework would not necessarily have given rise to the same degree of possibilities for identification and introjection as in the example given above. This would

however be predicted to possibly be a feature of future sessions with Mary if the therapist maintained a consistent stance towards her.

By maintaining a sympathetic but therapeutic stance at all times and maintaining as far as possible the frame of therapy, the therapist will be more helpful to the patient in the long run than if he abandons the therapeutic frame altogether. Quinodoz (1993) puts the point well when she observes that some patients, in an unconscious expression of their greed and envy, attempt to take everything from the therapist including the very ability, bound up in the containing framework, that would allow the therapist to function properly and so ultimately to help the patient. Quinodoz contends that the patient's pressures on the analyst to abandon aspects of the ground rules can sometimes be interpreted as "unconscious attacks on the creative container function of the analyst and on that of the patient himself" (p634) and she regards it as important that the therapist demonstrate to the patient that he or she will not be undermined in this fashion, a stance which is respectful of the therapist and ultimately of the patient. It is this quality of real respect for patients that is often lacking in psychiatric institutions. Coupled with this is the lack of respect for psychotherapy that is frequently in evidence at psychiatric hospitals (McCleary, 1992 and section 5.2.12 above). The reasons for this are multifaceted and partly due to the lack of proper training and poor standards of practice of psychotherapy in institutional contexts.

It would seem that abstinence has an important function in therapy in a hospital context but it has to be tempered by an attitude of essential caring for the patient. Stone (1981) remarks that the attitude of essential austerity in relation to the patient on the part of the therapist performs an essential function in the therapeutic process but then carefully warns against an excess of this austerity. For Stone there can be no analysis without 'abstinence' but he is quick to point out that this must not be equated with "coldness, aloofness, arbitrary withholding, callousness, detachment, ritualization or panicky adherence to rules for their own sake" (p100).

Stone's point seems to be very reasonable, and it is a point that has been made by many other theorists if not quite as elegantly. As therapist one has to display a certain 'reserve' towards patients in order to separate out the therapeutic conversation from the social conversation.

McCurdy (1985) observes that this analytic 'reserve' does not mean cold and withdrawn. Other analysts have echoed this point and added the recognition that while a certain amount of ritual is necessary in the therapy space, unthinking ritualisation has its dangers. The logic of Lacan's shortened sessions¹⁵ appears to be bound up with his thoughts on the need to move away from the obsessive need for ritual observed by the establishment analysts. Lacan (1977) observes:

A technique is being handed on in a cheerless manner, reticent to the point of opacity, a manner that seems terrified of any attempt to let in the fresh air of criticism. It has in fact assumed the air of a formalism pushed to such ceremonial lengths that one might well wonder whether it does not bear the same similarity to obsessional neurosis that Freud so convincingly defined in the observance, if not in the genesis, of religious rites. (ibid. p37)

Forrester (1990) reminds us that Lacan's attempts at shortening sessions functioned also as part of a broader conception of 'punctuation' of the analysand's productions in therapy. This concept of punctuation, Forrester argues, meshes with the view of the analyst as a "commentator, writing in the margin of the patient's text" (ibid. p173). But Forester criticises this non-verbal commentary on, and annotation of the "patient's text" pointing out that there are other means of emphasis that are available within the structure of psychoanalysis; methods that involve language and interpretation. Forrester adds cogently:

One might also voice a Lacanian criticism of this Lacanian practice: Why this reticence? Why this unease with the word, with speech, when one might legitimately claim that the analyst is precisely someone whose very existence depends upon his or her ability to find the right word? - though, to be sure, at the right time. But if the analyst is not at ease in the art of conversation, surely something has gone fundamentally astray? (ibid. p173)

Forrester's telling point about the analyst needing to be at ease in the art of conversation, even though it is apparent that in this instance he seems to confuse the requirements of social discourse with therapeutic discourse, relates to the broader point being made about the analyst needing to be a character and to have character; to have grown sufficiently to be able to use the ground rules of therapy, not in a defensive fashion or for countertransference

¹⁵ Lacan's shortened sessions are not carefully explicated by him in any systematic way (Macey, 1988; Forrester, 1990) and one finds short cryptic references to this practice throughout his work.

reasons, but in order to provide a constant, consistent setting for the analysis of the patient's productions in therapy and to separate out the therapeutic relationship from other social relationships and to separate therapeutic discourse from social discourse. Langs (1982) remarks:

The ground rules of psychotherapy, and the basic conditions of the therapeutic relationship, must of necessity have unique qualities that are at variance with the proper hallmarks of social relationships. It is these very distinctive attributes of the therapeutic relationship, however, that are basic to the cure of the patient. (ibid. p438)

The difference between the two forms of discourse is nicely made by Hillman (1983). Arguing for the ritual of the therapy hour and, ironically, in view of his iconoclastic position towards the institutional aspects of practice (Hillman and Ventura, 1993), Hillman recognises the need for a form of framework, within which therapy can occur, in order to separate the therapeutic discourse from the ordinary social discourse (ibid.). Hillman points to the need for a kind of reverence, a seriousness and a gravity of the therapy discourse when he argues for the sanctity of the 'tomb' which is the therapy room. He contends that:

...you have to have ritual because the psyche moves through ritual. I can be downstairs chatting, my wife's seeing a patient, I'm seeing a patient, those two patient's happen to know each other, so and so and so, we're all standing and we are just before our hours: we go up the stairs, my wife takes her person into her room, I take my person into my room, and the conversation is completely different: one enters the room, you've moved through the doorway, we're in another place, you enter the sanctuary, or you've walked through the propylaem, something has happened. The conversation changes. The place is different. I'm not exaggerating it, but it's different; a temenos is established. You must have that framework...I think you can't just do analysis sitting on a park bench: I used to think you could and now I'm not so sure. You can have a good psychological conversation on a park bench, but the sanctuary of the *tomb* is constellated by the analytical room. (ibid. p63)

Although the components of Hillman's framework are not actually specified by him they would appear to be far removed from the rigours of the Langsian framework. Some of the differences are immediately apparent from the passage quoted above. More important however than the exact details of what constitutes Hillman's ground rules for therapy is the important recognition on his part that there needs to be this separation of the therapy, that it needs to be given this space and this sanctity in order to constitute itself as therapy.

On first encountering the work of Langs one is struck by the sureness and certainty that he displays about the importance of the frame.¹⁶ The frame is the most conspicuous and basic component of the communicative paradigm, and it is the element that is most readily implemented by therapists first approaching Langs's opus. Implementing a rigidly secure framework without consideration of the development and implementation of other therapy skills will potentially have disastrous consequences for the therapy. It would appear to be more prudent to err on the side of securing the patient's positive working relationship or positive transference even if this means breaking one or two of the minor ground rules relating to sympathetic interventions and then carefully listening for the validation or non-validation of these interventions. The containing and therapeutic function of therapy cannot be artificially obtained by simply rigidly adhering to rules and techniques.

Discussing the finer points of how rigid a frame to ultimately maintain seems to be acutely ironic in the context of a discussion about the framework of therapy conducted in this institutional context. It is very clear from this study that there are many serious framework deviations in this hospital context (see Chapter 5 and Chapter 6) and these clearly need to be dealt with before one even remotely approaches the problem of a frame that is perhaps too rigid. It is appropriate to delineate, at this point in the discussion, some of the more prominent and serious deviations that were actually encountered in this study. In this study it is apparent that patients are sometimes handed over for therapy several times in a short space of time (Nerina, Mary), therapists run groups with the patients concurrently to the individual therapy (Shariah), and run groups prior to individual therapy (Mary), and do family therapy with their patients at the same time as individual therapy (Grace). There is frequently chaos around the handing over of patients for therapy (Mary) and chaos around the appointment times (Valery). Clerks tariff patients and collect fees from them (Lala, Monica, Nerina, Grace). Clerks make the appointments for patients (Monica, Lala, Nerina) and frequently do not make the appointment at the same time every week (Lala, Nerina). Clerks sometimes interfere drastically in the therapy by giving patients erroneous and disturbing information about the pending termination of their therapy (Monica). In addition there is a lack of a private waiting area for patients, patients are seen concurrently for medication by doctors and

¹⁶ Casement (1990) remarks that it was this dogmatic sureness that first attracted him to Langs's work and he now recognises this as being an earlier manifestation of a regressive need for certainty.

there is a general lack of privacy and confidentiality in the therapy with files being kept on patients in a central area. This study has shown that these are not minor deviations to some arbitrary rules but serious deviations to crucial ground rules that have major implications for the experience of therapy for the patient. It is clear that the patients in this study respond to these deviations in ways that indicate their unconscious concern with the deviations (see section 7.2). These deviations clearly need to be rectified before one can even begin to talk about the problems of a rigid framework and the degree of rigidity that should be tolerated in an institutional context. However, given that it is recognised that these serious deviations to the ground rules in this hospital context should be rectified, and that it is clearly possible to rectify them in this institutional context (see Chapter 5) the question remains as to how far one does go in their rectification. There is no simple answer to this question. The point is that it depends on the patient, the therapist and what is happening in the therapy space between the therapist and patient at any one time. This does not mean that anything is acceptable in the framework, depending on the whims of the therapist at that particular moment. It simply means that the communicative therapy framework and ground rules provide a basic structure that is essentially to be adhered to but that might need to be altered from time to time if necessary and with complete regard for the consequences, within the patient's material, of any alteration to that structure. This is a point that is conceded by Langs (1982). But any alterations would be in the at the request of the patient and will be in terms of the patients need rather than in response their desire (Grotstein, 1994).

This attitude of essential caring on the part of the therapist is particularly hard to define and it is almost harder to find clear examples that are themselves not open to criticism. The attitude of caring is bound up with the question of the therapeutic ambience and the therapist's stance towards the patient. It is bound up with a genuine concern with the well-being of the patient but without undermining the well-being of the therapist or the therapist's ability to function effectively. It would involve three important components. It would involve creating the space and the opportunity for patients to bring their problems and their issues to therapy, it would involve understanding the patient fully, and it would involve communicating that understanding to the patient in a way and at a time that is ultimately beneficial to the patient. It must be emphasised that this essential attitude of caring on the part of the therapist need not necessarily involve breaks in the ground rules of therapy, but

neither would they involve an adherence to rules simply for the sake of adherence to them. Thus for example a request from the patient to borrow a pen in order to write out a cheque would not be met with the silent waiting for the production of derivative from the patient. This minor and simple request would be granted. The silent waiting for derivative material in this type of situation is a feature of the Langsian framework (see Silverstein, 1984) and would seem to be erroneously harsh and rigid. It seems clear that if one handled a minor request in this manner it would come across as rude and unnecessarily punitive to the patient. It would certainly seem to be erroneously harsh in a therapy conducted in this particular hospital context where framework deviations abound. It is envisaged that other minor breaks in the ground rules of this type would not prove to be detrimental to the therapy and it is contemplated that breaking these types of ground rules, with regard to the necessity for paying attention to the resultant derivative material would enhance the therapy rather than detract from it. The communicative approach to psychotherapy seems to be particularly appropriate for listening to patients and for understanding their productions in therapy, but the dearth of allowable interventions would seem to be problematic, especially in the institutional context.

CHAPTER 8

CONCLUSION

8.1 LIMITATIONS OF THE RESEARCH

Part of the criticism of Langs's methodology is that he focuses too relentlessly on the underlying content to the exclusion of the real manifest issues that are brought to therapy by the sort of patients that are seen in psychiatric clinics and hospitals. Two points are relevant here. Firstly patients, by the very fact of their being patients are likely to have more negative outside relationships and experiences as well as a more detrimental history than the normal population. They are more likely to fill the analytic space with more negative anecdotes than other people thus providing a higher possibility of confirmatory negative derivatives to the interventions of the 'framework deviant' therapists in training whose work Langs relies on for his case examples. The neophyte therapists that Langs quotes at length in his work are, by definition, bound to exhibit many framework deviations in their work. The coexistence of these two phenomena could lead to premature conclusions regarding their causal relatedness or even their connection in any way (Rees, 1995a). This general criticism of Langs's work and work in the communicative realm generally (Smith, 1991a), applies also to some extent to this study.

Apart from this specific criticism of Langs's work which is also discussed in relation to the issue of trauma in Chapter 2 and in section 7.3 above, there is a more subtle difficulty with the use, in this study, of therapists who are relatively inexperienced in the particular techniques of communicative psychotherapy. Although some of the therapists were more experienced than others, none of the therapists in this study were experts in the communicative method of doing therapy. Gill's (1984) comment about the difficulty of implementing the techniques of communicative psychotherapy, even for experienced therapists, proved to be apposite. This meant that the sound communicative interventions were not in evidence in the sessions examined in this study. Thus specific, positive, confirmation of the communicative formulations within the therapy space could not be obtained. Essentially this would have required therapists, well versed in the communicative methodology, to formulate their understanding of the material in the form of an actual interpretation to the patient. The accuracy of this formulation, and its subsequent

embodiment in the expressed interpretation to the patient, would stand or fall on the basis of the patient's response to the interpretation. Thus an important part of the communicative listening process involves subjecting the therapist's interpretations (and hence the therapist's understanding and formulating) to a process of validation based on the patient's unconscious response to the interpretation. This lack of good, well constructed, interpretive work in the study, suitably validated by the derivative material from patients, tended to lessen the generalisation of the findings, and more importantly, to narrow the focus of the study and to lessen the strength of the conclusions that could be drawn. The inferences drawn from the material relating to the breaks in the ground rules, no matter how well argued and extensive this material might be, remain inferences and they cannot be elevated to the status of concrete and indisputable fact. What is clearly needed is to have more experienced therapists, competent in the communicative technique, expose their work to scrutiny as illustrations of good therapy practice. These sessions could be examined for, amongst other things, confirmation, in derivative fashion, of the tightening up of the framework and of the sound communicative interventions of these competent therapists. This scrutiny would provide much needed positive validation of many of Langs's propositions about psychotherapy.

However, despite the difficulty in obtaining examples of sound interpretive work in the realm of communicative psychotherapy, in the literature as well as in this particular study, one can still draw important inferences from the material that was examined in this study particularly in relation to the responses of patients to the ground rule breaks discussed in section 7.2. These inferences will be discussed below in conjunction with proposals for tightening up the framework in this institutional context.

8.2 PROPOSALS FOR TIGHTENING THE FRAMEWORK IN THE INSTITUTIONAL CONTEXT

Langs (1982) remarks that it is ironic that therapists who are starting out in therapy are required to learn their craft in environments that, not only do not provide ideal conditions for the practice of therapy, but are even quite destructive of it (p354). He is referring here to the inpatient or institutional setting where most therapists learn to do therapy. What is also ironic is that this study has shown that the fact of the therapists being in training is also, in

and of itself, a major contributor to the breaks in the ground rules in the institutional context. Thus therapists in training are more likely to be handing over patients for therapy because of their movement at regular intervals between training placements, and are more likely to be needing supervision for therapy. Thus trainees have a specific impact on the general requirement for the continuity of therapy, affecting ground rules 1 and 3 particularly, and all the other ground rules generally. In addition supervision has an impact on ground rule 10 requiring privacy and confidentiality.

One ground rule that stands out in this study as being consistently and almost intractably violated in the institutional context is ground rule 10, requiring a one to one relationship with privacy and confidentiality. This ground rule was consistently broken in a number of different ways in all twelve sessions examined in this study (see sections 5.3.10 and 7.2.2 above). The breaking of this ground rule is almost built in to the institutional context in many different ways (see section 5.3.10), suggesting that it would be difficult, if not impossible to completely eradicate its breach, in this context. It seems clear from the material in the sessions in this study that there are ways to minimise the damage caused by the breach of this ground rule. The most important aspect of maintaining this ground rule would seem to be to keep the 'therapy space' free from intrusions from other people. This would require preventing intrusions from the side of the hospital personnel (see section 5.2.10 above) as well as intrusions which might come about because of a perceived need to do family therapy or couple therapy. It appears, from the material presented in section 7.2.2, that these kinds of intrusions are more likely to be adversely perceived by patients as harmful. If family therapy or couple therapy is at all contemplated for a patient in this institutional context, then it seems clear from the evidence above that it should be carried out by a separate therapist. Given that the patient is referred to another therapist for family therapy or couple therapy whilst still engaged in individual therapy, the patient's productions in the individual therapy should be specifically monitored for commentary on this situation.

Langs (1988) remarks that there is a difference in the framework breaks that cannot be helped by the therapist, or that are forced on the therapist by the work environment in that the patient will perceive these deviations in a less catastrophic light than if the deviations are as a result of circumstances within the power of the therapist (*ibid.* p144). This makes sense if

one looks at the meaning underlying the ground rules of therapy for the patient, the holding and containment that they provide through the display of the introjectable qualities of the therapist, and the sense of security, through stability and continuity, that they deliver. It would appear that this was true for patients in this study in regard to the important issue of privacy and confidentiality (see section 7.2.2). It seems that patients in this institutional context do not react to the ordinary, everyday breaks in privacy and confidentiality that are part of the institutional context but react unequivocally to the breaks that are specifically allowed or engineered by their therapists such as the breaks involved in sessions with Grace, Monica, and Nerina (see sections 6.8, 6.10, and 6.12).

