THE THERAPIST AS A "BAD OBJECT": THE USE OF COUNTERTRANSFERENCE ENACTMENT TO FACILITATE COMMUNICATION IN THERAPY

PENNY WEBSTER
November 2004

Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy (Humanities), Rhodes University, Grahamstown.

ABSTRACT

Psychoanalysis as it exists today is not constituted by a single theoretical framework describing pathology and indicating a specific set of interventions. Since Freud originally conceptualised psychoanalytic understanding of pathology and psychoanalysis as a mode of intervention, there have been many revisions and reformulations of his theory. This thesis has attempted to integrate some psychoanalytic ideas regarding personality formation, psychopathology and psychotherapeutic intervention (Fairbairn, 1952; Ogden, 1992, 1994), with interpersonal (strategic / structural) ideas regarding intervention (Minuchin, 1974; Sullivan, 1940, 1953, 1964). In order to do so, the thesis used the relational psychoanalytic perspective, as depicted by Aron (1996) and Mitchell and Aron (1999), as an overarching conceptual framework. The focus from these points of view is the patient's internalized relationship patterns and the therapist's participation in their repetition. It is held that internalized relationship patterns are not only based on, but can be changed by, lived experience. From this perspective, the goal of therapy is to enhance the patient's capacity to reflect and think about experience, and therefore, to communicate about it. This means a change in the patient's predominant mode of communication. Ogden's (1994) modes of communication were described. The thesis suggested that Ogden's modes of communication can be stretched or translated into the types of communication outlined by Langs (1978).

This thesis aimed to explore the deliberate use of countertransference responses to facilitate communication in the beginning stages of therapy with patients functioning predominantly in the paranoid-schizoid mode (Ogden, 1992). Patients who operate in this mode are often unable to tolerate interpretation and therefore traditional

approaches to intervention are not effective. A "strategic / structural relational psychoanalytic" approach to treatment was proposed. It was suggested that therapists utilize joining and accommodation techniques as described by Minuchin (1974) and alter their style of interaction to match that of the various object relational constellations that they have managed to identify within the patient via their countertransference responses. It was hypothesized that patients need their therapists to be similar to their original objects in order to feel safe in the therapeutic environment and that this may facilitate communication in the beginning stages of therapy.

The research utilized a qualitative research approach. Qualitative research methods attempt to use data gathered phenomenologically, always acknowledging the researcher's biases when gathering the data. The data gathered is then interpreted according to various theories or hermeneutic lenses. The hypothesis mentioned above has been investigated by analyzing three cases in terms of the research questions based on Langs' (1978) classification of communication.

The thesis described the difficulties inherent in collecting clinical data from psychologists working from within a psychoanalytic framework. Eventually three sets of therapy details and verbatim therapy transcripts were obtained, provided in the thesis and analyzed in terms of the research questions. However evidence for the success of the hypothesized alternate approach was not found in this research study. It was suggested that other possible methods might be useful to investigate the hypothesized approach further.

ACKNOWLEDGEMENTS

This thesis is part of my own attempt to integrate ideas from the interactional and psychoanalytic schools of theory and practise. I would like to say thank you to the following people who have helped me in this process:

Professor Charl Voster and Professor Dave Beyers for sharing with me their pragmatic communication skills, powerful use of paradox in therapy and for offering me this starting point; Professor Mariekie Joubert for imparting her knowledge of "ecosystemic epistemology", for showing me how to "join" and "accommodate", and for the years of supervision and mentoring.

Professor Gill Straker, Cora Smith and Dr Jaqui Watts, who opened a door to object relations theory and a glimpse at what lies below the surface. Thank you for these insights and for paving the way to the course work PhD programme at Rhodes University. This unique PhD programme offered the opportunity to learn from really gifted lecturers and clinical supervisors. I would like to express my thanks to:

Professor Gavin Ivey and Dr Jaqui Watts for teaching me so much about object relations theory and practise and for introducing me to Robert Langs and Thomas Ogden; Dr Chris Milton for the fascinating workshops about Jungian theory, his acknowledgement of the importance of *"coagulatio"*, and his excellent clinical supervision; Professor Bep Mook for her in-put regarding "being there" and "interpretation" – phenomenology and hermeneutics; Michelle Stern for sharing her in-depth knowledge about self-psychology, Heinz Kohut and for her "optimal responsiveness"; I would especially like to thank Professor Charles Malcolm for teaching me more about Thomas Ogden, introducing me to intersubjectivity theory and especially for introducing me to Lewis Aron and relational psychoanalysis – a way for me to integrate different theoretical frameworks and modes of intervention.

I would like to thank my academic supervisor Dr Zelda Knight for her extensive contributions, warmth, sensitivity and academic expertise. Also, Professor Chris Stones for his encouragement and steadfast support.

Thank you Cora Leibowitz, Dr Joan Schön, Shayleen Peek and Dr Joel Shapiro for sharing your clinical and theoretical wisdom. In addition, all my colleagues, especially those who gave their time and shared their therapy with me, and their patients who provided their consent. Also my eagle-eyed proofreaders who have helped so much over the years especially Robin Hamilton.

Thanks to my friends and family who have shared this process with me. There are many who have managed to keep me as a "good … but absent object" − Bryony, Jessica, Lilian and Thandi. There are many others but especially I would like to name: Dr Jo King, Wendela Leisewitz, Avril van der Velde and Carol Whitford.

Thank you to the ever-amazing Grace for all your help. Most of all, thank you Chris, for your encouragement, your positive attitude and your practical support.

CONTENTS

CHAPTER THREE: RELATIONAL PSYCHOANALYSIS

CHAPTER FOUR: A HYPOTHESIZED "STRATEGIC / STRUCTURAL RELATIONAL PSYCHOANALYTIC APPROACH"

CHAPTER SIX: RESULTS

CHAPTER SEVEN: DISCUSSION

CHAPTER EIGHT: CONCLUDING REMARKS

APPENDICES

I can wade Grief –
Whole pools of it –
I'm used to that –
But the least push of Joy
Breaks up my feet –
And I tip-drunken –
Let no Pebble-smile –
'Twas the New Liquor –
That was all!

Emily Dickinson (as cited in Edinger, 1985, p. 99)

CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

This thesis attempts to integrate[1] psychoanalytic ideas regarding personality formation, psychopathology and psychotherapeutic intervention (Fairbairn, 1952; Ogden, 1992, 1994), with interpersonal (structural/strategic) ideas regarding intervention (Minuchin, 1974; Sullivan, 1940, 1953, 1964). It investigates the strategic use of countertransference enactment as a useful therapeutic technique, especially in the early stages of therapy, in order to establish a therapeutic relationship with patients who are unable to tolerate the interpretative response advocated by psychoanalysis.

The approach being described is "psychoanalytic" in that it conceptualizes the "mind" as being a dialectical process between conscious and unconscious components. It explores a dialectic between past and present, grounds states of mind in bodily experiences and, in the therapeutic setting, emphasizes the patient listening to the patient's associations, a play in the dialectic between fantasy and reality, and focuses on feelings about the analyst (transference) and psychical obstacles to uncomfortable

[1] The post modern trend towards integration parallels the movement away from thinking that there is one model for understanding personality and therapy towards a post-modern understanding of "multiple realities". Discussing the integrative shifts taking place in psychotherapy, Lebow (1997), states that "integration" refers both to the process of bridging concepts and interventions of schools of therapy, and to the product that results from this activity. He differentiates between "integration" and "eclecticism". Both involve the application of theoretical concepts and interventions that cross theoretical boundaries. However, Lebow (1997) identifies "eclectic" as a pragmatic, case-based approach in which ingredients of different approaches to therapy are employed without concern for theory. In contrast, "integration" presumes a more extensive blending of approaches onto a meta-level theory that juggles with and works through the juxtaposition of the meanings of different concepts or interventions. He states that integrative models can be constructed on the level of theory, strategy and intervention. At a conceptual level, integrative approaches build a meta-theory, an understanding of the essential elements of human functioning and change process. At the level of technique the therapist assembles and uses specific techniques to execute the strategy (Lebow, 1997). This thesis proposes that relational psychoanalysis be used as a meta-theory to integrate object relations and interpersonal theories regarding human functioning and to provide for the flexibility in technique required by the strategic use of enactment. Further discussion of this issue is warranted, but beyond the scope of this thesis.

thoughts and feelings (resistance) (Mitchell & Aron, 1999). However, in line with the approach taken by *relational* psychoanalysts such as Aron (1996) and Mitchell and Aron (1999), this thesis presents challenges to the psychoanalytic rules of abstinence and neutrality.

The thesis takes relational theorizing one step further, however, in that it proposes and investigates the possibility of the use of "enactment" as a positive therapeutic strategy. In contrast to the well-known suggestion of Alexander and French (1946), who also challenged these psychoanalytic ideals by proposing that psychotherapists should consciously adopt an attitude and behave in a manner *contrary* to their patient's negative transference expectations, what is suggested here is that the therapist should utilise his[2] countertransference feelings and enactments to consciously plan strategies of intervention that *"fit"* with the intra-psychic structure of the patient. In other words, the therapist should choose to resonate with the predominant self and object representations of the patient that he has been able to identify via countertransference. This may involve active intervention, an altering of style or mode of communication, as well as verbal intervention, rather than the traditionally accepted techniques of interpretation and psychoanalytic holding consistent with the analytic attitudes of abstinence and neutrality in the early stages of therapy, with patients who are unable to utilize interpretation. Therefore, because it is essentially "psychoanalytic" in nature, this thesis constitutes a challenge to the basic "frame" of psychoanalysis. Changes to the basic frame are usually seen as anathema to psychoanalytic psychotherapists and discussion of the possibility of change evokes some anxiety and resistance at times. The approach being described is psychoanalytic,

[2] The therapist is referred to as "he" throughout this thesis, although the researcher acknowledges that psychotherapists can in practice be either male or female.

however, in that the ultimate goal of therapy is to facilitate development of the capacity to communicate towards the stage where the patient can be receptive to interpretations.

The literature review will initially focus on Fairbairn's (1952) conceptualization of psychopathology and his notion of "attachment to bad objects", because this theory can be useful to conceptualize some patients who find it difficult to allow the therapist into their "closed system of internal objects", to be described in Chapter 2. Because of the spatial limitations of this thesis, this will be supplemented by Ogden's (1992, 1994) revised view of the object relations theories of psychopathology and intervention, which integrates the original object relations theories of Klein, Bion, Winnicott and Fairbairn. Relational psychoanalysis (Aron, 1996) and Mitchell and Aron (1999), which integrate object relations theories with the interpersonal approach (the researcher's starting point to be described below), will then be used as the organizing conceptual framework and for a new theory of intervention, which will then be proposed and researched.

This research will explore the possibility that countertransference enactment may be consciously utilized as an active strategic therapeutic intervention in psychotherapy. This involves the strategy of "joining". "Joining" (Minuchin, 1974) can be described as a changing of communication style on behalf of the therapist, to "fit" with the communication patterns of the client system with which he is working. It is suggested that deliberate utilization of countertransference responding or "joining" as a therapeutic strategy may be particularly useful in the beginning stages of therapy with patients who have a closed system of internal object relations (Fairbairn, 1952) and

function predominantly in the paranoid-schizoid mode (Ogden, 1992). Patients who operate in this mode are often unable to tolerate interpretation and therefore traditional approaches to intervention are not effective.

The focus is thus both on the patient's "modes of communication" and organization of experience and the therapist's mode of response. Ogden (1992, 1994) views all human experience as representing the outcome of a dialectical interplay of the depressive, the paranoid-schizoid, and the autistic-contiguous modes of generating experience. From that point of view, psychological change is not conceptualized in terms of making the unconscious conscious or of transforming id into ego. Instead, Ogden understands psychic change as a reflection of a shift within the dialectical interplay of these modes, such that a more generative and mutually preserving and negating interaction is created. According to Ogden (1992, 1994), environmental failure leads to a shift in the dialectical interplay of the autistic-contiguous, paranoid-schizoid, and depressive positions. The thesis suggests that Ogden's "modes of communication" can be stretched or translated into the "types of communication" outlined by Langs (1978) (or vice versa). It is suggested that when the therapist enacts the patient's intra-psychic structure he or she also matches the communicative type as described by Langs. Langs' theories regarding communicative styles will be used as a hermeneutic lens to scrutinize the research data. It is proposed that countertransference responding may lead to increased receptivity to interpretation and increased capacity for symbolic communication (Langs, 1978).

1.2 A CASE STUDY RESEARCH METHOD

A case study research method (Edwards, 1998) will be used, applying methodological procedures drawn from the hermeneutic research approach. The approach is based on Husserl's phenomenology, whose aim was the rigorous and unbiased study and description of things as they appear, and Heidegger and Gadamer's philosophical hermeneutics, which emphasized the historicality of understanding, (Bleicher, 1980; Valle, King & Halling, 1989). Gadamer (1975) builds on Heidegger's exposition of fore-structures of understanding and says that all understanding is prejudicial. He states that the historical character of understanding should be acknowledged as a positive moment, rather than as an impediment to objectivity.

For this reason, the researcher's theoretical fore-structures will be briefly outlined:

1.3 THE RESEARCHER'S STARTING POINT

> "... If to live is to invent, it is to invent beginning with specific givens."
>
> (Merleau-Ponty, 1982-1983, p. 55)

My training involved a phenomenological basis to therapy. The phenomenological basis was advocated as a first stage to any psychotherapy: "… the stage of recognition of that which reveals itself" (Bouchard & Guérette, 1991). My understanding of psychopathology and psychotherapy was from an interpersonal framework, based on the work of Sullivan (1940, 1953, 1964). What characterises the interpersonal approach is the contention that human nature and the social order are products of communication. The direction taken by a person's conduct is seen as something that is constructed in the reciprocal give and take of interdependent people who are adjusting to one another. From this perspective, the therapist is never able to be neutral or abstinent, but is seen as a "participant-observer". Sullivan's

interpersonal approach was expanded by Bateson in 1956 (as cited in Watzlawick, Beavin & Jackson, 1967). Central to this approach is the notion of "circular causality", i.e. the assumption is that human relationships are not cause and effect, but embedded in a network where effect influences or alters the cause, where the person affects and is affected by the environment. The interpersonal approach is concerned with what happens, not why it happens. Abnormal or pathological behaviour is seen as a way of handling relationships. The interpersonal approach was also influenced by the "Mental Research Institute", founded by Jackson in 1958 (as cited in Watzlawick et al., 1967). This institute developed the "strategic model" of psychotherapy. Strategic psychotherapists believe that it is impossible not to influence or manipulate while interacting. The problem is, therefore, not how influence and manipulation can be avoided, but how they can best be comprehended and used in the interests of the patient. The therapist's main task is one of taking deliberate action to alter poorly functioning patterns of interaction as powerfully, effectively and efficiently as possible (Watzlawick & Weakland, 1977; Watzlawick, Weakland & Fisch, 1974). [3]

Another notion central to the strategic approach is that of "fit" or "structural coupling" (Dell, 1982, 1985). According to Dell (1982, 1985), in order to have the psychological experience of causing something to happen we must fit ourselves to the situation. "We must fit our structure to the structures with which we are dealing" (Dell, 1985, p. 9).

[3] These approaches to therapy have become known as the "interactional approaches".

The strategic therapist thus manipulates his relationship with the patient in order to achieve change in the patient's relationships with others. One of the most important tasks of a strategic therapist is thus to "join" with whatever system presented itself. As mentioned above, "joining" (Minuchin, 1974) can be described as a changing of communication style on behalf of the therapist, to "fit" with the communication patterns of the client system with which he is working.

The notion of the therapist as a participant-observer, who can strategically alter his way of communicating to "join" or "fit" with the patient, is thus the starting point for further thinking about the therapeutic relationship, the therapeutic alliance, and the research being undertaken.

1.4 OVERVIEW OF THE THESIS

A literature review which consists of a brief description of Fairbairn's (1952) conceptualization of psychopathology, and Ogden's revised theory of object relations (Ogden, 1992) and their theories of intervention follows in Chapter 2. An interpersonal/relational critique is included. The relational approach to psychoanalysis and psychoanalytic intervention will be described in Chapter 3. This chapter includes critiques of more traditional psychoanalytic and object relations theorizing. Chapter 4 details the researcher's hypothesized additional approach to the traditional object relations and relational psychoanalytic approaches to therapy. It is entitled "A strategic / structural relational psychoanalytic approach". A critique of the hypothesized approach is also included. Chapter 5 discusses a research method for testing these hypotheses. Chapter 6 contains the results. These will be discussed in Chapter 7. Chapter 8 concludes the thesis.

CHAPTER 2: OBJECT RELATIONS THEORIES

2.1 INTRODUCTION

Object relations theories can be described as theories that are concerned with exploring the relationship between real external people and internal images of people and residues of relations with other people, and the significance of these for psychic functioning (Greenberg & Mitchell, 1983). Some of the most important aspects of object relations theories will be pointed out and some of the most important contributors mentioned. The central role of internalized object relations, as described by Fairbairn (1952), will be described in detail. However because of spatial limitations, other forerunners of object relations theories will not be explicated in detail. Rather, Ogden's integrative revised theory of psychopathology and his theory regarding intervention will be the focus.

2.2 FAIRBAIRN

For Fairbairn (1952), endopsychic structure is depicted as a closed system of portions of the ego and internalized objects.

2.2.1 Fairbairn – the endopsychic structure and the schizoid condition

Based on Freud's notion of psychic structure (the superego) being created through the internalization of external objects via identification, Fairbairn (1952) stressed the obligatory internalization (and alteration) of unsatisfying external objects. Internal objects are images of the needed but unsatisfying external person, modified (exaggerated and/or transformed) by the subject's capacity for fantasy. Unsatisfying relationships are experienced as intolerable, and are internalized as both "rejecting internal objects" and "exciting internal objects". Also internalized are aspects of the

ego identified with the "rejecting" and "exciting" internal objects and the affective or libidinal link between them. Fairbairn thus replaced the Freudian dichotomy of ego and id, and structure and energy with the notion of dynamic structures. These dynamic structures are conceived of as aspects of mind capable of acting as independent agencies with their own motivational systems. According to this theory, each bit of ego, or aspect of personality, defensively splits off in the course of development, and functions in relation to internal objects and in relation to other sub-divisions in the ego.

2.2.2 Fairbairn – the attachment to bad objects

In his first theoretical paper in 1940, Fairbairn (1952) hypothesized that the child's reaction to the experience of being rejected by his or her object, is an increased attachment to the object that had failed to meet his or her needs. In fact, according to Fairbairn, the child forms a profound fixation on the object. The shadow of these internal object relations falls on all further interpersonal relations and alters the manner in which they are perceived (Grotstein & Rinsley, 1994). For Fairbairn, "bad objects" are aspects of parents that make them unavailable to the child and frustrate his or her longing for contact and closeness. The child's needs are potentially satisfiable, but parental inadequacy intensifies them and produces secondary intense rage. This "excess" need and accompanying rage necessitates the internalization of "bad objects". For Fairbairn "bad objects" have two facets:

> Unlike the satisfying object, the unsatisfying object has, so to speak, two facets. On the one hand it frustrates; and on the other hand, it tempts and allures. Indeed its essential "badness" consists precisely in

> the fact that it combines allurement with frustration (Fairbairn, 1952, p. 111).

Fairbairn describes that in psychopathology a large portion of the child's ego, or self, becomes attached to the unsatisfying exciting/rejecting object. With the internalization of the bad object a large portion of the child's ego is thus also split and internalized as described above. In other words, there is an over-identification with the object. Leaving the object with whom they are identified is like leaving a part of themselves. These patients cling to their original unsatisfying objects, or substitutes for these objects by suppressing themselves and their own needs, adapting their needs to the needs of the object:

> Implied in these various manifestations of resistance on the part of the patient is a further defensive aim which I have now come to regard as *the greatest of all sources of resistance – viz. the maintenance of the patient's internal world as a closed system.* In terms of the theory of mental constitution which I have proposed, the maintenance of such a closed system involves the perpetuation of the relationships prevailing between the various ego structures and their respective internal objects, as well as one another; and, since the nature of these relationships is the ultimate source of both symptoms and deviations in character, *it becomes still another aim of psychoanalytic treatment to effect breaches of the closed system which constitutes the patient's inner world, and thus to make this world accessible to the influence of outer reality* (Fairbairn, 1958, p. 380; emphasis in the original).

From a Fairbairnian perspective psychopathology is characterized by the return to exciting/rejecting objects or their substitutes. These "bad objects" are seen as the only possible source of nurturance and validation, and as a consequence, other potential "good objects" are ignored. There is thus a reversal of the normal process of going towards "good objects" and away from "bad" ones. These patients often resort to a "moral defense" (Fairbairn (1952). That is, they tend to blame themselves and defend their objects for damaging aspects of relationships. The moral defense serves to strengthen ties to the bad object, first because it prevents a clear assessment of the object's badness and because it prevents a sense of the patient's "goodness":

> Framed in such terms the answer is that it is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil. A sinner in a world ruled by God may be bad; but there is always a certain sense of security to be derived from the fact that the world around is good – "God's in His heaven – All's right with the world!"; and in any case there is always a hope of redemption. In a world ruled by the Devil the individual may escape the badness of being a sinner; but he is bad because the world around him is bad. Further, he can have no sense of security and no hope of redemption. The only prospect is of death and destruction (Fairbairn, 1952, pp. 66-67).

Fairbairn likens the situation to one of demon possession and the task of the analyst to that of exorcism and the casting out of devils. He states that the release of bad objects from the unconscious is one of the chief aims of psychotherapy. He emphasizes

though that the *bad objects can only be released if the analyst has become established as a sufficiently good object for the patient* (italics mine).

Grotstein and Rinsley (1994) state that Fairbairn inaugurated a series of pivotal changes in psychoanalytic theory. These authors state that he was the first to formulate a true object-related (relational) nature of the self. They thus describe Fairbairn as the founder of relational psychoanalysis. He helped to establish the psychoanalytic conception of infantile dependence, in contrast to primary autoerotic infantile sexuality, thus formulating the principles of infantile innocence and entitlement that anticipated the work of Bowlby on attachment, which were also integrated by relational psychoanalysis (see Chapter 3). Fairbairn developed the notion of an endopsychic structure. In this he was the forerunner of object relations theories.

2.3 OGDEN'S REVISED THEORY OF OJECT RELATIONS

From Fairbairn (described above), Ogden develops the idea of the internalisation of object relations units, each consisting of split portions of ego, split portions of the object, and the relationship between them. Ogden (1992) points out that it is useful to conceptualize Klein's formulations as hypotheses, which can be built on and developed. He proposes a revised theory of object relations utilizing Klein's basic ideas and supplementing them with contributions from Fairbairn, Winnicott and Bion. In doing so, Ogden (1994) admits that he stretches the meta-psychologies to their breaking point in an attempt to reconcile the diversity of the forms of knowledge that we have at our disposal. Referring to his attempt to integrate these theories, Ogden

(1994) states that each epistemology is separate unto itself and at the same time stands in dialectical tension with the others:

> Each is slowly and sometimes painfully being transformed by the others, and, as a result, one is not dealing with a linearly expanding body of knowledge. For instance, Klein's work can be viewed as an interpretation of Freud, and Winnicott's work can be viewed as an interpretation of Klein. Moreover, since Freud's writing contains more meaning than he himself recognized, a study of Klein and Winnicott, for example, provides a necessary avenue for the development of a fuller understanding of Freud's work (Ogden, 1994, p.194).

2.3.1 Ogden's revised theory of object relations – crucial concepts

The following are other key object relations concepts integrated by Ogden, which pertain to the discussion of the research.

Object relations theories emphasize the importance of the infant's relationship with the mother prior to the oedipal conflict, the theory of unconscious phantasy, and the notion of splitting as the primary defense mechanism on which all other defense mechanisms are built, most particularly projective identification (Klein, 1946; Ogden, 1992; Segal, 1964).

Ogden (1992) re-conceptualizes the Klienian notion of "instinct" as "psychological deep structures". Expanding the linguist Chomsky's concept of linguistic deep structures, Ogden (1992) states that humans have certain inherited modes of

organizing experience that are analogous to animal instincts. For instance, the chick has an inherited code with which to organize and respond to stimuli, e.g. the shape of a predator's wing, a code that precedes any actual experience. The chick will, without prior experience of predatory danger, scurry for cover, when exposed to the wing pattern of a predator. Thus, Ogden sees a "phantasy" as the infant's interpretation of experience. Using the paradigm of codes analogous to psychological deep structures, Ogden restates Klein's ideas as follows: The relative constitutional endowment of life and death instincts is a major determinant of which code the infant will use to interpret experience. The psychological correlates of the life instinct include loving, sexual, nurturing, attachment seeking, and generative motivations, whereas psychological correlates of the death instinct include destructive, disintegrative, envious, and hostile motivations. Experience interpreted in terms of the life instinct will be understood in terms of loving meanings. Experience interpreted in accord with the death instinct will be attributed aggressive dangerous feelings. Ogden (1992) cites Grotstein who, building on the work of Bion, describes the infant as constitutionally endowed with a set of preconceptions that allows him to interpret experience in terms of possible danger of a prey-predator type. The death instinct is conceived of as the origin of unconscious ego defenses as well as many autonomous ego functions which perform the function of seeking out and managing both internal and external danger. Ogden uses Bion's ideas regarding "preconceptions" and "realizations". The instincts are conceived of as biologically determined organizations that utilize actual experience to link a preconception with its "realization". For example, the preconception of danger is linked with a facet of reality that can be experienced as dangerous. "The preconception is not an idea, but the potential for an idea. It is only

in the linking of the preconception with the real that a conception (a thought) is generated" (Ogden, 1992, p. 18).