It is apparent that most of the ground rule violations that occur in the hospital context can be avoided with some changes in technique on the part of the therapists (see Chapter 5). Most of the ground rule violations could be said to occur as a matter of choice of technique on the part of the therapist. Only two of the ground rules appear at first sight to be almost intrinsic to the hospital context and these are ground rule 10 mentioned above, and ground rule 2 requiring a single fixed fee, with full responsibility for attendance at all sessions.

It seems from the evidence of this study (see sections 5.2.2 and 7.2.1 above) that the way the fees are charged in the institutional context is intrinsically more in keeping with the spirit of Langs's ground rule 2 than is the case in most private practice settings in this country (Rees, 1995a) and in the United States (see Herron and Welt, 1992) in the sense that once the fee is determined in the hospital context, the patient bears financial responsibility for all sessions attended or not on a monthly basis. However the fee levied in this hospital context would be considerably lower and obviously (even to patients) lower than that of private practitioners in that the patient effectively pays only for one session per month and even this is at a rate lower than the fee charged by private practitioners. The obvious way to minimise the effect of this ground rule deviation, such as it occurs, would be to increase this monthly fee for psychotherapy. This issue is however in the hands of the national and provincial health administration who set the level at which fees are levied for services in government hospitals and as such it does not fall within the powers of individual therapists, or even institutional heads to change the fee structure at hospitals. Consequently changing this ground rule, as it applies in the institutional context, would require considerable effort. Given the small

degree of patient commentary on this point and the fact that the situation as it currently pertains is in the spirit of the Langsian framework, coupled with the fact that many of the patients who make use of the services in the hospital are not well off (Rees, 1993) it does not appear to be appropriate to go to great lengths to attempt to change this ingrained administrative procedure. What does seem important however is that therapists operating in this context, including trainees, are completely aware of the fees policy of the institution and are able to explain this policy to their patients at the beginning of therapy. Thus therapists would be able to make full use of the fortuitous fact that this fees policy, through its requirement of payment for all sessions in a particular month whether attended or not, does coincide with an important aspect of the ground rules and would be able to avoid situations like that applying to Lala (see Appendix 9 and section 6.9) where the patient came less regularly to therapy, erroneously believing that she was saving money.

The techniques for accessing the patient's unconscious, ground rules 4, 5, and 6 (relating to the use of the couch, free association and free floating attention respectively) and the use of the appropriate interventions, ground rule 7 stand squarely as a matter of choice for therapists, whatever the context of therapy. While the use of psychoanalysis would probably not be encouraged in a hospital context with its heavy emphasis on supportive techniques and biological psychiatry, the use of techniques to access the patient's unconscious communications is an important and useful part of exploratory psychotherapy. The use of the couch is not absolutely necessary for the maintenance of ground rule 4 (see section 3.4.4 above) and a regular location within the therapy room would be entirely adequate. Approximations to free association are possible and the attempt on the part of the therapist to carefully listen to the latent content of the patient's communications without intrusion into these productions would go a long way to adequately maintaining ground rules 5 and 6 (see sections 3.4.5 and 3.4.6 above).

The interventions made by the therapist in psychotherapy in any context are generally a function of choice and training and in the institutional context this is no exception. While listening in a communicative way seems relatively uncomplicated, intervening in a satisfactory communicative manner would seem to require a great deal of skill and training (Gill, 1984). This training would be necessary for the implementation of ground rule 7.

Ground rules 8 and 9, the two relationship ground rules, pertaining to therapist anonymity and the absence of a prior, concomitant or post therapy relationship are also more a matter of therapist choice and technique (see sections 3.4.8 and 3.4.9 as well as sections 7.2.7 and 7.2.8 above). A careful attention to these matters, even in the inpatient ward setting of the hospital context could prevent much of the institutional contamination mentioned in sections 5.3.2 and 5.3.8 above. However it is doubtful that the Langsian framework can be adequately maintained in the context of a therapy ward with its many impingements onto the ground rules. It seems that a broader strategy is called for in order to meet the need for an interdisciplinary team approach to treatment in the therapy wards whilst at the same time providing a functional psychotherapy service worthy of the name.

This broader strategy could involve the setting up of a specific and autonomous psychotherapy service, separate from the inpatient therapy wards. It would simply involve locating therapists in a separate building. The infrastructure for such a project is already in place in this particular institution. It should not present too many administrative difficulties and should be a relatively straightforward enterprise requiring only a few administrative details to be put in place. Essentially, this undertaking would allow for the referral of selected patients, both inpatients and outpatients, for psychotherapy, within the context of the hospital. This psychotherapy centre could provide the much needed stability and continuity to patient's psychotherapy, as well as the important attention to the other ground rules which are regularly broken in this hospital context (see section 5.2 and 5.3). Suitable patients could be referred for psychotherapy even while they are inpatients and could then continue to receive psychotherapy from the same therapist when discharged, if necessary. Therapists operating in this psychotherapy centre would not be involved in the psychiatric assessment of the patients on the wards and would also not be involved in the ward activities or in running groups in the ward context. Operating a psychotherapy centre would obviously not preclude other psychologists from working in the ward context and neither would it prevent the rendering of psychological services in other units but it would go some way to allowing for a rational and clearly bounded setting for psychotherapy in the hospital context.

While the referral, specifically for psychotherapy, would be the rationale for this separate psychotherapy centre it would not prevent counselling or even supportive therapy from taking place in the ward context should it be required with certain kinds of patients. Clearly the referral for psychotherapy would involve the handing over of patients, something which has been shown to be both very prevalent in this institutional context and of great concern to patients, if their unconscious communications are to be believed (see Chapter 6 and section 7.6.1). The value of this specific centre for psychotherapy would be that it would, in the long run, minimise the necessity of handing over of patients in the sense that once patients have been referred for psychotherapy they would then remain with their therapists and would not have to be referred from inpatient case managers to outpatient therapists. This would prevent the type of situation developing where Nerina (see Appendix 13) was handed over four times for therapy in the space of a few months and Mary (see Appendix 2) was handed over erroneously to two different therapists. Similarly, it would clearly prevent the situation of dual relationships where therapists run groups and attempt to do exploratory therapy at the same time.

Other strategies would also be necessary to deal with the other structural ground rule breaks in this institutional context insofar as they impact on this psychotherapy centre. A strategy would have to be adopted of educating support staff in the institution about the importance of patient's privacy and confidentiality and of the vital importance of not interfering in any way in the therapy even in seemingly innocuous ways. Therapists operating in the psychotherapy centre would attempt as far as possible, to make their own bookings with patients thus eliminating the need for a bookings clerk. Although a waiting room would be provided for the use of patients in this centre, they would have the option of simply arriving on time for their appointments and thus would not actually need to use this waiting room. Therapists would of course be available to see their patients exactly on time.

The setting up of a psychotherapy centre, whilst going a long way to eliminating some of the more blatant and problematic ground rule breaks would not eliminate all of them and other strategies would also be required. With the necessity to hand patient's over for therapy due to the inevitable movement of therapists in training institutions, two strategies would seem to be suggested to minimise the damage. Firstly it is clear that the movement of therapists and

the handing over of patients for therapy should be kept to an absolute minimum. This might require alterations in the trainee placement strategy of the hospital, particularly in regard to O.P.D. It is a requirement of trainees to rotate through the various placements in order to gain exposure to the various units and currently an intern psychologist rotates through O.P.D. every four months. It would appear that, with a little imagination, the timetable could be rearranged to allow all of the interns to spend a portion of the year continuously at O.P.D. on a roster basis thus allowing them to continue to see their outpatients throughout the year without the necessity to hand them over after four months. This arrangement would not eliminate entirely the necessity for interns to eventually hand over therapy cases, in that internships inevitably come to an end after a year, but it would significantly cut down on this problem. Secondly, it is vital for therapists to be aware of what patients might be saying about being handed over for therapy and to respond appropriately to the underlying message of the patient and hence to at least provide the patient with some kind of validation for their unconscious perception. This second suggestion is one that would naturally apply to all ground rule deviations in that it is vital to actually listen to the patients' unconscious commentary on these violations.

It seems clear that no matter how carefully organised the institutional context, some deviations to the ground rules of therapy will always occur, either as a matter of error, ignorance, or choice on the part of therapists. It seems clear from the literature and from the evidence from this study in a hospital context that any deviations from these ground rules should be carefully thought through, if they are to occur at all, and the patients' productions in therapy carefully monitored for their reactions to these deviations.

From the results of this study it is apparent that despite the many framework breaks in evidence here, there is no intrinsic reason why therapy in this institutional context should not be substantially of a secure frame variety, especially for outpatients (see section 5.3) and for inpatients seen in a psychotherapy centre away from the wards. Even the all pervading lack of privacy and confidentiality can be tightened up considerably without a great deal of effort. The study has shown that some of the more intractable institutional impingements on patient privacy do not appear to receive the expected disapproval in the form of patients' derivative commentary (see section 7.2), whilst the ones that do receive this apparent disapproval are, in

any case relatively easier to change, given the determination to do so on the part of the therapist. All of this bodes well for the possibility of conducting therapy of a substantially secure frame variety in this institutional context. It is doubtful that there can be an absolutely secure frame in any context and even Langs (1982, 1988) acknowledges that there can only be degrees of security of the frame even in non-institutional contexts and the therapist has to be constantly monitoring and rectifying the framework deviations which are thrown up by the countertransference and by the therapists technique, or lack of it, together with the patient's role responsiveness pressure (Sandler, 1976; Troise and Quinn, 1991) and framework deviation pressures (Langs, 1982, 1988) that are placed on the therapist.

Langs (1982) remarks that despite the modifications to the frame that are inevitable in a clinic setting and that prove detrimental to the therapy, it is possible to accomplish something of value in therapy in this context. In this sense then it is not the actual rigidity of the framework that is important but the way that the therapist attempts to implement the ground rules in the face of the impingements. It is the way that the therapist listens to the unconscious derivatives of the patient when the therapy has been impinged on and the ground rules have been broken that conveys the therapist's integrity and consolidates his or her holding and containment of the patient. It is the way that the therapist rectifies the framework deviations and the impression that this gives of the therapist's own capacity to contain the chaos within the patient and within himself or herself that conveys a reason for the patient to hope for his or her own integration as a result of the therapy with this particular therapist. It is the way that the therapist listens for the unconscious derivatives that contain a criticism of the therapy and the therapist's compassionate willingness, without burdening the patient with confessions about his or her shortcomings, to look to this criticism seriously and to take steps to rectify it, that conveys the therapist's profound respect for the patient. All of this can occur within an institutional context.

8.3 CONCLUDING COMMENTS

What is exhilarating about Langs's communicative paradigm is that it brings alive the spirit of discovery in every session of psychotherapy. Even when working with severely disordered patients within a compromised framework there is still the important task of listening to the patient's veridical unconscious commentary on the ground rules and framework. Langs

moves away from an intrapsychic model of psychology to focus on the interaction between therapist and patient, but more than this he provides the methodology to carefully scrutinise this interaction.

Langs, in his vast opus, methodically explicates how to listen to the patient, how to get in touch with the patient's deep unconscious. In the Langsian paradigm there is a systematic process of listening beyond the manifest content to the all important latent content. While other psychoanalytic paradigms recognise the importance of the unconscious, Langs provides an operationalised, formalised methodology, that goes beyond intuition and self reflection, for gaining access to the unconscious without falling into the false security of a sterile positivism.

Langs's method is first and foremost a method of understanding the patient in the context of the therapy room and in supervision. It has been adapted for use as a research tool (see section 4.4.5) and this adaptation poses the danger that it will lose something of the creativity and spontaneity displayed in the therapy context. In the translation of the patient's narrative into themes for the purposes of this research, some of the life of the patient's story is excised, leaving the material with a flat and prosaic feel and lending the method a dull and pedantic atmosphere, far removed from the exciting possibilities opened up by employing this listening approach in the context of the therapy room. Despite this drawback it seems clear that the communicative methodology is an important and practical research tool and one that needs to be honed and refined for wider use.

Langs has some important ideas about doing psychotherapy and it is vital that those operating in this field, even if they do not embrace his ideas, at the very least engage him in debate. Even though, as has been found in this study, the communicative framework is not compatible with a milieu therapy approach and it is not possible to maintain a perfectly secure framework in the context of a therapy ward with all of the built in impingements onto the ground rule requiring a one to one relationship with privacy and confidentiality that are structured into this context, Langs's ideas about the framework and ground rules of psychotherapy still have relevance in the broader hospital context, especially in regard to psychotherapy in a setting outside of the therapy wards.

The communicative approach to psychotherapy appears to have much to offer practitioners, especially in the realm of the technique and ground rules of therapy and in the realm of listening to what patients are saying in therapy (Smith, 1991a). From the twelve sessions of therapy examined in this study it is clear that, far from being irrelevant in the institutional context, the issues raised by the communicative approach seem to be even more relevant in this hospital context. Therapists in this context would do well to listen to what patients are telling them about the conditions of therapy, and to heed these messages by improving these conditions where possible.

A perfect framework seems to be an impossibility, especially in an institutional context. What seems important therapeutically, especially in this institutional context, is how the framework is experienced and how deviations are rectified. If the modifications to the frame are proposed by the therapist, countertransferentially, for defensive or other purposes, then it appears from this study that the damage to the therapy will be far greater than if the ground rule deviations are beyond the control of the therapist and are objectionable to him or her. This is important for the possibility of conducting therapy in environments where the security of the frame faces structural impingements, such as the institutional context wherein this study was conducted.

Finally, it has to be concluded that Langs's methodology is a valuable accomplishment, one that builds on the achievements of Freud and contributes in important ways to therapeutic practice as well as to the philosophical and epistemological aspects of therapy. This methodology is no less valuable in the institutional setting.

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APPENDIX 1

THERAPIST QUESTIONNAIRE

The following questions were used as a guide to the interview with the therapists. Responses were followed up by requests for elaboration and clarification where necessary.

1. Does your therapy take place in a single setting?
2. Does the therapy take place at a set time and day?
3. Does each session of therapy happen over a constant, specified period of time?
4. Do you and the patient occupy a set location in the therapy room?
5. Do you disclose things about yourself to the patient?
6. Who makes the appointments for your sessions?
7. When the patient arrives for his or her sessions, where does he or she wait?
8. Do you fetch the patient from the waiting room?
9. Do you have any sort of conversation with the patient outside of the therapy room?
10. How do you begin the therapy session?
11. Do you have, or have you had any sort of relationship with the patient outside of the therapy? Do you plan to have any relationship after their therapy is over?
12. Is there any physical contact at all between you and the patient?

APPENDIX 2

MARY: SESSION 1

1. Brief background information

Mary is a 38 year old married woman with two children. She works as a shop assistant, doing temporary work. She has a long history of marital conflict and depression. She was admitted to Lentegur hospital with symptoms of depression and suicidal ideation following marital conflict. Her husband has a long history of alcohol abuse which contributes to the marital conflict. She has a std 8 education. She was previously seen for five sessions of psychotherapy approximately eighteen months prior to her current admission but has no other history of note.

2. Adaptive contexts of session

1. The patient had been handed over for therapy by her previous therapist who had applied for and had been given a transfer to another ward.
2. The patient had been assessed by her previous therapist and her case had been presented to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
3. The patient had attended groups on the ward run by her current therapist.
4. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
5. The patient had seen the psychiatric registrar on the ward for assessment for medication.
6. A misunderstanding had occurred on the ward where the psychiatric registrar had assumed that she would be taking over the patient for therapy from her original therapist. She had in fact been in session with the patient when the mistake was pointed out to her and she had then cut short the almost completed first session with the patient and the patient was then handed over to her current therapist.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

3. The excessive use of questions in the session by the therapist.

4. Quantitative data of session

No. words therapist	2389
No. words patient	2610
No. words total	4999

Summary of therapist interventions

Questions	53
Clarifications	10
Confrontations	0
Interpretations	1
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	8
Reflections	13
Encouragement	4
Suggestions	0
Advice	0
Total therapist responses	89

5. Therapist issues

The therapist felt, on the basis of information from the ward staff and the previous therapist, that the patient was in a delicate emotional state and would not be able to cope with exploratory therapy. It was felt that anything other than supportive interventions would result in a deterioration in the patient's functioning. There was some concern as to whether she should be allowed to go home for the weekend because of her acting out in a violent relationship with her husband over the previous weekend and because of her emotional turmoil on her return from the weekend leave. The staff on the ward felt that she was in such a bad state that she should not be allowed to go home for the weekend because of the aggressive acting out that was occurring between her and her husband with both of them

threatening to kill each other and the husband in fact almost succeeding in this endeavour by driving their car while in an inebriated state

6. Themes from session¹

1. Someone is very irresponsible and I must look after him, watch over him. I cannot rely on him and this has placed a lot of stress on me and on our relationship. (1-6)
2. This person makes *me* feel that *I* am the big problem. (1-8)
3. This person says that I am mad and he says that I see things that are not there. (1-10)
4. I have always felt insecure and felt that people would abandon me and this has happened now in this relationship. (2-1)
5. I had to share this person with many people. (2-3)
6. I have always felt angry towards this person. (2-3)
7. I have always had to accept a lot of responsibility. (2-3)
8. I have always been anxious and afraid of going out alone. (2-3)
9. I have always been found wanting because of my anxiety and withdrawal and consequently I never got this person's attention. (2-11)
10. I have always been angry towards this person. (2-11)
11. I have always had this unwanted feeling and it makes me angry towards this person and it makes me reject her. (3-1)
12. I find it difficult to be myself and I think that people like the other person better. (3-3)
13. When I am with other people I am not true to myself, I have to be alone to be really myself. (3-7)

T It feels as if this has been around for a long time, that it happens in most situations and it happens also with your husband. (3-14)

14. In order to get acceptance from people I have to explain things. (4-3)
15. I am in a relationship with someone who is not responsible, who is chaotic, who makes promises he does not keep, who is unreliable and who has illicit relationships with other people. (4-15)
16. There is nothing I can do to save this relationship. (5-1)

¹ The numbers in brackets refer to the page and paragraph numbers of the original transcripts of the sessions.