Ogden uses Bion's conceptualization and development of the Kleinian idea of projective identification to explain how internal object relationships attain energy and motivation because of the portions of the ego they are invested with. Ogden emphasizes Winnicott's conceptualization of the mother-infant unit, the importance of the mother providing a psychological matrix, within which the child can develop, and the importance of her holding, weaning and surviving functions. Ogden describes Winnicott's idea of potential space and transitional objects as being important in supplementing Klein's theory of the development from the paranoid-schizoid to the depressive positions. Transitional objects are important in the conceptualization of the development of creativity, the capacity to symbolize, and to play and to think. According to object relations theories, psychopathology is characterized by the lack of the ability to symbolize. The goal of therapy is that the therapist should become a transitional object for the patient, thus facilitating the development of this capacity. These ideas will be discussed further below.

2.4 PSYCHOPATHOLOGY

The most important contribution to the understanding of pathology made by object relations theorists is the understanding of pre-oedipal pathology. Their theories suggest that a large proportion of pathology results from early disruption in the mother-infant relationship. Klein's (1946) conceptualization of the paranoid-schizoid and depressive positions probably constitutes her most important contribution to the

understanding of all aspects of human behaviour. The term "position" is used to refer to a level of psychological organisation with its characteristic manner of object relatedness, forms of symbolization, modes of defense, type of anxiety, and maturity of ego and superego functioning. The positions are not passed through as stages, but continue throughout life as coexisting modes of organising experience.

It is held, however, that a paranoid-schizoid mode of operation predominates in pre-oedipal pathology, where the patient has not yet reached the depressive position, and attained the capacity for abstract thought and symbolization regarding his emotional functioning (Ogden, 1992). Fairbairn's conceptualization of pathological development was described above. Ogden has reformulated this conceptualization and framed it in terms of Klein's positions or modes of defense, which translate into modes of communication, and which will be discussed below.

2.4.1 Psychopathology according to Fairbairn and Ogden – an integration

Fairbairn's notion of a split endopsychic structure was described above. Re-framed within Ogden's theoretical framework, when there is a breakdown of functioning of the mother-infant unit, the role of the mother as provider of a buffer against feelings of helplessness in a world of not-me objects must be taken over by the infant himself. In other words, what had been, to a large extent, an interpersonal and intersubjective form of defense or illusion must become increasingly an intra-psychic act of self-defense on the part of the infant. According to Ogden (1992), these patients' predominant defense can be seen as that of "splitting" and/or "failure of splitting" and/or "failure of integration".

As described above, according to Ogden (1992), the most basic mode of management of danger is that of separating the endangering from the endangered. Like the chick scurrying for cover when exposed to the wing pattern of a predator, the human infant tries to flee the attacker by splitting, "… a biological phenomenon with psychological manifestations" (Ogden, 1992, p. 44). Ogden (1992) postulates that each of the primitive psychological defenses can be understood as constructions based on the mode of managing danger by splitting. This view holds that projective identification develops as a psychological-interpersonal elaboration of the process of splitting. In addition to dividing his objects into categories that help to separate the endangering and endangered, the infant also divides his perception of himself. Based on Fairbairn and Klein, Ogden states that the object is never split without a corresponding split in the ego. Facets of the object-related experience are isolated from each other. The loving self (as object) stands in relation to the loving object, and is set apart from the hating self (as object) and the hating object. Ogden (1992) also embraces the notion of the "failure of splitting". Ogden's view is that the infant must be able to split in order to feed safely without intrusion of the anxiety that he is harming his mother, and without anxiety that she will harm him. Splitting not only safeguards the infant's need to love, but also safeguards his need to hate. Correspondingly, Ogden (1992) describes a failure of integration. He describes splitting as an early defense that serves to regulate, by mutual isolation, the relationship between loving and hating facets of experience. However Ogden says that an inability to diminish reliance on splitting reflects excessive anxiety about the dangers involved in the interpenetration of feeling states, particularly love and hate. Splitting processes, fuelled by anxiety of this type, become rigid, unchanging, and in Fairbairn's terms form a closed system which is difficult to penetrate.

Re-phrased again in Fairbairn's terms, the pathological object relationship is internalized or split off from conscious ego functioning, i.e. the splits are horizontal. The splits are also vertical in that the rejecting bad object and corresponding ego representation of a bad self are split off from the exciting object and its libidinal tie to the good or pleasing self. There are thus multiple dynamic entities. According to Ogden (1994), the infant protects himself through the use of increased reliance on omnipotent forms of thinking as opposed to relying on interpersonally created states of illusion. This relates to what Fairbairn has termed a "closed system" of internal object relations. What had been previously predominantly an experience with the mother-as-environment has now become the experience of mother-as-object against whom the infant must at times protect himself. According to Fairbairn, the patient does this by splitting. This is done by idealizing the external "bad object" and forming a "pact with the devil" – evil, be thou my good – ("God's in His heaven – All's right with the world!") and internalising the bad object via the moral defense "(it is better to be a sinner in a world ruled by God") (Fairbairn, 1952, p. 67).

Ogden (1992) emphasizes that splitting is not simply a defense; it is a mode for organizing experience. It is a form of mental operation that is used in the beginning by the infant to create order out of chaos based on categories inherent in his instinctual deep structure (referred to above). It is a boundary-creating mode of thought and therefore part of an order-generating (not yet personal meaning-generating) process. That is, memory and a sense of "I-ness" has not yet developed. From within Ogden's framework, splitting is part of the paranoid-schizoid mode of generating experience or mode of operation.

Ogden (1992, 1994) views all human experience as representing the outcome of a dialectical interplay of the depressive, the paranoid-schizoid, and the autistic-contiguous modes of generating experience. From that point of view, psychological change is not conceptualized in terms of making the unconscious conscious or of transforming id into ego. Instead, Ogden understands psychic change as a reflection of a shift within the dialectical interplay of these modes, such that a more generative and mutually preserving and negating interaction is created. According to Ogden (1992, 1994), environmental failure leads to a shift in the dialectical interplay of the autistic-contiguous, paranoid-schizoid, and depressive positions.

A predominance of the paranoid-schizoid dimension of experience is the most obvious in extreme forms of pathology, but compromises of the patient's ability to generate experience in a predominantly depressive mode occur in every analysis.

None of the three modes of experience postulated by Ogden (1994) exists in isolation from the others – each creates, preserves, and negates the others dialectically. Each mode generates an experiential state characterized by its own form of anxiety, types of defense, degree of subjectivity (I-ness) and related form of object relatedness. Ogden's descriptions of these three modes of generating experience and the communicative style associated with each will now be outlined.

2.4.2 Psychopathology and modes of communication – Ogden

According to Ogden (1994), the *autistic-contiguous* position is associated with the most primitive mode of attributing meaning to experience. Ogden cites Bick, saying

that it is a psychological organization in which the experience of self is based upon the ordering of sensory experience, particularly sensation at the skin surface. The predominant anxiety is that of the collapse of sensory boundedness upon which the rudiments of the experience of a cohesive self are based. This loss of boundedness is experienced as the terror of falling or leaking into endless shapeless space. The individual attempts to defend himself from this type of anxiety by means of a "second skin formation" (Bick, as cited in Ogden, 1994). Ogden (1994) provides examples of defensive efforts of this sort as including tenacious eye contact, continuous and unrelenting talk and compulsive wrapping oneself in many layers of clothing. He states that in the autistic-contiguous position, psychological change is mediated by imitation, which does not require a fully developed sense of inner space into which the qualities of the other can be taken into. "In imitation, the qualities of the external object are felt to alter one's surface, thus allowing one to be 'shaped by' or 'to carry' attributes of the object" (Ogden, 1994, p. 141).

Ogden describes the *paranoid-schizoid* position as generating a more mature and differentiated state of existence than the autistic-contiguous position described above. He states that while the autistic-contiguous position can be thought of as being pre-symbolic, the paranoid-schizoid position is characterized by symbolic equation. There is little capacity to differentiate between symbol and symbolized. "In other words, there is almost no interpreting 'I' interposed between oneself and one's lived experience" (Ogden, 1994, p. 141). There is thus immediacy to experience. There is an absence of the sense that experience can be thought about, and the psychological defense is enactive and evacuative. In other words, impulses, feelings and thoughts are enacted or behaved. Behaviour is not thought about, and it is of the nature that it

evokes intense responses in others. It also evokes a tendency to enact a response (projective identification). In the paranoid-schizoid position there is little capacity for guilt as the individual does not experience himself as a subject capable of taking responsibility. Ogden describes this as an "a-historical" state because of splitting. "A beloved object who is suddenly absent is not experienced as a frighteningly unpredictable good object, but as a bad object. In this way, one's loving self and objects are kept safely disconnected from one's hated and hating self and objects" (Ogden, 1994, p. 142). Ogden describes a rapidly shifting sense of self and object, with little recollection of the altering feeling states. He states that each new affective experience of the object and the related affective experience of the self unmasks a "truth" about how the relationship is and *always* has been. According to Ogden, anxiety in this mode of experience takes the form of the fear of impending annihilation and fragmentation resulting from the destruction of the loving aspects of self and object by hating and hated aspects of self and object.

Ogden (1994) describes the *depressive position* as being the most mature, symbolically mediated psychological organization. He cites Winnicott who says that in this experiential state, thoughts, feelings and perceptions do not simply happen. Winnicott describes patients for whom the sense of self is generally taken for granted to feel situated, continuous and alive. Such patients whose problems lie within the self, have a relatively cohesive self inside of which, in a felt sense, is a complex conflict. In the paranoid-schizoid position thoughts, feelings and perceptions are experienced as a "clap of thunder or a hit" (Winnicott, as cited in Ogden 1994, p. 143). In the depressive position "… one's thoughts and feelings are experienced as one's own psychic creations that can be thought about and lived with and need not be

immediately discharged in action or evacuated in omnipotent fantasy" (Ogden 1994, p. 143). In the depressive position, with the development of the awareness of subjectivity, there is a development of the awareness of the subjectivity of others and therefore of concern. With this comes the capacity for guilt and the wish to make reparation for the harm inflicted on others (real and imagined). History is created:

> In the depressive position, for better or for worse, one is stuck in the present. Past experience can be remembered and at times reinterpreted, but the past remains immutable. There is sadness, for example, in the knowledge that one's childhood will never be as one wishes it had been, but one's rootedness in time lends stability to one's sense of self (Ogden 1994, p. 143).

Ogden emphasizes that no dimension of experience is encountered in its pure form – each experience is created and negated by the others, as pointed out above, diachronically and synchronically. It seems that these modes of experiencing influence the way that patients communicate. Ogden (1994) refers to this as the "matrix of the transference/countertransference".

2.4.3 Psychopathology according to Fairbairn and Ogden – a summary

To summarize the integration of concepts being presented here:

Fairbairn has described the basic schizoid nature of human functioning. We are all basically split as a result of parental failure. However, when the failure is extreme then large portions of the ego are split off from consciousness, resulting in a failure or

deficit in conscious ego functioning – a horizontal split. Extreme failure also leads to vertical splits, with various portions of the ego being attached to both rejecting and exciting internal objects in a dynamic way. The individual externalizes or lives out these internalized object relationships in a rigid manner, believing that "bad" is "good". This system of beliefs seems fixed and absolute, i.e. it is a closed system. Fairbairn states that the internalized bad objects have to be "exorcized", and that this can only be done when the analyst has been established as a "good object".

Ogden has framed the attachment to bad objects in terms of modes of communication. When patients are attached to "bad objects" they operate in a predominantly paranoid-schizoid mode. There is little capacity for "I-ness", or little capacity to self-reflect or to "play" or to "think". Because of their incapacity to play and to think and to engage in symbolization, it is difficult to form a therapeutic alliance within which interpretations can be made. Object relations theories of pathology therefore involve a shift from the way that psychoanalysis traditionally was envisaged, and in the way it is conducted.

2.5 THE PROCESS OF THERAPY:

Like classical analysts, object relations analysts are accepting of the basic psychoanalytic frame. The "frame" consists of a set of rules governing the psychoanalytic treatment process. According to Langs (1982), the rules can be divided into three categories:

The spatial, temporal and financial constants: include the provision of a private relatively neutral space, free from outside intrusions; fixed session and duration times;

and a single fixed fee, which the patient is expected to pay personally, without mediation by third parties such as spouses, medical aids, etc.

Rules concerning the relationship between therapist and patient: include that the relationship between patient and therapist is defined as being a one-to-one relationship, without any prior, concomitant, or post-treatment relationship between patient and therapist. There is an essential absence of physical contact and the patient has the right to total privacy and confidentiality. Langs (1982) includes in these rules the maintenance of the therapist's relative anonymity.

Rules concerning the nature of the therapist's interventions: include the adoption of the fundamental rule of free association; the therapist's maintenance of free-floating attention; and the therapist's use of appropriate silence, framework management, neutral interpretation and playback of selected themes having latent significance (Langs, 1982).

Langs provides detailed clinical evidence obtained from supervision sessions to show that framework deviations are experienced by patients as dangerous, seductive and undermining of the therapeutic process. Although there is some debate about the exact nature of the rules, most psychotherapists working from within the psychoanalytic perspective, whether from a classical or object relations point of view, regard the psychoanalytic "frame" or the basic ground rules as described above, as sacrosanct and although it is widely accepted that changes are inevitable, deliberate change is regarded with suspicion.

For classical psychoanalysts the dominant mode of intervention was interpretation, the goal of which was to acquire insight into drives, defenses and transference resistance. The role of the analyst was seen to be that of a blank screen or mirror. While transference was seen as the patient reliving past defenses in the present, countertransference was perceived as something to be got rid of via the analysis of the analyst's own unresolved conflicts. For object relations theorists, the emphasis is on the therapist providing a holding environment for the patient and on the therapist providing a new mode of relating for the patient and on the patient's gradual internalization of the therapist as a good object. The relationship between the patient and therapist is seen to be primary and interpretation is seen as a mode of communicating deep and empathic understanding, rather than as imparting knowledge and insight.

2.5.1 The process of therapy: Fairbairn and Ogden – an integration

Although Fairbairn has written little on technique, it seems that he maintained a standard classical psychoanalytic technique, focusing on the therapist's use of genetic interpretations. He did express concerns that this approach coupled with technical neutrality may convey excessive distance on the part of the analyst. This concern was echoed by an analysand, Guntrip (1975). According to Kernberg (1994), Fairbairn questioned the use of the couch and stressed the importance of the relationship with the analyst as a decisive therapeutic factor in bringing about a synthesis in the personality by reducing the horizontal and vertical splits: "that triple splitting of the pristine ego which occurs to some degree in every individual, but in some individuals to a greater degree than others" (Fairbairn, 1958, p. 380). Theoretically Fairbairn

stressed that therapeutic efforts do not derive only from the analyst's interpretations, but also, and fundamentally from the analyst's capacity to provide, by means of real interest and concern, the necessary counterbalance to the activation of bad repressed object relations in the transference:

> I cannot help feeling that such results must be attributed, in part at least, to the fact that in the transference situation the patient is provided in reality with an unwontedly good object, and is thereby placed in a position to risk a release of his internalized bad objects from the unconscious and so to provide conditions for the libidinal cathexis of objects to be dissolved (Fairbairn, 1952, p. 69).

Other object relations' conceptualizations of intervention will now be outlined. The emphasis will be on Ogden's re-conceptualizations of psychoanalytic technique. It seems that for Ogden, psychoanalysis consists of the careful analysis and interpretation of the process of transference and countertransference between patient and analyst.

Transference: the emphasis on object relations brought with it a change in emphasis in psychoanalysis and the importance of the relationship between the analyst and the patient was acknowledged. The emphasis is on transference and countertransference. Transference is seen as the patient reliving both self and object relationships in the present, at times projecting the self on to the therapist and at times projecting the object onto the therapist. The therapist's own reactions thus become very important in "diagnosing" the patient's predominant mode of object relating

Countertransference: in his paper reviewing the development of the concept of countertransference, Jacobs (1999) points out that before the Second World War most of the questions concerning countertransference that have preoccupied analysts today had been raised for consideration. He points out that although Freud considered countertransference as something that should be mastered, it was Ferenczi who advocated the usefulness of countertransference and who indeed advocated its selective disclosure. Winnicott in his paper, "Hate in the countertransference", echoed Ferenczi's contention that some countertransference reactions are objective responses to qualities in the patient and not neurotic in origin (Jacobs, 1999). Winnicott held that negative countertransferences play an important role in treating disturbed patients and that negative feelings of the analyst should be used as an essential part of treatment:

> In analysis of psychotics the analyst is under greater strain to keep his hate latent, and he can only do this by being thoroughly aware of it. I want to add that in certain stages of certain analyzes the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love … It seems that he can believe in being loved only after reaching being hated (Winnicott, 1992a, p. 199).

Winnicott's approach, which viewed countertransference as induced by projections of the patient's internal objects, was expanded by colleagues of the object relations school (Jacobs, 1999). They equated countertransference with the analyst's total responses, which reflected the displaced inner object world of the patient.

Ogden (1982, 1990, 1992, 1994, 1996, 1997) extends this conceptualization of countertransference. Integrating Kleinian and object relations theories, he utilizes the Kleinian notion of projective identification, Winnicott's conceptualization of potential space, and Bion's concept of reverie.

Projective identification: Ogden (1990) differentiates between empathy, which occurs within the context of potential space, and projective identification. He says that in potential space, one "plays" with the idea of being the other while knowing one is not. Ogden emphasizes the importance of dialectic between fantasy and reality:

> It is possible to try on for size one identification and then another (i.e. to play with the feeling of being the other in different ways) because the opposite pole of the dialectic diminishes the danger of being trapped in the other and ultimately of losing oneself in the other (Ogden 1990, p. 107).

Projective identification, on the other hand, means experiencing the feelings of the other as one's own and can be thought of as occurring outside the dialectic of being and not-being the other (i.e. outside of potential space). Ogden states that interpersonally, projective identification is the negative of playing. It is a coercive enlistment of another person to perform a role in the projector's externalized unconscious fantasy. Ogden states that neither projector nor the recipient of the projective identification is able to experience a range of personal meanings. The "processing" of a projective identification by a therapist can only be understood as the therapist's act of re-establishing a psychological dialectic process in which the induced feeling state can be experienced, thought about, and understood by an

interpreting subject. Ogden (1982) conceptualizes the processing of projective identifications as consisting of three phases. Firstly, based on the primitive defense of splitting, or separating dangerous internal objects from endangered internal objects (Ogden, 1992), there is the unconscious fantasy of projecting part of oneself into another person and of that part taking the other person from within. Then, there is pressure exerted through interpersonal interaction that induces the recipient of the projection to feel, think, and behave in a manner congruent with the projection. Finally, after being psychologically processed, by the recipient, the projected feelings are re-internalized by the projector. Ogden states that the analyst should attempt to process the projections of the patient via reverie to be discussed further below.

Psychoanalytic holding and containment: Winnicott (1965a, 1965b, 1965c, 1990, 1992a, 1992b) emphasizes the importance of a holding environment, interpretation and the timing of interpretation, opting in his later writings for fewer interpretations and more holding. Like Winnicott, Bion (1959, 1962a, 1962b) also emphasizes the importance of the holding, or what he describes as the containing environment. Britton (1998) describes holding as "the idea of being inside something safe". Britton sums this up by saying: "The analytic situation could be described as endeavouring to provide both a bounded world and a place where meaning can be found".

The emphasis is thus on containing the patient's projective identifications and in reflecting this back to the patient in "manageable doses". What the patient really needs is not the immediacy of reflective mirroring but also a thoughtful response that understands him in depth, as is described by Bion's model of the mother's reflectiveness to the child's projective identifications.

The emphasis in object relations therapy is thus on "naming" via reflection or mirroring and interpretation, and "containing" via the therapist's neutral stance and verbal and non-verbal communication of warmth, empathy and non-judgemental positive regard. It is through the abstinent and neutral attitude of the therapist that the patient is able to find potential space. Ogden (1990) states that Winnicott's concept of potential space might be understood as a state of mind based upon a series of dialectical relationships between fantasy and reality. It seems that the poles of this dialectic are formed by the structure of the limits of the psychoanalytic frame on the one hand, and the structure of the limitlessness of the analyst's neutrality and abstinence on the other. Both the limits and the limitlessness are part of the psychoanalytic frame and allow the patient both the freedom and the security to play and to think. According to Ogden (1996), the creation of an analytic process depends upon the capacity of the analyst and analysand to engage in reverie.

Reverie: Ogden uses Bion's term to refer not only to the material of the patient, but also to a varied collection of states that may at first seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, day dreaming, sexual fantasizing and so on (Ogden, 1994). In other words, Ogden considers all seemingly random thoughts, feelings and behaviors of the analyst to be significantly related to the therapeutic interaction at the moment. Although belonging to the analyst, the evocation of the particular thoughts, feelings and behaviors, their form and content are influenced by the patient/analyst interaction. Ogden (1994) refers to the analytic intersubjectivity as the "analytic third". He stresses, however, that it is important to conceptualize the therapeutic interaction as a dialectical process, which includes

individual subjectivity with intersubjectivity. According to Ogden (1994), we must continually ground the concept of countertransference in the dialectic of the analyst as a separate entity and the analyst as a creation of the analytic intersubjectivity. Neither of these "poles" of the dialectic exists in pure form and our task is to make increasingly full statements about the specific nature of the relationship between the experience of subject and object, between countertransference and transference at any given moment:

> … the analytic experience occurs on the cusp of the past and the present, and involves a "past" that is being created anew (for both analyst and analysand) by means of an experience generated between analyst and analysand (i.e. within the analytic third) (Ogden, 1994, p. 9).

According to Ogden, in any given analytic interaction, a compelling argument could be made for a variety of understandings of what is occurring and an equally varied array of possible responses on the part of the analyst could be defended (Ogden, 1997).

Psychoanalysis might be viewed as involving recognition not only of transference and resistance, but also of the nature of the intersubjective field within which transference and resistance are generated. Based on Winnicott, Ogden (1996,1997) emphasizes the dialectical nature of the psychoanalytic process intended to enhance the analysand's capacity to be alive as a human being. For Ogden, analysis takes place in the oscillation between reverie and interpretation. He stresses the importance of the dialectic between privacy and communication. For this reason he disputes the

"fundamental rule" of free association, stating that it would interfere with the dialectical interplay of the analyst and analysand for reverie:

> To privilege speaking over silence, disclosure over privacy, communicating over not-communicating, seems as un-analytic as it would be to privilege the positive transference over the negative transference, gratitude over envy, love over hate, the depressive mode over the paranoid-schizoid and autistic-contiguous modes of generating experience (Ogden, 1996).

Ogden's emphasis is thus on reverie and the asymmetrical experiencing of the analytic third by both analyst and analysand that provides a window into the unconscious internal object world of the analysand that is ultimately verbally symbolized via interpretation. Ogden's model is based on that of Bion (1959, 1962a, 1962b). In his model, the mother, in a state of *reverie*, first receives and takes in those states of the infant which are intolerable to it. She contains or transforms these projections and having done so, she returns them to the infant in a detoxified and digestible form and at such time that they may be of use to him. Bion termed the process of giving back in a meaningful way, "publication" (Bion, 1959, 1962a, 1962b). Classically, publication has involved verbal interpretation, but as will be described below, Ogden (1994), has extended the definition of interpretation to include that of "interpretive action".

Interpretation: like classical psychoanalysis, the cornerstone of psychoanalytic technique for object relations therapy has been its use of interpretation. Winnicott

(1990) states that the simplest form of interpretation is giving back to the patient what he has communicated.

There is some debate about what an interpretation actually is. For instance, Giovacchini (1990) questions Winnicott's definition of an interpretation, citing Winnicott's own example of self-disclosure as being an "interpretation". Ivey (1998) has defined interpretations as: "… those verbal interventions that attribute a deeper meaning or alternative meaning context to a patient's consciously intended verbal or non-verbal communications".

He states that interpretative activity is still regarded as the primary means of promoting therapeutic change. According to most psychoanalytic approaches, deviations from the use of interpretation as a therapeutic technique should be discouraged. Non-verbal communications on the part of the analyst have not been acknowledged or have been disparagingly labelled as "acting out", "acting in" or "enactments". Deliberate use of a non-interpretative technique is regarded as a "parameter of technique". Eissler (1990, p. 400) defines a parameter of technique as: "… the deviation, both quantitative and qualitative, from the basic model of technique, that is to say, from a technique which requires interpretation as the exclusive tool".

He refers to Freud who advocated that the parameter to be introduced be the minimum without which no progress could be made. Eissler concurs that a parameter must be introduced only when it is proved that the basic model does not suffice and it should involve minimal changes to the basic psychoanalytic technique. It should be done away with as soon as possible and should not have a lasting impact on the

transference. Eissler states that this fourth condition may be difficult to fulfil during the acute phases of the treatment. He states that if it has happened that a parameter has influenced the transference in a way that cannot be undone by interpretation a change of analyst may be necessary.

Ogden (1994) uses a definition of interpretation provided by Laplanche and Pontalis, where interpretation is described as a procedure, which brings out the latent meaning in what the subject says and does. Ogden states that interventions should be aimed at expanding analytic space, i.e. facilitate the capacity for symbolization of conscious and unconscious experience. Although accepting of more traditional definitions of the "psychoanalytic situation" (Bleger, 1990), including the use of the couch to facilitate reverie, for Ogden, it is important that the intervention should be experienced as a transitional phenomenon.

Therefore, in contrast with more traditional approaches to technique, Ogden (1994) extends conceptualizations of interpretation like the ones provided above by including in his notion of interpretation, the idea of "interpretative action". By "interpretive action" or "interpretation-in-action", Ogden (1994) is referring to the analyst's communication of his understanding of an aspect of the transference/countertransference by an activity other than that of verbal symbolization. Ogden cautions that an important aspect of interpretative action is the analyst's consistent formulation for himself of the evolving interpretation in words. In the absence of such efforts, the idea of interpretive action can degenerate into the analyst's rationalization for impulsive non-self-reflective acting out.

Further, Ogden (1994) pays attention to the manner of the patient's verbal communications, which he calls the matrix of the transference. This recreates in the analytic setting the patient's fundamental modes of structuring experience (autistic-contiguous, paranoid-schizoid, and depressive) and the interplay between these modes. Ogden (1994) points out that the analyst's interventions must often be directed to the mode or matrix of the transference, i.e., the way that the patient is thinking, talking and behaving, before it becomes possible to address other inter-related aspects of transference (for example, the unconscious symbolic meanings of what the patient is thinking, saying or enacting). According to Ogden (1994), the analyst should interpret the interplay between the context (matrix) and content of the analytic interaction, attempting to direct the patient's attention to the moment of substitution of one form of thinking, feeling, and behaving for another. There is an assumption that the patient has experienced thoughts, feeling, and/or sensations that were so disturbing as to lead him on to alter the way he is communicating:

> … the patient alters his way of generating experience in such a way that one or another of the dimensions of experience (the autistic-contiguous, the paranoid-schizoid, or the depressive) defensively excludes the others. This alteration in the way experience is being generated is in part perceived by the analyst through his monitoring the shifts in the countertransference. The experience of being with the patient undergoes a subtle, but discernible change resulting from an intersubjective shift in the balance of modes contributing to the transference-countertransference experience (Ogden, 1994, pp. 152-153).

Furthermore, Ogden describes how he often deliberately matches his verbal interpretations, and his interpretations-in-action to the patient's communicative style. This type of thinking and intervening has much in common with the interpersonal notion of "fit" to be discussed further later.

2.5.2 Modes of communication in therapy – Ogden and Langs

In line with the integrative approach being taken in this thesis, it is proposed that Ogden's modes of communication may be related to or "stretched" (Ogden, 1994) to accommodate the classification of communication in therapy by patient and therapist described by Langs (1978) (or vice versa). Langs' model has been included, as his classification of communication will be used as a research tool or "hermeneutic lens" to scrutinize the communication patterns of the patient and therapist, in the research case studies presented in Chapter 6.

Although essentially a classical psychoanalyst, Langs (1978) uses an "adaptational-interactional" clinical meta-psychological approach to the patient and therapeutic interaction which takes into account both conscious and unconscious intra-psychic and interactional processes. In line with object relations theory (Ogden, 1992, 1994) and relational psychoanalysis (Aron, 1996), he conceptualizes the psychoanalytic situation as a bipersonal field. The field metaphor suggests that every point in the field – every communication, interaction, structure and occurrence within and between the two members of the therapeutic dyad – results from input from both participants. That is, every communication of the patient is influenced by the therapist and vice versa. The management of the framework is considered specifically as an

intervention and therefore as a meaningful communication to the patient. According to Langs, unconscious reflections and communications of all the therapist's interventions, verbal and nonverbal, must be identified in terms of their form, nature, meaning and functions.

Langs (1978) views the patient's communications to the analyst as adaptive responses prompted by emotionally meaningful stimuli that arise within or outside of the analytical situation. He describes this as the "adaptive context". Langs identifies three individual communicative styles that result from "adaptive contexts".

The first is *Type A* type, which involves symbolic communication, play and transitional space. It is proposed here that this style corresponds to Ogden's *depressive position* described above. The second communicative style, *Type B*, involves patients and analysts who utilize projective identification and action discharge or acting out as their primary mode of expression. It is proposed here that this style described by Langs corresponds to Ogden's *paranoid-schizoid mode* of processing experience described above. The third style, *Type C*, is characterized by efforts to create impervious and impenetrable barriers to underlying chaotic disturbances in the analyst and patient. It is suggested here that this style corresponds to Ogden's autistic-contiguous mode. Langs also delineates three modes of organizing the patient's communication. These include, firstly, working with manifest content only, and secondly, working with latent content and *Type One* derivatives, which are associations made by the analyst or patient regarding the patient's internal world, and thirdly, working with latent content and *Type Two* derivatives, i.e. derivatives organized around "adaptive contexts" within the therapeutic interaction. It seems that

according to Langs, the goal of therapy is to work with *Type Two* derivatives pertaining to the immediate relationship between the analyst and patient in a *Type A* communicative mode. That is, it is ultimately therapeutic for the patient to be able to "play" with ideas and to "think" about the way he communicates with the therapist within the immediate therapy situation. This type of communicative style corresponds to operating mainly from within the depressive position, whereas the *Types B* and *C*, correspond to paranoid-schizoid and autistic-contiguous modes of communication. (For complete definitions of the adaptive context, the *Type A*, *B*, *& C* Fields and communicative modes and *Type One* and *Type Two* derivatives as defined by Langs (1978) refer to Appendix H).

2.5.3 The process of therapy: Fairbairn, Ogden and Langs – a summary

In today's object relations terminology, Fairbairn's goal of psychotherapy can be described as the integration of the part-objects and the part-self representations. Integration of the two part-objects (exciting and rejecting) occurs to produce a single constant object who is both rewarding and frustrating, and integration of the two part-selves (libidinal ego and anti-libidinal ego) becomes part of an integrated, expanded, and realistic central ego (Celani, 1993).

From Ogden's perspective, psychopathology can be seen as the excessive use of splitting and a breakdown in the dialectic between the autistic-contiguous, paranoid-schizoid and depressive modes of experience and communication. Although the approach to treatment that he favours is interpretative and he favours the use of the couch, Ogden expands his notion of interpretation to include "interpretive action". According to Ogden (1994) acting out and acting in on the part of the patient are now

more widely understood to be valuable components of the analytic dialogue and not simply a disruption of it. He says that the task of the analyst is not to get the patient to stop the acting out or acting in, but to "fold" these communications in action into the analytic space in the manner described above, where Ogden interprets both the content and context/matrix of the transference/countertransference. For Ogden, the analyst's interpretations-in-action represent one-step in this process. "With very disturbed patients, the notion of interpretation-in-action and the idea of providing a holding environment become virtually synonymous concepts" (Ogden, 1994, p. 190).

Langs (1978) has developed an "adaptational-interactional" clinical meta-psychological model which can be utilized to scrutinize the process of patient/therapist interaction which takes into account both conscious and unconscious intra-psychic and interactional processes. This model can be related to Ogden's "modes of communication" and his concept of the analysis of the "matrix of the transference/countertransference". This model will be used to analyze the cases presented in the research.

2.6 A RELATIONAL AND INTERACTIONAL CRITIQUE:

What Fairbairn seems to have been aware of, and what Ogden is addressing is the need for some kind of modification to psychoanalytic technique. The researcher believes that Ogden (1994), with his acknowledgement of "interpretative action", recognizes the first axiom of communications theory:

> First of all, there is a property of behaviour that could hardly be more basic and is, therefore, often overlooked: behaviour has no opposite. In

> other words, there is no such thing as nonbehaviour or, to put it even more simply: one cannot not behave. Now if it is accepted that all behaviour in an interpersonal situation has message value, i.e., is communication, it follows that no matter how one may try, one cannot *not* communicate. Activity or inactivity, words or silence all have message value: they influence others and these others, in turn, cannot not respond to these communications and are thus themselves communicating (Watzlawick, Beavin & Jackson, 1967, p. 49).

In other words: we cannot not communicate (Aron, 1996).

Aron (1996) states that the classical model of psychoanalysis distinguishes between "words" and "acts". The classical model was based on a model of the mind that held that impulses could be channelled into one of two paths – *efferent*, which leads to motor activity or action, or *afferent*, which leads to the stimulation of sensory apparatus, thought, fantasy and ideation. According to Aron, Ferenczi challenged this. He held that we are always communicating verbally and non-verbally. Words are acts, and acts have meaning. "The talking therapy is an active and interactive technique. For Ferenczi, and later for interpersonalists, psychoanalysis is where the action is!" (Aron, 1996, p. 193).

It follows then that everything is an "act". To do nothing is an act as much as doing something. Smith (1988) refers to Schafer's advocacy of action language. He states that in Schafer's terms, non-defensive passivity is an owned act of the subject as agent. This conception of action transcends the ordinary active-passive duality. He says that analysis reveals defensive disclaiming of agency, whether in reference to

behaviour ordinarily considered “active”, or “passive”. Disclaiming of either amounts to “defensive passivity”. The owning of both allows for non-defensive, claimed as one’s own “activity” and also “non-defensive passivity”. According to Smith, the contrary to activity is defensive passivity, the complement non-defensive passivity. He describes errors of commission and errors of omission. Thus, for Smith, the withholding of an intervention that is analytically indicated, but not part of the usual repertoire of psychoanalytic methodology, is analytically a technical error. When referring to the basic analytic attitude Smith states:

> Our basic attitude in working with patients reflects our understanding of developmental universals pertaining to what each individual is called upon to accomplish in each era of his or her life. The test of each therapeutic intervention is whether or not it fosters or at least leaves the door open for the eventual accomplishment of previously aborted developmental tasks rather than, of course, whether it conforms to some currently defined type of therapy (Smith, 1988, p. 411).

From this perspective, psychoanalytic holding, interpretation and the introduction of parameters are all acts, which may or may not be analytically indicated. The emphasis is thus not only on what we say, but also how we say it and indeed whether we say it all, as well as on what we do, how we do it and indeed whether we do it at all. It is the contention of this thesis that psychoanalytic holding and interpretation is only one type of technical approach which may be used. In line with the relational approach to technique, it is suggested here that other types of technique may be necessary,

depending on the patient and also the stage of therapy. This is the case in particular with patients who can be described as operating mainly in the paranoid-schizoid mode. In these instances the techniques utilized may need to be of a different type of activity to the activity of the psychoanalytic techniques described in Chapter 2. In other words, what is needed is a change in psychoanalytic technique.

It seems that by his acknowledgement of the intersubjectivity of the analytic situation and the existence of the "analytic third", his recommendation of the use of reverie in understanding of the unconscious of the patient, the extension of the concept of interpretation to include "interpretative action", and his deliberate tailoring of his level of interpretation and/or interpretive action, Ogden has moved increasingly in the direction of "relational psychoanalysis"[4].

However, relational analyst Aron (1996) is critical of Ogden. He states that his reading of Ogden leaves him with the impression that Ogden views his own subjectivity largely as reactive to the patient rather than as initiating particular forms of interaction, nor does he view the analytic participation as mutually influenced from the beginning. Aron (1996) says that Ogden does not go far enough in recognizing the impact of the analyst as a person on the unfolding of the patient's transference. This relative neglect may be because, although broadly relational, Ogden tends to draw his influence largely from British psychoanalysis. Aron is more influenced by American interpersonalists. Along with Aron (1996), the relational psychoanalytic view propounded here assumes the mutual, even if unequal, participation of patient and analyst from beginning to end.

[4] These changes have been described by Reis (1999) as "Thomas Ogden's phenomenological turn". Reis suggests that Ogden's conceptualization of the "intersubjective analytic third" is similar to Merleau-Ponty's phenomenological conceptualization of intersubjectivity and that this philosophy forms a grounding for psychoanalysis, a subject related to, but beyond the scope of this thesis.

Further in this line, relational theorist Maroda (1991, p. 21) cites Wachtel who argues for abandoning the clinical notion of neutrality. She also cites Greenberg who says that "neutrality" has become a "burdened term". According to Maroda (1991), Greenberg states that the concept of neutrality needs to be maintained because it has fallen prey to the same linguistic mutilation as the term "interpretation". That is, it has been over-used and over-applied in the same way as interpretation, with neutrality becoming synonymous with providing a safe and non-judgemental environment. Maroda says that Greenberg's statements seem to reflect a fear that the importance and necessity of providing the appropriate analytic environment may be lost if the term "neutrality" is abandoned. She states that usually the influence of the analyst is recognized and acknowledged by the advocates of neutrality, but the claim is made that one can and should strive to minimize that influence as much as possible. Thus while strict neutrality is admitted to be impossible, relative neutrality is put forth as a valid and salutary ideal. This seemingly sophisticated and realistic position is described by Wachtel as "much like describing someone as a little bit pregnant" (Wachtel, as cited in Maroda, 1991, p. 21).

In line with this view, the interactional view that serves as this researcher's starting point not only disputes the possibility of neutrality, stating that "in the presence of another, all behaviour is communication", but also emphasizes that there are many levels to communication and one always pertains to the relationship in which it occurs (Jackson, 1977; Watzlawick & Beavin, 1977). In other words, there are always report and command aspects to communication. From this perspective, the relationship

between therapist and patient is not only "asymmetrical", but the therapist is quite clearly in a superior position:

> To control a relationship a person must be in a position to establish the rules for what is to happen between himself and another person. The fact that a therapist must take a superior position and must be in charge in therapy is obvious when one considers how impossible the situation would be if he did not (Haley, 1963, p. 72).

According to Haley (1963), a problem in describing psychoanalysis as well as other schools of psychotherapy is that the reports of psychotherapists emphasize the theory of the school, rather than what actually happens between the therapist and the patient. Haley (1963) criticizes psychoanalytic approaches to psychotherapy, stating that although there is voluminous literature on psychoanalytic theory, there is little information available on what actually happens in the analyst's office. Haley questions whether psychoanalysts are not more directive than they would admit to be for publication. He emphasizes that traditional psychoanalysis assumes that people could change through self-understanding. However, from an interactional perspective it seems that the ability to change because of self-understanding is limited and a description of psychoanalytic process which includes both therapist and patient, rather than subjective processes within the patient, makes apparent other possibilities besides self-understanding as the source of therapeutic change. Haley points out that it is possible to find in psychoanalytic method similarities with other quite different supposedly "non-directive" methods.

According to Haley (1963), "non-directive therapy" is a misnomer. From Haley's perspective, whatever the therapist says or does not say is a directive to the patient. Whatever the therapist says as well as what he does not say circumscribes the patient's behaviour. From the interactional perspective described by Haley (1963), the crucial aspect is that the patient cannot get control of the psychoanalyst's behaviour. If the psychoanalyst both directs and denies that he is directing, he will be in control of the relationship. Haley points out that the psychoanalytic psychotherapist takes charge while claiming that he does not. He states that the therapist does not oppose anything that the patient does, short of physical assault, and whatever the patient does or does not do in his personal life should not provoke advice or opposition from the therapist. Whatever the patient says or does not say does also not provoke a response from the therapist:

> When someone goes to an authority for advice and help and is told to do the talking himself, he is faced with a paradoxical situation. He is told to take charge of what happens in the interview, and the fact that he is *told to do so* means that he is not in charge (Haley, 1963, p. 80).

In short, in this approach therapy is seen as posing a paradox to a patient, controlling the patient's behaviour, while at the same time denying such control. Psychotherapists working from within an interactional view espouse that as many aspects of communication as possible should be acknowledged (Haley 1977). Further in this vein, Watzlawick, Weakland and Fisch (1974) describe how solutions to problems often become part of the problem. Psychotherapeutic approaches which prescribe rigid techniques run the risk of becoming part of an escalating cycle of "more of the

same" (a subject related to, but beyond the scope of this thesis). According to this approach to psychotherapy, techniques and interventions should therefore be adjusted to "fit" the problem of the individual patient[5].

According to Aron (1996), a relational psychoanalyst, no technical formula regarding intervention can eliminate the need for the analyst to make a personal and professional decision, in each instance, on a moment-to-moment basis about what course of action is most compatible with that patient at that moment in time. He says that what feels to one analyst like disciplined restraint and the holding and processing of feelings, may feel to another analyst like being overly constrained, emotionally withholding, or falling back on authority. Aron (1996) cites Mitchell who suggests "… a combination of the two approaches to balance thoughtful restraint and discipline with the vitality of spontaneity and free emotional expressiveness" (Mitchell, as cited in Aron, 1996, p. 252). He states that neither technical style is more humane or clinically effective than the other and that what is most exciting about contemporary

[5] A detailed discussion of ecosystemic epistemology and systems theory is beyond the scope of this thesis. Suffice it to say here that the patient and the therapist can be perceived as two separate systems or as a patient/therapist system, depending on the level of recursion that is punctuated (Keeney, 1983). Each of these three systems can be seen as having a relatively coherent structure. Maturana, (cited in Dell, 1982) a biologist, describes systems as being more or less structurally plastic, a structurally plastic system being one that undergoes structural changes as a result of interacting with itself, its environment and other structurally plastic systems.

In the therapeutic environment this can be conceptualized as a patient system, which is (theoretically) less structurally plastic, and a therapist system, which, because of the therapist's relative ability to self-reflect and to reflect on her interaction with the patient system, is more structurally plastic. Dell (1982) argues that psychotherapy helps individuals to a new state within their ongoing coherence if the interventions fit with the current system structure (structural coupling – Maturana). The therapist therefore needs to adapt his or her behaviour to "fit" with that of the patient. However, Dell (1982) points out that in order to be successful in triggering system-transforming behaviour the therapist must also use behaviours (i.e. interventions) that differ from those being used within the system. Dell describes the individual's behavioural coherence as the lock and the interventions used as the key. He states: "It is always the lock that determines which keys will work. There is no truth (i.e. one key). There is no causality (i.e. the key that makes the lock open). There is only fit (i.e. those keys that are complementary to the lock)" (Dell, 1985, p. 35).

The emphasis is thus on the therapist's structure being the same as the patient's structure – fit – as well as being slightly different – the notion of movement – the key that fits, turning the lock.

developments in clinical psychoanalysis is the new openness to pluralism and diversity.

A relational approach, which embraces the interpersonal approach (see below), affords the analyst flexibility in terms of technique. The theoretical foundations of this approach and its critique of certain aspects of object relations theories and its implications for the conceptualization of psychopathology and psychotherapeutic intervention will be discussed in more detail in Chapter 3. However, it will be shown in the critique of this approach that it does not always take cognisance of interactional principles, which it supposedly embraces

CHAPTER 3: RELATIONAL PSYCHOANALYSIS

> "Perhaps the most important aspect of the term relational is precisely that it *includes* the *relation* between the individual and the social, internal objects and external interpersonal relations, self regulation and mutual regulation."
>
> (Aron, 1996, p. 63)

3.1 INTRODUCTION

Evolving in the post-modern era, relational psychoanalysis is a hybrid epistemology that has developed a theory of human functioning, pathology and therapeutic practice. It is post-modern, in that its philosophical premises oppose the uncritical acceptance of objectivity. It is relativistic in that it takes the position that theories only provide a partial perspective and it attempts to understand reality contextually. Relational psychoanalysis emphasizes dialectical processes. It is strongly influenced by object relations theory, the interpersonal school, attachment theory, self-psychology, psychoanalytic feminism and intersubjectivity theory[6].

According to Aron (1996), relational theory was meant to bridge the perceived gap between British school object relations theories and American interpersonal theory. Some aspects of the different object relations theories and Ogden's revised theory of object relations were described in Chapter 2. A brief description of American interpersonal psychoanalysis follows.

[6] Although, attachment theory, self-psychology, psychoanalytic feminism and intersubjectivity theory they are integrally related to relational psychoanalysis, spatial limitations do not allow for the detailed discussion of these important bodies of knowledge. Rather, object relations theories and American interpersonal psychoanalysis are focused on

3.2 INTERPERSONAL PSYCHOANALYSIS

Like object relations theories, interpersonal psychoanalysis does not constitute a unified, integral theory. Rather it is a conglomerate of different approaches to theory and clinical practice bound together by a shared set of assumptions. These approaches tended to de-emphasize the internal world and internal psychic structures, and place emphasis on the role of society and culture in shaping personality. A figure central to the development of interpersonal psychoanalysis is Harry Stack Sullivan.

Based on his work with schizophrenics in the 1920s, Sullivan (1940, 1953, 1964) developed a theory of personality and psychopathology that emphasized the importance of interpersonal relations. Sullivan's attempt to build a two person or field theory of psychoanalysis was strongly influenced by Ferenczi. According to Sullivan's theory, personality, or the patterning of interpersonal situations, develops from and is composed of relations with others. He argued that that mind occurs in what he called "me-you patterns", a precursor of later formulations of relational configurations.

Sullivan viewed psychopathology in terms of characteristic patterns of integrating relations with others. Sullivan attempted to demonstrate that schizophrenic phenomena were not random products of neurological deterioration, but conveyed *meaning*, in the same way that Freud had demonstrated the meaning of neurotic symptoms twenty years earlier (Greenberg & Mitchell, 1983). For Sullivan, conflict derived from competing relational configurations, some being in the service of "need satisfaction" and others serving the purpose of the avoidance of anxiety. Sullivan anticipated later contributions of Klein, Fairbairn and others by pointing out the

frequency with which sexual wishes and conflicts are often the vehicle for other, often earlier, infantile thoughts and impulses involving dependency longings. Within Sullivan's system, *anxiety about anxiety* is at the core of all psychopathology. Anxiety arises as a response to anxiety in others. As a result of anxiety certain dimensions of experience are excluded. Sullivan insisted that language is dangerous and he objected to the reification of internal processes. Sullivan was sceptical of theory regarding the excluded aspects of the personality; he claimed to prefer "operationalism", i.e. a focus on data that is publicly available, the patient's behaviour, the content and manner of the patient's speech, the feelings and actions of the therapist in the presence of the patient. The most basic underlying principle in Sullivan's work, the idea that mind always emerges and develops contextually in interpersonal fields led him to portray the analyst as a "participant-observer", a precursor of contemporary constructivist accounts of the analyst embedded in a transference-countertransference matrix (Mitchell & Aron, 1999).

For Sullivan[7], the personal relationship between patient and therapist is the most important determining factor, positively or negatively, in treating the patient. This focus on the "here and now" and the focus on the current context of the patient's communications has led to the misconception that Sullivan denied the existence of the unconscious.

[7] As mentioned in Chapter 1 Sullivan's interpersonal approach was expanded by Bateson in 1956 (cited in Watzlawick et al., 1967). Central to this approach is the notion of "circular causality", i.e. the assumption is that human relationships are not cause and effect, but embedded in a network where effect influences or alters the cause, where the person affects and is affected by the environment. The interpersonal approach is concerned with what happens, not why it happens. Abnormal or pathological behaviour is seen as a way of handling relationships. The interpersonal approach was also influenced by the Mental Research Institute, founded by Jackson in 1958 (cited in Watzlawick et al., 1967). These approaches have coined the term the "interactional approach".

It seems, however, that though he tacitly acknowledged the past as influencing the present, because of his fear of using language and theory to reify internal components, Sullivan did not articulate a mediating process between the intra-psychic and interpersonal. This is the most striking difference between Sullivan's model and those developed with the British school of object relations which use language to articulate internal objects, structures and processes (Greenberg & Mitchell, 1983).

Aron (1996) states that we need to think in terms of both/and, rather than either/or. We need to think dialectically about the individual and the social, the innate and the learned, the body ("drives") and the interpersonal, autonomy and mutuality, intrasubjective and intersubjective, agency and communion. Mitchell and Aron (1999) cite Charles Spezzano who suggested the term "American Middle Group" for relational theory that operates in the dialectic between the intra-psychic and interpersonal, which had previously been dichotomised in the classical and interpersonal traditions. A more detailed discussion of some of the most basic principles of relational psychoanalysis follows.

3.3 RELATIONAL PSYCHOANALYSIS – CRUCIAL CONCEPTS

A relational approach to psychoanalysis can be summed up using four words: hermeneutics, dialectics, mutuality and intersubjectivity.

3.3.1 Hermeneutics

Based on hermeneutic philosophy, patient and analyst are perceived as pattern makers, or co-constructers of narrative that make human existence intelligible. According to relational theory, the psychoanalytic process is not one of archaeological reconstruction, but rather an active co-construction of a narrative about the patient's

life, based both on the patient's contributions, and the analyst's theory and personality.

3.3.2 Dialectics

"Dialectic" is a process in which opposing elements each create, preserve, and negate each other. Each stands in a dynamic, ever-changing relationship to the other. Dialectical movement tends towards integrations that are never achieved. That which is generated dialectically is continuously in motion (Ogden, 1994). Although the relational movement places human relationships rather than biological drives at its theoretical centre, it does not discount the importance of human biology, preferring a "both/and" rather than an "either/or" philosophy regarding human existence. The relational perspective approaches traditionally held distinctions dialectically, attempting to maintain a balance between internal and external relationships, real and imagined relationships, the intra-psychic and interpersonal, the intrasubjective and the intersubjective, the individual and the social. It fits into the "potential space" between the Freudian and interpersonal world-views (Aron, 1996).