17. I could not tell him how I felt. (5-1)

18. This person is chaotic belligerent and looks for trouble. (5-1)

19. If I complain about my treatment then this person makes others believe that I am mad.
(5-1)

T Yes it sounds like he had been undermining you by saying that you are mad and it has made it difficult to stand up for yourself. (5-2)

20. This person makes me feel that I am not good enough for him. (5-3)

21. If I talk to him about the chaos then he asks me what am I doing about the relationship. He doesn't tell me what he wants but he makes me feel that I am not doing enough in the relationship. (5-3)

22. Then I give up and I don't have the energy to answer him. (5-3)

23. This person's chaos and irresponsibility have become too much for me. (5-7)

T He is like a young child whose mother will be there to pick up the pieces. It sounds to me like maybe you got into this marriage, maybe.....maybe because you are used to that role as a child, the oldest child you were a parent as well as a child. Maybe when you married him you felt like he was someone who needed looking after. (5-10)

24. I got into this relationship because I was hoping that this person would look after me.
(6-2)

T But you are more of the adult, you have become like that over the years. (6-3)

25. Just recently this person has spoken about reforming but I don't know how long it will last. (6-4)

26. I have always needed other people in order to go out I can't do it alone. (6-18)

27. I have restricted contact with people because I find it painful to talk to them and I get hurt easily and because I have never felt good about myself and look down on myself. (8-2)

28. I have the tendency to protect myself from painful things by not hearing them. (8-4)

T So what you are saying is that you avoid. You avoid those situations because it makes you feel upset and can really make you feel bad about yourself. That makes it much easier to avoid people and situations rather. But it sounds like you have become a bit dependent on your husband then and your family because they are safe and it is nice and easy to be with them. (8-5)

29. My comparing myself to another person who was bright and smart gave me a spur to improve myself. (8-6)

30. I get panicky if I have to do something and can't do it or if someone tells me to do something then it overwhelms me. (10-6)

T It sounds to me like, if you become anxious then it gets much worse. So it seems like you sometimes struggle to learn things. You feel annoyed because you have to learn things over again. Sounds like that's because you are not relaxed. There is a lot of anxiety that happens at work from difficult customers and things like that. (10-7)

31. If someone is able to do things and they are junior to me then it works on me. (10-8)

32. I am struggling to fit in and to preserve this relationship. (11-1)

33. If things go on like they have been going on then I will end this relationship. This person has some good qualities but the chaos overwhelms them and makes it difficult to be with him. (12-3)

34. Even though this person is chaotic and unreliable he accuses me of being sick and of being mad. (12-8)

T It sounds like he is probably not going to change unless you prove to him how serious you are about separating, or divorcing him. But that is something that you need to work out for yourself because it is a difficult thing. Some time you have to come to a point in your life where you have to decide. Do I grow as a person and become separate, maybe cut him off for a while in order to sort myself out or do I stay in that situation. It sounds like, from what you are saying you need him. You struggle to cope on your own because of this difficulty. You want to avoid difficulty. (12-9)

35. I have often threatened to leave this person but I am afraid that there is no alternative.
(13-2)

T Sure. You have a husband of your own and if you have to deal with your husband then you don't have to deal with some of those awful things that you don't want to have to deal with. That's why I think therapy is going to be important. You are going to have to come on a weekly basis. Come and just talk. Talk about whatever comes to mind. That is the only way that you will begin to understand things. That's the only way I know that you will be helped, if you come and talk about whatever comes to mind, dreams, fantasies nightmares whatever is happening, whatever is going wrong. That is the only way that I can suggest will help. If you take pills they might make you feel better for a day, they might make you feel better for a week but really eventually you have to start facing up to some of these things. Does that make sense to you?

The session ended at this point with the patient agreeing to come for therapy. There were no further themes in this session.

7. Analysis of patient's material

Type of communication field

Generally Type B but with some elements of Type C. There is potential for a Type A communicative field but the therapist is working mainly at a manifest level, dealing with issues manifestly and not relating them back to the latent meaning.

Manifest representations of the adaptive contexts

There are no direct manifest representations of the adaptive contexts. The patient however alludes to the adaptive contexts through themes of irresponsibility and chaos (themes 1, 15, 18, 23, 25, 33) and themes of abandonment rejection and lack of love (themes 4, 9, 11, 14, 16, 20, 32).

Mode of relatedness

The patient alludes to her perception of the therapeutic relationship as being one of pathological autism through her themes of abandonment and rejection (themes 4, 9, 11, 14, 16, 20, 32)

Mode of cure

There is evidence of avoidance and a deep defence against difficult, disturbing issues (themes 8, 9, 26, 27, 28, 30).

Dynamics and genetics

The patient speaks of a deep seated ontological insecurity from infancy that results in panic attacks and a phobia for strange places. She is overly and pathologically dependent on her husband and her children for a sense of security and needs her family in a pathologically symbiotic way in order to function. Despite her obvious intelligence she is functioning at a low level and finds relating to people painful and energy sapping. Although she is reliant on him, her husband is not a source of understanding and support and she is becoming increasingly frustrated and angry with his lack of responsibility and the chaos that ensues from his behaviour. She displays an avoidant style of dealing with unpleasant realities.

Central pathological figure

While the dynamic and genetic issues mentioned above are at play in the patient's unconscious they have been reactivated by the adaptive contexts pertaining to the current session. The central pathological figure is the therapist and more broadly the ward context that the patient finds herself in at the moment and they need to be acknowledged and addressed before the pathology of the patient can be addressed. That they are not being addressed, leads the patient to feel that she is shouldering all the blame and responsibility. The patient unerringly puts her finger on this when she remarks "I could never actually rely on him and at the end of the day he makes me feel that I am the big problem." (p1 par. 8) and again "He says that I am mad and he says that I see things that are not there." (p1 par. 10). "If I called the police he would get the policemen to believe that I am not right in the head. Afterwards I could actually feel that there was something wrong with me. He is very convincing." (p 5 par. 1).

APPENDIX 3

MARY: SESSION 2

1. Brief background information

Mary is a 38 year old married woman with two children. She works as a shop assistant, doing temporary work. She has a long history of marital conflict and depression. She was admitted to Lentegeur hospital with symptoms of depression and suicidal ideation following marital conflict. Her husband has a long history of alcohol abuse which contributes to the marital conflict. She has a std 8 education. She was previously seen for five sessions of psychotherapy approximately eighteen months prior to her current admission but no other history of note.

2. Adaptive contexts of session

1. The patient had been handed over for therapy by her previous therapist who had applied for and been given a transfer to another ward.
2. The patient had been assessed by her previous therapist and her case had been presented to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
3. The patient had attended groups on the ward run by her current therapist.
4. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
5. The patient had seen the psychiatric registrar on the ward for assessment for medication.
6. A misunderstanding had occurred on the ward where the psychiatric registrar had assumed that she would be taking over the patient for therapy from her original therapist. She had in fact been in session with the patient when the mistake was pointed out to her and she had then cut short the almost completed first session with the patient and the patient was then handed over to her current therapist.
7. The patient had not been aware of her session time and had to be reminded by the therapist.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1419
No. words patient	1918
No. words total	3337

Summary of therapist interventions

Questions	5
Clarifications	12
Confrontations	0
Interpretations	0
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	2
Reflections	27
Encouragement	1
Suggestions	0
Advice	0
Total therapist responses	47

5. Therapist issues

The therapist felt more comfortable about the patient's ability to handle therapy of a more exploratory nature and of her ability to be contained in therapy on an outpatient basis. The patient was on the point of being discharged and it was decided to see her on a weekly basis to explore some of the issues that had arisen in the therapy to date.

6. Themes from session

1. I am worried about someone, especially when I am not around them, he gets up to things and things get out of hand. (1-6)

2. This person can't just promise me that he will change. (1-6)
3. I can't carry on looking after him forever. (1-6)
4. I know I can't go on like this, its not good for the people I have to look after. (1-10)
5. We are not actually talking we are fighting and arguing. (1-10)
6. When this person is sober then he is very nice. (1-10)
7. I don't think this person realises the seriousness of the situation although he says he does. (1-10)
8. I know how hard it is to change and I wish I could convince him to go for help. (1-10)
9. When this person is sober then things are good and he looks after me well. (2-3)
10. When this person is drunk then things get chaotic and we fight and argue and I am not allowed to say anything. (2-3)
11. I keep hoping things will get better but I don't think that they will. (2-3)
12. I don't tell people what is going on because I feel ashamed. (2-5)
13. I get so angry with what is going on that I could hurt myself. Nothing seems to work, everything seems so hopeless. (2-7)
14. When I get like this I become crazy and I want to fight with this person and I don't like that. (3-1)

T It sounds like what you're talking about is a big feeling of frustration and rage. Some of that frustration must be because you can't seem to handle him. You are relying on him so you want to change him. (3-4)

15. I have trouble accepting the fact that I can't control myself. (3-7)

T That's the part that's worrying you is that you're not in control of yourself. It sounds like you've been knocked around by his problems and issues and you're feeling an overwhelming anger and overwhelming feelings that are hard to even understand. (3-8)

16. When I get like this people think that I am crazy and they blame me, they don't know that it is the only way that I can demonstrate how I feel. (3-9)
17. I get criticised for not accepting this person's behaviour and the chaos around it. It seems to be the norm around here. (3-11)

T It feels like people, like your mother are a bit critical, they don't seem to understand what you're having to go through and your fears and how desperate you feel sometimes. You could lose your house. It sounds like its the feeling of fear that you are feeling sometimes, you have nothing to hold onto, nothing that is stable. (4-1)

18. This person does not seem to be aware of what he is doing to me and others. (4-4)

19. I feel that I am deteriorating and I could become a tramp. (4-8)

T I agree with you, its important to try to work on yourself, to try to work through some of the feelings that you have and that's the way that you can start dealing with things outside you but you have to work first on things inside you. I think you have been trying to work on yourself but you've been feeling criticised by others. Your mother says "Ach he's just like that you must accept it." You've been feeling a bit criticised and its hard to try to do these things especially when it seems that people are criticising you. Maybe you even feel a bit criticised by us here in the ward as well. But I agree with you its useful to look at what you can do in yourself. That's why you are in therapy I suppose. (5-6)

20. I have trouble identifying how I feel. (5-7)

21. I wonder about my lack of feelings for others. Someone got very sick in front of me and I did not feel anything. (5-9)

22. Things can be chaotic around me and I don't feel anything. I don't understand myself in this regard. (6-3)

T Yes its very important to try to understand yourself. But it sounds like you're feeling a bit cut off from feelings. You're not feeling things at the time but the feelings are coming back at other times and you're getting out of control. Maybe the problem is that you are telling yourself how you should feel, what you should feel instead of just feeling. One part of you is saying that you must feel sad because someone died. But that's not really true because there is no such thing as how you must feel - its really a case of what you feel that is important....whatever you feel. (6-4)

23. I must be abnormal because I don't feel what others expect me to feel. (6-5)

T Sounds like you are a bit scared of feeling abnormal. People will look at you and say that you are abnormal and that is part of the worry. (6-6)

24. I don't want to think about myself or try to understand myself. (6-7)

T The trouble with that is that you float above all of these feelings and then these things catch up with you and you suddenly find yourself out of control. (6-8)

25. Something burst and destroyed all the good things that I wanted. (7-3)

26. When things are going well it is not likely to last long and it will just burst. (7-7)

27. I don't want to be in contact with what I am feeling. (8-1)

28. I don't know why this person says that he does not know me or understand me. (8-5)

29. I have a feeling of not belonging, of insecurity, of not being able to rely on the other person. I feel separate from other people. (8-9)

T Sometimes these things don't necessarily mean it was just one event that happened. It is not necessary that something happened. Maybe in therapy sometimes you get in touch with things that have happened - little things. Sometimes in talking about things you remember certain things that happened. Things become more clear..... But it felt like nothing happened at that stage. (9-1)

30. I have always felt insecure and have always been anxious around other people and I don't know why I am like that and others are not. (9-2)

31. Someone can tell other people about their behaviour but can't tell me about mine. (9-4)

The session ended at this point with no other themes emerging.

7. Analysis of patient's material

Type of communication field

Generally Type B but with elements of Type C

Manifest representations of the adaptive contexts

There are no manifest representations of the adaptive context but the thematic material as a whole points to elements of the adaptive contexts in that the patient refers to someone being irresponsible and chaotic (themes 1, 7, and 10) and specifically to the chaos being the norm (theme 17) and the complete lack of awareness of its effects on people (theme 18). The patient refers to the lack of interactional interventions in her themes of being blamed (themes 16 and 17).

Mode of relatedness

There are allusions to pathological autism on the part of the patient (themes 21, 23) as well as on the part of the therapist (themes 28, 31) as a mode of relatedness.

Mode of cure

There is a tendency to merger and to action discharge on the part of the patient together with evidence of avoidance (themes 20, 22, 24, 27) as a means of dealing with problems and difficulties.

Dynamics and genetics:

The patient's ontological insecurity emerges again in this session (themes 26, 29, and 30). She speaks of her difficulty in controlling herself (theme 15) and of her anger and rage and feelings of helplessness (themes 13 and 14). She alludes to a feeling of being cut off from others (themes 22 and 23) and also to being cut off from her own feelings (theme 24).

Central pathological figure

The central pathological figure is the therapist, or more specifically the framework of therapy.

APPENDIX 4
MARY: SESSION 3

1. Brief background information

Mary is a 38 year old married woman with two children. She works as a shop assistant, doing temporary work. She has a long history of marital conflict and depression. She was admitted to Lentegur with symptoms of depression and suicidal ideation following marital conflict. Her husband has a long history of alcohol abuse which contributes to the marital conflict. She has a std 8 education. She was previously seen for five sessions of psychotherapy approximately eighteen months prior to her current admission but no other history of note.

2. Adaptive contexts of session

1. The patient had been handed over for therapy by her previous therapist who had applied for and been given a transfer to another ward.
2. The patient had been assessed by her previous therapist and her case had been presented to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
3. The patient had attended groups on the ward run by her current therapist.
4. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
5. The patient had seen the psychiatric registrar on the ward for assessment for medication.
6. A misunderstanding had occurred on the ward where the psychiatric registrar had assumed that she would be taking over the patient for therapy from her original therapist. She had in fact been in session with the patient when the mistake was pointed out to her and she had then cut short the almost completed first session with the patient and the patient was then handed over to her current therapist.
7. Just prior to her discharge the patient had been interviewed by a nursing student with two tutors present as part of the student's practical examination.
8. The patient was being seen on an outpatient basis, for the first time in this session and no discussion of fees or assessment for fees had taken place.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.
3. Prior to the session the patient had been joined in the waiting area by an inpatient from her previous ward who sat and engaged her in conversation.

4. Quantitative data of session

No. words therapist	1315
No. words patient	1745
No. words total	3060

Summary of therapist interventions

Questions	6
Clarifications	10
Confrontations	0
Interpretations	3
Silences	1
Playback of derivatives	0
Framework management	0
Patient management	1
Reflections	12
Encouragement	3
Suggestions	0
Advice	0
Total therapist responses	36

5. Therapist issues

The patient had been discharged from hospital and was now attending therapy on an outpatient basis. The patient had arrived early and had been sitting quietly in the waiting room when she had been joined by one of the current inpatients from her old ward. The second patient was fairly disturbed and had a reputation for being aggressive and consequently was not a popular patient in the ward. Several community meetings had had to

be called in order to deal with issues that had developed in the ward as a result of her behaviour. The therapist had been concerned that the second patient was intruding on his patient prior to the session.

The therapist was more relaxed about the idea of the patient in an exploratory mode of therapy rather than a supportive mode and there was less fear on his part of the patient's deterioration in the session. Consequently the therapist was allowing the patient more latitude to explore issues and attempting to be more in the background in the sessions. This was evident in the lower number of questions and the higher number of clarifications and reflections noted in the therapist's interventions.

6. Themes from session

1. Someone is trying hard to give up drinking. I can smell that he has had something to drink but I can't actually see it. (1-4)
2. I am still afraid that he will drink and get aggressive with me. I can never relax because I don't know when it will happen again. (1-4)
3. It has happened many times in the past that he gives up drinking temporarily but then he goes back to it again. (1-4)
4. Someone is not working at the moment and it worries me. (1-6)
5. I don't talk about the important things that worry me because I am scared to know. I don't ask about things like money because I am scared to know the answers. (1-6)
6. I can see that someone is desperate to begin work. (1-8)
7. Someone complains that he does not get the chance to be the man in the house but he was never responsible with money. (1-8)
8. It is a good time to let go of this money responsibility and let someone take it over because I am tired. (1-8)
9. I am tired and I do not have energy. I know that there are things that I need to do but I don't want to hear bad news. (2-1)
10. I don't want to delve into things. (2-7)

T Mhmmn. It looks as if that has always been there and if someone does not go and scratch there then it stays there always. But I can hear what you say, you are saying that you want to keep it all behind your back, you want to keep it all covered up. (2-8)

11. Someone keeps on telling me to go back to work but I don't feel like it. (3-7)

T So they phone and they ask you to come in and you feel a bit like you don't want to come in and work? Why not?

12. I want to be alone and I don't want to be around people. (3-14)

T Mhmmn. As I understand it, its not something that is new, it has been there for a long time. You've always had a problem about being among people and still have a problem now. It's making you anxious. It is part of what is difficult about coming here to talk to me. It sounds like what you're saying is that you are finding it difficult to go back to work. You're finding it difficult to come here, this is a little bit like work and here is a strange person you have to talk to and it's making you anxious. You just want to be removed from everything and you will feel better, but part of you is saying that maybe you shouldn't be removed, maybe you should come to therapy and do some work, going to work. (4-1)

13. I have difficulties being around people and I find it easier to be alone. If I am expecting a visitor I get anxious and I am glad if they don't arrive. (4-6)

14. I always feel pressure on me to talk and be jolly and to keep the atmosphere nice. (4-10)

15. When I am sitting talking to someone I suddenly get into a different mood and want to be alone as a result of something that I think about and then he gets cross and wonders what is going on with me. (5-1)

T Uhuh, sure. But it sounds like, from what you are saying it sounds like you were thinking about something that made you feel upset and it was hard to sort that out and then you had this mood swing and felt terrible, and your husband notices. Sure, I think its important to try to look at those things. I think sometimes you don't give yourself a chance to look at them because its painful and you just want to run away from them and then it happens that you get

in those moods because even if you run away from it - it is still there, it still catches you.
(5-2)

16. I have to force myself to be with people. I prefer to be alone. (5-3)

17. All of my relationships are an effort for me and I have to force myself to do things. (5-5)

18. I keep having to repeat myself so I don't want to come in for therapy. (6-2)

19. Everything seems to be a big effort for me. (6-4)

T It is just about as bad as going to work, except that this is perhaps worse, you're having to come back here to think about those horrible things that make you feel tired, moody and its like you're being forced to talk sometimes. It's difficult - but you forced yourself to come because you thought that maybe you can get some benefit, maybe you can work through some of these things. (6-5)

20. I am afraid of a horrible feeling of not wanting to live and I would do anything to prevent that feeling coming back. (6-6)

21. I don't know how to help myself get over this feeling. I do everything that is expected of me. (6-8)

T You're talking of many things that are expected of you, but it is almost that you are saying that this is what people are expecting of you, this is not what you are expecting of you. Sounds like you want to be good, and be fixed up, but for me or for the doctor, or because the doctor is expecting you to talk. The doctor is going to expect you to be well. It sounds like it is difficult to get in touch with what you want, to find out what you want. It's difficult to get in touch with the real part of you. (7-1)

22. Everyone expects me to be jolly and happy and full of energy and I try to please them but deep inside I am not and I want to be alone to be myself. (7-2)

T No demands on you if you're alone. But everyone makes demands on you especially here. It sounds like you are struggling to find that part of yourself, that real self. When you are alone its easier because you can drift off into your fantasies and thoughts. Then its

easier. Then you can be in your own thoughts. Then you feel yourself, when you are alone, but with other people it is difficult. (7-3)

23. Someone, who seems to be more at ease with people than I am can see the problem in me. (7-4)

24. I don't know how to be myself any more I am so used to being for other people. (7-6)

T Lets just finish up quickly. So you are finding it difficult to be, um, relaxed. Very difficult to just be. You're finding it hard to get back to what you were like and also back to a kind of coping. This is what you're doing and this is what you want to do and maybe you are a little bit worried that you are going to deteriorate if you don't get things under control and um...with your husband things have been a little bit difficult because you are not sure what is happening with him and you don't want to ask him too much. It sounds a little bit like here as well you don't want to go too much into your own stuff or it might make you feel bad. It sounds like you are wanting to stop this deterioration and you want to continue to come to therapy. I think its important to come on a regular basis and to keep talking about what comes to mind and in that way you start to get to know yourself a bit better. (8-3)

The session ended at this point with no further themes emerging.

7. Analysis of patient's material

Type of communication field

Type B but with many Type C elements.

Manifest representations of the adaptive contexts

1. ... today it was even difficult for me to come here today. (p2 par 3).
2. ... it felt like I wanted to phone to say that I was not coming...it was difficult for me because I find it difficult to...as I told my doctor...I don't want to talk about myself any more, to talk about things that hurt, I don't want to go and scratch any more. (p2 par 7)
3. Yes I was afraid that I would get sick again if I didn't come in and things get too much for me and because I find it difficult to speak about things outside. (p3 par 5)

Mode of relatedness

There are many allusions to pathological autism on the part of the patient (themes 12, 13, 15, 16, 17, 22)

Mode of cure

The preferred mode of cure is through merger and action discharge rather than through insight and holding.

Dynamics and genetics

The patient again refers to her deep seated ontological insecurity that causes her a great deal of difficulty in being around other people and in simply relating to other people in a natural way. This causes her anxiety in going out to work and being around people in the work situation and it also results in feelings of anxiety if she is expecting a visitor (p4 par 6). It also causes her difficulty in coming into the hospital for her sessions and she almost phoned to cancel the session. Despite her obvious intelligence she is functioning at a low level and finds relating to people painful and energy sapping and would rather spend time alone (themes 12, 13, 15, 16, 17, 22). She has a great deal of difficulty simply being herself and finds herself "being for others" (themes 14, 21, 22, 24). She displays an avoidant style of dealing with unpleasant realities (themes 5, 9, 10, 11, 17).

Central pathological figure

The central pathological figure is the therapist or the framework of therapy.

APPENDIX 5
MARY: SESSION 4

1. Brief background information

Mary is a 38 year old married woman with two children. She works as a shop assistant, doing temporary work. She has a long history of marital conflict and depression. She was admitted to Lentegeur hospital with symptoms of depression and suicidal ideation following marital conflict. Her husband has a long history of alcohol abuse which contributes to the marital conflict. She has a std 8 education. She was previously seen for five sessions of psychotherapy approximately eighteen months prior to her current admission but no other history of note.

2. Adaptive contexts of session

1. The patient had been handed over for therapy by her previous therapist who had applied for and been given a transfer to another ward.
2. The patient had been assessed by her previous therapist and her case had been presented to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
3. The patient had attended groups on the ward run by her current therapist.
4. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
5. The patient had seen the psychiatric registrar on the ward for assessment for medication.
6. A misunderstanding had occurred on the ward where the psychiatric registrar had assumed that she would be taking over the patient for therapy from her original therapist. She had in fact been in session with the patient when the mistake was pointed out to her and she had then cut short the almost completed first session with the patient and the patient was then handed over to her current therapist.
7. The patient was being seen on an outpatient basis and no discussion of fees or assessment for fees had yet taken place.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1071
No. words patient	4391
No. words total	5462

Summary of therapist interventions

Questions	5
Clarifications	9
Confrontations	0
Interpretations	1
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	1
Reflections	16
Encouragement	11
Suggestions	0
Advice	0
Total therapist responses	43

5. Therapist issues

The patient's husband and children had accompanied her to the hospital and during the session they were playing together with the family dog on the lawn area outside the therapy room. The therapist was initially distracted and irritated by the sounds from outside the therapy room. It felt like an intrusion into the therapy space on the part of the husband.

6. Themes from session

1. My husband used to go out and get drunk a lot and then, he used to not be himself and used to come home and fight with me. This turned my life upside down and upset me. (1-10)
2. My sister in law told me that my husband was having an affair with a good friend of hers and she took me there. (1-12)
3. I got hysterical and fought with my husband and everyone who was around. (1-12)
4. I got very angry when someone admitted that they had been worried that the partying was going to be discovered and I hit my husband with a beer bottle. (2-1)
5. My husband denies to this day that he had an affair. Other people tell me that he has had an affair so I am left in the middle. (2-1)
6. I do not trust my husband at all at the moment and when he is not at home I suspect that he is back there again. (2-1)
7. I was so mixed up I did not know who to believe and it made me hysterical and combative. (2-1)
8. This woman's husband came to tell me that his wife and my husband were out together and I became out of control. (2-1)
9. I tracked my husband down and I argued and fought with him.
10. Everyone turned against me and my sister in law slapped me and my husband did not defend me against this attack. (3-1)
11. Everyone blamed me for the situation and felt that it was my fault. (3-1)
12. My husband's sister said ugly things to me in front of my children. (3-3)
13. I cannot understand because I thought I was acting on what my sister in law had told me and I wonder what really happened on that day. I cannot understand why she was cross with me and why she laid a charge against me. (3-3)
14. People blame me for what happened and they accuse me of being mad. (3-3)
15. I am angry that my husband did not support me and I cannot forgive him. If I see this woman then something pushes up in me that I cannot control. (4-1)
16. When my husband came to talk to me at my grandmother's funeral I pushed him away because I was feeling so angry and frustrated with him. I could not get over what had happened. (4-2)

T So it just shows you how feelings are really important, they can make you feel sick. If your feelings are so bad, they can actually make you want to stay in bed. And that sounds like that was all to do with your husband, first of all having an affair, and then betraying you and denying it. So its kind of like it undermines you, it takes away your reality, it takes away what you are certain about. And then also just the way his sister was behaving. It sounds like you could not feel secure in your husband from that day. You could not trust him and feel secure in him. He was doing things behind your back with other people. (4-5)

17. My husband always does things with other people and neglects me. I think its because I don't drink or smoke or like wild parties. (4-8)

18. I still feel that I can't trust things and I have to go and check that my husband's car is at her house. (5-5)

19. I feel as though I have been made a fool of and laughed at. (5-7)

20. My husband is very irresponsible and could not pay our bond this month. (5-7)

21. My husband and I don't speak to each other. (5-7)

22. My husband has squandered his severance pay. (6-1)

23. I don't ask what he has done with the money because I am afraid to find out. (6-5)

24. I just accept things and have handed over responsibility for finances to my husband even though I am disturbed by it. (6-9)

T Yes you feel you just have to accept everything otherwise there is going to be a big fight and everyone will be disturbed, the children and everyone. Yes it looks like it is part of the problem the fact that you really need him. Even though things are a bit messed up, at least there is someone there. He is there and it is someone that you can be with even though you feel very unsettled and you feel very angry with him, you feel that you need him. It sounds like it is part of the reason that you are so angry with him, the fact that you actually need him. You feel a bit helpless. Even though things are really mixed up at home, if you think of the alternative then it sounds even more difficult. (6-12)

25. What upsets me is that my husband's emotions influence me. I just go along and get caught up in his emotions. (7-3)

26. Everyone feels that I should just accept things, that other women have husbands who drink. But it is difficult for me to do because of my anger. (7-7)

27. My husband abused me one night and the next day I went to fight with him at the place that he goes to party. (7-7)

28. I was so out of control with anger that I drove the car in a reckless manner and I nearly killed my husband and it was only afterwards that I realised it. (7-9)

29. I sometimes get a feeling of being scared and angry and I do things that I would not normally do. (8-1)

T What happens, as I understand it, things become too much when you can't be yourself and these feelings get pushed under and if you can't be yourself for a few months then those feelings come out. You try to be calm and eventually it has to come out when you can't take it any more. (8-2)

30. Everyone gets angry with me and speaks about me and tells me that I must learn to control myself. (8-3)

31. I get blamed for being mad when people hear me shouting and screaming at my husband but they can't hear what my husband has said to me in his soft voice. (8-5)

32. My husband tried to go out one night in order to give a woman a lift home but I insisted on going along with him because I didn't trust him. (8-7)

33. Because of this my husband accused me of being mad. (9-1)

34. My husband's sister accuses me of being mad and has spread this about me at the school where she teaches. (9-5)

35. This made me so angry that I was going to report her to the principal but I changed my mind in order to protect my child. (9-5)

36. I don't know who or what I am. (9-5)

37. Other people blame me and talk of my shortcomings because my husband tells people about these shortcomings and he does so right in front of me and that makes me feel nothing for myself. (9-5)

38. My husband goes around telling people about me and it makes me feel tired of myself. (9-5)

T Yes, I can see what you say. If people, important people say things then you begin to feel that it is really like that. You have a sensitive nature that makes you feel that what people say is true about you. In all situations and circumstances you are very sensitive. When people talk about you and tell you what they think about you it can very quickly make you feel hurt. (10-2)

39. This all makes me feel that I do not want to have contact with people because I get hurt very easily. (10-3)

T It sounds as though on the one hand you don't have much energy any more, on the other hand it is in a situation where you can be with people and they can become a bit insensitive and you don't get to feel very good in those circumstances. (10-6)

40. My church group does not understand how I can be sick or depressed if I just pray to God and what they tell me makes me feel sick also. (11-1)

41. I can't handle the fact that my husband is so sympathetic and understanding to other people but not to me. (11-3)

T Yes its very difficult for you to confront him or to say to him that he has done something to make you feel bad. For people in general. Then you have to now and then confront people and all these pent up feelings come out. Then you feel worse because people speak about you and you feel bad because things become worse. (11-6)

42. I get angry with myself because I allow my husband to upset me by saying these things. (11-7)

43. If someone says something bad to me it catches up to me after a while and I feel it later even though I try to push it down. (12-1)

T Yes all these feelings that have been there for months come out like a kettle that is building up steam. But it looks as though you are trying to understand yourself and to talk about yourself and it also sometimes is difficult to talk about yourself here. It is a difficult

thing but it looks as if you are trying to bring things out and trying to understand them and then to make them right. (12-6)

44. I managed to push down the thought of coming to therapy but then it came back to me and made me feel bad. (12-7)

45. If someone says something bad to me I will not hear but afterwards I wonder what that person has said. (12-7)

46. Years ago my mother said something to me that I chose not to hear and I have worried about it until this day wondering what it was that she said to me on that occasion. (12-9)

The session ended at this point with no further thematic material emerging.

7. Analysis of patient's material

Type of communication field

Mainly Type B. There is much potential for a Type A communication field in this session but the therapist works mainly on a manifest content level. The patient alludes to the lack of a Type A communication field with themes of poor communication (themes 21, 45, 46).

Manifest representations of the adaptive contexts

1. "Yes when I woke up this morning I thought to myself what day is this, and I had been thinking already since Monday night about my session. You know it was just funny that I had forgotten that today was my session and this morning it was just as though it was something that just struck me, my session is today, oh Yenna! You know, its those things....I try to do things, that I don't want to do and I know that you are going to say something that might hurt me very much. Somehow I can actually make as though I will not hear you but afterwards then I wonder what did you say to me, he wanted to say something to me that I knew was not nice" (p12 par 7)

Mode of relatedness

The patient alludes to her perception of a therapeutic relationship of pathological autism through her themes of not being supported, defended or understood. (themes 10, 15, 17, 40, 41).

Mode of cure

The patient alludes to a maladaptive mode of cure through action discharge in her themes of getting out of control and hysterical and fighting with people (themes 3, 4, 7, 9, 15, 27, 28).

Dynamics and genetics

Most of the session is taken up with the patient's behaviour and feelings in relation to her husband but her deep seated insecurity is manifest in this session. She is overly dependent on her immediate family for a sense of security and needs her family in a pathologically symbiotic way in order to function. When her husband is perceived to abandon her through his affairs she becomes out of control with rage. Her avoidant style is more evident in this session with her acknowledgement that she sometimes simply does not hear things that might have a negative connotation. (themes 23, 43, 44, 45, 46).

Central pathological figure

The central pathological figure is the therapist or the framework of the therapy.

APPENDIX 6

MARY: SESSION 5

1. Brief background information

Mary is a 38 year old married woman with two children. She works as a shop assistant, doing temporary work. She has a long history of marital conflict and depression. She was admitted to Lentegeur hospital with symptoms of depression and suicidal ideation following marital conflict. Her husband has a long history of alcohol abuse which contributes to the marital conflict. She has a std 8 education. She was previously seen for five sessions of psychotherapy approximately eighteen months prior to her current admission but no other history of note.