3.3.3 Mutuality

The classical view of psychoanalysis depicts analysis as optimally operating as a one-way influence, with the analyst influencing and changing the patient and not vice versa. In contrast to the mainstream approaches the American interpersonal and relational approaches are distinguished by their epistemology, theory and use of therapeutic methods that recognize and emphasize the mutual regulation, mutual influence and mutual generation of data by patient and analyst. The emphasis on mutuality does not mean acceptance of equality. The relational perspective maintains

an ethic of asymmetry. In other words, although the influence of both therapist and patient is seen to be mutual, they have separate roles, functions and responsibilities and therefore the data they generate are not equivalent, i.e. their roles are asymmetrical (Aron, 1996). Recognition of the differences in power and responsibility of patient and analyst are intrinsic to this approach.

3.3.4 Intersubjectivity

> "Intersubjectivity theory views psychoanalysis as the dialogic attempt of two people together to understand one person's organization of emotional experience by making sense together of their intersubjectively configured experience."
>
> (Orange, as cited in Orange, Atwood & Stolorow, 1997, p. 5)

The study of interacting subjectivities, relational configurations, social construction and co-construction, reciprocal and mutual influence, and the interlocking nature of transference and countertransference have a history of being called by different names. Intersubjectivity theory per se and relational theory are similar, but they are connected to different schools of psychoanalysis, self-psychology and interpersonal psychology (Aron, 1996). The relational approach uses the concept of a relational matrix, the web of relations between self and other, as an overarching framework to include the psychoanalytic concepts from diverse schools which are in some ways contradictory and incompatible.

3.4 PSYCHOPATHOLOGY

True to its integrative nature, the relational psychoanalytic perspective of psychopathology incorporates ideas from the interpersonal school, self-psychology, attachment theory and object relations theory.

The influence of self-psychology can be seen in the relational view of psychopathology as arising as a response to parental failures in empathy. It also incorporates ideas from self-psychology of the importance of relations with others in constituting the "self". It maintains the interpersonal view of psychopathology being inherent in relationships and of psychopathology as a meaningful mode of communication. However, it also incorporates the object relations emphasis on the importance of early relationships and developmental concerns in the formation of psychopathology. It incorporates object relations and attachment theory notions of internalization of past relational configurations, and their re-configuration in the present. However, it maintains an emphasis on the analyst's role in re-creating specific relational configurations and as such is an essentially "two-person psychology" (Aron, 1996). Aron refers to Stephen Mitchell's relational approach which:

> … brings together in one model those theorists like Winnicott and Kohut, who have emphasized *the self*; those theorists like Fairbairn and Klein, who have emphasized *the object*; and those theorists like Bowlby and Sullivan, who have emphasized *the interpersonal space between self and other* (Aron, 1996, p. 33).

Relational conceptualizations of psychopathology do not eschew the notions of conflict or drive. Unlike the drive model, however, conflict is seen as existing between relational configurations. Relational theory rejects Freud's dual drive theory. There are various relational proposals regarding human motivation (e.g. Ghent, 1992; Greenberg, 1991; Lichtenberg, 1989; Sullivan, 1953), the details of which will not be discussed here. For most relational theorists, however, drives are not defined in biological terms, but are seen as psychological constructs. Biology enters human experience in so far as it is mediated through interaction. The body is not represented in the mind in a direct or unmediated way, but bodily sensations are constructed in a linguistic interpersonal field. The actualization of drives as human needs and the form the needs take emerge from the quality of individual interpersonal experience (Aron, 1996). Although, as in drive theory, there is an acknowledgement of the role of conflict in human motivation, conflict is seen to exist between different relational configurations. Following Fairbairn, conflicts are seen as being internalized and as continually dividing people's selves, leaving an internal world constituted by a variety of internal structures in conflict with one another.

3.5 THE PROCESS OF THERAPY

In line with interactional theory described above, relational analysts do not differentiate between words and acts. The emphasis is not so much on interpretation and insight as on creating new relational configurations. Although old patterns are inevitably repeated, what is important is that the patient has a new experience of relating based on a new relationship. From this perspective, interpretation and verbally achieved insight are relational experiences, and interaction is itself interpretative, that is, it conveys meaning (Aron, 1996). The relational view of

technique and clinical intervention is in line with that of Ferenczi who adopted a term suggested by a patient, "the elasticity of technique", in which "the analyst, like an elastic band, must yield to the patient's pull, but without ceasing to pull in his own direction" (Ferenczi in Aron, 1996, p. 140). The self-psychology ideal of "optimal responsiveness" is also evident in this conceptualization of intervention.

Relational analysts therefore tend to advocate a high degree of spontaneity of expression on the part of the analyst. From a relational perspective, analysts cannot not self-disclose. No therapeutic interventions can be delivered from a point of view of neutrality. In line with Sullivan, the analyst is seen as a "participant-observer" and all interventions are reflective of the analyst's subjectivity (Aron, 1996; Renik, 1993). In fact, further along this line, because every intervention is seen as an expression of the analyst's subjectivity, deliberate self-disclosure of countertransference is often advocated as a clinical technique (Aron, 1996; Ehrenberg, 1992; Maroda, 1991).

Transference: when considering transference, relational theory maintains an intersubjective approach influenced by interpersonal theory and attachment theory (Aron, 1996). In other words, the patient is seen as bringing to the analytic relationship internalized relational configurations or expectations about patterned relationships between self and other. Because of the emphasis in relational psychoanalysis on mutuality, however, it is not possible to discuss transference and countertransference separately. For this reason, the interplay of transference and countertransference is sometimes referred to as "cotransference" (Orange, as cited in Orange, Atwood & Stolorow, 1997).

Countertransference/cotransference: this approach sees the patient-analyst relationship as continually being established and re-established through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other. From this perspective, the patient's thoughts, feelings and communications are not only seen as endogenously determined, drive determined, autistic creations of the patient, or the result of expectations derived from past interpersonal experiences. Rather the communications are seen as the patient's effort to deal with the reality of the therapist. According to this view of the therapeutic relationship, patients always accommodate the interpersonal realities of the analyst and the analytic relationship. Aron (1996) cites Racker, who stated that analysis of the patient's fantasies about the analyst's countertransference largely constitutes the transference, and the analysis of this is the most important part of therapy:

> A consequence of the analyst's perspective on himself as a participant in a relationship is that he will devote attention not only to the patient's attitude toward the analyst but also to the patient's view of the analyst's attitude towards the patient (Gill, as cited in Aron, 1996, p. 78).

From this perspective, resistances are seen as defensive efforts by a patient to cope with a particular analyst and these resistances are patterned by the patient to accommodate to some aspect of the patient's perception of the analyst's psychology: "Anonymity is never an option for an analyst. You can sit, but never hide behind the couch!" (Aron, 1996, p. 97).

The focus is thus on the patient's awareness of the analyst's subjectivity. Analysis of the patient's fantasies about the analyst will contribute to a clearer understanding of the patterns of expectations about relationships that patients bring to the analytic relationship, but also to awareness of aspects of the psychology of the analyst about which the analyst has not always been consciously aware. Obviously, because of the asymmetrical definition of the relationship, the successful result of analysis of the fantasies of the patient about the analyst is that the patient should learn more about their own psychology than about that of their analyst. From a contemporary interpersonal perspective transference-countertransference interactions are mutually constructed, and are never simply talked about. They are always enacted as they are being discussed. Even when "accurately" interpreting a transference-countertransference enactment, the analyst will be participating in or enacting another enactment. When we speak, we act on the person spoken to (Aron, 1996).

Projective identification: in line with Sullivan's operational approach to communication, the relational approach demystifies the concept of projective identification. Instead of adhering to the object relations conceptualization of projective identification as referring to the fantasies of ridding the self of unwanted aspects, along with the enactment of object relations that accompany these fantasies, the relational approach emphasizes the actual interactions that go on between two people. The relational approach considers the patient's verbal and nonverbal behaviour and asks: what did the patient do and in what way did the patient act that would evoke those responses in the analyst? It would also ask: what is there in the analyst that would respond in that way to what the patient did?

The relational approach is critical of object relations definitions of projective identification that obscure the behavioural and interpersonal components that would be useful in explaining the phenomenon. The concept of projective identification serves as a bridge between intra-psychic and interpersonal. For relational theorists, projective identification brings us back to the artificial distinction between words and deeds. According to Aron (1996), analysts who use this term distinguish between patients who use various forms of subtle and not so subtle forms of action to communicate, because they are not sophisticated enough to communicate with words. From more traditional psychoanalytic perspectives, words are privileged over actions and are viewed as more healthy and mature than actions. For relational theorists, however, words and acts are not sharply distinguishable. Some words may be more like actions than others and some actions, including silence, may be more communicative than others. For relational theorists interaction enactment and projective identification are all ubiquitous. Projective identification is a clear manifestation of intersubjectivity. That is, it is an expression of how the subjectivity of one person influences the subjectivity of the other, with a change occurring in the subjectivities of both parties.

The patient and analyst continuously influence the other. From this perspective, analysts can't easily explain their own and their patient's reactions via the notion of projective identification without simultaneously examining their own particular contributions to the patient's experience. From a relational perspective, the processes that result in mutual influence are seen to be very complex and are never reducible to a simple formula such as projective identification. According to relational theorists,

the simplicity of the concept of projective identification may lead the analyst to a premature, false sense of complete comprehension of the patient-analyst interaction.

Holding and containment: the relational approach is critical of object relations theories' use of metaphors of the analyst as a "good-enough mother" (e.g. Winnicott, 1965c) or as a "container" and a "metabolizer" of the patient's pathological contents, where the analyst is advised to be "free from memory and desire" (e.g. Bion 1962a). According to the relational approach, there is a tendency for the "blank screen" of the classical approach to be replaced with an "empty container" in the object relations approaches to therapy (Aron, 1996). From a relational perspective, the clinical centrality of the analyst's subjectivity is emphasized. Based on feminist psychoanalytic criticism, the relational approach is critical of theories of development that do not acknowledge that the baby does not recognize the mother as a subject in her own right.

Interpretation: relational theorists object to the term interpretation as it is used in the classical sense, in that it implies an active authoritative analyst "giving" an objective interpretation to a relatively passive and less informed analyst (Aron, 1996). Aron sees an interpretation as a creative expression of the analyst's conception of some aspect of the patient. He refers to relational writers such as Maroda (1991) and Renik (1993), who prefer the word "intervention" to "interpretation". In line with postmodern philosophies of hermeneutics and contextualism he states that an analyst may interpret with conviction while eschewing certainty and positive epistemological presuppositions.

In line with the conception of mutuality, the relational tradition views interpretation as a bipersonal and reciprocal communication process, a mutual meaning-making process. Interpretation is seen as a complex intersubjective process that develops conjointly between analyst and patient (Aron, 1996). There is thus an emphasis on the mutual generation of data by patient and analyst. Aron's use of the term "interpretation" is extremely broad. From this perspective, all action (verbal and non-verbal' active and passive) communicates meaning and therefore is interpretative of both the analyst's and patient's subjectivity. As mentioned above, this usage moves in the direction of breaking up the distinctions between verbal interpretations, which have been traditionally given higher status, and other verbal and nonverbal interventions that have traditionally been less highly valued. In line with this approach, Safran and Muran (2000) prefer the term "metacommunication" and state that it is important to keep in mind that an interpretation is only one person's subjective attempt to make sense of something.

Relational analysts generally believe that what is most important is that the patient have a new experience rooted in a new relationship. Old patterns are inevitably repeated, but, it is hoped, the patient and the analyst find ways to move beyond these repetitions, to free up their relationship and construct new ways of being with each other. This is what is critical and ultimately what leads to change. Sometimes interpretation and insight may be the optimal way to move a relationship forward; sometimes changing our ways of interacting more directly may accomplish the same thing. Relational analysts are more likely than traditional theorists to credit interaction as directly leading to change. Optimally for all analysts, the combination of insight and new forms of interpersonal engagement works synergistically to produce change

(Aron, 1996). Further, in the context of psychoanalysis, interpretation and verbally achieved insight are relational experiences and interaction is itself interpretative, i.e. conveys meaning.

According to this approach to intervention, rather than avoid enactment it is preferable to create an analytic climate where a greater range of behaviour in the analyst is tolerated than is traditionally acceptable. An attempt is made to analyze all communications as much as possible. However, it is acknowledged that analysts will not be able to analyze them all completely. Relational theory does not dictate a particular form of analytic activity so much as it insists on the recognition of inevitable and continuous participation:

> "A picture is worth a thousand words," and a patients or analyst's actions can have a greater impact than some verbal communications. We have come to value patient's 'acting out' as an important communication, similarly analyst's actions may at times be more valuable than their interpretations (Aron, 1996, p. 116).

From a relational perspective, the psychoanalytic process can thus be seen as one of negotiation (Aron, 1996). Aron describes "negotiation" as an inherent feature of the relational model because the theory takes for granted that the analyst influences the patient and the patient influences the analyst. Aron states that not only do patient and analyst negotiate fees, schedules and cancellation policies; they also negotiate the meanings that are co-created between them. Aron says that interpretation and the locations of resistances, and the construction of psychoanalytic narrative is negotiated. So too, is the affective climate, and the amount of psychological distance between

analyst and patient. Aron describes all of these as products of interpersonal, conscious, and unconscious negotiation – a meeting of minds.

The contemporary relational perspective maintains a dialectical approach by considering both that individuals determine relationships and that relationships determine individuals. Interventions which are appropriate for one person at a particular stage of therapy are not necessarily appropriate for another person or for the same person at a later stage. Aron (1996) quotes Mitchell in this regard:

> What may be most crucial is the process of negotiation itself, in which the analyst finds his own way to confirm and participate in the patient's subjective experience, yet over time establishes his own presence and perspective in a way that the patient can find enriching rather than demolishing (Mitchell, as cited in Aron, 1996, p. 139).

In the same vein, Ehrenberg (1992) quotes Bateson:

> As we see it, the process of psychotherapy is a framed interaction between two persons in which the rules are implicit but subject to change. Such change can only be proposed by experimental action, but every such experimental action, in which a proposal to change rules is implicit, is itself a part of the ongoing game. It is this combination of logical types within the single meaningful act that gives to therapy the character not of a rigid game like canasta, but instead that of an evolving system of interaction (Bateson, as cited in Ehrenberg, 1992, p. 117).

Further, from this perspective, re-enactment of the patient's relational constellations is seen as valuable and therapeutic. For instance, Maroda (1991) states that rather than remain outside and interpreting, she believes the situation demands that the analytic therapist co-operate with the patient and accept the role being offered. Re-enactment becomes the goal of treatment rather than something to be avoided. The caveat, however, is that this time, the patient must succeed in making something different happen. She says that the role of the therapist is to facilitate a new, more positive outcome while helping the patient to understand how and why it is different from what happened in the past:

> If we believe that all patients need to return to the scene of the crime and that some of them need to do this completely and in a way that recapitulates the original depth of feeling, then unwillingness or inability of the therapist to participate lends new meaning to the concept of *resistance* (Maroda, 1991, p. 81).

Maroda (1991) cites Watchtel who states that in the very act of participating the analyst learns what is most important to know about the patient. However, she and others (Aron, 1996; Ehrenberg, 1992; Ogden 1994) emphasize the importance of the process by which the therapist is able to reflect on and verbalize the experience evoked by the patient. Without it the therapist merely acts out the imposed projections, resulting in what Grinberg (1962) terms projective counter-identification[8].

[8] Grinberg (1962) states that the therapist may *counter-identify* himself and suffer the effects of the projective identification without any awareness thereof.

3.5.1 The process of therapy – summary

An overview of object relations theory emphasizing Ogden (1992, 1994) and relational psychoanalysis emphasizing Aron (1996) reveals that their conceptualizations of pathology are similar, and their conceptualizations of the therapeutic environment have much in common. Both approaches recognize that all the therapist's acts are meaningful.

It seems however, that the relational approach embraces changes to the basic frame of psychoanalysis described in Chapter 2, in that the acknowledgement of a wide range of interactions between patient and therapist is introduced. According to Aron (1996), the term "interaction" in mainstream psychoanalysis remains an ambiguous and controversial term. He states that all analysts today acknowledge interaction. The problem is, how to acknowledge this while at the same time maintaining a focus on the intra-psychic. Aron (1996) states that many new terms such as "interaction", "enactment" and "actualization" have been coined, but each contains the word "act". Aron (1996) says that their introduction into the lexicon of psychoanalysis as technical terms points to a major shift in theory that moves psychoanalysis from a treatment that relies on associations and interpretations, words and understanding alone, to recognition that the psychoanalytic process involves verbal and nonverbal action and interaction. "If words are acts, and if acts are communications, then psychoanalysis can no longer be thought of as only a talking cure; psychoanalysis must involve action and interaction" (Aron, 1996, p. 192).

Relational theory does not dictate a particular form of analytic activity as much as it advocates the recognition of inevitable and continuous participation; the emphasis is

on the analyst as a participant-observer (Aron, 1996). According to Aron (1996), for relational psychoanalysts the critical issue seems to be whether the analyst's interventions invite further engagement and communicative activity from the patient.

Building on the new openness to pluralism and diversity advocated by relational psychoanalysis, and embracing the interactional notion of the therapist as expert described in Chapter 2, this thesis aims to explore the possibility of incorporating techniques used by the strategic / structural school (e.g. Minuchin, 1974) into the psychoanalytic armamentarium of intervention. Based on the relational notions of the therapeutic process, as a process of negotiation, and accepting that modification of technique is required when working with more regressed patients, this thesis endorses the inevitability and usefulness of re-enactment.

3.6 MODIFICATION OF TECHNIQUES

It has long been accepted that work with patients with primitive, pre-oedipal pathology (narcissistic or borderline pathology) requires modification of the basic techniques of psychoanalysis. As discussed above, Eissler (1990) suggested the introduction of parameters of technique. Other examples of modifications of technique include Kernberg (1980, 1984), who has refined Eissler's suggestion and provided an alternative model of psychoanalytic psychotherapy based on psychoanalytic object relations theory. Masterson (1990) suggests an approach which uses either confrontation or interpretation of narcissistic vulnerability, depending on the intra-psychic structure of the patient. Kohut (1984) advocates an approach based on empathic reflection of the patient's mirroring and idealising transferences and empathic responsiveness to the analyst's failures. Based on Winnicott's notion of a "good-enough mother" this thesis suggests that in order to be a "good-enough

therapist", the therapist may at times need to satisfy the needs of a very regressed patient. This may involve what relational analyst Summers (1999) has called creating the "illusion of fusion".

3.6.1 Good-enough mother / good-enough therapist

Winnicott (1965c) describes the absolute dependency of the infant. The parents need to provide an environment in which the infant can mature. In order to do so the parents must adapt to the individual needs of the infant, which change during the maturational process. Winnicott refers to the mother's "primary maternal preoccupation" which allows the child a "continuity of being". The main function of the maternal holding environment is to reduce traumatic impingements. Casement (1985) points out that at birth, there is no distinction between needs and wants. However, with the development of a capacity to tolerate increasingly manageable degrees of frustration growth-needs begin to differentiate from wants. Casement states that in due course an infant's growth-needs begin to include the need to discover manageable degrees of separateness.

According to Casement, patients re-enact these different stages in the course of therapy. The therapist should therefore try to distinguish between libidinal demands (wants), which need to be frustrated, and growth-needs, which need to be met.

It is suggested here, however, that very regressed patients are not themselves able to distinguish between their needs and wants. Like the mother who initially has to gratify the infant's needs and wants the therapist may also have to attempt to gratify the patient's needs and wants. It seems further that in order to get the patient to attach to

the therapist and the therapeutic situation, the therapist may have to resonate in some ways with the earlier objects to whom the patient was attached. The provision of the psychoanalytic holding environment is too different from the patient's original environment and thus too anxiety provoking.

3.7 INTERVENTION – A HYPOTHESIZED "STRATEGIC / STRUCTURAL RELATIONAL PSYCHOANALYTIC APPROACH"

Chapter 4 of this thesis develops the notion of good-enough mother/good-enough therapist further by suggesting that re-enactment of the patient's internalized object relations units may be useful in that it provides a containing environment for those patients, who are attached to "bad objects". It is possible that if the therapist responds in a manner that is similar to the patient's already established, but dysfunctional, relationship patterns, this may provide an important attachment function for the patient. So, for instance, if the patient has had a critical and distant mother, he or she will probably tend to evoke this response from the therapist. Traditionally psychoanalytic psychotherapists may interpret this. However, it is suggested that the therapist use this countertransference response and behave accordingly. It is possible that the patient may feel safer with a therapist who tends to behave in a critical and distant manner, than with a therapist who behaves in a warm and empathic manner. In other words, if the therapist is perceived as a familiar and safe object, albeit a "bad object", the patient will feel free to risk attachment (attachment to a "bad object"). In line with the relational approach, this constitutes a challenge to the psychoanalytic rules of abstinence and neutrality. However, in contrast to Alexander and French (1946), who also challenged these psychoanalytic ideals by proposing that the therapist should consciously adopt an attitude and behave in a manner *contrary* to their patient's negative transference expectations, what is suggested here is that the

therapist should utilise his counter-transference feelings and enactments to consciously plan strategies of intervention that *"fit"* with the intra-psychic structure of the patient. In other words the therapist should choose to resonate with the predominant self and object representations of the patient.

The thesis embraces the notions of "joining" and "accommodation" described by Minuchin (1974), and the principles of "change" described by interactional theorists such as Watzlawick and Weakland (1977), and Watzlawick, Weakland and Fisch (1974). This hypothesized alternative approach will be discussed further in Chapter 4 where objections to a relational psychoanalytic approach from both object relations and interactional perspectives will also be presented. A critique of the hypothesized approach will also be presented. A research method for testing the hypothesis will be outline in Chapter 5. The results will be presented in Chapter 6, and discussed in Chapter 7. Chapter 8 concludes the thesis.

CHAPTER 4: A HYPOTHESIZED "STRATEGIC / STRUCTURAL RELATIONAL PSYCHOANALYTIC APPROACH"

"Not so much looking for the shape

As being available

To any shape that may be

Summoning itself

Through me

From the self not mine but ours."

(Ammons, as cited in Ogden, 1999, p. 491)

4.1 INTRODUCTION

Based on the strategic approaches to psychotherapy (e.g. Minuchin, 1974), this thesis suggests the deliberate utilization of the therapist's style of communication as a therapeutic tool to facilitate "joining" with the patient, and thus the formation of the therapeutic alliance. The strategic approaches advocate the importance of the therapist as expert and suggest that the therapist utilize an armamentarium of deliberate and well thought-out strategies to facilitate change. Structural approaches to psychotherapy approach the individual in his social context. Therapy based on this framework is based on changing the organization of the family. When the structure of the family group is transformed, the positions of members of that group are altered accordingly (Minuchin, 1974). This thesis suggests, however, that the psychoanalytic therapist use these strategic and structural techniques to focus on the "family" inside the individual, as well as the family outside of the individual:

> A therapist working within the framework of structural family therapy, however, can be compared to a technician with a zoom lens. He can zoom in for a close-up whenever he wishes to study the intra-psychic

> field, but he can also observe with a broader focus (Minuchin, 1974, p. 3).

Based on the object relation's notions of internalized object relations units and the relational notions of internalized relational constellations described in Chapters 2 and 3, it is suggested here that the therapist utilize his countertransference responding to "identify" the family within the individual. Further it is suggested here, that the psychoanalytic psychotherapists utilize the strategic / structural approaches to therapy to be described below and then deliberately and strategically "join" with this family. This constitutes enacting various relational constellations of the patient, i.e. enactment of "bad" object relationships. From a traditional psychoanalytic perspective enactment was discouraged and thought of as "bad" practice. Recent object relations and relational approaches recognize the ubiquity of enactment and encourage its interpretation (see Chapters 2 and 3). It is suggested here that the therapist deliberately enact the "bad" relational constellations that he has been able to identify via his countertransference responding, in order to enter the "closed system" of internalized object relations units described by Fairbairn (see Chapter 2). This means that the therapist initially has to be "bad" from a traditional psychoanalytic perspective (deliberate enactment), in order to become "good" (use verbal symbolic communication – interpretation). The strategic and structural techniques are suggested as being useful in the beginning stages of therapy when working with patients who are attached to "bad objects" (Fairbairn, 1952) or operating in a pre-dominatingly paranoid schizoid mode (Ogden, 1994).

In line with this view and from a relational psychoanalytic perspective, Summers (1999) states that the analytic relationship differs from all other relationships in that it

is created by "art" in the Aristotelian sense – that is "… by the conscious design of the analyst to facilitate new ways of being and relating for the patient. This analytic purpose is what ultimately differentiates the analytic object relationship from all other object relationships" (Summers, 1999, p. 117).

It is the "art" of using the experience of transference and countertransference in a positive way to promote change in the intra-psychic structure of the patient that constitutes psychoanalytic psychotherapy. However this thesis holds that psychoanalytic theory regarding appropriate intervention can be supplemented by ideas and interventions from the strategic and structural frameworks and that what is seen from the psychoanalytic framework as "countertransference enactment" can be actively used as a strategy to "join" with the patient, and ultimately foster the restructuring of the personality via verbal interpretation.

As has been mentioned in Chapter 3, there is no way to avoid countertransference enactment and attempting to deny its power can be dangerous. The question at this point is not whether to use enactment, but how. It is suggested here that countertransference should be used in a strategic manner (art) to alter the structure of the family within the individual.

In line with earlier writers on countertransference, relational analysts such as Aron (1996), Ehrenberg (1992) and Maroda (1991) distinguish between the reactive dimension of countertransference, which has to do with what we find ourselves feeling in response to the patient that is often a surprise rather than a choice, and the kind of active response that takes into account this reactive response as data to be used towards informing a deliberate clinical intervention. Silence, or any other

reaction, can fall into either category. The point is that active use of countertransference requires a thoughtful decision process with regard to how to use awareness of one's reactive countertransference responses to inform what will then become a considered response. According to Ehrenberg (1992), the amount of overt activity that takes place is not indicative of whether or not the analyst is actively or passively responding to his or her countertransference impulse. In fact, the same overt response can reflect either kind of internal process. She states that the analyst's ability to use countertransference constructively, particularly in the face of more severe kinds of pathology, is often the factor that determines whether an analysis will have a chance of succeeding. As has been suggested above, it is proposed here that the therapist should deliberately utilize his countertransference responses to become a "bad object" for the patient.

4.2 THE THERAPIST AS A "BAD OBJECT"?

It has already been discussed how Masterson (1990) changes his therapeutic strategy based on the intra-psychic structure of the patient. It is possible that other psychotherapists who change the basic psychoanalytic model to deal with patients with borderline pathology may inadvertently be resonating with the bad objects of their patient's internal world. An example is a case study presented by Kernberg (1976). Although Kernberg advocates the importance of technical neutrality, he uses phrases such as:

"When I attempted to clarify…" (Kernberg, 1976, p. 170)

"When I confronted…" (Kernberg, 1976, p. 170)

"I stimulated him to talk…" (Kernberg, 1976, p. 171)

"When I became insistent …" (Kernberg, 1976, p. 174)

These quotations are all from a single session, and suggest the possibility that Kernberg's rather confrontational style may have contributed to the fact that his patient asked him if he was aware that he looked like Eichmann – a Nazi. It seems possible that Kernberg, although he states that he does not confront when angry and that he attempts to maintain empathic respect, may, in fact, be resonating with the patient's aggressive, sadistic self and object representations. In his discussion on destructive narcissism, Ivey (1999) comments on a similar tendency in himself, which he feels contributed to the failure of the therapy.

In contrast to *this* view, it is suggested here that countertransference enactment may actually contribute to the therapeutic process, by allowing the patient to form a relationship with an object, which is similar to the objects with which he is familiar and to whom he is already attached. In order to become the "bad object" for the patient, it is suggested that the therapist use the "joining" techniques utilized by family therapists such as Minuchin (1974) to be described further below. This idea is based on the ecosystemic notions of "fit" and "structural coupling" mentioned in Chapters 1 and 2.

It is suggested in this thesis that the therapist alter his therapeutic strategy to join with the different self and object representations that he has been able to identify via countertransference (that is "join" with the different dyads or the family he has been able to identify within the patient). In order to join with the family inside the individual, the therapist may begin to create a "map" of the intra-psychic structure of

the individual, utilizing the patient's various interpersonal styles, as well as his own countertransference responses to these.

In family therapy, a diagnosis is the working hypothesis that the therapist evolves from his experiences and observations upon joining the family. A family diagnosis involves the therapist's accommodation to the family to form a therapeutic system, followed by his assessment of his experiences of the family's interaction at present. The process of gathering different classes of information achieves an interpersonal diagnosis. What people say, organized into a logical sequence in terms of the significance of the material presented, is of utmost importance. So are nonverbal cues such as voice pitch, body language and silence (Ogden's (1994) matrix of the transference). Additional material can be gleaned from the order of remarks: who speaks to whom and when. The therapist's impact on the family is part of a family diagnosis. The therapist's impact is in itself seen as a massive intervention. The family therapist recognizes and uses his assessment of the family's reaction to him to assist his diagnosis. Interpersonal diagnosis constantly changes as the family assimilates the therapist, accommodates him, and restructures, or resists structuring interventions (Minuchin, 1974).

In order to "join" with the family or different parts of the family, the therapist may emphasize the aspects of his personality that are synchronic with that of the family (Minuchin 1974). In other words, the therapist alters his style of communication to "fit" with that of the "family" he has identified within the individual. The joining techniques will be described as they pertain to families in family therapy, but it should

be remembered that what is actually being referred to here is the family inside the individual – that is his intra-psychic structure.

4.3 JOINING AND ACCOMMODATION

According to Minuchin (1974), insight into joining and accommodation can be obtained from anthropology. An anthropologist joins the culture he is studying in order to understand its culture subjectively. Minuchin cites the anthropologist Claude Levi-Strauss on accommodation:

> Leaving his country and his home for long periods … without mental reservations and ulterior motives, he assumes the modes of life of a strange society. The anthropologist practices total observation, beyond which there is nothing except … the complete absorption of the observer by the object of his observations (Levi-Strauss in Minuchin, 1974, p. 124).

However, Minuchin points out that at the same time, the anthropologist disengages from the society under observation in order to analyze it.

> We really can verify that the same mind which has abandoned itself to the experience and allowed itself to be moulded by it becomes the theatre of mental operations which, without suppressing the experience, nevertheless transform it into a model which releases further mental operations. In the last analysis, the logical coherence of these mental operations is based on the sincerity and honesty of the person who can say … "I was there" (Minuchin, 1974, p. 124).

Minuchin states that like the anthropologist, the family therapist joins the culture with which he is dealing. In the same oscillating rhythm he engages and disengages. He experiences the pressures of the family system. At the same time, he observes the system, making deductions that enable him to transform his experience into a family map, from which he derives therapeutic goals. To understand and know a family in this way is a vital component of family therapy.

According to this line of thinking about therapy, the family moves only if the therapist had been able to enter the system in ways that are syntonic to it. He must accommodate the family and intervene in a manner that the particular family can accept. Unlike the anthropologist, the family therapist (acknowledging that he cannot not influence) is bent on changing the culture he joins, and he has the skills to do so. But his goals, his tactics, and his stratagems are all dependant on the process of joining. Joining techniques may not always advance the family toward the therapeutic goals, but they are successful when they ensure that the family return for the next session. Joining a family requires a therapist to adapt.

Minuchin (1974) states that joining and accommodation are two ways of describing the same process. Joining is used when emphasizing relating to family members in the family system. Accommodation is used when the emphasis is on the therapist's adjustment of himself in order to achieve joining. Minuchin says that to join the family system, the therapist must accept the family's organization and style and blend with them. He must experience the family's transactional patterns and the strength of those patterns. That is, he should feel a family member's pain at being excluded or

scapegoated, and his pleasure at being loved, depended on, or otherwise confirmed within the family. The therapist recognizes the predominance of certain family themes and participates with family members in their exploration. He has to follow their paths of communication, discovering which ones are open, which are partly closed, and which are entirely blocked, When he pushes beyond the family thresholds, he will be alerted by the system's counter deviations (resistances).

The family's impingements on the therapist are the factors that make known the family to him (i.e. his countertransference responses). The therapist thus adapts his style of communication to that of the family. Such adaptation, which is here called accommodation, can be either unaware or deliberate, although Haley (1977) states that it is generally assumed that it is unwise for a therapist to join coalitions while denying to himself that he is doing so. He will thus be instituting a pathological system and repeating pathological patterns without acknowledging that he is doing so for a reason. This is similar to Ehrenberg's (1992) notion of deliberate and acknowledged use of countertransference described above:

> The art of family therapy seems to be that of developing ways of siding with all family members at once, or of clearly taking sides with different factions at different times while acknowledging this, or of leaving the coalition situation ambiguous so that family members are uncertain where the therapist stands (Haley, 1977, p. 47).

Minuchin (1974) describes various types of accommodation. They are detailed below.

4.3.1 Maintenance

This refers to the accommodation technique of providing planned support of the family structure, as the therapist perceives it and analyzes it. The therapist elects to maintain specific transactional patterns. Maintenance operations often involve the active confirmation and support of family systems. In the inter-twining of therapy, the maintenance operations may have a restructuring function. This can also be seen as a paradoxical injunction to "stay the same" (Weakland, Fisch, Watzlawick & Bodin, 1977; Watzlawick, Weakland & Fisch, 1974) which, according to these authors, is effective in facilitating change.

4.3.2 Tracking

Minuchin (1974) describes this as an accommodation technique where the therapist follows the content of the family's communication and behaviour and encourages them to continue:

> He is like a needle tracking grooves in a record. In its simplest form, tracking means to ask clarifying questions, to make approving comments, or to elicit amplification of a point. The therapist does not challenge what is being said. He positions himself as an interested party. Tracking operations are typical of the non-intrusive therapist. (Minuchin, 1974, p. 127).

Tracking confirms the family members by eliciting information. The therapist does not initiate action; he leads by following. He ratifies the family as it is by encouraging and accepting its communications. Like maintenance, tracking is a paradoxical injunction to stay the same and can also be used as a restructuring strategy. This

intervention can also be seen as “re-framing”. To “re-frame” means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and place it in another frame that fits the same concrete situation equally well or even better, thereby changing the meaning (Watzlawick, Weakland & Fisch, 1974).

4.3.3 Mimesis

Minuchin describes mimesis as a universal human operation. A therapist uses mimesis to accommodate to a family’s style and affective range. He adopts the family’s tempo of communication, slowing his pace, for example, in a family that is accustomed to long pauses and slow responses. In a jovial family he becomes jovial and expansive. In a family with a restricted style, his communications become sparse. This increases a sense of kinship or as Harry Stack Sullivan put it we “are all more human than otherwise” (Minuchin, 1974, p. 128). Often, psychotherapists perform mimetic operations without their even realizing it. Like other processes of accommodation, mimetic operations can be used to restructure. For instance, Watzlawick, Weakland and Fisch (1974) describe how mimetic operations can be exaggerated and emphasized, in order to cause a movement in the opposite direction.

4.3.4 Restructuring

Restructuring operations are the therapeutic interventions that confront and challenge a family in an attempt to force a therapeutic change. They are distinguished from joining operations by the challenge they pose. Joining operations do not challenge; they decrease the distance between the family and the therapist, helping the therapist to blend with the family. Restructuring operations and joining operations are

nevertheless interdependent. According to this model of therapy (Minuchin, 1974), therapy cannot be performed without joining, but it will not be successful without restructuring. It is often difficult to distinguish between the two. Joining can be used as a restructuring technique, but when a joining operation is used to restructure, it does so without confronting. Minuchin (1974) describes restructuring operations as the highlights of therapy. They are dramatic interventions that create movement towards therapeutic goals, but they depend for their success on a therapeutic unit firmly established via the process of joining. Minuchin (1974) describes at least seven categories of restructuring operations. A detailed discussion of these is beyond the scope of this thesis.

The goal of the therapeutic approach being suggested here, however, is ultimately of a psychoanalytic nature. The initial joining procedure has the aim of establishing a therapeutic relationship in which the patient is eventually able to tolerate verbal interpretations and thus internalize the therapist as a "good object" capable of successfully processing the patient's projective identifications verbally. That is, the goal of therapy is the increased capacity of the individual patient's ego for thinking and self-reflecting:

> It is commonly held that in work with very disturbed patients, interpretation is disruptive to the patient, and as a result, one must offer such patients "supportive" therapy. Supportive therapy is often a euphemism for a type of therapeutic relationship in which the patient is treated as an infant incapable of understanding in words the nature of the anxieties that prevent him from conducting his life in a more

> maturely integrated and object-related way. Such a point of view fails to understand that one of the most integrative, and therefore "supportive" things that we have to offer a patient is the power of verbal symbols to contain and organize thoughts, feelings, and sensations and thus render them manageable by the patient. Words help bring that which has been experienced as physical objects or forces into a system of thoughts and feelings that are experienced as personal creations that stand in a particular relationship to one another. That is symbols help create us as subjects (Ogden, 1994, p. 186).

Regarding the techniques of joining and accommodation, it is the view of Minuchin (1974) that when used deliberately, joining and accommodation can speed up the early phases of treatment and facilitate treatment. It is suggested here that these techniques should be included in the psychoanalytic armamentarium of interventions when working with individuals who are attached to both internal and external "bad objects" (Fairbairn, 1952), that is operating in a pre-dominatingly paranoid-schizoid mode (Ogden, 1994). It is proposed that the techniques of joining and accommodation as described above are useful in the early stages of therapy, and help to establish a therapeutic alliance.

The usefulness of the techniques of joining and accommodation can also be seen in terms of Ogden's theory regarding intervention, and Bion's notion of the establishment of links, to be described further below:

4.4 JOINING AND ACCOMMODATION TRANSLATED INTO AN OBJECT RELATIONS PERSPECTIVE

From the point of Ogden's theory of intervention, the joining and accommodation techniques described above can be seen both in terms of Ogden's notion of interpretive action described in Chapter 2, and in terms of working at the level of the matrix of transference countertransference also described in Chapter 2. The value lies in what the therapist does (interpretative action) and in how he alters his style to match that of the patient (the matrix of the transference). Neither of these techniques necessarily involve verbal interpretation, although this is not precluded.

Futhermore, Bion's (1959) idea of a preconception, integrated by Ogden's use of Klein and Bion (see Chapter 2), and the idea of the preconception of the existence of links, is relevant here. It is suggested by this researcher that by joining with the patient and enacting the bad object, the therapist also becomes a good object for the patient. This process can be described in terms of Bion's theory as described below.

Bion (1959, 1962a, 1962b) differentiates between thoughts and the apparatus developed to deal with thoughts – thinking. Psychopathological developments may be associated with either the lack of development of thoughts, or a breakdown in the development of the apparatus for "thinking" or dealing with thoughts. Thoughts may be classified according to the nature of their developmental history as preconceptions, conceptions or thoughts, and finally concepts. Concepts are named and are therefore fixed conceptions or thoughts.

According to Bion, a preconception needs positive realizations, i.e. subjective reinforcing experiences to become a conception. Only at this point does the negative

realization, i.e. the absence of reinforcement of the preconception through experience, become tolerable. The frustration of the expectation of a positive realization can give rise to a thought. Thinking means the creation of mental links between thoughts and the emotional quality of these links is influenced by the quality of the first experience of a realization.

It is suggested here that it is possible that by processing the patient's need for a "bad object" and by "publication" (Bion, 1959, 1962a, 1962b), (see Chapter 2) or giving it back to the patient in a modified form, i.e. enacting a "bad object" who is also thinking and reflecting about what the patient needs, the therapist is also being a "good object", thus linking together the possibility of "good" objects and "bad" objects. It is the contention of this thesis that the intentional resonance of the therapist to the "bad" self and object representations (i.e. the intra-psychic structure of the patient) provides a positive realization to the preconception of the existence of a "good" object (a thought about a good object), and to the possibility of links (Bion, 1959) between "good" and "bad" objects, which had not been available previously. The frustration of the preconception occurs because the therapist is unable to be "good" or "bad" enough, although always attempting to be aware of this.

The positive emotional quality of this experience of both the realization of the preconception and the subsequent frustration of the conception is achieved because of the therapist's "fit" with the structure of the patient. In other words, when the patient's anxieties have been taken in and processed by the therapist, his capacity to tolerate them increases, and the negotiation and modulation of love and hate on the way towards the depressive position corresponds in Bion's terms to the creation of links between opposing feelings. There has been a realization of the preconception of

a “good object” (thought about a good object) and the establishment of a link between good and bad objects (thinking about thoughts) in a positive way (Bion, 1962a).

The above then describes the possible value of joining and accommodation from an object relations perspective. These techniques can also be translated into relational terms.

4.5 JOINING AND ACCOMMODATION TRANSLATED INTO A RELATIONAL PERSPECTIVE

From a relational perspective, joining and accommodation can be seen in terms of the process of negotiation and re-enactment referred to in Chapter 3. For instance, Aron (1996, p. 139) cites Pizer who states that the therapeutic action of psychoanalysis is constituted by the engagement of two persons in the process of negotiation. Patient and analyst will say to each other, “You can make this of me but not that of me”; “I will be this for you, but not that for you.” He quotes Pizer who writes, “The very substance and nature of truth and reality – as embodied both in transference-countertransference constructions and in narrative reconstructions – are being negotiated toward consensus in the analytic dyad” (Aron, 1996, p. 139). Aron states that we might think of the analytic dyad as a continually invented, destructed and reinvented *combination* (italics mine). When joining and accommodating to the patient, the therapist allows the patient to “make something of him” in that he re-enacts the patient’s relational constellations. The difficulty with this approach is knowing how much or how little to accommodate. This will be discussed further below.

However, as mentioned above, from a relational perspective re-enactment of the patient's relational constellations is seen as valuable and therapeutic. Re-enactment becomes the goal of treatment rather than something to be avoided. From a relational perspective, the re-enactment is taken as grist for the mill and commented on. This is similar to, but not the same as, joining and accommodation, where joining is done as a deliberate therapeutic strategy *on its own*. Commenting on a particular process would be seen from a strategic / structural perspective as a re-structuring technique, only to be done *after the establishment of the therapeutic relationship*.

4.6 SUMMARY

A strategic / structural relational psychoanalytic approach to treatment has been described. It was suggested that psychotherapists utilize joining and accommodation techniques as described by Minuchin (1974) and alter their style of interaction to match of the various object relational constellations that they have managed to identify within the patient via their countertransference responses. It has been suggested that patients need their psychotherapists to be similar to their original objects in order to feel safe in the therapeutic environment and that this may facilitate communication in the beginning stages of therapy. This hypothesis will be investigated by looking at three cases and the therapeutic interaction between patient and therapist. The cases will be analyzed in terms of the research questions formulated in the next chapter.

4.7 CRITIQUE OF THE HYPOTHESIZED "STRATEGIC / STRUCTURAL RELATIONAL PSYCHOANALYTIC APPROACH"

As mentioned above, the relational psychoanalytic approach embraces Ferenczi's notion of "elasticity of technique" and his emphasis on mutuality and the possibility for self-disclosure on the part of the analyst. As cited by Aron (1996, p. 222), however, Freud took issue with Ferenczi's stance, stating:

> But in psychoanalytic relations things often happen differently from what the psychology of consciousness might lead us to expect. Experience does not speak in favour of an affective technique of this kind. Nor is it hard to see that it involves a departure from psychoanalytic principles and verges upon treatment by suggestion. It may induce the patient to bring forward sooner and with less difficulty things he already knows but would otherwise have kept back for a time through conventional resistances. But this technique achieves nothing toward uncovering what is unconscious to the patient. It makes him even more incapable of uncovering his deeper resistances, and in severe cases it invariably fails by encouraging the patient to be insatiable: he would like to reverse the situation, and finds the analysis of the doctor more interesting that his own. The resolution of the transference too – one of the main tasks of the treatment – is made more difficult by an intimate attitude in the doctor's part … I have no hesitation, therefore, in condemning this kind of technique as incorrect.

As mentioned above, from a classical psychoanalytic perspective, changes in technique are termed "parameters" (Eissler 1990). Objections to the introductions of parameters are multiple and may be summarized as follows.

The introduction of parameters prevents and/or contaminates the development of the transference. Parameters of technique contaminate the analysis of transference because of the possibility of uncontrolled introduction of countertransference elements. Thus the uncovering of the patient's unconscious relational constellations is prevented. The introduction of parameters also prevents the process of projection and introjection necessary for the modification of the ego and super ego – the introduction of parameters thus prevents structural change and prevents the evolution of the psychoanalytic holding environment, which is often considered to be the most supportive of all environments. The introduction of parameters limits transitional (potential space) by concretizing what should be symbolic. And most importantly, deflective and suppressive measures add to the sense that there is an intensity of feeling which nobody can manage and encourages the notion that feelings can be dealt with by avoidance.

More specifically, psychoanalytic psychotherapists feel strongly about maintaining the "frame" as described in Chapters 1 and 2, and there are good reasons for this, which will be discussed in the section below.

According to Bleger (1990, p. 426). "The frame can only be analyzed within the frame, or, in other words, the patient's most primitive dependence and psychological

organization can only be analyzed within the analyst's frame, which should neither be ambiguous, nor changeable, nor altered".

The point is that if there are not specific rules and guidelines regarding intervention, then how will psychotherapists know when they have deviated from the norm? If "anything goes" then how are we to know when we have done something different? How then can enactments then be identified? Bleger (1990) states that the frame is a fixation of the psychotic part of a person that only becomes evident when there are frame breaks. He refers to the "dumbness of the frame" – it only reveals itself when it has stopped being dumb.

Further in this regard, Ponsi (2000, p. 689) quotes Freud and Winnicott, stating that there are two types of bond for the patient – one relating to the treatment and one relating to the analyst: "It remains the first aim of the treatment to attach him (the patient) to *it* and to the person of the doctor" (Freud, as cited in Ponsi, 2000); and "If it is in an analysis that these matters are taking place, then the *analyst*, the *analytic technique*, and the *analytic setting* all come in as surviving or not surviving the patient's destructive attacks" (Winnicott, as cited in Ponsi, 2000) (italics in Ponsi, 2000).

From this perspective, the analytic device consists of applying the analytic method inside its proper framework. This allows the patient and the analyst to work together, making use of the analytic tool. The analytic frame, the analytic boundaries and the analytic object are interdependent aspects of the analytic situation. Alterations in

technique and the introduction of parameters therefore are indicative of the failure of the analyst to "survive" attacks by the patient.

Discussing this point regarding what it is that constitutes psychoanalysis, in the same article, Ponsi (2000) asks whether there is a clear-cut distinction between psychoanalytic and non-psychoanalytic modalities. She asks what the role performed by non-interpretive mechanisms and by interventions other than interpretation is. She questions whether supportive modalities are part of true psychoanalytic treatment. Does the analyst's focus on the collaborative relationship mean nothing but abandoning psychoanalysis for more or less disguised forms of support, manipulation, suggestion, seduction, collusion, transference cure, etc.? She suggests that we adopt a wider concept of interpretation in order to bypass the problem of what we are doing when we don't interpret. Ponsi (2000) suggests that a psychoanalytic act lies in the analyst's ability to help a patient arrive at an understanding of his unconscious mental state and to stimulate self-reflective ability. But then the spectre of countertransference looms. How are we to know whether our own issues or those of the patient motivate our interventions?

Referring to frame breaks and changes in technique, Ivey (1992) emphasizes the expressly pathological dimension of countertransference and its implications for the therapeutic relationship. He points out that the peculiar depth of intimacy and intensity established in the therapeutic relationship not only invites the patient's madness but also invokes that of the therapist. He says "… the typical life histories that predispose of this profession and equip us with the prerequisite qualities also

make us vulnerable to the same pathology we hope to heal in others" (Ivey, 1992, p. 35).

Ivey points out that the problem arises when we act consciously or unconsciously on our countertransference feelings and in doing so inflict our pathology on our patients. Discussing countertransference pathology in South Africa, Ivey expresses concern that in the main, the treatment approaches taught in most clinical training institutions tend to have their basis in cognitive and humanistic orientations. He states that countertransference pathology is difficult to identify, monitor and rectify in therapeutic orientations other than the psychoanalytic paradigm. Because such orientations not only de-emphasize the role of transference-countertransference in the form of the interventions they sanction, they almost elevate countertransference pathology to the level of what he describes as "legitimate techniques". He points to problems associated with approaches where countertransference is not acknowledged and stresses the importance of having a framework that will allow us to identify, contextualize, and rectify countertransference deviations in our therapeutic interventions. His main point is that non-analytic approaches do not explicitly acknowledge or address the persistent reality of countertransference behaviour.

Discussing breaks in the "frame", Gabbard and Lester (1995) differentiate between boundary crossings and boundary violations. They state that the contemporary view of countertransference enactment as ubiquitous and useful presents a dilemma for the analyst in that it is difficult to know where to draw the line between legitimate psychoanalytic work and exploitative boundary violations. Gabbard and Lester provide some guidelines to assist analysts in determining whether the enactments that

they are involved are therapeutic or not. These guidelines include whether the analyst has been able to "catch himself in the act", i.e. *"in statu nacendi"* (Gabbard & Lester, 1995, p. 27). These authors also cite the capacity of both analyst and patient to *discuss* the enactment as determining whether behaviour is productive or destructive. A third guideline to assist analysts in determining whether the enactments that they are involved in are therapeutic or not, is whether or not the enactment is repetitive and unresponsive to the analyst's own self-analytic attempts. Gabbard and Lester (1995) provide a poignant case vignette describing boundary violations of a patient, Dr K, where despite seemingly extensive intellectual knowledge regarding psychoanalysis both Dr K, and her analyst entered into a long series of enactments that seemed to be mutually deleterious.

It seems that the most dangerous aspect of any therapeutic approach is lack of self-reflection on the part of the analyst. But it *also* seems that the most dangerous thing about denial (or lack of self-reflection) is that you don't know you have it (or don't have it)! In an article entitled "When the therapist needs therapy" McHenry (1994) refers to the well-known archetype of the "wounded healer". Many psychotherapists become caught in a cycle of trying to "heal the self" by "healing others" and thus become enmeshed in their patient's problems.

This point highlights the concern of Ivey (1992) discussed above, regarding the lack of in-put regarding transference and countertransference in the training of South African psychotherapists. Ivey recommends that lecturers and supervisors should systematically emphasize this issue, even if they do not subscribe to a psychoanalytic

paradigm. He also emphasizes the importance of psychotherapists undergoing their own therapy and supervision.