2. Adaptive contexts of session

1. The patient had been handed over for therapy by her previous therapist who had applied for and been given a transfer to another ward.
2. The patient had been assessed by her previous therapist and her case had been presented to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
3. The patient had attended groups on the ward run by her current therapist.
4. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
5. The patient had seen the psychiatric registrar on the ward for assessment for medication.
6. A misunderstanding had occurred on the ward where the psychiatric registrar had assumed that she would be taking over the patient for therapy from her original therapist. She had in fact been in session with the patient when the mistake was pointed out to her and she had then cut short the almost completed first session with the patient and the patient was then handed over to her current therapist.
7. The patient was being seen on an outpatient basis and no discussion of fees or assessment for fees had yet taken place.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1061
No. words patient	3116
No. words total	4177

Summary of therapist Interventions

Questions	3
Clarifications	3
Confrontations	0
Interpretations	2
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	1
Reflections	23
Encouragement	12
Suggestions	0
Advice	0
Total therapist responses	44

5. Therapist issues

The patient had arrived on time and unaccompanied for the session and the session had proceeded smoothly and the therapist had been grateful for this and felt that therapy was proceeding smoothly, with the patient starting to explore areas of her own functioning and difficulties.

6. Themes from session

1. I have a constant fear that something bad will happen to my children and this fear is worse when they are out of sight. (1-1)

T If they are away from you then you feel fear and anxiety. And you struggle to let go of them. (1-4)

2. My daughter is starting to go out with her friends more and although its difficult for me, I let her go. (1-5)

3. I have a good relationship with my children and we can talk about anything but I am overprotective of them. (1-5)

4. I get into a panic if my children are not home at the time that they are supposed to be. (2-1)

5. I wonder how other parents handle the pain and the heartache when things happen to their children. (2-5)

6. I don't allow any adults to play with my children because I feel very protective of them and this has caused arguments between my husband and I. (2-7)

7. My sister told me that she had been sexually abused by my uncle and that contributes to my feeling wary about people, even close family members. (3-2)

T It makes you feel very scared. It makes you feel very bad that people who should be protecting people, that should be close to people, are not doing that and it leaves you feeling very anxious. (3-5)

8. I am very wary when this abusive uncle is around my children. (3-6)

9. I can't tell my mother about this and I don't know why. (3-6)

10. I feel that my uncle has been very cruel to my sister. (3-6)

11. I was lucky that the same did not happen to me because my uncle tried to get me out of my bed and into his bed. (3-8)

12. I remember what my uncle did to me because my sister told me what had happened to her. (3-10)

13. I don't know how to protect my daughter without getting everything out of proportion. (4-1)

14. I don't trust anyone around my children and its not a good feeling. (4-3)

T It is also a feeling that you are trying to work out with yourself. I think it is very difficult because you want to get close to people and you want to trust them but the feeling is that they are a bit dangerous, like your uncle with your sister. They can look as though they are being helpful but they are not trustworthy. (4-6)

15. People try to protect the wrong doers but other people get hurt in the process. (4-7)

16. I nearly got myself molested if I had allowed it. (4-7)

T Mhhmn. You feel a bit about your uncle, on the one hand you feel that you were lucky and you had to be careful but on the other hand you want to protect him. You feel very strongly about what happened, very cross about that. (4-8)

17. I have a close bond with my daughter but she is getting to the age where she has her own friends. (5-2)

18. If my daughters are not with me then I am mainly alone. (5-4)

19. I feel very hurt about my friend who just seems to come and go into my life as she pleases. (5-6)

20. I always take her to places but she never seems to bother to ask me and it makes me feel hurt. (5-6)

21. We do things together and we talk together and then we lose contact and this happens often because she keeps disappearing from my life. (5-6)

22. I don't have the courage to tell her that I feel bad about that. (5-6)

23. I get very attached to this friend and then she just disappears. (6-1)

24. I feel a bit jealous if my friend is with someone else and I deliberately avoid contacting her. (6-3)

25. People must feel like I do. If I am friendly with someone then I will always make an effort, I will always be there. (6-5)

26. My husband abuses me but I have trouble retaliating because I feel sorry for him. (6-5)

27. I always seem to trust the wrong people and make friends with people who desert me. (7-1)

28. I feel used because if this person has a problem then they will call me but when things are going well for them then they don't call me. (7-3)

29. I get along better with men than with women because I am more spontaneous with men. (7-5)
30. I feel unconscious in the presence of women because they make me scared anxious and nervous. (7-9)
31. Other women make me feel that I am not good enough. (8-3)
32. I feel uncomfortable with women because I seem to think that they are better than me. (8-11)
33. My mother always expected that I should be someone else. (8-13)
34. My mother never accepted me for who I am. (9-3)
35. My mother preferred my sister who had a stronger will than me. (9-3)
36. I was always scared and anxious and found it difficult to trust other people or be with other people. (9-3)

T Yes its a feeling that you get every now and then with your girl friend and with your husband and with other people. One day they just won't be there for you. If you get attached to someone they are going to let you down and leave you. One day they just won't be there for you. And its also a feeling that your therapist is also going to let you down and leave you. It feels that it happens at all levels and in all cases. (9-8)

37. I am angry with myself because I have let other people become important to me. (10-2)
38. I always had the feeling that my mother was going to abandon me and I get angry with her because of it and so I don't go around to her house if she invites me. (10-4)
39. I feel that my mother loves my other brothers and sisters more than she loves me. (10-8)

T It feels as if she has more time for other people and that happens also in general. It feels like your husband and friend, they have more time for other people. It feels like all the people, your mother, your husband, your friend and even perhaps your therapist, they all seem to have more time for other people. (10-9)

7. Analysis of patient's material

Type of communication field

Mainly Type B. There is potential for Type A communication and much derivative material comes out in the session, but the therapist works mainly on a manifest level in this session. The patient alludes to a communication problem broadly when she speaks of not being able to tell someone something important (themes 9, 22).

Manifest representations of the adaptive contexts

There are no manifest representations of the adaptive contexts but the patient's material in the session as a whole points to the adaptive contexts. There are themes of seduction and sexual abuse of defenceless people, and of her own near abuse (themes 7, 8, 10, 11, 12, 16). There are themes of someone being inconsistent in their relating (themes, 19, 20, 21, 23, 27, 38) and themes of someone preferring someone else to her (themes 35, 39). In addition there are themes of not being able to tell someone something important (themes 9, 22).

Mode of relatedness

The patient alludes to her perception of the therapeutic relationship as being pathologically autistic through her themes of someone deserting her and not being consistent in their relating to her (themes 19, 20, 21, 23, 27, 28). In addition there are themes of someone not accepting her (themes 33, 34) and preferring someone else to her (themes 35, 39).

Mode of cure

The patient alludes to a maladaptive mode of cure through merger in her themes of being overprotective of her daughter (themes 1, 3, 4, 6, 8, 13, 14).

Dynamics and genetics

The patient speaks of her dependence on her immediate family, particularly her daughter, for a sense of security and in order to function. She is becoming more aware of the fact of her daughter growing up and away from her and of her increasing inability to rely on her husband as a source of stability and security. She has a close friend who reminds her of how she was with her husband before she was married to him and he started taking her for granted but this

friend is also proving to be not consistently available for her and this leads to feelings of rage at her perceived abandonment

Central pathological figure

While the manifest content of this session relates mainly to the patient and her difficulties the derivative material still points more towards the therapist and the frame as the central pathological figure in this patient's material.

APPENDIX 7

VALERY: SESSION 1

1. Brief background information

Valery is a 39 year old married woman with four children ranging in age from 15 to 21. She works in a factory as a machinist. She married her husband at age 17 after becoming pregnant. She reports a history of physical and emotional abuse at the hands of her husband, dating from shortly after their marriage. She reports a history of depression for the past two years when she discovered that her son had been involved in a gang and had been arrested for criminal activity. Her son had been found guilty of theft and robbery and had been sent to a reform school for a period of two years.

2. Adaptive contexts of session

1. The patient had received long term therapy in the past and had experienced disruptions in her therapy on two previous occasions when both her two previous therapists had resigned from the service and had referred her on for therapy. She had been referred to a therapist at O.P.D. who, very sensibly, had immediately referred her on for therapy following a brief discussion with her, when he became aware that he would not be able to provide the long term relationship that the patient needed in view of his own pending departure from the unit.
2. On referral, the referring therapist explained his reasons for the referral and walked with the patient across the grounds to the office of the new therapist and introduced the patient to the new therapist. At this meeting the new therapist shook hands with the patient and arranged a time that was mutually acceptable, explaining that it was to be a set time. No further interactions occurred with the patient at this brief first meeting.
3. The patient did not appear for her first appointment with the therapist and tried in vain to contact him, eventually leaving a message. The therapist contacted the patient to set up another time for therapy on a different day.
4. The following week the patient arrived for therapy on her original day, forgetting that the day had been changed. She waited unannounced in the waiting area and was noticed after ten minutes by her therapist who was fortunately able to see her at that point although starting the session some fifteen minutes late.
- 5 The patient was seeing the medical officer at O.P.D. concurrently for medication.

6 The patient's confidential file is kept at the reception desk at O.P.D. (following standard procedure at O.P.D.)

7 The patient pays for her therapy at a reduced monthly rate, regardless of the number of sessions that she has during the month (following standard procedure at O.P.D.)

3. Triggers from within the session

1. The therapist does not make any sound communicative interventions within this session.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1113
No. words patient	4324
No. words total	5437

Summary of therapist interventions

Questions	16
Clarifications	5
Confrontations	0
Interpretations	0
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	7
Reflections	23
Encouragement	1
Suggestions	0
Advice	0
Total therapist responses	52

5. Therapist issues

The therapist had felt mildly annoyed by the mix up in the times for the session and by the fact that the patient had arrived at a time when it was not really convenient to see her.

6. Themes from session

1. Someone got involved with gangsters and it made me feel bad. (1-6)
2. People go to work and are robbed. (1-6)
3. I felt bad because someone close to me was involved with robbing other people. (1-6)
4. Someone was sent away to a place for punishment and I had trouble accepting this, it was very heavy for me. (1-6)
5. Things became chaotic because of this. (1-6)
6. There is someone that I no longer understand like I used to do. (1-6)
7. Someone felt that I must do all the talking and that became too much for me, it made me feel very lonely because it seemed like I was standing alone and he was not supporting me. (1-6)
8. Someone said that we have to stand together but it seemed that I was alone and he was just giving out rules that have to be carried out and we then became like two strangers and this made me feel hurt. (1-6)
9. I am doing everything in my power to keep things together despite the difficulties and to my disappointment I found out that people close to me drink. (2-1)
10. Even though this person is old enough to drink I feel that, because of his position he should lead an exemplary life and not drink, but he has and I feel very disappointed. (2-2)
11. Someone drinks and does not care about others and it made me feel depressed. (2-2)
12. When I felt depressed I went to the Doctor who gave me something to calm myself and he spoke to me and it helped because there was someone that I could talk to. (2-2)
13. When I became depressed and suicidal the Doctor sent me to O.P.D. and I was helped. (2-2)
14. I made an effort to talk and laugh and to make jokes even though I was depressed. (2-2)
15. I am glad that someone is how they are now compared to how they were before. (2-3)
16. Someone was about to lose his privileges and he ran away. This disturbed me very much but I demanded that I get support. (3-1)
17. I am grateful to these people who are firm but kind. (3-1)
18. Things were so serious generally that I became closer to someone and I developed more trust talking to him about how I feel and where I feel he is wrong. (3-1)
19. Sometime during that period of chaos this person was oppositional and would not listen and I would feel that he was wrong and he never gave me a chance to talk. (3-1)

20. I felt lonely and unsupported and I could not talk about my needs. (3-1)
21. I want this person to be happy. He caused his difficulties and he must suffer the consequences but I hope that we can pick up again and be happy. (4-6)
22. I don't want to be apart form people. (4-10)
23. I spoke to someone recently asking him to be more demonstrative and to show his caring and his interest. (5-2)
24. When things go wrong I am the one who has to do the talking. (5-4)
25. I had the suspicion that someone had been drinking and it devastated me because it felt like I was losing everybody. (5-4)
26. This person denied drinking but he said that he had been pushed away by someone. (5-6)
27. I spoke to someone and I told him that he had an ugly attitude because he pushed people away. I told him that he must give people a chance to talk to him. Before people can open their mouths he says he doesn't want to hear anything and I think that is wrong. (5-6)
28. I don't want someone to think that they have caused the problem, I want us to be together and to support each other. (6-3)
29. Someone has given their co-operation lately and he has shown that he values what we are doing. (6-5)
30. I am trying to keep this person away from people who are a bad influence on him. (6-5)
31. I want someone to not have contact with his friends who are a bad influence and it seems possible.
32. Someone had a tattoo mark on his leg and I burnt it off with boiling plastic just to show how serious I was about him not affiliating with bad company. (7-1)
33. Someone is very easily influenced and just seems to go in whatever way people say he must go. (7-7)
34. I neglected to check up on someone and I discovered that he was not where he should be and this lack of attendance has been going on for some time and it gave me a shock to see what he was up to. (8-4)
35. Someone does not support me and their are times when he does not do his duty. (8-4)
36. There was a time when I was so sick that I did not even know my own children. (9-4)
37. Someone is drinking and I am afraid that they will cause someone else to lose their life and this is now the second one. (9-8)

38. I thought this person would be a good example to others but he is not and it makes me feel depressed and it makes me want to just be alone with no one around me. (10-3)

39. This made me feel so depressed that I contemplated suicide and I left a note for the family in case I ever did it. (10-9)

T And the feeling was that if you hadn't written it then your man would not do such a thing. Its also a feeling that you are feeling bad and you are feeling that something will happen to you. And perhaps its also a manner of trying to explain to your husband about how strongly you feel about things. (10 - 12)

40. Someone was drinking and carried on with me in such a way that it made things very chaotic. (11-5)

41. I felt that I had to be careful as to what I said because this person would start drinking again and using drugs. (11-5)

42. I was very forgiving and always forgave this person but when things went badly everything came back to me. (11-5)

43. I can't seem to talk to someone without his getting irritable and into a rage and we became estranged. (11-5)

44. I feel hurt because someone did not bother to make enquiries. (11-9)

45. I have taken risks in regard to someone because I care and have rights over this person. (12-1)

46. Someone undoes my good work by using violence instead of talking and it makes me feel hurt. (12-1)

47. If someone uses violence it does not encourage people to talk. (12-3)

T It makes you feel bad. You are trying to get them together and this happens and so you end up thinking that its a bit hopeless. (12-4)

48. Someone drinks when he is not around me and I saw it accurately. (12-5)

T This is now the second son, he is now beginning to do things over weekends. This was now another shock. So you began to feel that you are not effective as a mother or that things are going wrong and what is happening. (12-6)

The session ended at this point without any further themes emerging.

7. Analysis of patient's material

Type of communication field

Generally Type B but with Type A moments.

Manifest representations of the adaptive contexts

1. The Dr said I must come to O.P.D.. And then I got further help there ...(p2 par 2)
2. Because I feel that it helps every time I speak about what is worrying me and so I feel actually encouraged to come again and again to come and talk to you people in spite of the fact that everyone I talk to at O.P.D. has gone away and I have been going from one to the other. (p3 par. 5)
3. Yes because you feel that you must every time start again from the beginning even though it stands in the file. (p4 par 1)
4. That was a big blow and then I just felt that I must go to the Doctor, and then I just went every time to the Doctor. (p9 par 2)

Mode of relatedness

The patient alludes to her perception of pathological autism on the part of the therapist in the therapeutic relationship with material relating to being pushed away by someone (themes 18, 26, 27, 43, 46, 47). There are also many themes of being alone and not being supported (themes 7, 8, 20, 35) and of someone neglecting their duties (themes 34, 35, 38, 44). To some extent these allusions are tempered slightly by some allusions to a more healthy therapeutic symbiosis which is represented by themes of being helped and supported (themes 12 and 13) but these themes are more at a manifest level and lack the force of the more negatively toned derivative material referred to above and hence the overall perception remains one of pathological autism.

Mode of cure

The preferred mode of cure is through action discharge and merger rather than through insight and holding.

Dynamics and genetics

There are virtually no allusions to the patient's dynamics and genetics in this session which is mainly taken up with her material regarding other people in her life and how their actions have troubled her.

Central pathological figure

Most of the thematic material of a derivative nature is negatively tinged and it relates mainly to the therapist (in a derivative manner) or more specifically to the deviant frame which needs to be attended to before the patients material can be foregrounded in the session.

APPENDIX 8

MONICA: SESSION 8

1. Brief background information

Monica is a 26 year old female with a professional degree. She was first admitted to the hospital approximately nine months prior to the current session, for symptoms of depression, social withdrawal, anxiety, nightmares and poor self esteem. These symptoms had started following the death of her fiancé seven months prior to her admission. She remained in the ward for six weeks and was then discharged for outpatient follow up by her ward therapist. She was seen for therapy for five months before being handed over to her current therapist, for the continuation of her therapy, following the completion of her first therapist's internship. She had been in therapy for over three months when the current session was recorded.