The thesis proposes the deliberate and strategic use of countertransference responses as a therapeutic strategy. Traditional approaches emphasize "thought about" verbal interpretations and Ogden (1994) endorses "thought about interpretative action". Generally object relations and relational psychoanalysis acknowledge that enactments should be "thought about" and interpreted and at times disclosed, but it seems that both may have difficulty with deliberate and "thought about" (strategic) enactment. For instance, writing from a relational perspective, Ehrenberg (1992) is critical of therapist's attempts to consciously adopt a role in relation to the patient. She states that the patient tunes in to what the analyst feels, whether or not the analyst is open about this. Ehrenberg (1992) states that from such a perspective the position of Alexander (1956) (referred to in Chapter 1 (Alexander & French, 1946)) and some contemporary analysts that there is benefit in assuming a deliberately predetermined attitude towards the patient would be considered to be untenable and to undermine the treatment process. She states that it would preclude an opportunity to use the immediate experience as analytic data and as a means to clarify very subtle interactive patterns that would otherwise elude awareness.

Further in this vein, Aron (1996) cautions that although the emphasis is on the fact that the analyst is a participant-observer, this should not be taken to mean that the analyst makes active or artificial attempts to participate or to influence the patient through the self-conscious or purposeful adoption of a role.

From the point of view of this researcher and the interactional viewpoint described briefly in Chapters 2 and 3, however, it seems that these relational psychoanalysts may be confused about what they advocate in theory and what they advocate in practice. In response to Ehrenberg (1992), the researcher would argue that the strategic / structural approach being hypothesized, that is, the suggestion regarding the utilization of countertransference responding as a therapeutic strategy, means utilizing interactional data as it emerges in the here-and-now of the therapeutic interaction. There is no reason why the conscious adoption of such a role is more "artificial" than any other form of intervention.

Furthermore, communications dictums are that one cannot not influence, i.e. not communicate, and also that all behaviour (words and their non-verbal accompaniments, e.g. posture, facial expressions and even silence, convey messages to another person. Messages conveyed have report and command aspects, the command aspects relate to how information is to be taken (Jackson, 1977; Watzlawick & Beavin, 1977). In the light of this theory, apparently accepted by relational psychoanalysis, the researcher is confused by Aron's statement (above) that the therapist should not consciously adopt a role, as a role will be adopted and perceived whatever the therapist does. Surely it is better to consciously and self-reflectively communicate than not to take account of all communications.

Referring to this issue, Fisch, Watzlawick, Weakland and Bodin ask: "… how do therapists in DOUBT try to bring about change? The answer, blunt, simple and shocking, is: by something they call direct intervention, but we must plainly label 'downright manipulation.'" (1977, p. 315). From this perspective, psychotherapists

ask, “What are patients doing?”, rather than “Why are they doing it?”. The goal of therapy becomes to intervene in any way to stop self-destructive behaviour, and to stop “games without end”. However these therapists also admonish that the goal of any intervention should be towards the patient’s heightened sensitivity, self-actualization, improved communication and improved attitude toward life, rather than any result that is more congenial toward the therapist.

However, to return to the original argument provided by Bleger (1990), it seems that in the absence of specified rules for defining what would be in the patient’s interest and rules regarding what types of therapist interventions may or may not be destructive for the patient (discussed above), this may be a difficult judgement call to make. It seems that the importance of the therapist’s capacity for self-analysis or self-reflection should be emphasized here.

Discussing the importance of the therapist’s capacity for self-analysis or self-reflection, Renik (1993, 1998) states that the analyst’s subjectivity is irreducible. Subjectivity cannot be quantified: it is impossible for an individual to judge whether at one moment his or her perceptions of the world are more or less influenced by personal psychological factors than at another moment. Objectivity, on the other hand, denotes the capacity to observe objects realistically. How can the analyst be objective if the analyst is irreducibly subjective? For Renik the answer to this question lies in recognizing that in analysis observations of reality are constructs, formed in relation to subjective interests. Aron (1996, p. 262) quotes Racker in this regard:

> The analyst's objectivity consists mainly in a certain attitude towards his own subjectivity and countertransference … True objectivity is based on a form of internal division that enables the analyst to make himself (his own countertransference and subjectivity) the object of his continuous observation and analysis. This position also enables him to be relatively "objective" towards the analysand.

In terms of self-reflection, Aron (1996) talks about "dialectical objectivity", which is informed subjectivity and includes within itself reflection on the subjective. He refers to the importance of the ability to reflect on our own participation in interpersonal relationships while recognizing just how limited that reflectiveness is.

4.8 THE WAY FORWARD?

In 1918 Freud expressed concerned about the "helpfulness" that seemed to be infiltrating psychoanalysis. According to Malcolm (1980, pp. 124-125) Freud sternly wrote that psychoanalysts should not make things:

> … as pleasant as possible for the patient, so that he may feel well there and be glad to take refuge there again from the trials of life. In so doing, they make no attempt to give him more strength for facing life and more capacity for carrying out his actual tasks in it. In analytic treatment, all such spoiling must be avoided. As far as his relations with the physician are concerned, the patient must be left with unfulfilled wishes in abundance. It is expedient to deny him precisely

> those satisfactions he desires most intensely and expresses most importunately.

On the other hand, contemporary views regarding psychotherapy hold that patients come to therapy because they want to feel better. They want to "cast out devils" both within themselves and in their external relationships, but struggle with this because they are "attached to the devils" (bad objects). The task of the therapist is to assist the patients in the process of exorcism (Fairbairn, 1952).

According to Renik (1993, 1998), in clinical psychoanalysis as in the rest of science, what is true *is* what works. Renik states that hypothesis-testing via prediction is possible in psychoanalysis. The hypothesis proposed in this thesis was that patients who are attached to "bad objects" (devils) are better able to make use of the therapy situation if the therapist behaves similarly to these objects. This thesis hypothesizes that the strategic use techniques of "joining" and "accommodation" (Minuchin, 1974) may facilitate communication in psychotherapy. This suggestion challenges the basic "frame" of traditional psychoanalysis and extends relational notions of intervention.

Although there are many objections to the hypothesized alternative approach, some of which have been outlined from a psychoanalytic perspective, it was decided to attempt to research whether some of these ideas were at all feasible. The methodology proposed to test this hypothesis is outlined in the next chapter.

CHAPTER 5: RESEARCH – THEORY AND METHOD

5.1 INTRODUCTION – QUALITATIVE RESEARCH

The research utilizes a qualitative research approach. *Qualitative research* is used to investigate human relationships and human societies, their structures and meanings. From this perspective, it is believed that social phenomena, such as language, decisions, conflicts, and hierarchies, exist objectively in the world and exert strong influences over human activities because people construe them in common ways. Things that are believed become real and can be inquired into. Knowledge is seen to be a social and historical product, and *facts* come to us laden with theory (Miles & Huberman, 1994). Qualitative research is not statistical or mathematical (Strauss & Corbin, 1990), but it affirms the importance of the subjective, the phenomenological, the meaning-making centre of social life. The aim is, however, to register and "transcend" these processes and thereby build theories that account for life events (Miles & Huberman, 1994). Qualitative research methods attempt to use data gathered phenomenologically, always acknowledging the researcher's biases when gathering the data. The data gathered is then interpreted according to various theories or *hermeneutic lenses*.

The qualitative method will be used to investigate the following leading questions that emerge from a dialogue between the researcher's starting point, i.e. interpersonal/structural/strategic psychotherapy (see Chapter 1), the literature review, i.e. object relations theories and relational psychoanalysis (see Chapters 2 and 3) and a hypothesized alternate approach to therapy (see Chapter 4).

5.1.1 The research questions

According to Kvale (1994), *leading questions* are necessary parts of many research procedures. The task is not to avoid leading research questions, but to recognize the primacy of the question and attempt to make the orientating questions explicit, thereby providing the reader with the possibility of evaluating their influence upon research findings and assessing the validity of findings. As was pointed out in Chapter 1, "In life, freedom is always at work in the situation from which it arises … if to live is to invent, it is to invent beginning with specific givens" (Merleau-Ponty, 1982-1983, p. 55). The "givens" in this case are the researcher's starting point explicated in Chapter 1, and the theoretical literature reviews outlined in Chapters 2 and 3. Out of a dialogue between these and the formulation of an alternative approach that includes the active use of countertransference responding as a therapeutic strategy, the research questions were formulated as follows:

The primary research question is:

Does countertransference responding (replication of existing bad object relationship patterns) lead to changes in the types of communication used, as defined by Langs (1978)?

The following secondary questions were formulated to explicate the primary research question:

1. *What are the self and object representations evident in the narrative?*
2. *What communicative fields and types of communicative modes, as defined by Langs (1978), are evident?*

3. *Are there changes in the communicative fields and modes of communication used by patient and therapist?*
4. *Does the therapist work with Type One or Type Two derivatives, as defined by Langs (1978)?*
5. *What frame breaks and enactments are evident?*

Kvale (1994) points out that the important issue is not where the interview questions lead, but whether they lead in important directions, yielding new and worthwhile knowledge. An important consequence of the qualitative approach is that research methods are adapted or created to satisfy the demands of the research questions (Denzin & Lincoln, 1994). A hermeneutic approach to be described below will be used, to investigate three case narratives in terms of the research questions.

As this research involves "hermeneutic case studies", the theory regarding case study research will be discussed briefly. Next, the hermeneutic philosophy regarding investigating data will be outlined. The actual research methodology used in the current research will then be described. The research results will be detailed in Chapter 6. In the Chapters 7 and 8 the issue of whether the research has led to new and worthwhile knowledge will be discussed.

5.2 THE RESEARCH – A THEORETICAL OVERVIEW

5.2.1 Case study research

Although used by Freud to demonstrate his theories of personality and pathology, the case study has long been discarded in social science research in favour of the "natural scientific" approach, which is based on a Cartesian split between what is observable

(body), and the inaccessible (mind) (Valle, King & Halling, 1989). In the last two decades, however, the case study research method has become an acceptable method of researching psychotherapy process (Edwards 1998; Kvale, 1994). As Edwards points out, it is the careful observation, description and discussion of individual cases that is fundamental to the development of knowledge in the human and social sciences.

According to Edwards (1998), theory and practice in psychotherapy have advanced by an accumulation of knowledge based on the study of individual cases. Edwards (1998) cites Bolgar who states that the case study method is the ideal way to generate hunches, hypotheses and important discoveries. The current research is based on a series of hunches and hypotheses generated by the researcher's own clinical experience, as described in Chapter 1.

Edwards (1998) describes six phases or types of case study work. He points out that it is important to say what phase or kind of case study the research is involved in. The current case study can be described as discovery-oriented psychotherapy research (Edwards, 1998). It is descriptive, in that it aims to describe what happens between a patient and therapist when a therapist enacts the patient's self and/or object relationships. It is hermeneutic in that theoretical frameworks from the existing literature on object relations and relational psychoanalysis, and the strategic / structural models will be used to deepen understanding of a case for which exiting case law does not seem to be readily applicable. Further, the approach being taken is hermeneutic in that both therapy and the research are about the construction of a narrative to interpret and explain the process of therapy. A case study research method

(Edwards, 1998) will be used, applying methodological procedures drawn from the hermeneutic research approach (Addison, 1992; Ricoeur, 1981, 1984).

5.2.2 Hermeneutics

Kelly (1994) states that the term "hermeneutic" derives from the Greek *hermeneuo* (to express, to explain, to translate), *hermeneia* (understanding, exegesis) and *hermeneutes* (the agent who practises understanding). He points out that etymologically the term is also associated with the Greek god Hermes, the "messenger god", who typically acted as intermediary and translator between gods and human beings.

The discipline of hermeneutics began to evolve into its modern form during the seventeenth century as part of the study of the principles of Biblical exegesis. Although initially focussed on Biblical texts, the scope of hermeneutics was gradually extended beyond these to secular texts. According to Kelly (1994), in the early nineteenth century Schleiermacher laid the foundations for secular hermeneutics by proposing a set of universal canons of textual interpretations. Dilthey, who conceived of an affinity between textural interpretation and psychological understanding extended his work. Dilthey proposed that understanding (verstehen) is the appropriate manner of investigation for the human sciences *geisteswissenschaften* (Palmer, 1969). Dilthey asserted that an operation distinct from the quantifying scientific grasp of the natural world is required to interpret expression of human life. He held that interpretation of human expression calls for historical understanding and a personal knowledge of what being human means.

According to Dilthey, the natural sciences are most appropriately approached through an investigative attitude leading to explanation and then to knowledge of the laws of the causal order of natural phenomena. Understanding, which is fundamentally concerned with reasons, is considered the most appropriate method for investigating the mind. "We explain nature, we understand mind" (Dilthey, as cited in Bleicher, 1980, p. 246).

According to Gadamer (1975), Dilthey was unable to accomplish the task that he had himself chosen, which was to justify the special methodological character of the human sciences and make them equals to the natural sciences. Gadamer examines Heidegger's description of the hermeneutical circle and highlights the importance of awareness of prejudice. Gadamer takes Heidegger's notions of a hermeneutic of *Dasien* further into what is described by Palmer (1969) as the "linguistic" phase – "Being that can be understood is language". In summary, his position is that all understanding is linguistic, and this is based on history (prejudice).

Ricoeur extends this conception into that of the "hermeneutic arch" that includes a theory of language as interpretation, and a theory of the interpretation of text (Bleicher, 1980). According to Ricoeur, "The simplest message conveyed by the means of natural language has to be interpreted because all the words are polysemic and take their actual meaning from the connection with a given context and a given audience against the background of a given situation" (Ricoeur, 1981, p. 12). According to Ricoeur (1984), both "guessing" (*verstehen)* and "validation" (*erklaren)* are involved in trying to understand, or "interpret" data. Because there are many meanings to linguistic events, we thus have to "guess" at the meaning of

linguistic data and "validate" data via consideration of other logical possibilities. A hermeneutic approach always acknowledges the "historicality of understanding" but attempts to "widen our horizons" to accommodate other views (Gadamer, 1975).

Ricoeur (1984) considers all human action as text. He refers to the "untold" stories in everyday experience. According to Ricoeur (1984), we tell stories because human lives merit being narrated. He describes human beings as being "entangled" in plots and adds that narrating is a secondary process, that of the story becoming known. For Ricoeur, understanding and interpretation are parts of the same larger process.

He cites Roy Schafer who considers Freud's metapsychological theories as a system of rules for re-telling life stories and raising them to the rank of case histories:

> This narrative interpretation implies that a life story proceeds from untold and repressed stories in the direction of actual stories the subject can take up and hold as constitutive of his personal identity. It is the quest for this personal identity that assures the continuity between the potential or inchoate story and the actual story we assume responsibility for (Ricoeur 1984, p. 74).

For Ricoeur (1984), narrative puts consonance where there was dissonance. He describes this as "enplotment". Enplotment is not, however, merely a matter of putting an implicit story into words. The hermeneutic mode of understanding allows for a legitimate plurality of interpretations. Ricoeur emphasizes the importance of reflection on the limits of concordance. He describes both the "violence of

interpretation" and the "redundancy of interpretation" (Ricoeur, 1984), that is, possibilities of the interpretative process going awry. Ricoeur (1981) considers the use of text interpretation methodology as a paradigm for the human sciences. This method includes the following steps:

- *The fixation of meaning*: descriptions of human interactions need to become linguistically fixed, i.e. written, so that they can become available for scientific enquiry.
- *The dissociation of meaning from the intention of the original subject*: in transcribing there needs to be some dissociation between what the subject (research participant) intends and what the writer (transcriber) intends. The text is opened up to a plurality of interpretations.
- *The display of non ostensive references and the universal range of* addressees: texts often tell us much more than the original author (subject) intended. Further, although a text is fixed, it can be interpreted differently by different readers.

To summarize, all human action (including therapeutic interaction and interviews) can be considered as text. Because they are linguistic, they have already been the subject of some interpretation and therefore some prejudice has been introduced. However, they can be transcribed and thus converted into a written narrative which is then "fixed" and which can then be interpreted differently by different readers who have different historical backgrounds (prejudices).

These principles will be adopted and converted into a research methodology to investigate the research questions outlined above.

5.3 THE RESEARCH METHODOLOGY

Based on the theoretical principles outlined above, the approach being taken here may be described as a "grounded hermeneutic approach". It is *grounded* in that object relations theory and relational psychoanalysis have been integrated and a new set of theoretical principles to guide psychotherapeutic interventions have been formulated. These principles as well as Langs' (1978) classification of the types of communication will be used as hermeneutic lenses to interpret the data collected. All action and interaction is considered as text (Ricouer, 1984). As mentioned above, hermeneutic analysis is a necessarily circular procedure. There is a backward and forward movement between collecting and analysing.

The collecting of data is done in the light of the research question. Addison (1992) outlines the following assumptions of a grounded hermeneutic approach: Participants in research are meaning-giving beings; meaning is not only what is verbalized; meaning is expressed in action and practices. To understand human behaviour, it is important to look at everyday practices, not just beliefs about those practices. The meaning-giving process is not entirely free; meanings are made possible by background conditions such as immediate context, social structures, personal histories, shared practices and language. The meaning and significance of human action is rarely fixed, clear, and unambiguous. Meaning changes over time, in different contexts and for different individuals; interpretation is necessary to

understand human action. Facts are always value-laden, and researchers have values that are reflected in their research projects.

In this research the material gathered in the three phases of the research, that is, the initial interview, the therapy transcripts, and the two follow-up interviews, have been combined and organized according to a standard case presentation format with a narrative structure (Edwards, 1998; Kvale, 1996).

In order to give some reliability to this process, as mentioned above, each therapist (research participant) was asked to read the case material as presented and asked to ensure that there had been no "violence of interpretation" or "redundancy of interpretation" (Ricoeur, 1984).

In order to give the reader a sense of the interactions between the psychotherapist and patient, four verbatim transcripts from case number one have been included and formatted according to the method recommended by the Committee on Scientific Activities of the American Psychoanalytic Association (Klumpner & Frank, as cited in Gabbard, 2000) (to be described below). A part of the interview data has also been included. A complete session and sections of session transcripts, case notes and interview data from cases two and three have also been included.

5.3.1 Subject selection

The method of sampling used can be described as "theory driven" (Miles & Huberman, 1994) or "discriminate sampling" (Strauss & Corbin, 1990). It is not

opportunistic, but guided by the researcher's theoretical and experientially formed judgments.

Based on her experience and the literature review, it was decided by the researcher that each participant would need to be an experienced psychoanalytic psychotherapist (with approximately five years of psychoanalytic practice), who had adopted a traditional object relations model of therapeutic intervention. The therapist selected would have to have had experience of making written verbatim transcripts of the therapeutic dialogue in sessions based on memory.

Each therapist would also have consented to provide case material of a patient who operated pre-dominatingly within the paranoid-schizoid mode as described by Ogden (1992), and to obtain consent from the patient to use the material.

Informed consent:

Obtaining informed consent is a difficult and controversial issue in psychoanalytic circles. In the case of the current research, obtaining informed consent from the psychotherapists was not an easy task. The protection of patient privacy in educational presentations and scientific publications is an everyday concern within analytic communities. Discussing this issue, Gabbard (2000) – chair of the American Psychoanalytic Association's "Joint Committee on Confidentiality" and a member of the same organization's ethics subcommittee – points to the dual responsibilities facing psychoanalysts. On one hand, we must safeguard the privacy inherent in privileged communications, but we must also have free exchange of information for psychoanalysis to develop as a science. Arguments about this dual responsibility

generally revolve around a choice: the use of thick disguise for identifying information versus the request of informed consent from the patient.

Aron (2000) stresses that despite some ambiguity, the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association suggests that psychologists are required to enforce a both/and rather than an either/or approach. In other words, they must obtain written consent, but they must also disguise confidential information. Disguise without consent is not acceptable. On the subject of consent, however, Aron (2000) has pointed out that we would be hard pressed to find any time either at the beginning of therapy or long after it has been terminated when the patient would be able to give permission outside the influence of transference. No matter how well intentioned the analyst may be, the request introduces a need of the analyst that is alien to the patient. Aron refers to the fact that we have only begun to fathom the unconscious issues brought into play by these problems. Further, obtaining informed consent may prevent self-disclosures by the analyst to the researcher. Thick disguise may offer a more candid account of countertransference.

Gabbard refers to the irresoluble nature of the challenges posed by presenting and publishing clinical material. He states that all published cases should be disguised to some extent, even when the patient gives permission. He concludes that the approach should be tailored to the setting of the case report. Ethical concerns about the protection of the patient's privacy must take precedence over the researcher's need to publish or for the profession's advancement. Likewise, Rhodes University has a policy which maintains that informed consent is mandatory for all research on human

subjects, and the Humanities Higher Degrees Committee requires that a participant consent form be submitted with research proposals. For these reasons, a pilot study was conducted.

The search for suitable participants - pilot study:

Because of the issues involving informed consent it was decided to conduct a pilot study to find out which, if any, experienced object relations psychotherapists would be willing to obtain informed consent. A letter (Appendix A: Letter to psychotherapists) was sent out to twelve members of an integrative object relations reading group, belonging to an association of psychoanalytic reading groups. Six psychotherapists responded. The six that responded were asked to participate in a standard general interview (Appendix B: General Interview). The interview was aimed at putting the participant's experience in context. Material from all the pilot study interviews was then combined to extract common ground and idiosyncratic differences regarding the issue of obtaining informed consent.

Three psychotherapists agreed to obtain informed consent. They were then interviewed again using the questions formulated for phase one (Appendix G) referred to above. At this stage they were given their instruction letters, letters to patients, and patient and therapist consent forms (Appendices C, D, E and F). They then provided the post-session memory transcripts and therapy notes and records to the researcher. The case that best represented the researcher's story line, as described above, was selected to be presented (Gilchrist, 1992). However, sections from the other two cases provided by the other psychotherapists are also provided.

The results of the pilot study will be discussed briefly.

Results – pilot study:

Of the 12 psychotherapists contacted via the e-mail letter, which was followed up with telephone contact, only six responded. Of those that did reply, all six agreed to participate in the first phase of the therapy. They were therefore interviewed using the structured interview format detailed in Appendix B.

The six who participated in the interview can be divided into two groups. Three had been qualified for more than 10 years (12, 16 and 19 years). The other three had been qualified for less than 10 years (five, seven and eight years). While all agreed that it is important to research the psychotherapeutic process, only three of the six agreed to participate in the next phase of the research. Interestingly, it was the three that had been qualified for longer than 10 years who declined to participate further, citing the disruption to the therapeutic process and the frame break involved by asking for informed consent, as the reason for their being unwilling to participate further.

The three who did participate all stated that they would alter the frame and their therapeutic stance to accommodate their perceived needs of these patients. (It is interesting to note that of the three who agreed to participate, two had had some interactional training.) The psychotherapists who agreed to participate were interviewed again twice, and provided therapy transcripts and session notes in the data collection procedure, to be detailed below.

5.3.2 Data collection

Data was collected by means of (1) a series of three semi-structured phenomenologically based interviews, and (2) through the use of therapist's notes regarding the sessions and written memory transcripts of the therapeutic dialogue. This method was chosen since in object relations psychotherapy the mechanical recording of sessions is generally regarded as an impingement on the therapeutic process, and would thus pose an ethical problem. In defense of this method, Schön (2000) points out that this procedure is common procedure in clinical research.

Phase one – initial interviews:

The three psychotherapists that agreed to participate were interviewed using a semi-structured interview format to obtain background information regarding the patient that they were considering presenting to the researcher.

Phase two – post-session memory transcripts:

This phase of the research involved the provision of written memory transcripts by the therapist (Appendix C: Instruction to the participant). Consent of both patients and psychotherapists were obtained during this phase (Appendices D, E and F). It should be noted that the consenting patients did not know whether they had been included in the study, nor did the patient or therapist know which specific material was being researched. As mentioned above, inevitably both therapist and patient would be influenced by the research. However, the aim of the present study is to assess the psychotherapeutic process in an ethical manner, while minimizing the impact of this, as discussed above (Gabbard, 2000).

Phase three – second interviews:

The psychotherapists were then re-interviewed in order to obtain further clarity on the selected written transcripts. The questions formulated for this interview were based partly on those formulated and refined by Thorpe (1989) in his research on the therapist's experience of identifying, containing and processing the patient's processing of projective identifications (Appendix G: Therapist interviews). It was reasoned that the experience of enacting an aspect of the patient's intra-psychic structure is part of the experience of processing the projective identification (see Chapters 2 and 3). The psychotherapists were asked to reflect on the interventions made during these sessions. Attention was paid to the psychotherapists' perception of the impact of the intervention on the narrative style and overall interaction pattern of the patients, and the psychotherapists' perception of fluctuations in the nature of the collaborative relational bond with the patients. The interview sessions were tape recorded and transcribed by the researcher immediately after the interviews.

Phase four – third interviews:

There were follow-up interviews with the psychotherapists to gain further clarity, and to elaborate on the meaning of issues raised in the earlier interviews.

5.3.3 Data analysis

Reduction of material:

Following Ricoeur (1981, 1984), who considers all human action as text, both the interview data and the transcripts of sessions were considered as text to be interpreted. All interview material was transcribed and combined with the post-session memory transcripts and session notes to create a narrative (Edwards, 1998; Kvale, 1996).