2. Adaptive contexts of session

1. The therapist had interviewed Monica previously, while she had been an inpatient at the hospital. This had been a one off, intake assessment interview and it had occurred approximately eight months prior to her outpatient therapy. Monica had no conscious recall of this specific interview, but recalls being interviewed by many people in the course of her referral and admission to the ward at that time.
2. Monica had been handed over for therapy approximately three months prior to the current session with the understanding, at the time of being handed over, that she could be handed over for therapy again when the therapist (who was in training) completed her placement at outpatient department and would have to move to her next placement.
3. Monica was seeing the medical officer at O.P.D. concurrently, for her medication.
4. Initially Monica was seen for therapy every second week, she was then seen on a weekly basis at the same time, on the same day, thus tightening up this aspect of the frame.
5. Approximately six sessions prior to this session the therapist had allowed Monica's current boyfriend into the session, at his request. During the session he had invited the therapist to have a meal with them. The therapist had politely declined the invitation.
6. The therapy was being supervised.

7. Monica was paying for her therapy on a monthly basis at a reduced fee (following the standard practice at O.P.D.)
8. Monica had missed some sessions because of her temporary employment.
9. The confidential patient folder is kept at the reception desk (following standard practice at O.P.D.).
10. Monica reports to the reception desk before her appointment and waits at the reception area along with many other patients prior to her appointment (following standard practice at O.P.D.).
11. The Outpatient department was in the process of restructuring and streamlining its services by requesting patients from other areas to be seen for follow up appointments by the clinics in those areas. Monica had gained the mistaken impression from the reception clerk, just prior to the current session, that this applied to her.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1630
No. words patient	6047
No. words total	7677

Summary of therapist responses

Questions	32
Clarifications	20
Confrontations	0
Interpretations	1
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	7
Reflections	11
Encouragement	13

Suggestions	0
Advice	0
Total therapist responses	84

5. Therapist issues

The therapist was in training and was coming to the end of her placement. This fact had been mentioned to the patient, early on in the therapy, together with the resultant possibility of her having to be handed over for therapy again to another therapist after four months. The therapist had decided to offer the patient the opportunity of staying on in therapy with her when she moved to her next placement but had not yet communicated this to the patient.

The therapist had felt that the patient's current boyfriend was inappropriate and was not a good influence on the patient. She felt that the patient needed to be helped to stand up to him and to learn to be more assertive towards him. Subsequently the therapist had learned with approval that he seemed to be out of favour with Monica.

The therapist felt that Monica did not give her much chance to talk and to say things. She felt that the patient closed up a bit and did not actually want to explore things but just seemed to wrap things up in a nice, neat summary, which often sounded too neat and trite.

6. Themes from session

1. My work is hard because I have to attend to many people and I have to take many messages. I feel exhausted and I can't wait for the end of the day. (1-7)
2. Someone is leaving me. (1-8)
3. I feel left out because this person does not seem to have much time for me and I realise that this is the last time for us. (1-10)
4. I'm not important for this person any more. (1-12)
5. I'm very surprised because I didn't ever think that this person would get involved with someone else. (2-1)
6. It is hard for me because I won't have this person to talk to when I am in a depression or when I am lonely. (2-3)
7. This person has tried to spend more time with me but it is clear that she is busy. (2-5)

8. This person doesn't want to talk about the issue of leaving because she is also scared. (2-7)

T So she's expecting you to protect her against your own feelings... (2 - 8)

9. This person is leaving quite soon but I can't believe its going to happen. (2-9)

10. I always thought that I would be the one to leave first because I've always been the main person in the relationship but now things have changed. (3-1)

11. I am excited for this person but I also feel sorry for myself. (3-3)

T I can see that, given the history that you have had with her as a friend, um, a lot has changed between the two of you. (3-4)

12. I'm always being left behind. (3-7)

T And that's something new for you because when you were younger you were always the one in the lead. (3-8)

13. I *also* want to be involved with someone who can look after me and I don't want to be on my own. (3-9)

14. The two most important people in my life have left me. (4-1)

15. I'm scared because perhaps no one wants me. (4-3)

16. I don't seem to be getting anywhere while everyone else seems to be making progress. I feel powerless and helpless. If I was involved with someone else then I would be happier. (4-7)

17. This person is damaging me and doesn't want to listen. This person scares me and hurts me. (4-8)

18. This person is abusive towards me and says negative things to me, pulls me down a lot and tells me that I am mad, deceitful and unfaithful. (5-1)

19. This abuse happens continually and after a while I begin to believe it myself. (5-3)

20. I have had to work hard for everything that I get. (5-7)

21. I could have been involved with someone beautiful if it wasn't for this person who then went and abandoned me. (5-9)
22. This person has been threatening to tell someone about me. (5-9)
23. This person keeps abusing me and won't listen to me when I tell him off. He can't see reality but accuses me of being mad. (6-4)
24. This person is very inconsistent with me, and it scares me and I want to get rid of him. (6-4)
25. I want this person out of my life because he spoils my chances with others. This person threatens me and threatens to kill anyone that I am with. (6-6)
26. I am scared not to be nice to this person. I could have gone into a relationship with this person but I know it could never work because he has had too many other people in his life. (6-8)

T It's important what you say there, that that you feel wiser than you did before, because you've been talking about how you're stuck, how you haven't moved on, how everyone else is ahead of you...you also know that you have learned about yourself. (7-1)

27. I know that this is not the right person to get into a relationship with, it will be a disaster and it will be digging a grave for myself. (7-2)

T So what you might see as not moving forward is in fact being more cautious about what you decide to let yourself in for. (7-3)

28. This person thinks that I am unfaithful, thinks that I am promiscuous and questions me about who I am with, even though I tell him that I am not committed to him. He has no right to reprimand me with regard to who I am with. I have the right to choose my friends. This person insists on doing that so I am convinced he is mad. He is weird and I don't know how to get rid of him. (7-4)

29. I should cut ties with this person but I feel sorry for him and I don't like being cruel. (7-8)

T And that's because of the nature...the secret nature of your communication, um its as though he has a hold of you in that way. (8-2)

30. I don't want other people involved in my relationship. (8-3)
31. This person is trying to use another person in order to force me to be involved with him and I don't want anyone else involved. (8-5)
32. Despite everything that this person does to me I need someone who can be nice to me (8-7) and that I can be special to. (8-9)
33. I think that I am being too fussy in rejecting this person. (9-1)
34. I don't want to have to work hard, I just want to be happy. I have been spoilt (9-3)
35. If I work I want to work at my own self understanding and work so that I can see the effect on people and the other person in the relationship must be able to support me. (9-5)
36. I don't want to work too hard but it feels as though everyone is getting ahead of me and I'm just starting out. (10-1)

T I agree with you that its a different thing to what's happened to most of the friends that you have, and it sounds as though everyone else is on the same wavelength and has gone through the same channel. But its not necessarily to say that you're behind them in any way. It's just that life's turned out different for you. And that's obviously something that you have to cope with and take into account when you're evaluating yourself. (10-6)

37. I think the solution for me is to find someone to commit myself to and then we will have a life together and they will be good to me. Other people are encouraging me to do that. (10-7)
38. I would get into a committed relationship if I had someone that I wanted. Other important people would like me to be in a committed relationship. (10-9)
39. This person is saying bad things about me to other people and telling them not to mix with me but he won't tell me what he is saying to others. (11-7)
40. This person won't allow me the freedom to feel what I feel about another person. This person doesn't respect my feelings and it makes me feel powerless. (11-7)

T I'm sure he does because everything that you've described to me about him is him trying to control you. If somebody is trying to control you, you are going to feel powerless. You...because everywhere you turn there's another wall which you hit against. And when you

came in the room now, when you started talking in this session, that was the feeling I got from you, that you felt powerless, and helpless and that the world was impacting on you in a negative way and you couldn't do anything about it. (12-3)

41. I feel powerless and unsure of myself as a person. My self esteem is very low and I don't like the way that I look. This person reinforces all of the negative thoughts that I have about myself. (12-4)

42. If I was not in therapy or on medication I would feel much happier. (12-6)

43. I'm trying to understand why I am like I am. It feels like I have an invisible stigma that won't go away. (13-3)

T And I think that you must realise that your ability to come to therapy is a power, a strength in you to look at yourself. (13-8)

44. I feel sad and unhappy because I have lost the person that I love so much. (13-11)

T There is a lot of sadness in you and a lot of unhappiness. I agree with that. Um...I think sometimes when things are feeling really bad, its easier to say; "I'm completely a sad person, and that's all that I am". And I don't think that's true. I think you are very sad, and there are parts of you that are still grieving deeply. But I don't think that that's all there is. I think there's someone with quite a lot of energy, and love, and things to give... (14-5)

45. I am very gullible to believe people. I allow myself to be taken in by people who are nice to me. I must be careful because some people are not always what you think they are and I could make a big mistake. (14-6)

46. I don't want to rescue this other person. (15-1)

47. I take in all the wrong things and its not good for me but I keep taking in these things because I feel bad and its damaging to me. (15-3)

48. I feel that I am letting myself go and I can't do anything about it. (15-7)

49. I am damaging myself by taking in too much and I do this because I 'm not expressing my feelings properly. (16-2)

T Mhmmn. Its absolutely that. I know it's got nothing to do with wanting to be fat. It's got to do with not wanting someone else to control you or to perceive that they can control you. (16-9)

50. I've been controlled all my life and I want to get into a relationship with someone in order to get away from this control but I don't want to get into a relationship with the wrong person. (16-10)

51. I am afraid of this person. She talks to me like a child but I always want to please her because she scares me. (16-12)

T Which is what makes it so hard for you to feel anger towards her, even for yourself you don't find it easy to do. (16-13)

52. This person loves me too much and that is why she tries to control me. She doesn't want me to be independent and to make my own mistakes. (17-1)

53. I feel angry towards these people because they try to control me, take away my independence and make me feel powerless. They are not malicious they just don't know how to treat me properly. (17-3)

The session ended at this point with no further themes emerging.

7. Analysis of patient's material

Type of communication field

Type B because of the unsecured frame and because of the lack of decoding of the patient's unconscious material. There is much evidence of the patient's use of type two derivatives but these are not interpreted interactionally by the therapist which would then have created a Type A communicative field.

Manifest representations of the adaptive contexts

1. If I wasn't seeing a psychologist and I wasn't being on medication....it feels almost as if I'm not right man. That would make me feel more happy. (12-6)

2. Ja, and what about the sessions for...like how long...I don't know if I qualify with the situation in front here with regards to going to other clinics or something like that. (18-1)

Mode of relatedness

The primary mode of relatedness is pathological autism with an inability to respond to the deep unconscious material from the patient. Much of the derivative material relates to inappropriate abandonment, absence at a time of need and rejection.

Mode of cure

There is evidence of an attempt at merger and action discharge as a mode of cure rather than true interactional insight.

Dynamics and genetics

The patient makes the most telling statement of the session when she talks about her realisation that she has lost a false foundation with the death of her fiancé and that she now needs to face up to herself and her limitations. This admission comes only at the end of the session when she realises that her therapy is not about to be terminated prematurely but that she is to continue seeing the therapist. The patient has a powerful mother and has had to deal all her life with issues of autonomy and independence and has struggled with feelings of intrusion and control. On the one hand she has appreciated the merger with a more powerful figure but on the other hand has not been able to deal with the lack of autonomy that this has entailed. All of the patient's issues are however obscured by the deviant frame which does not allow her the space to bring up and deal with her dynamics and genetics because the more pressing issues of the frame breaks come to the fore.

Central pathological figure

The central pathological figure in the current session is generally the therapist or more broadly the context of the therapy, with the patient alluding generally and symbolically in derivative fashion to many issues that need to be addressed in the frame.

APPENDIX 9

LALA: SESSION 4

1. Brief background information

Lala is a 24 year old female with a long history of childhood sexual abuse with several perpetrators. She reports that her childhood was chaotic with her parents divorcing and her mother living with several friends. She reports that her mother abused her physically. The sexual abuse began at approximately age four and several of her mother's friends were the perpetrators. Because of the chaos in her mother's home she went to live with an aunt and uncle and the sexual abuse continued at the hands of her uncle. It stopped at puberty.

Lala was admitted to the crisis intervention ward at this hospital with symptoms of depression four months prior to the current session . She has reportedly been dysthymic since puberty but her depression was exacerbated by her finding herself in the same working environment as one of the perpetrators of her childhood sexual abuse This, together with the remarriage of her mother caused a crisis in her life and necessitated an admission to the unit. She is currently living with another of her aunts and currently shares a room with an adult male cousin. Despite her intelligence and high school education she works at low level factory jobs.

2. Adaptive contexts of session

1. The patient was referred for therapy by the medical officer at O.P.D. and continues to see this person concurrently for medication on a regular basis.
2. The patient's confidential file is kept at the reception desk at O.P.D. (following standard procedure at O.P.D.).
3. The patient reports to the reception desk prior to her appointment and waits in the reception area along with many other patients (following standard procedure at O.P.D.).
4. The patient comes for therapy only every second week. She does not have a regular time but makes the appointment every session.
5. Prior to the current session the patient had been admitted to the inpatient crisis intervention ward for a three week period. She was discharged from this ward and followed

up by the outpatient department and thus handed over for therapy by her therapist on the ward to her current therapist.

6. The patient is aware that her therapist is in training and will be transferred to another ward at the end of her four month placement period with implications for the continuation of the therapy.

7. The therapy is supervised.

8. The patient pays for her therapy at a reduced monthly rate, regardless of the number of sessions that she has during the month (following standard procedure at O.P.D.).

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1033
No. words patient	4314
No. words total	5347

Summary of therapist interventions

Questions	44
Clarifications	5
Confrontations	1
Interpretations	0
Silences	2
Playback of derivatives	0
Framework management	0
Patient management	1
Reflections	15
Encouragement	29
Suggestions	0
Advice	0
Total therapist responses	97

5. Therapist issues

The therapist reported feeling well disposed towards the patient and wanted to keep her on as a long term therapy case when she moved to her next placement although, at the time of the session here recorded, this had not been communicated to the patient and the understanding was that there was a possibility of termination at the end of the therapist's placement at O.P.D.. The therapist reported that the patient seemed to be talking about many rather superficial things in the therapy sessions without getting down to the real issues and real feelings in the therapy. Indeed the whole question of her previous sexual abuse had not yet surfaced in the therapy and neither had any particularly deep topics, according to the therapist.

6. Themes from session

1. I was reluctant to work at this factory because it involved working with family. (1-8)

T What kind of factory is it?

T Are you working as a machinist?

2. I do a mundane job and nobody bothers me. (1-14)
3. I didn't want to do the job because it became too much for me and things broke. (1-14)
4. I don't communicate much with other people. (2-10)
5. I don't want to get too involved with some people. (2-12)
6. These people seem to turn issues around. (2-14)
7. The work I do bores me. (2-16)
8. I got excited because I knew answers to some questions. (2-18)
9. I just sit around not actually talking to anyone. (3-6)
10. Someone was impressed with me because I knew a lot of the answers. (3-6)
11. Someone asked me what I would like to study next year and I answered psychology. (3-14)
12. I've learned a lot through my experiences that someone is trying to learn about in books. (4-2)
13. When I spoke about my aspirations of becoming something, someone used to laugh and not say anything. (4-6)

14. I wanted to help other people because I couldn't be helped myself. (4-10)

T Mhmmn. Ja that makes a lot of sense for both psychiatry and law. In psychiatry and psychology you're helping people with emotional difficulties and with law you're fixing injustices. I'm sure as a child you felt a lot of injustice was done to you, and you wanted to fix that. (4-11)

15. Someone tried to put me off my therapy but I refused because it is important. (5-2)

16. Someone agreed that I come for therapy. (5-4)

17. Someone wanted me to put off my appointment but I insisted and I asked her what is more important the work or my health. (5-4)

18. Someone seems to think that money might be more important than my health. (5-6)

19. Someone asks me "what's wrong?" when I appear quiet but when I do something about what is wrong then they suggest that I change my appointment. (5-12)

20. Someone has given me the means to attend therapy but I am a bit bothered by what she said. (6-3)

21. There is some confusion, but people seem to want me to come for therapy and they provide the means for this. (6-6)

22. Someone is angry with me because I am ignoring them. (6-10)

23. But this person can't seem to decide whether they want a relationship with me or not. (6-12)

24. This person, who can't seem to decide on a relationship with me, tries to get intimate with me and forces me to respond after previously rejecting me and it opens up old wounds. (6-12)

25. This person expects me to switch on and off like an appliance but I just can't switch on and off, I need consistency. (7-1)

26. If this person cannot understand my need for consistency then I don't want this relationship. (7-1)

27. This person seems to get angry when I stand up for my rights to avoid them. (7-3)

28. Many people want me to make contact again with this person, but it is for their own reasons. (7-3)

29. Someone is cross with me but I don't feel like making contact with them because then they will think that I am in need of them. (8-4)
30. Every time we have an argument then I have to apologise first but this time I'm not because this person chose to break up with me and I'm standing by this choice. (8-6)
31. The work that I am doing is not very interesting, I just pull pieces of thread. (9-3)
32. I spend a lot of time thinking. (9-7)
33. Someone only has short superficial conversations with me. (10-1)
34. I don't feel like going to stay with someone because I know how things are there. (10-1)
35. The only time someone has contact with me is when I am working. (10-3)
36. Someone offered me the chance to go and live with them but I declined because I know what they are like. (10-5)
37. I can talk to this person that I am with quite comfortably but not this other person who seems to want me to come and live with them. (10-9)
38. I have very superficial conversations with this person. (11-1)
39. This person doesn't tell me that there is something wrong although I can tell that there is. (11-5)
40. This person gets upset when I tell them that I don't know when I can come to see them. (11-7)
41. I keep quiet with this person because I was punished previously for saying things. (11-9)
42. If I say something then I will be punished. (11-11)

T As a child with those kinds of rules, you're powerless to do anything else...which is why I'm glad to hear that with your boyfriend at the moment, although I understand that it's difficult, it sounds as though you are saying what you want to say to him. (11-12)

43. I'm the one doing most of the talking, this person wants to wait until later or wants to wait until next week. (12-3)
44. But then when the time comes this person doesn't want to talk. He doesn't say a lot and he seems to feel inferior to my friends. (12-5)

T Which makes it harder for you, because you can't share your friends with him. (12-6)

45. Someone is more comfortable talking about superficial things. (12-7)
46. Someone has strange outdated ideas (about a woman's place being at home). (12-9)
47. I feel that I am the only one working in this relationship, so when this person made the choice to break up, I agreed and wanted to stick with it. (13-6)
48. Even though this person is older than me, he is less mature than me and does not want to grow up. He does not want to commit himself, he wants to be free and I say he can be free because I'm wasting my time. (13-10)
49. This person doesn't want to make up his mind and commit to the relationship so I would rather break off the relationship because I have seen too much. (14-2)
50. I make compromises for someone but they don't for me. (14-6)
51. I would not have an intimate sexual relationship with friends because it will ruin the friendship. (14-6)
52. If I know somebody too well then I don't want to be in an intimate sexual relationship with them. (15-3)

T We've got a few minutes left...um...do you....do you want to reflect a little bit on how you feel, now that it's the end of the session? (15-4)

53. I'm not going to let anyone pull me down or depress me. I'm going to do what I feel like doing. (15-5)

T Mhmmn. My impressions of you today...you seemed um, I'm not sure how to describe it, but you have a bit more energy today than when I've seen you previously. And obviously there's changes, and there are still a lot of things in your life that are affecting you deeply. And I think hearing from your mother this week was quite something. (15-8)

54. I can see that some things are totally wrong. Sometimes you have to loosen the stitch on a garment and it is still wrong. (15-13)
55. You can never teach older people, they don't want to be taught. (16-1)
56. It is no use trying to teach older people so I'd rather just leave them because they are stubborn. (16-3)
57. I won't bother with someone because it will cause an argument so I just leave it. (16-8)

7. Analysis of patient's material

Type of communication field

Generally type B but with Type C elements. There is potential for a Type A communication field but the therapist is working mainly with manifest content in this session.

Manifest representations of the adaptive contexts

1. I told my aunt I've got an appointment and so she said can't I change it? And I said no, that's my appointment and I can't change it. (p5 par 2)
2. And then I told my uncle that I had an appointment and he said but you have to go. (p5 par 4)
3. Ja, um when I'm quiet then she asks what's wrong with me. But then when I'm coming to the hospital or something, then "can't you change it for another day?" And so I said no, I don't feel like it, it was my appointment so I'm going on that day. (p5 par 12)
4. ...then I told my uncle that I've got an appointment, so he said okay. (p6 par 6)

In addition to the above manifest representations of one of the adaptive contexts (relating to the lack of a set time) there are many allusions in the patient's thematic material to other adaptive contexts. Thus there are themes of not wanting to have dual relationships with someone (themes 1, 51, 52), themes of someone being ambivalent about wanting a relationship with her (themes 23, 24, 25, 29) and themes of breaking off a relationship with someone (themes 47, 49, 56).

Mode of relatedness

The patient alludes to her perception of the pathological autism on the part of the therapist through her themes of someone having short superficial conversations with her, of not being real with her, of putting off talking to her or of not working in the relationship (themes 33, 38, 39, 43, 44, 45, 47)

Mode of cure

The preferred mode of cure is through action discharge and merger rather than insight and holding.

Dynamics and genetics

The patient has experienced appalling neglect and abuse as a child and yet has emerged from her childhood with relative strengths. In this session she refers to her mother not allowing her to talk about things and punishing her if she does. Linked to this is an expressed need for her objects to be constant, reliable and, in her words, to be real. There is the expressed need to maintain boundaries and to have consistency in her relationships and not to put off important things.

Central pathological figure

The central pathological figure in this session is the therapist or more specifically the therapeutic frame which needs to be rectified before the patient's material can be properly foregrounded.

APPENDIX 10

GRACE: SESSION 8

1. Brief background information

Grace is a 56 year old Muslim woman who was seen for psychiatric intervention approximately nine months after the death of her second husband. Approximately four years prior to this her two adult sons had converted from Islam to Christianity. This had been a source of great anguish for Grace who, according to her understanding of the dictates of Islam and according to the express wishes of her extended family, was now forbidden to have any contact whatsoever with her two sons. Although fully mobile the patient has a long history of physical problems and has had operations to her back. She was initially referred to psychiatry from the pain clinic at Groote Schuur Hospital because of her suicidal ideation.

2. Adaptive contexts of session

1. The therapist saw the patient together with the referring doctor at O.P.D. for a joint session of family therapy together with the patient's two sons. This occurred shortly after the patient was handed over for therapy on an individual basis to the therapist.
2. The joint family therapy has not occurred again but it has not explicitly been terminated and thus the possibility that it may occur again is implicit.
3. The patient was initially seen on a supportive basis but, according to her therapist this was changed recently to a more exploratory basis. This essentially involved the therapist taking a less active role and allowing the patient more space to talk.
4. The patient is seen concurrently for medication by the referring doctor at O.P.D..
5. The patient's confidential file is kept at the reception desk at O.P.D. (following standard procedure at O.P.D.)
6. The patient reports to the reception desk prior to her appointment and waits in the reception area along with many other patients (following standard procedure at O.P.D.).
7. The therapy is supervised.
8. The patient pays for her therapy at a reduced monthly rate, regardless of the number of sessions that she has during the month (following standard procedure at O.P.D.).

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	896
No. words patient	2821
No. words total	3717

Summary of therapist interventions

Questions	30
Clarifications	7
Confrontations	0
Interpretations	0
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	1
Reflections	18
Encouragement	2
Suggestions	0
Advice	0
Total therapist responses	58

5. Therapist issues

The therapist is a Christian. She felt very sympathetic towards the woman's plight but felt that somehow the issue would be best handled by some kind of talk leading to a compromise between the patient and her two estranged children. The therapist agreed to take part in the joint family session with the referring doctor hoping that this would lead to a compromise between mother and children. Over the past few sessions the therapist had moved from a supportive approach to a more exploratory approach. In line with this approach the therapist had become less active in the sessions and had resolved not to undertake any further sessions of family therapy with the patient. None of this had been communicated to the patient.

During the session the therapist had been surprised by the revelation of the existence of the patient's boyfriend. No indications had been given of this in previous sessions. The therapist was also concerned about the patient's suicidal ideation and considered the possibility of hospitalisation.

6. Themes from session

T How have things been going? (1-1)

1. I am sheltering with someone because things are not going well with me. (1-2)
2. I have become involved with someone, who at first was very nice and spoke nicely but has now become aggressive. (1-4)
3. I used to be intimately involved with this person in the past. (1-6)
4. I thought that it would be nice to have someone to talk to but instead of things changing for the better things have changed for the worse. (1-6)
5. Someone has changed from the person that I knew previously and is proving to be aggressive. (1-6)
6. I struggle to handle my own feelings of anger without also having to deal with this person. (1-6)
7. I wouldn't let this person in so he tried to barge his way in and someone had to rescue me. (1-6)
8. I am living with someone in order to get away from this person. (1-8)
9. Someone is different from how I first knew them. (1-10)
10. This person is trying to mould me like a piece of clay and I do not want to be moulded. (1-10)

T It sounds like you resent the fact that he's trying to mould you. And you've been moulded all your life by your husband. (2-1)

11. I have been moulded all my life and I do not want to be moulded any further. (2-2)
12. Someone is trying to use violence on me in order to mould me. (2-2)
13. People close to me will protect me from the violence against me. (2-2)

T What you're saying is that you won't tolerate still being moulded at this stage. It sounds like despite you and the family's differences about your children they are still protective over you. The family is aware of him being in your life?

14. People close to me initially approved of my relationship with this person because it meant that I had someone to talk to. (2-4)

15. This relationship has just complicated matters because I am now afraid of the unpredictable violence from this person. (2-6)

16. The violence started a few months ago when this person tried to mould me the way he wanted to. (3-11)

17. I told this person not to try to mould me and that we have to compromise or else we have to end the relationship. (3-3)

18. This person didn't seem to understand and accept what I needed. (3-5)

19. I am not going to allow this person to tell me what to do the whole time because I have to deal with my own feelings. (3-7)

20. I haven't got the strength to fight someone telling me what to do and it has made me deteriorate. (3-7)

21. I am afraid of doing some harm to myself impulsively. (3-11)

22. Doing harm to myself would be a way out of the situation. (3-13)

23. I have to defend myself from people talking about me and it is difficult to do this without proof. (4-3)

24. People have been talking about me, slandering me and not believing me when I try to refute this. I am tired of defending myself and of being blamed for things that I have not done. (4-5)

25. If something happened to me then people might believe me but it seems like I have to keep defending myself. (4-7)

26. Someone said to me that they would simply shrug off any slander, but I feel that I have to prove that the slander is not true. (4-9)

27. If someone talks about me I can't be in relationship with them. (4-9).

28. There is always talk about me but never in front of me and no one admits to talking about me. (5-4)

29. People are pressing me into a corner and waiting for me to make a mistake. (5-6)

30. People are jealous of the fact that my father spoilt me. (5-8)
31. No one ever admits to things that they are doing even when I confront them with things. (5-10)
32. People are slandering me so badly that I think the only solution is to end my life. (6-1)
33. I have so many things to deal with that I want to explode. (6-5)
34. Someone has assaulted me in the past and is likely to do it again. (6-11)
35. Someone professes to be upstanding but gets aggressive with me and violently tries to mould me. (7-1)

T It's difficult for you to make sense of things because of the type of person you expected him to be which must be disappointing for you. I was wondering whether you had thought about how you're going to deal with the situation. (7-2)

36. I have to end this relationship but I don't know how. (7-3)
37. I would like to leave town but I need help and I have appointments to keep. (7-3)

T You speak about going away for a while, but it sounds like not dealing with the problem. You could go away and come back and the problem would still be there. (7-6)

38. Someone is sheltering me from this person and if necessary I will take legal action to prevent further violence against me. (7-7)
39. I want to enlist all available help to keep this person from me. (7-9)
40. I didn't talk about this before because I thought it was just between the two of us but its not. (8-5)
41. I refuse to be treated like a child when I am a grown woman. (8-7)
42. I have established my self and my life already. (8-11)
43. I don't want my independence and identity to be disrupted by this person. (8-13)
44. I'm not prepared to be moulded and pulled around like a piece of clay, I'm too old for that. (9-1)
45. I am going through many things that I can't even tell this person about. (9-5)
46. I'm not sure whether someone will understand me and accept me or whether their past life and experiences will interfere with their understanding of me. (9-7)

- 47. Someone thinks that their way is the only correct way. (9-9)
- 48. I can't tell this person this because they get violent with me. (9-11)
- 49. This person has done this previously and I am determined that it will not happen again. I do not want to end up in a psychiatric hospital because of their damage to me. (9-13)
- 50. I keep quiet just to keep the peace. (9-15)

T It seems reminiscent of your relationship with your husband where you had to be a good wife and not backchat. It's almost like reliving all of that. (10-1)

- 51. Someone is trying to push me into a dark tunnel and I am trying to resist that. (10-4)
- 52. I don't know how long I can hold on for, if I hadn't been rescued it would have been the end for me. (10-8).
- 53. I don't know who I can trust to talk to. (5-4)

The session ended shortly after this with no further themes emerging.

7. Analysis of patient's material

Type of communication field

Type B with elements of Type C.

Manifest representations of the adaptive contexts

There are no manifest references to the adaptive contexts but the patient alludes to the adaptive contexts through her thematic material of someone changing from previously and becoming more aggressive (themes 2, 3, 5, 9); themes of someone violently forcing themselves on her or pressing her into a corner (themes 7, 12, 15, 29, 34, 35, 49); themes of someone trying to mould her (themes 10, 12, 16, 35) and themes of not wanting to be moulded or treated like a child (10, 11, 17, 19, 41, 42, 43, 44, 51); themes of defending herself against slander and of people talking about her (themes 23, 24, 25, 26, 27, 28, 32) and themes of something not being confined to just the two people (themes 40, 53)

Mode of relatedness

The patient alludes to her perception of the therapeutic relationship as being one of pathological autism through her derivative material of people not understanding her or believing her or admitting things when she confronts them (themes 18, 24, 31, 45, 46, 47).

Mode of cure

The preferred mode of cure is through action discharge and merger rather than through insight and holding.

Dynamics and genetics

The patient talks of having been spoilt by her father and of feeling that others might have been envious of her. She grew up in a family where she was the only daughter, with nine brothers so there would certainly be some truth in that perception of being special to her father. She has the sense of being moulded all her life and presumably of being very obedient to the dictates of her large extended family and of her religion. She does things impulsively and without much deliberation having recently (a few months prior to the session) married the man she refers to in this session as her boyfriend. She talks of impulsively taking all her tablets and of moving to another city in order to get out of her difficult situation.

Central pathological figure

The central pathological figure is the therapist or the framework of therapy, which needs to be properly rectified before the patient's material can be adequately addressed.

APPENDIX 11

GRACE: SESSION 9

1. Brief background information

Grace is a 56 year old Muslim woman who was seen for psychiatric intervention approximately nine months after the death of her second husband. Approximately four years prior to this, her two adult sons had converted from Islam to Christianity. This had been a source of great anguish for Grace who, according to her understanding of the dictates of Islam and according to the express wishes of her extended family, was now forbidden to have any contact whatsoever with her two sons. Although fully mobile the patient has a long history of physical problems and has had operations to her back. She was initially referred to psychiatry from the pain clinic at Groote Schuur Hospital because of her suicidal ideation.

2. Adaptive contexts of session

1. The therapist saw the patient together with the referring doctor at O.P.D. for a joint session of family therapy together with the patient's two sons. This occurred shortly after the patient was handed over for therapy on an individual basis to the therapist.
2. The joint family therapy has not occurred again but it has not explicitly been terminated and thus the possibility that it may occur again is implicit.
3. The patient was initially seen on a supportive basis but, according to her therapist this was changed recently to a more exploratory basis. This essentially involved the therapist taking a less active role and allowing the patient more space to talk.
4. The patient is seen concurrently for medication by the referring doctor at O.P.D..
5. The patient's confidential file is kept at the reception desk at O.P.D. (following standard procedure at O.P.D.)
6. The patient reports to the reception desk prior to her appointment and waits in the reception area along with many other patients (following standard procedure at O.P.D.).
7. The therapy is supervised.
8. The patient pays for her therapy at a reduced monthly rate, regardless of the number of sessions that she has during the month (following standard procedure at O.P.D.).

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	593
No. words patient	1845
No. words total	2438

Summary of therapist interventions

Questions	14
Clarifications	2
Confrontations	0
Interpretations	2
Silences	0
Playback of derivatives	0
Framework management	0
Patient management	2
Reflections	14
Encouragement	0
Suggestions	0
Advice	0
Total therapist responses	34

5. Therapist issues

The therapist was beginning to be concerned about the patient's suicidal ideation and the general air of hopelessness that was beginning to appear in the material from the patient. The therapist was beginning to feel that hospitalisation for a short period might be an option for the patient, but this was not brought up in this session.