The transcribed material was arranged according to process method, an experimental format devised especially for the examination of therapist-patient interactions proposed by the Committee on Scientific Activities of the American Psychoanalytic Association (Klumpner & Frank, as cited in Gabbard, 2000). This method suggests that enough verbatim data must be provided to enable readers to judge for themselves about the deductive process by which the person writing the report reached his or her conclusions. The format is designed to allow readers to judge the data on their own merits. In their suggested model, the author first identifies the way the process was recorded. The stage in treatment and the setting should be described, as well as how many sessions were conducted per week. The patient's comments are reported in lower case, while the therapist's comments are in capitals. Non-verbal information is reported in parentheses. Private thoughts of the therapist are reported in parentheses. This is the method that has been used to present the research case studies.

Reading guide:

Data analysis proceeded using a reading guide method developed by Brown, Tappan, Gilligan, Miller and Argyris (1989). This procedure involves the generation of different levels of questions. These questions are refined as the research proceeds. The goal of the reading guide is to present a theoretical perspective. Multiple readings are necessary because each reading approaches the data from a different standpoint. The reading guide provides a framework that the reader uses to guide him or herself through the different readings of the narrative, as he or she enters the hermeneutic circle by "building" an interpretation of that narrative. In line with the research questions, the reading guide focused on identifying themes relating to the patient's self and object representations implicit in the data. It also aimed at identifying the

types of communication, as defined by Langs (1978) and used by both patient and therapist. It looked for changes in the type of communicative pattern, as well as for frame breaks and enactments by the therapist. Care was also taken to question the account or look for disconfirming or negative evidence (Miles & Huberman, 1994).

5.4 RELIABILITY AND VALIDITY

As described above by Ricoeur (1981, 1984) both "guessing" (*verstehen)* and "validation" (*erklaren)* are involved in the process of reading and interpreting a text. Hence striving for validity in interpretation necessarily involves taking seriously the dialectic between guessing and validation. Guessing and validation are circularly related as subjective and objective approaches to the text. Ricoeur refers to the conflict between interpretations ("violence of interpretation" or "redundancy of interpretation", Ricoeur, 1984). An interpretation must not only be probable, but more probable than another. The logic of validation allows us to move between two limits of dogmatism and scepticism.

According to Brown et al., (1989), in practice, the logic of reliability and validity is operationalized most clearly when readers are able to discuss their respective interpretations of the same text. Therefore opportunity exists for alternative interpretations to be entertained and the relative probabilities of each to be considered – "interpretative agreement" (Brown et al., 1989, p. 156). In concurrence with this approach, Miles and Huberman (1994) emphasize that there are no infallible decision rules for establishing the validity of qualitative research. Their approach is to analyze the many sources of potential biases that may invalidate qualitative observations and interpretations and to outline different tactics for testing and confirming findings.

Only in this way can the dialectic between guessing and validation emphasized by Ricoeur be maintained.

In order to ensure reliability in the results phase of the research presentation, selected sections of therapy transcripts and session notes and interview material that had been combined to form a narrative were presented to the participating psychotherapists in order to ensure that in the process of constructing the narratives no misinterpretation or possible misrepresentation had occurred i.e. the researcher attempted to obtain interpretative agreement (Brown et al., 1989).

In the discussion, the data will be interpreted in line with the reading guide, the literature review and the biases or prejudices of the researcher, already outlined above. In order to ensure the validity of the research, the data was read and analyzed by another experienced object relations psychotherapist (external judge). This was to not only to ensure that the external reader's analysis was similar to and thus corroborated that of the researcher, but as pointed out above, according to Brown et al., (1989), in practice the logic of validation is operationalized most clearly when readers are able to discuss their respective interpretations of the same text. It follows further that the external reader should be able to follow the logic of the interpretative argument of the researcher (Packer & Addison, 1989; Ricoeur, 1981).

CHAPTER 6: RESULTS

6.1 INTRODUCTION

Table One summarizes the psychotherapists, the patients, the setting and the length of time in therapy, and the type of data presented in this thesis.

TABLE ONE

THERAPIST	**L**	**B**	**S**
Patient	Thandi	Vanessa	Hazel
Length of time in therapy	Six months	Three years	Seven months
Frequency of sessions	Weekly	Twice weekly	Weekly
Setting	Private practice	Private practice	Provincial clinic
Transcribed sessions	Four complete sessions	One complete session and parts of two	No
Case notes	No	Yes	Yes
Interview data	Yes	Yes	Yes

For the first case, Thandi, all four of the sessions provided by therapist L will be presented in full. They will be presented in the format recommended by Klumpner and Frank, as cited in Gabbard (2000), and described in Chapter 5, so that the reader is provided with enough material to make their own informed decision regarding data reduction and analysis. As mentioned above, this method suggests that enough verbatim data must be provided to enable readers to judge for themselves about the deductive process by which the person writing the report reached his or her conclusions. The patient's comments are reported in lower case, while the therapist's comments are in capitals. Non-verbal information is reported in parentheses. Private thoughts of the therapist are reported in parentheses.

For case two, parts of two sessions are presented, as well as one complete session along with abstracted case notes and interview data. They will also be presented in the format recommended by Klumpner and Frank, as cited in Gabbard (2000). For case three parts of the therapist's case notes and interview data are presented.

As mentioned in the section on data analysis, all the psychotherapists concerned were given a chance to check the accuracy of the reduction process (the ability of two or more interpreters to agree on their particular interpretation and understanding of a particular interview narrative, i.e. "interpretative agreement" (Brown et al., 1989), assumes that both are reading the text in the same way, or interpreting the same text.)

6.2 THANDI – I NEED YOU TO TELL ME WHAT TO DO

Thandi is described by her therapist L as an attractive, friendly 11-year-old girl. Her presenting problem was that of stealing, usually food, from her mother, teacher, friends, and the school tuck-shop. She attended therapy for six months on a weekly basis, with some disruptions because of holiday breaks. Verbatim transcripts of sessions were recorded in written form by the therapist within 12 hours of the session, The therapy ended because Thandi and her family relocated to a far off city.

6.2.1 Thandi – background information

Thandi is the child of a homeless street woman. Her mother was a poverty-stricken alcoholic and Thandi was neglected and uncared for until taken into a children's home at the age of 5 months. The rules in the children's home were rigid and the children were left unattended in their cots. Thandi's adoptive mother C was a political activist and journalist and started to visit the baby when she was six months old. She

describes her as being a really sweet baby – "as good as gold". She is also described as a baby who would not cry. C adopted Thandi and took her home for about six months, but then due to administrative issues regarding cross-racial adoptions, Thandi was removed to the children's home for a further six months. When she was 18 months old, Thandi was taken to live with C full time. C has subsequently married M and Thandi has a half sister aged five years and a half brother aged 18 months. The stealing started when she was six. She saw a therapist when she was about seven years old, for six months and has been on Ritalin since the age of eight years because she tends "to be a dreamer". The therapist L describes her impression of Thandi's home life as being chaotic. The mother is described as very aggressive and the father as withdrawn.

6.2.2 Thandi – progression of therapy and transcripts

It seems as if Thandi entered the therapy with some ambivalence. On the one hand, she said that her earlier therapy had ended but that she felt that she needed "more time to play" (sic). On the other hand, she was extremely threatened by the unstructured nature of the psychoanalytic play situation. She seemed desperate to please the therapist, but evoked anxiety in the therapist L, who increasingly felt pressurized to be pleasing herself, and felt pressurized into telling her what to do. Transcripts from two of Thandi's first sessions follow, so that the reader can get some idea of the quality of the interaction between therapist and patient.

Thandi – therapy transcript one:

(T arrived 20 minutes late due to traffic. Her father brought her to the session. She presented as friendly, went to sit on the couch where she had sat the previous week. I started by reminding her of the 2 sessions, after which I would meet with parents and we would think together about how best to help her.)

L: AS YOU CAN SEE, I HAVE TOYS AND THINGS TO DRAW WITH AND WE CAN TALK, YOU CAN DO WHATEVER YOU LIKE, THE TIME WE HAVE TOGETHER IS YOURS TO DO WITH AS YOU LIKE.

(Silence – she appears shy and uncertain, gives L a small smile.)

L: IT SEEMS DIFFICULT TO KNOW WHAT TO DO.

T: Yes … at school today I got a bit scared because I had a history project due and I wasn't going to finish in time, but luckily my friends were very nice and they helped me. I thought that my teacher would be cross but she wasn't, she said I could finish it at break. (Underlining in original transcript.)

L: GOSH, YOU MUST HAVE BEEN RELIEVED.

T: I was.

L: IT ALSO SEEMS THAT IT'S REALLY NICE TO GET HELP NOT ONLY FROM YOUR FRIENDS BUT THAT YOUR TEACHER WAS UNDERSTANDING.

T: Yes.

L: IT'S A LITTLE LIKE WHAT IS GOING TO HAPPEN HERE WITH ME. I'M HERE TO TRY AND HELP YOU AND WITH YOUR PARENTS TO TRY AND UNDERSTAND YOUR FEELINGS.

T: (Nods and looks around the room.) I don't know what to do.

L: ARE YOU MAYBE WISHING THAT I WOULD TELL YOU WHAT TO DO?

T : Yes (says this with great enthusiasm). At school I know what to do, and at home if I tell my mother that I'm bored she tells me to do my homework or go and play.

L: SO YOU'RE USED TO BEING TOLD WHAT TO DO, OR YOU JUST KNOW, SO BEING HERE WITH ME AND ME NOT TELLING YOU FEELS DIFFERENT.

T: Yes, at home I play with my beads (shows me the bracelets she made) or I read a bit or play outside.

L: MAYBE, ALSO BECAUSE YOU KNOW SCHOOL AND HOME AND WHAT IS EXPECTED OF YOU. THIS PLACE AND ME ARE NEW TO YOU, IT IS ALL UNFAMILIAR SO YOU'RE UNSURE OF WHAT TO EXPECT.

T: I feel clueless.

L: CLUELESS, MMMM, THAT'S A GOOD WORD, LIKE WITH NO CLUE WHATSOEVER, DOES CLUELESS MAKE YOU FEEL NERVOUS INSIDE?

T: Yes, please tell me what to do.

L: THE NERVOUS FEELING IS UNCOMFORTABLE AND IF I TOLD YOU WHAT TO DO THEN IT WOULD GO AWAY.

T: Yes.

L: (I feel terrible pressure to help her out of her discomfort and am beginning to feel as if I'm being punitive.)

L: I SUPPOSE IT'S HARD TO UNDERSTAND WHY I'M BEING DIFFERENT TO YOUR TEACHERS, YOUR PARENTS AND MAYBE YOUR FRIENDS. IT'S NOT BECAUSE I WANT TO BE MEAN, OR THAT I WANT YOU TO HAVE A NERVOUS FEELING, BUT BECAUSE IN THIS ROOM, UNLIKE OTHER PLACES YOU LEAD ME AND I WILL FOLLOW YOU.

T: But what if what I want to do, you don't want to do.

L: IT'S IMPORTANT TO YOU THAT I'M O.K.

T: Yes, because what if I want to play cards and you don't want to.

L: YOU SEEM WORRIED THAT THEN I MIGHT FEEL BAD OR GET CROSS.

T: You will then feel lonely, or left out. I won't want to draw if you are just waiting there, but if you had work to do then I'd feel all right drawing.

L: SO, IT'S LIKE YOU ALWAYS HAVE TO THINK ABOUT THE OTHER PERSON FIRST BEFORE YOU CAN THINK ABOUT YOURSELF. GOSH, THAT SOUNDS LIKE HARD WORK.

T: (Laughs) I don't want you to get upset.

L: WHAT DO YOU THINK COULD HAPPEN IF I GOT UPSET? BECAUSE IT'S LIKE YOU'RE WORRIED SOMETHING BAD COULD THEN HAPPEN.

T: If you got upset then you'd tell my mother and it would be a big "gemors" (mess-up).

L: YOU'D GET INTO TROUBLE.

T: Yes, have you got cards?

L: PLAYING CARDS?

T: Yes.

L: I DO, WOULD YOU LIKE ME TO SHOW YOU WHERE THEY ARE?

T: Yes.

L: (I get up, fetch them and pass them to her.)

T: Do you know any card games?

L: ONLY TWO, SNAP AND GO FISH.

T: So you don't know Speed.

L: NO, BUT YOU COULD EXPLAIN IT TO ME.

T: I'm not good at explaining (looks a bit crestfallen).

L: I TELL YOU WHAT, WHY DON'T YOU TRY, AND IF I'M CONFUSED I'LL TELL YOU AND THEN WE CAN MUDDLE THROUGH TOGETHER.

L: O.K.

(She explains the game to me while she demonstrates with the cards. She asks me if I understand, and I reply yes. We play the game. After the first game …)

T: Will you tell me if you're bored?

L: (I smile.) THERE YOU GO AGAIN, WORRYING ABOUT ME. (She smiles and we restart the game. I tell her we have 5 minutes left and remind her of next week.)

Session ends.

Thandi – Therapy transcript two:

(T sits down immediately at the little table and chairs. I join her.)

T: I brought something to do today (opens her school bag).

L: YOU HAVE COME PREPARED.

T: Yes.

L: THEN YOU DON'T HAVE TO WAIT AND WONDER WHAT TO DO.

T: I won't waste time.

L: LAST WEEK FELT LIKE A WASTE OF TIME?

(No response, she takes out a maths book and her pencil case. I think to myself, oh no, she's going to spend the session doing homework. We sit silently for a long time while she does her maths homework. She then proceeds with her history and science. Her presentation is very different to the assessment sessions when she appeared concerned about my bored or interested feelings. Her not wanting to be in the session was very strong, and I was left feeling irritated, at a loss as to what to say or do, and

generally felt that it was a waste of time. I tell her that we have 5 minutes left, she packs her books away.)

T: How long am I going to be coming here?

L: YOUR MOTHER, FATHER AND I HAVEN'T SET A TIME, BUT WE DID TALK ABOUT TILL THE END OF THE YEAR AND THEN WE WOULD THINK SOME MORE.

(Session ends.)

(When I saw the Mom in the waiting room I felt quite embarrassed, like a fraud, and secretly hoped that Thandi wouldn't tell her that she spent the time doing homework!)

The therapy continued in this vein, with Thandi alternating between wanting to please L and bringing her gifts, e.g. a beaded bracelet that she had made, and seeming distant and remote. L alternated between feeling increasingly anxious and wishing to provide Thandi with some reassurance and structure, and feeling irritated, superfluous and useless. In her interview, L stated that she was aware of feeling increasingly under pressure to help Thandi by telling her what to do. Eventually, knowing that she was changing her usual more interpretative stance, L knowingly gave in to the pressure. She conducted a session where she told Thandi exactly what to do. She suggested games and participated in them actively, correcting Thandi when she made mistakes. According to L, the result was that of extreme relief for both L and Thandi. A transcript of this session is not available as it was stolen when the therapist's car was stolen. However a transcript of a subsequent session and the session before the termination session of the therapy will now be provided.

Thandi – therapy transcript three:

(I will not see her next week, family in another city). The session felt very much like the separations have made it difficult for her to feel somewhat safe and comfortable with me. She was distant and bossy in the room. She came in with a muffin. Begins to pick at it. We say our hellos and I welcome her back.)

T: What can I do? (She picks in a bored disinterested manner at her muffin.)

T: What's that? (She points in a very general direction.)

L: UMMM…

T: That red thing.

L: A VIEW MASTER.

(I tell her what it is and she goes over and fetches it.) (She sits/lounges on the couch with the view master glued to her face. I feel the distance and of being totally shut out. We sit like this for what feels like forever.) (Underlining in original transcript.)

T: Don't stare at me.

L: YOU DON'T WANT ME TO EVEN LOOK AT YOU.

T: You're staring and it's rude. Allie (her sister) stares and I hate it.

L: I HAVE BECOME LIKE YOUR LITTLE SISTER WHO IRRITATES YOU.

T: Look over there (she points to a place in the office opposite to her.)

(At this point I have already begun to feel disempowered and also helpless, like I cannot even think.)

L: IF I DON'T EVEN LOOK AT YOU, BUT LOOK OVER THERE THEN WE FEEL AS IF WE ARE FAR AWAY FROM EACH OTHER. LIKE WE COULD BE IN DIFFERENT ROOMS EVEN.

T: Get out!

(I just look at her, and feel quite shocked.)

T: Get out!

L: YOU WANT ME TO LEAVE.

T: Yes, GET OUT! (Capitals in the original transcript.)

L: DURING THE SESSION, NEITHER OF US LEAVES THE ROOM.

(T continues to look through the view master. I don't comply with her demand to look elsewhere. I notice her peeking at me over the top or around the side of the view master.)

L: I SEE YOU PEEKING AT ME.

(This becomes like a little game between us, and it feels as if we are sharing something, but I still feel her hostility, distance and irritation. This peeking at each other continues on and off for a while. When she has finished the slides, she puts the view master back and picks up the marbles.)

T: Do you know any marble games?

L: I KNOW THE ONE WHERE WE EACH TRY TO HIT THE OTHER PERSON'S MARBLE (I demonstrate).

T: O.K., let's play that.

(Empties the marbles and looks at them.)

T: Do you know the names of the marbles?

(I begin to feel quite tested and challenged and uncomfortable.)

L: SOME OF THEM.

(We begin to play, but she feels aggressive and bossy and changing the "rules" to suit herself. I feel totally disempowered and feel incapable of making meaningful comments. I want to retaliate and tell her that it's no fun playing with her, and that she's actually being quite mean and hurting my feelings. I feel like a child.)

(Underlining in the original transcript indicating the intensity of the therapist L's feelings).

The family was moving to another city. (In spite of being told that Thandi should not be allowed to engage with a therapist only to have the process curtailed, the parents had committed to therapy. They only informed the therapist after therapy had been started, of their plans to move.)

Thandi – therapy transcript four:

(C (the mother) requested that she speak with me for a few minutes before the session. The three of us entered the room. The tension between C and T was obvious, and T looked as if she had been crying. C told me that she had received a call from the school that morning to inform her that T had been stealing food from their tuck shop. C was clearly angry and suggested to me that because she couldn't trust T to stay for the next week with a friend, that she travel with C and her siblings to (the new city) the next night, rather than stay on and travel with M (her father). This would mean, however, that we would miss our termination session. C didn't know what to do. I told C that T and I would talk about it in the session and let her know. C left.

Neither T nor I say anything. She is sitting on a chair on the edge of the room – distressed.)

L: IT'S DIFFICULT TO TALK ABOUT.

T: Yes.

L: I CAN SEE HOW UPSET YOU ARE (she begins to cry). CAN YOU TELL ME WHAT HAPPENED? (She proceeds to tell me that she took food on 3 occasions, and

lied to cover it up, but a friend's mother discovered her eating yesterday. She said C had been screaming and swearing at her all the way to the session.)

T: I know it was wrong, I know I shouldn't have taken the food and lied, but I can't help myself.

(This was said in a truly desperate way, and my heart went out to her.)

L: IT'S SOMETHING YOU CAN'T CONTROL, AND THAT'S SO HARD TO UNDERSTAND.

T: I don't know why, and I don't know how this has helped. I thought it would but I'm still doing it.

L: LIKE A CONFUSION AND A BIG DISAPPOINTMENT.

T: Well, I still don't know why I'm doing it and it's still there.

L: YES.

(T cries quietly.)

T: I don't know what to do, and it's worse.

L: WORSE…?

T: It's happened again and my Mom will never trust me. She's not going to believe anything I say anymore. But I don't understand.

L: IT'S VERY PAINFUL TO KNOW THAT IT'S WRONG TO TAKE THINGS, BUT TO FEEL THAT THERE ARE TWO SIDES INSIDE OF YOU. THE ONE SIDE THAT KNOWS THAT AND THE OTHER SIDE THAT DOES IT ANYWAY.

T: It's horrible.

(She cries some more, we sit quietly for a while.)

L: WE DON'T REALLY KNOW WHY YET.

T: Then how has this helped?!

(She is more upset and desperate than angry.)

L: THIS IS WHAT COMING HERE HAS BEEN ABOUT, TO TRY AND FIGURE IT OUT, BUT THAT IT'S TERRIBLY DIFFICULT 'CAUSE IT'S TAKING LONG AND THERE'S NO SIMPLE ANSWER.

(Silence for a while.)

L: BUT IT SEEMS TO BE BECAUSE YOU ARE UNHAPPY ABOUT SOMETHING.

(Silence.)

T: My Mom makes me unhappy.

(Silence.)

T: I hate her and wish I could have another Mom. I would keep my Father, but I know that it will never happen, that we are going to have to stay together.

(Silence.)

T: She shouts all the time, and when I try and talk to her and tell her not to shout, she says that she shouts because of me.

L: LIKE IT'S YOUR FAULT.

T: That if I didn't do these things then she would be nicer. I know that she doesn't want another daughter but I wish I could have another Mom.

(Silence.)

T: I can talk more to my Father, he is more gentle and quiet, but then he tells my Mom, and then she shouts.

L: I GUESS THAT COULD FEEL QUITE LONELY SOMETIMES.

(Silence while she cries.)

T: I don't want to go to (the other city) with her tomorrow, my bags to stay at my friend are in the car.

(I think three things: that her parents have told me that she struggles if her routine changes; that going to (the other city) early would feel like a punishment; but also I feel very strongly about us needing the last session as we have planned.)

L: TO SUDDENLY CHANGE YOUR PLANS AND TO LEAVE SO SUDDENLY, NOT ONLY THE SCHOOL AND YOUR FRIENDS BUT FOR US TO HAVE TO SAY GOODBYE TODAY UNEXPECTEDLY WOULD FEEL HARD.

T: I'm pleased to leave the school, but I was looking forward to staying with my friend.

L: SO WOULD IT BE O.K. IF I TOLD YOUR MOM THAT THINGS MUST STAY AS ARRANGED? YOU GO TO YOUR FRIEND, WE HAVE OUR LAST SESSION NEXT WEEK, AND YOU LEAVE ON FRIDAY WITH YOUR FATHER.

T: Yes.

(The last few minutes of the session she spent telling me what she and her friend had been planning to do. When her mother, C, arrived I told her that things must remain the same. She seemed O.K.)

6.3 VANESSA – I NEED YOU TO TELL ME TO GO AWAY

Vanessa is an intelligent and attractive woman of Asian descent, who is 26 years old. She had been seeing the therapist, B, twice a week for the previous four years. Verbatim transcripts of the sessions were made within 12 hours of the session. Notes were written within one to two days of the session. According to B, Vanessa presented as anxious and agitated initially, and stated in the first session that she had come to stop running. She had been feeling demotivated and lethargic at work (she is

a qualified professional), and spoke of an impotent anger that threatened to explode. She spoke about presenting a happy compliant façade to the world, that she hates confrontation and that she lives to make everyone else happy. She can't say no. Vanessa spoke about feeling expendable, and that she makes herself indispensable to others. She mentioned that her car was the most important thing in her life and that she would take long drives at high speed to relax and escape.

6.3.1 Vanessa – background information

In recounting her story she told B that she has a sister, five years younger, and that her mother had died when Vanessa was six years old. There was some suggestion that she had been rejected by her mother and had been raised in part by her maternal aunt. She had been daddy's girl, but after her mother had died he had turned from her to care for her sister. He was reportedly suicidal and seems to have remained somewhat depressed, passive, and emotionally flat and unavailable ever since. The paternal grandmother helped raise them, but her relationship with Vanessa was conflictual, with Vanessa describing her as selfish and stern. The four of them continue to live together. She says she had to grow up quickly, and that "big girls don't cry". There were further losses in the extended family and she lost contact with her maternal family, with whom she had been close, due to some dispute.

Prior to coming to therapy, Vanessa had been having what she thought were panic attacks and that she was reverting to a variety of obsessive-compulsive defenses. She said that she had large gaps in her long-term memory, and that some of these memories were slowly re-emerging. She was struggling with eating, which she controlled and limited, and she talked about "controlling voices" inside her that

functioned to keep her going. She saw herself as a monster and as dirty, and would spend hours in the shower scrubbing herself. B and Vanessa talked about her fear of needing, and of her needing B, and her vulnerability to feeling abandoned.

As memories emerged, she recounted experiences of molestation by different people, but the memories were vague. She recalled engaging in self-soothing rocking and excessive masturbation as a child.

B's impressions were that Vanessa seemed to lack integration and had some borderline organization. She seemed to either avoid, or feel engulfed by relationships. B thought that she had developed a false self and that she had had to become prematurely self-sufficient, without really becoming autonomous. She appeared to have sadistic/rejecting internal objects. B describes her as having paranoid features. He states that she used projection, especially of hostility, and seemed to have a fragile observing ego.

6.3.2 Vanessa – progression of therapy, transcripts and interview data

In the first stages of therapy, B became aware that Vanessa was out of contact and delusional. She was functioning professionally but had become socially isolated and anxious, and more controlling and obsessive in her behaviour. She reported a dream (after hearing that her first boyfriend was getting married and having a child), with herself in a wedding dress, running through the streets with blood running down her legs. She was clearly distressed. B received a series of phone calls at home early in the morning. The first was a song playing on B's answer machine. The second was Vanessa saying that she had seen the light, that she loved B and was to have his

children. B referred her to a psychiatrist, who put her into hospital, and medicated her. He then diagnosed a manic episode of Bipolar Disorder. She was, and still is, medicated with mood stabilizers.