6. Themes from session

1. I am staying with my brother. (1-5)

2. I am sleeping a lot during the day and hoping that when I wake up things will be better. (1-7)
3. I am in a bad relationship with someone and my brothers are helping me to deal with it by speaking to the person concerned. (1-13)
4. I have know this person for a long time but haven't seen him for a long time and he has changed. (1-13)
5. This person has aggressive ways and it is difficult to deal with it so I am staying with my brother. (1-13)
6. I am afraid of bumping into this person. (2-3)
7. This person has apologised but whenever I try to say things to him, sparks begin again. (2-5)
8. I am just trying to not think about my problems. (2-5)
9. Things seem hopeless and won't come right. (3-1)
10. Things won't come right so I just try to blank things out and think of nothing. (3-3)
11. Things seem scary and painful. If I think about my children I am in pain and if I think about my family I am afraid they will know that I have seen my children. (3-7)
12. I sometimes want to talk to someone in the middle of the night and there is not anyone. (3-11)
13. I question God and then I feel guilty about it. (4-4)
14. Sometimes I eat and I don't know what I am eating. I am always hungry but I am losing weight. (4-6)
15. I am not taking in any food that is nourishing to me and my health is deteriorating. (4-8)
16. I think that all of this has happened to test my faith. (4-10)
17. I sometimes feel that I might end it all but then I realise that I have someone in my brothers and they are beginning to understand and they take me wherever they go. (5-5)
18. But sometimes I am alone and there is no one to talk to. (5-5)
19. I sometimes worry about being called mad but I think that I have overcome that. (6-1)

T It sounds like it is an upward battle and its difficult. What you're experiencing is difficult. It sounds like there are things that you've accomplished and you've overcome certain things and there are other things you still need to do and it might be a long battle

ahead. But it sounds like you have the strength and the courage to overcome the obstacles.
(6-7)

20. I don't know how I will act if one of my sons returns. I don't know if I will accept him back or if I will want to punish him. I am worried about what people will think. (6-10)

T It sounds like it comes back again to what other people might think rather than what your own feelings about it might be, and maybe that's a scenario that you're still trying to deal with. And that's your fantasy which is important to you which we could address. Maybe we can look at that next time. Okay?

The session ended shortly after this with no further themes or interventions being made.

7. Analysis of patient's material

Type of communication field

Type C with elements of Type B.

Manifest representations of the adaptive contexts

1. Do you feel it's better if you tape? (p1 par.)
2. Anyone seeing me going to Lentegueur Hospital - I couldn't care less. Anyone asks where you're going - I'm going to Lentegueur Hospital. I'm seeing a psychiatrist, psychologist whatever. I don't care what they think anymore because I've got enough of my own having to battle. (p6 par 4)

Mode of relatedness

The patient alludes to her perception of the therapeutic relationship as being one of pathological autism through her thematic material of being in a bad relationship (theme 3); themes of someone having aggressive ways (themes 5 and 6) and themes of tension in the relationship with someone (theme 7); themes of no one being available when she needs them (themes 12, 18)

Mode of cure

The preferred mode of cure is through action discharge and merger.

Dynamics and genetics

Not much material is available in this session to speculate about the patient's dynamics and genetics. The patient is attempting to avoid her difficulties by not thinking about things and by blanking out her mind to the realities of her situation. There is the thought that she can end her difficulties by impulsively taking all of her medication.

Central pathological figure

The central pathological figure is the therapist and specifically the framework of therapy.

APPENDIX 12

NERINA: SESSION 3

1. Brief background information

Nerina is a 41 year old divorced, Muslim woman who converted to Islam from Catholicism approximately 18 months prior to her therapy. She works as a clerk, doing temporary work. Her parents were divorced when she was four years old and her mother remarried when she was six years old. Her stepfather had four other children. She reports that she was sexually abused on several occasions when she was 10 years old, by her step father. Her mother refused to believe her and accused her of trying to break up their marriage by reporting such things.

She was previously married for five years to a man who abused her physically. She has a 22 year old son from this marriage. She is currently in a sexual relationship with a Muslim woman whom she has known for two years and with whom she lives. She was referred to hospital because of symptoms of depression following tensions in her relationship, around the issue of her son and his dependence on her, which is resented by her partner. Other sources of conflict are her son's use of alcohol which is frowned on by her partner for religious reasons and her son's resentment of her lesbian relationship. Other sources of stress for her are her son's pending court case for sexual abuse of a child.

The patient spent three weeks in the crisis intervention ward and was given the diagnosis of adjustment disorder with dependant and narcissistic traits. She had two sessions of family therapy in the ward (with her partner and her son) and then apparently failed to keep two follow up sessions with her case manager/ therapist on the ward and was referred to O.P.D. for follow up. She was apparently reluctant to be discharged from the ward because she felt that she was not ready for the discharge.

2. Adaptive contexts of session

1. Nerina had been seen initially by a therapist in the ward who had then left the hospital service and had passed her on to another therapist on the ward. This therapist had in turn

referred Nerina for follow therapy to an out patient therapist who in turn had handed over Nerina to her current therapist when she had moved on in her training.

2. Nerina had been seen for family therapy (involving her son and her lover) by the two therapists in succession on the ward.
3. Nerina's lover, Zelda had also been present at her initial consultation with her current therapist (at Zelda's request) and she had attempted to come into the second session but the therapist had asked to see Nerina alone.
4. Nerina was seeing the Medical Officer at O.P.D. concurrently, for her medication.
5. Nerina's sessions were not at the same time on the same day but were at approximately weekly intervals whenever a time could be found for her.
6. The therapy was being supervised.
7. Nerina was paying for her therapy on a monthly basis at a reduced fee (following the standard practice at O.P.D.)
8. The confidential patient folder is kept at the reception desk (following standard practice at O.P.D.).
10. Nerina reports to this reception desk before her appointment and waits at the reception area along with many other patients prior to her appointment (following standard practice at O.P.D.).

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.

4. Quantitative data of session

No. words therapist	1268
No. words patient	1597
No. words total	2865

Summary of therapist interventions

Questions	56
Clarifications	4
Confrontations	0
Interpretations	0

Silences	1
Playback of derivatives	0
Framework management	0
Patient management	8
Reflections	28
Encouragement	5
Advice	7
Suggestions	1
Total therapist responses	110

5. Therapist issues

The therapist had complained that the session had been particularly difficult because of the extreme reluctance of Nerina to actually make use of the therapy and to talk. This is in spite of the fact that her file recorded that she was beginning to open up and talk and make more use of the therapy in the ward context prior to her discharge. Much of the current session had been characterised by the therapist's attempts to elicit verbal responses from a very untalkative patient. This had been very frustrating for the therapist.

6. Themes from session

T You're not feeling very well today. (1-1)

1. Someone is needy and I would like to help them and someone else is preventing me from doing so. I feel bad about this because we are in a position to help. (1-4)
2. This person says that she will help me and support me but will not support those close to me and I feel bad about it. (1-12)
3. I am hurt about this and the hurt keeps me silent. (1-14)
4. I feel particularly bad because I said to this person that I would help them but because of this other person saying no, I couldn't help them. (2-5)
5. This person helps someone that they want to help but they won't let me help the person that I want to help, (3-8)
6. So that makes me hurt and I keep quiet. (3-8)
7. I can't say what I really want to say so I keep silent. (3-18)

T Tell me a little more about that. (4-2)

8. It has happened twice before that when I speak my mind the other person packs her bags and says she'll leave. (4-5)

T So if you talk about what you feel perhaps you will make Z very angry and then you feel scared she may leave. (4-6)

9. I avoid arguments with someone because they get angry. (4-9)

10. This person says horrible things about someone who is close to me. (4-11)

T Perhaps if you gave him food you could allow her to be angry. Perhaps you could say "Z I know this will make you angry but I feel this is important to me." (5-6)

11. Someone was in the middle between two people and would tell these two people bad things about each other, causing problems. (5-13)

12. Someone will just get angry again. (6-16)

13. I don't say anything to this person until she is calm and normal. (6-18)

14. I think its better just to keep quiet. (6-20)

T Perhaps sometimes you could say how you feel and how she feels. (6-23)

15. Most of the time I worry about this other persons feelings. (7-1)

T I do get the feeling that a lot of the time you're concerned about her feelings first and disregard your own feelings. (7-2)

T Perhaps you could say "I understand you are angry, but this is very important to me to give my son some food." How would she respond? (7-8)

T How has work been? (7-18)

T Nerina it is important to let Z know how you feel, its hard to do. (7-22)

16. I don't like speaking to this person because she gets upset. (8-3)

17. If this person gets upset with me she might leave me. (8-5)

18. The more upset and angry I feel the more I just keep quiet. (8-13)

19. I felt like telling this other person that she helps who she wants to help but she won't let me help someone close to me. (9-7)

20. I would prefer it if this person does not have contact with another person. (9-13)

Telephone interrupts. T takes message.

T Sorry about that.

T On the one hand its hard for you to express your needs and on the other hand you feel she doesn't understand. I'm wondering if there's any connection between the two things. (10-7)

21. This other person can be very abrupt and she just speaks her mind. (11-5)

The session ended at this point with no further themes emerging.

7. Analysis of patient's material

Type of communication field

Type C.

Manifest representations of the adaptive contexts

There are no manifest representations of the adaptive contexts but the patient's thematic material as a whole points towards the adaptive contexts of concern to her. In particular there is a concern that if she speaks her mind then this will evoke an unpleasant response and she might be abandoned.

Mode of relatedness

Pathological autism (insofar as can be ascertained from the very scanty derivative material)

Mode of cure

Relief through action discharge and merger.

Dynamics and genetics

There is evidence from her history of being abandoned by her father. She reports that she was abused by her stepfather and that her mother was upset by her reporting this fact to her. It is clear that, for Nerina, talking to people about her concerns does not always elicit a sympathetic reaction.

Central pathological figure

According to the patient's limited derivative communications, both the therapist (or rather the deviant frame) as well as the patient appear to be the central pathological figure.

APPENDIX 13

SHARIAH: SESSION 4

1. Brief background information

Shariah is a 26 year old, divorced, unemployed woman who was referred to the ward with symptoms of depression by the day hospital. She has had three unsuccessful marriages and reports that she was physically abused by her third husband. She has one child, a six year old son from her first marriage and she reports that he had recently been sexually molested by her third husband. The child was in the care of her first husband and the ward team felt that this situation should not be changed as Shariah did not appear to be in a position emotionally or financially to take custody of the child as she was unemployed, dependent on her mother, and was not in a position to fend for herself. She was reported to have a conflictual relationship with her mother with whom she is currently staying. Her mother was not in favour of Shariah's child coming to live with her.

Shariah has a long history of chronic eczema. She was diagnosed on the ward as having dysthymia with dependent and hysterionic traits. It was decided to work in a very supportive way with her and to involve the mother as far as possible in the therapy.

2. Adaptive contexts of session

1. The patient had been assessed by her therapist and her case had been presented by her therapist to the consultant psychiatrist in a ward round. All the members of the staff had been present in that ward round. The patient had been called in and questioned in that ward round (following the standard practice on the ward).
2. The patient was attending groups on the ward run by her therapist and a co-therapist.
3. The patient's details and issues had been discussed on a daily basis in the cardex round attended by all the staff members (following the standard practice on the ward).
4. The patient had seen the registrar on the ward for assessment for medication.
5. The therapy was supervised.
6. The therapist had contact with the patient on an informal basis on the ward.
7. There was no set time or set day for the therapy sessions.
8. The therapist had disclosed some information about herself to the patient.

3. Triggers from within the session

1. The lack of communicative interactional interventions on the part of the therapist.
2. The session was taped.
3. The excessive use of questions in the session by the therapist.
4. The therapist suggests that the patient's mother come into the hospital to be interviewed, albeit by another therapist, and that the results of the interview be discussed at the ward round.

4. Quantitative data of session

No. words therapist	1707
No. words patient	1810
No. words total	3517

Summary of therapist interventions

Questions	41
Clarifications	9
Confrontations	1
Interpretations	0
Silences	2
Playback of derivatives	0
Framework management	0
Patient management	10
Reflections	22
Encouragement	8
Suggestions	0
Advice	2
Total therapist responses	95

5. Therapist issues

The therapist felt well disposed and friendly towards the patient especially because they were of the same religious background. Shariah was the first patient that the therapist had clerked

and case managed on the ward in her internship and this also added a special element to the therapeutic relationship.

6. Themes from session

1. Someone understands how I feel but I don't know if it is going to last long. (1-8)
2. There is someone that I want to have with me. (1-12)
3. I think that this person is being neglected. (1-16)
4. This person's physical needs are being met but not their emotional needs. (2-1)
5. People don't care about this person. Someone is preventing us from being together because of their not wanting to get mixed up with what has happened to this person. (2-5)
6. People who should have helped don't show any interest. (2-7)
7. The person who sexually abused someone denies it. (2-7)
8. This person's financial needs are looked after but not his emotional needs. (2-15)
9. Things are chaotic at home. (2-17)
10. Someone wants to come to be with me but they can't just yet but, I keep reassuring them that they will one day. (3-2)

T You need to consider that if you want him to live with you, what your options are, and what you can do about that? (3-3)

11. If I live with someone then I have to abide by their rules and they forbid me to have this person with me. (3-4)

T Perhaps we could get W (another therapist) to raise the issue with your mother and discuss it at the ward round. (3-5)

12. I asked someone to get involved but she was not interested because she put her work first. (3-8)
13. I am responsible for this person but he is very spoilt and people don't like him. (3-10)

T It seems to me that he is quite consistent with the maintenance - that he supported A all the time. So if you live with your mother and he has been consistent, I don't think that he's going to change. (3-13)

14. It is affecting me that I can't have this person with me. (4-1)

15. I have a good understanding with someone. (4-3)

16. I can't talk or express myself very well. (4-9)

T I see you are becoming quite anxious now. (4-10)

17. Someone is teaching us things and it helps me to keep my cool when people argue with me. (4-13)

18. People are aggressive to me because they know that I am soft. (4-15)

19. I get angry but I don't show my anger, I tell people not to be rude. (5-1)

20. People take advantage of me because I can't retaliate and I can't talk for myself. (5-9)

21. I blame someone for trying to control the way that I am thinking. She does not allow me to speak and tells me that I am stupid. (5-13)

22. This person is still doing this. (5-15)

T You mentioned building your self esteem on the ward. You've learned to take control of a volatile situation. It seems to me that before you would respond by keeping quiet until it comes to a point where you can't keep quiet, then you burst out crying, become angry and throw things around. It seems from what you are saying that yes, you go home and they are still the same, but that you are handling the situation differently. You fend for yourself. You stand up for yourself. And you are feeling very proud about it. That's very positive, that's good. (6-11)

23. I'm communicating better, I'm always smiling. (6-16)

24. I used to be a loner but now I spend time with other people. (6-18)

25. I don't care what people say about me. (7-1)

26. It was a good idea to come for help. I used to be scared of coming for help but things got too much for me. (7-9)

T And you feel that's helped - that the counselling has helped. You've obviously learned some things on the ward. How else can you be helped? Or rather what else would you like to learn on this ward? (7-10)

27. I feel as though I have improved and I am handling myself better. (7-11)

28. According to some regulations I am not supposed to have this person with me. (9-4)

29. But according to another set of regulations I am entitled to have this person with me. (9-6)

30. This person is being looked after financially but is not being looked after educationally and in other ways. (9-4)

31. People don't care about this person and he is being neglected. (9-10)

32. Someone is blocking my right to have this person with me. (9-14)

33. Many people want me to be with them but I am wary. (9-14)

T I heard you saying that you can't stay with your mother because you can't have A with you and you also don't want to take up the offer of living with friends. And then you said that if you go and work you don't keep your jobs long - so you're going to end up again with no place to go. (10-1)

34. It is confusing for me. (10-2)

T It is as if you 're already saying now that if I leave my mother and I go and live with these male friends, and I have a job and it doesn't last, what's going to happen again. Then you have to go somewhere else and start the same scenario over again. So what do you think can be done about that?

35. I think it is best if I stay in my present situation. (10-6)

36. If things go wrong then at least things will be secure if I stay in my present situation. (10-9)

37. I am concerned that this person is not getting the proper care that he needs. This person's educational and spiritual needs are not being met. (11-1)

38. Someone is being neglected and is determined to be with me. (11-7)
 39. I long to be with this person and when I look at his photo I black out. (11-15)

7. Analysis of patient's material

Type of communication field

Type C. The communication is at a purely manifest level with both parties seemingly concerned to keep the communication at this level.

Manifest representations of the adaptive contexts

1. Like S (O.T. assistant) is teaching us self assurance and stuff, positive thinking which will help me because I used all the techniques this weekend. (p4 par 13)
2. I'm learning a lot. Like I told S this morning in the weekend planning. I must just forget the past and look to the future. (p5 par 7)
3. It was good for me to come here. I used to be scared of coming here because I classified this hospital as a mad house. I came for counselling and advice. (p7 par 9)

In addition to the manifest representations the patients thematic material points towards some of the adaptive contexts in that there is derivative material relating to her not being able to communicate, or be heard, or be allowed to talk (themes 16, 20, 21, 22), themes of someone or something preventing her from doing something that she needs to do (themes 5, 11, 28, 32) and themes of someone being neglected or not cared for properly (themes 3, 4, 5, 6, 8, 12, 30, 31, 37 and 38).

Mode of relatedness

The patient alludes to parasitism in the therapeutic relationship through her themes of someone being neglected or not cared for properly (themes 3, 4, 5, 6, 8, 12, 30, 31, 37, 38)

Mode of cure

The preferred mode of cure is through action discharge and merger rather than through insight and holding in the therapeutic relationship

Dynamics and genetics

In this session there is not much narrative from which to formulate speculations about the patient's dynamics and genetics. Most of the material is of a purely manifest nature. The patient does however give glimpses of her early relationships with a punitive mother who does not allow her to speak and who abuses her when she attempts to express herself (theme 21).

Central pathological figure

The central pathological figure is the therapist or the framework of therapy which needs to be addressed before the patient's material can be accessed.