B states that much their work was around reality testing, challenging her delusions, and preparing for the December break (in part by encouraging her to establish effective support systems). B then went on holiday for three weeks. When Vanessa left B her final payment in an envelope, he found in it a series of poems and a letter confiding her love for him. On returning in the New Year, B confronted her about the letter and its contents, explaining that her infatuation was not about the real B, but about what he represented for her in fantasy. She informed B about covert messages he had been sending her (via the colours of the clothes he wore) and that although he was saying that he could not be her lover, the real B, not the therapist B, was sending conflicting messages.

As the months passed, it became clear that Vanessa had continuous fantasies that B and Vanessa were married and had children. This delusional situation continued until they had a session, of which the following excerpt is provided.

Vanessa – therapy transcript excerpt one:

In this session she came in and spoke a little about "us" (herself and B). She asked B to set her free. At some point in the session B stated that he could not give her what she was asking for (romantic attachment).

V: That's a nice way of saying something.

B: A NICE WAY OF SAYING SOMETHING HARSH?

V: Of rejection, and of nothing.

(She says something about needing me to say I don't love her and never will. I try and explore around it but she shuts down and asks again.)

B: VANESSA, I DON'T LOVE YOU.

V: And you never will.

B: AND I NEVER WILL.

(She is stunned and there is quiet for a while. At some point she says she feels relieved, lighter. No one has ever said that to her. She feels set free, and relates that in all her relationships, she was denied the love she needed but never set free. She said she no longer felt like a puppet on a string. I felt I had said too much already.)

During the interview, B stated that he realized that what he had said to Vanessa was not the truth. He said that he realized that, in fact, he did care for her very deeply, but in a paternal way, although he did have some erotic feelings at times. He said that as he told her that he did not love her, he regretted it and apologized to her for what must have seemed to her like cruel and sadistic rejecting behaviour.

Vanessa – therapy transcript excerpt two:

(I felt that she needs a protective figure, someone that will see her, acknowledge her. All her relationships have been about someone else's needs.)

B: LISTEN, I NEED TO APOLOGIZE FOR WHAT I SAID TO YOU JUST NOW. IT MUST HAVE SEEMED QUITE INSENSITIVE.

V: No … no … no … no … actually … it wasn't **quite** insensitive, it was **very** insensitive, very insensitive! (Bold used by the researcher on transcribing to the taped interview.)

When interviewed, B stated that although he realized that he had enacted a rejecting paternal object, he had wrestled with the idea of saying this to her. In saying it he had felt pulled out of his usual role as therapist. But he felt it was cruel not to say it to her. By not telling her, he was keeping her fantasy of a marriage relationship with him alive. He also felt that this enactment had somehow set Vanessa free.

Vanessa – excerpt from taped and transcribed interview with B:

"She is actually a very amazing person. Her psychiatrist is very taken by her progress. For one – that she has been able to work all the way through a psychotic process. She is able to regulate her moods. She is able to use a psychodynamic understanding in a kind of cognitive way. She has got this very systematic mind, so she takes the therapy and kind of incorporates it. So she will be talking about things and I will suggest some kind of an understanding or interpretation, for instance with her dreams or with her delusions, and through that she would begin to understand how her mind works. So for example, she will come to me and say, 'The universe was talking to me today. I kept seeing these NO FEAR (a clothing brand) stickers and I became more and more anxious and the birds started singing louder and the dogs started barking louder …'

" But what she then does, she starts thinking, well this is some of my manic stuff. We then talk about what was happening in the day, and we start making links and associations, and eventually it will be explained somewhere what this NO FEAR sticker is about. She realizes that the NO FEAR stickers are about her anxiety. Then she will think about … 'OK when did it happen? I did notice that there was a white Mazda that drove past me … the white Mazda is the same car that is driven by my

uncle, and I saw my uncle this morning. I had a conversation with my uncle and he said that he had seen my first boyfriend and he …blah … blah … blah' … so she understands that her anxiety at that moment is about her first boyfriend. She is able to make links all the way and find out what the anxiety is about! And in doing so the anxiety drops and the birds quieten down!!

"It is FANTASTIC that she can do that. She has increasingly become more and more adept at that, and in a way I understand it as some way internalizing the therapy process, the therapy way of thinking and it is possible because she has a very good abstract and systematic mind. She is able to stand back in those moments and start reconstructing everything and so she has been able to hold her moods. Increasingly as we have gone along in this year, things would throw her off in her relationship and throw her in to some kind of vortex, where it would take her time to come out of it, she has been able to kind of circumvent those things and be aware of … this is happening … this is how it is happening … this is how I respond … this is what it is about…this is what I can do about it. So she has … you know for instance she would get terrible headaches, then she would realize the headaches are about a build up of emotional material, unprocessed memory stuff, or undigested. She thinks about what the headache may mean. She realizes now when she gets headaches that she needs to find expression, but it is hard and it can take her days to find an outlet and then she may revisit old CD s or go through letters, or wait for something to come up for her on an emotional level and then that seems to open it up and then she will cry. Then she will have a relief and the headaches will disappear. Then she is able to bring that stuff and we can talk about that stuff. So she is amazing the way that she can think about stuff, especially if you think that she had a major psychotic breakdown.

"She knows herself. If she becomes unsettled she knows what to do. She knows to take herself off to the psychiatrist. She knows when she has not had enough sleep. She has become more assertive at work. This is really been in the last eight months, she has decided to stop herself from being used and abused."

Vanessa – therapy transcript subsequent to interview:

(V enters the room, sits, smiles, and after a while says that she has nothing to say, and doesn't want to talk. She adds that she is feeling very sensitive and this is not helped by the fact that she is pre-menstrual. I gesture her to explain and she tells me that it is about her work and the people there. She says she is angry and frustrated. She said that the annual increase had come through and that the increase was small, "ludicrous, insulting". She looks exasperated, saying they had just received it today.)

B: FROM WHAT YOU'VE BEEN SAYING OVER THE PAST MONTHS, IT SEEMED THAT THINGS WERE GOING WELL THERE. YOU WERE FEELING THAT THEY RECOGNISED AND VALUED YOU. THEY EVEN GAVE YOU WHAT AMOUNTED TO A PROMOTION, SUPERVISING THE CLERKS.

V: It's not just me, we all got poor increases, and they didn't tell us how they worked it out.

B: YOU MUST BE SO DISAPPOINTED … AND ANGRY.

V: I am. I feel like I've been dropped.

B: YOU WERE CRUISING ALONG ON THE WORK FRONT, MUST FEEL LIKE YOU HIT A WALL.

(She sits back, rubs her face.)

V: I'm feeling very tired, a little dizzy. I'm slipping away.

(I nod understandingly – this is usually a defensive manoeuvre – I fear preceding something dissociative).

B: IT'S BEEN HUGELY FRUSTRATING, AND IT'S A HORRIBLE DISAPPOINTMENT.

(We wait a little while she gathers herself.) (I have an image in my head of her hands being tied.)

B: IT'S HARD TO FEEL SO ANGRY?

V: I'm furious!

B: AND YOU DON'T KNOW WHAT TO DO.

V: I could speak to J, but he'd say speak to A. A doesn't know what I do.

(She talks about how much money she earns the company, and how that doesn't at all reflect what she earns.)

B: LAST WEEK YOU TALKED ABOUT YOUR FEAR THAT C WOULDN'T HEAR YOU WHEN YOU CONFRONTED HIM, AND WE LINKED THAT TO A COMMON THEME THROUGHOUT YOUR LIFE. THIS SOUNDS LIKE IT FEEDS INTO THAT. TO THEM YOU FEEL INVISIBLE, UNACKNOWLEDGED.

(She nods.)

B: THAT MAKES YOU FURIOUS, BUT IT'S AN ANGER THAT HAS NOWHERE TO GO, IMPOTENT.

V: I got angry. I was mad. I stabbed the paper, I just kept stabbing it.

B: YOU KILLED THE PAPER, BUT J AND A ARE STILL ALIVE. THINGS HAVEN'T CHANGED. I'M NOT SUGGESTING YOU KILL THEM (she smiles), BUT IT'S LIKE YOUR HANDS ARE TIED. IT FEELS LIKE ABUSE, AND YOU JUST HAVE TO TAKE IT.

V: I feel like I'm back where I started.

(She tells me of a job offer in November last year that she turned down because it was a client and it wouldn't have been very ethical – she regrets it now.)

V: I just want to tell J to fuck off. I will phone that client and see if the post is still vacant, otherwise I need to get my CV out there again. I'm back where I was months ago, I should have left then.

B: IT LEAVES YOU IN A DIFFICULT POSITION. IT'S HARD FOR YOU TO FIGHT THIS, TO CONFRONT THEM ABOUT YOUR WORTH. IT'S ALSO SCARY TO CONTEMPLATE, AGAIN, THE PROSPECT OF LEAVING, OF HAVING TO ADJUST TO SOMETHING NEW. SO YOU ARE LEFT WITH THE HISTORICAL OPTION OF JUST HAVING TO SWALLOW IT.

V: I can't do it anymore. They know it's hard for me to leave because they give me flexi time, and there are few jobs like that.

(She talks about the others saying they want to down their pencils, or just slack off. She says she can't, her work is an extension of herself, and it's part of her, a reflection of her.)

B: YOU OFTEN GET CAUGHT THINKING THAT OTHERS SHARE YOUR ETHICAL MOVES AND PLAY FAIR. YOU FEEL CRUELLY DISILLUSIONED AGAIN.

(She talked around job options and disappointment. At some point she said that another problem was a new clerk, who is "loud, obnoxious and arrogant". How he tells everyone how good she is, that she's better than everyone else, has the most to teach. But she feels he does it in a way that embarrasses her, and has a mocking tone. She says she would like to "smack his face". I am wondering about this, how it relates to what had preceded it, what it means about deception and acknowledgement, about projection or displacement, but she has moved on. She tells me her sister is

asking for advice on her relationship, which is in trouble. She says that I know that she dislikes the guy, but she has made a big effort to be civil to him and make him feel welcome. She says she cannot give advice on this, and wishes her phone would stop ringing. I'm now thinking of the transference. I'm thinking how she didn't want to talk initially.)

B: EVERYTHING FEELS LIKE AN IMPINGEMENT. YOU'VE TAKEN A LOT OF ABUSE IN THE LAST COUPLE OF WEEKS, AND FELT VERY INSECURE TOO.

V: C (her boyfriend) has been very sweet. He's trying really hard.

(She describes how he talks to her, his messages and how he misses her. It makes her nervous though (too good to be true).)

B: IT'S THAT ROLLER-COASTER AGAIN, UP AND DOWN, AND THE BAD COMING FAST ON THE HEELS OF THE GOOD … IT FEELS LIKE THERE'S BEEN TOO MUCH DISILLUSIONMENT AND DISAPPOINTMENT TO TRUST THAT THE GOOD WILL LAST.

(She nods and smiles. She talks about the pressure of a job that needs to be finished, and that it will be a while till she can get down to Durban. There is a moment's silence.)

V: Say something.

(This is common.)

B: WHAT WOULD YOU LIKE ME TO SAY?

V: Anything.

(After a while I say):

B: YOU CAME IN NOT WANTING TO TALK, AND THEN YOU TALKED WITH A LOT OF INTENSITY AND FEELING, AND HAD A LOT TO SAY.

YOU'VE RUN OUT OF WORDS, AND THAT FEELS UNCOMFORTABLE. YOU WANT ME TO GET THE TALK GOING AGAIN.

V: I have a lot to say, I just don't open up the feelings again, I could talk for days on this that I'm feeling.

B: YOU WANT ME TO DISTRACT YOU, TALK ABOUT SOMETHING ELSE.

(She nods, smiling.)

6.4 HAZEL – I NEED YOU TO BREAK BOUNDARIES AND TO BE EVASIVE

Hazel was originally seen for family therapy at a provincial children's clinic, because both her daughters, D (17) and E (15), had attempted suicide. The family was seen by a team of psychologists which included S, who is also her current individual psychotherapist. Although S and the team were aware that from a psychoanalytic perspective it is not ideal that the same therapist be involved in family therapy and individual therapy, it was decided that Hazel would see S because the family's financial circumstances did not permit private individual consultation. This constitutes a frame break. In her interview S stated that she was aware of this and also thought that it is significant that she was prepared to ask Hazel for informed consent. She said that when she thought about it she realized that she would not have easily asked any of her other patients to sign consent forms. Case notes were written up between one and seven days after the session.

S sees Hazel and husband M as a youthful couple in their 40s. S describes Hazel as being pretty, slim, and girl-like. She says that she always looks well groomed, not dishevelled. S states that she thinks Hazel finds it difficult to be adult. She is inclined to cross boundaries – she phones the daughters' boyfriends – she phones everybody –

including her daughter's therapist. S states that one is inclined to treat Hazel like a child. She says that that is how she thinks Hazel would like to be treated, by her husband, and by her children. Her daughter D says to her that she is more like a child than a parent. She describes Hazel as being obsessed with her cell-phone. The family is always sending text messages to each other. Hazel would often read the messages to S.

Hazel did not seem able to voice her own opinions. For instance, she was keen to have a break after Christmas as she had worked very hard, but could not voice her wishes to M. She could only tell him in a roundabout way, saying that her friend had said she needed a break. She also often used comments that S had made to communicate with her husband and daughters, but twisted them to suit her own needs. Hazel's husband is suffering from a lot of somatic symptoms. He keeps on having operations to widen his oesophagus – he is not able to swallow. He has tinnitus, and has been diagnosed as having an adult form of Attention Deficit Disorder.

6.4.1 Hazel – background information

Hazel describes herself as having wealthy, socialite parents with lots of servants. They got divorced when Hazel was 13 years old and gave Hazel the choice of who she was going to live with, both thinking that she would choose themselves. S thought this was incredibly difficult, but Hazel did not seem to find this decision hard, realizing that they wanted her to make the choice. She chose her father – as he was the more stable of the two. Hazel did not seem to be aware of the fact that her early life may have affected her functioning as an adult. She said her mother like pretty girl things like she did, wanting everything neat. Her mother kept a cupboard of tins

in many neat rows. Hazel said she felt bad when her cupboards didn't have many tins in them. She said her mum used to make a big fuss of her birthday, making a lovely party, and taking her to buy treats. Her mother loved dinner parties and had her domestic worker go on cordon bleu courses. Her mother was often depressed and had been a hypochondriac. She had had many nervous breakdowns, and was admitted to hospital. She is reported to have put crushed glass into Hazel's bed.

Hazel spoke fondly about her and her father, and the period of time that she lived with him. She felt that she was the apple of his eye. She experienced this as a very blissful period. Then her father re-married. Hazel was very upset and hated her stepmother. After the divorce, her mother continually questioned her about choosing her father to live with. Hazel remembered often being unwell as a child. She remembered riding on her father's shoulders. He rang the nurse's bell for a joke. The nurse came out and thanked him for reminding her that visiting hours were over. Hazel felt so angry that his actions meant he had to go, instead of staying longer.

6.4.2 Hazel – progression of therapy and case notes[9]

S initially stated that she felt positive about Hazel and the therapy. However after some discussion, she realized that she had been feeling rather angry with Hazel. There had been many cancelled sessions and Hazel asked S to change sessions and accommodate the demands of her daily life, without any consideration of the impact that this might have on S or her appointment schedule. For example, she usually arrived late and asked S to accommodate her appointments with the outpatient unit to see the psychiatrist. She did not seem to give any thought to arranging her life to

[9] Case notes presented in italics.

accommodate therapy. She seemed preoccupied by her husband's somatic conditions and regularly took cell phone calls and messages in the sessions.

She also tended to ask personal questions of S, for example she repeatedly asked S when her birthday was. She also, over a period of months, repeatedly asked S to telephone her husband's doctor (Dr X).

The following are excerpts from S's case notes regarding some of the sessions with Hazel.

Hazel – case notes excerpt one:

S: Hazel had changed the time of the appointment, which also meant a shorter session. She talked about her relationship with her husband and talked of wishing to phone his doctor, Dr X, without M (her husband) knowing, to ask the doctor to suggest that M goes to therapy. I talked about taking things up in an open way. H thought she might go along and voice concerns in front of M.

The daughter E very upset and tearful, she phoned her therapist, J, to ask for an appointment.

J said she could see her on Thursday. If very worried could call Lifeline.

Hazel called J but hasn't spoken to her.

I talked it through with Hazel, acknowledging her worry/upset/disappointment/anger. Explored why it might be.

Encouraged her to support E to go but recognize E's private space with J.

I emphasized the importance of trusting J and E to address it.

J phoned while Hazel was still in the session with me.

Hazel spoke to J for some time, going over the concerns we had just discussed.

She ran over time slightly and apologized.

She then said M complained she nagged.

She said it was because she was insecure in her relationship.

He asked how she could be insecure after all this time.

I talked briefly of difference between nagging and asserting herself and that to know more about her feelings of insecurity would help us to make more sure of difficulties to discuss next year.

H had started by asking if I was "excited" about my holiday. I acknowledged difference between her working hard and me being on holiday. I said that it might be difficult for her to deal with differences while I was away.

H asked to start a week after I got back on 14th, although she would ring if it was an emergency. I gave her a hospital information sheet; she thought she'd be fine, even if it was difficult. She wished me a happy holiday as she left.

The following is an excerpt from a session after the researcher's follow-up appointment with S. The researcher had questioned S about her feeling about all the changed sessions. S stated that she had not been aware of it and resolved to confront the issue.

Hazel – case notes excerpt two:

S: H said she had her monthly appointment with Dr Q at the Outpatients' Department (OPD) next week, so could she come on Thursday, after the appointment, instead of Wednesday. I said I could see her on Thursday but only at 11.00 a.m., before OPD

rather than afterwards. She said she'd try to get there on time but she might be a bit late. I said that as she booked her appointments at OPD a month in advance, could she make it to fit in with our Wednesday's session as it would not always be possible for me to move her time to her doctor's appointment. She said she would try to do that.

Hazel – case notes excerpt three:

S: H's cell phone rang and she said she'd better answer it in case it was M, but looked uncomfortable as if she thought I'd be disappointed in her taking the call. It was a message from M, saying his niece was leaving tomorrow and so they'd be going over to have coffee this evening to say goodbye. She paused and stared into space for a few moments, then resettled on her chair. She said, oh that sounded more like his usual self. Something seemed to calm in her. She said if his niece wasn't leaving tomorrow he wouldn't have gone, but she was pleased M was prepared to go out. I said that hearing M more his usual self "really seemed to calm something inside her". When he was very distressed/irritable it seemed to trigger a collapse of some sort inside her, where she felt hopeless, unable to access thoughts of better times. When he was able to draw on something inside himself to gather himself together, then so was she. H looked at me and said, are these the mood swings that Dr X was talking about when he thought M was bipolar? I said it seemed she was getting a lot of different confusing information. She asked if I would please speak to Dr X. (She had asked me this before and I had said I couldn't without M's permission.) She said, please would I, she didn't know what to do. A new diagnosis would probably mean more money they couldn't afford. (I became pre-occupied with my own worry about Dr X here.) I wondered if M would come here to be seen within state service, but H

said she didn't think he'd come here. She thought M actually had time for Dr X, seemed to like him and didn't want to take that away. But she did feel worried, could I please call him? I said that professionally I didn't think I was allowed to. I would check with my professional body and let her know. She asked if I might call them now. I said that she was going to see Dr Q (at the OPD) after our session, and I would try to find out then.

She said she didn't know what Dr Q would think seeing her like this, she didn't really feel like going. I said it might be helpful for Dr Q to see her when she does feel very distressed. She said she didn't seem to have fun at all in her life. Her friend from school had asked her over for coffee, but M wouldn't go. I reminded her that she had gone without M last time and seemed to get some brief relief by going out. She agreed and said she had laughed there. I commented that when she felt worried about M, it was hard for her to balance that with what she might need for herself, and that if he decided not to go, it didn't necessarily mean she couldn't either. She nodded and said she had better go up to see Dr Q (a few minutes before the end of our session, which had been moved a day to fit in with this appointment). She said she would come by afterwards to find out about me calling Dr X. I said I would be unavailable at – but would telephone her to let her know, if I didn't see her.

She returned just before my next appointment. I let her know I hadn't been able to reach someone but would call her. She said Dr Q suggested family therapy again, but she didn't think M would agree. I called later that day to reiterate I could only call Dr X with M's permission.

In the interview S admitted that she had never made (or intended to make) the telephone-call to the professional body. She stated that she did not know how to get through to Hazel that she was not prepared to break a boundary and refuse to call M's doctor, as she had told Hazel on several occasions that it would be difficult to do so. Hazel did not seem to be prepared to accept this and persisted with her requests.

(In fact, the researcher pointed out that Hazel had continued to request that S contact M's doctor over a period of seven months. She had persisted in asking about S's birthday over a period of 8 months, until S capitulated and told her when it was.)

S stated that although she recognized that this evasion constituted an enactment of sorts, she also did not feel that Hazel would be receptive to interpretations regarding her relationship with the therapist. S also stated emphatically, however, that she did not believe that any of her enactments had been useful. She stated that since they had been pointed out to her, she had ceased to enact in this way. She said that she felt that presently she had become aware of her negative feelings regarding Hazel and stated that the quality of the relational bond was at "an all-time low".

The results will now be discussed in Chapter 7.

CHAPTER 7: DISCUSSION

> I have finally come to realise that it is an unavoidable task of the analyst: although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetuated against the patient.
>
> (Ferenczi, as cited in Aron, 1996, p. 168)

7.1 INTRODUCTION

As Ferenczi acknowledges and as is shown by the three cases presented above, enactment of the patient's intra-psychic structure is inevitable and ubiquitous. This has been widely acknowledged in object relations and relational psychoanalytic literature reviewed above. As mentioned above, Ogden's revised object relations theory and relational psychoanalysis have much in common. Both object relations and relational psychoanalysts acknowledge that countertransference enactments occur and that they be privately acknowledged and thought about by the therapist and at times interpreted. The relational psychoanalytic approach emphasizes the fact that the patient is absolutely aware of the analyst's subjectivity. It therefore also advocates the judicious verbal disclosure of countertransference at times.

From this researcher's perspective, based on the first axiom of communications theory that we cannot not communicate (Aron, 1996; Watzlawick, Beavin & Jackson, 1967), it seems that the differences between Ogden's approach to the practice of psychoanalysis and those practices advocated by relational psychoanalysis are mainly on the level of acknowledging and endorsing a multiplicity of levels of communication. In line with the interactional approaches described above, which are integrated by relational psychoanalysis, the researcher is of the view that traditional

approaches to psychoanalysis do not acknowledge or utilize consciously all the communicative aspects of the psychoanalytic situation. Thus, for example, Ogden's use of the couch communicates as much as any verbal communication.

This thesis not only acknowledges the importance of the therapist's re-enactment of the patient's various relational constellations, as described by relational psychoanalytic approaches regarding intervention, but goes one step further in that it advocates the deliberate and strategic use of the therapist's countertransference responses, that is, the active utilization of immediate analytic data. It is suggested that the therapist's countertransference responses be utilized in ways that exceed the use of verbal interpretation and that the therapist deliberately alter his style of communication to match that of the patient, thereby using joining techniques described by strategic / structural therapists such as Minuchin (1974).

A "strategic / structural relational psychoanalytic approach" was hypothesized in Chapter 4. These interventions suggested would not demand that the therapist behave in a manner that is incongruent with what he is experiencing in the moment of the psychotherapeutic process, but rather that countertransference responses be actively thought about and re-enacted in an authentic manner via the therapist deliberately changing his communication style to "fit" that of the patient's relational constellations. It is suggested that the therapist deliberately enact the "bad" relational constellations that he has been able to identify via his countertransference responding, in order to enter the "closed system" of internalized object relations units described by Fairbairn. It is suggested that in the beginning stages of therapy enacting the "bad object" is in itself reparative or "good" for the patient because it communicates to the

patient that the therapist is able to process or think about what he or she really needs to feel safe enough to begin to relate and explore. Thus, the therapist initially has to be "bad" from a psychoanalytic perspective (deliberate enactment), in order to ultimately become "good" from a psychoanalytic perspective (use verbal symbolic communication – interpretation) (Langs, 1978; Ogden, 1992, 1994).

In order to try to demonstrate communication styles, the thesis translates Fairbairn's (1952) notions of "attachment to a bad object" into Ogden's theoretical framework. Further, in line with the integrative approach being taken in this thesis, it was proposed that Ogden's modes of communication may be related to or "stretched" (Ogden, 1994) to accommodate Langs' (1978) classification of communication by patient and therapist (or vice versa). This was included, in that Langs' classification of communication was used in this research as a research tool or "hermeneutic lens" to scrutinize the communication patterns of the patient and therapist.

Interpretation of the data collected, will now be discussed using the reading guide method developed by Brown et al., (1989) and described in Chapter 5. The reading guide questions are detailed in Appendix I. As a reminder, the reading guide questions are based on Langs (1978), but as explained above, his conceptualizations have been stretched to incorporate the views of Ogden (1994) (or vice versa), and Fairbain (1952), whose ideas were earlier translated into those of Ogden (see Chapter 2).

The reading guide questions investigate evidence of the following themes within the data: (1) self and object representations; (2) communicative fields; (3) changes in

communicative fields; (4) *Type One* and *Type Two* derivatives; (5) frame breaks and enactments by the therapist.

The above themes will be discussed in an integrated way, as it is difficult at times to separate them.

Following on, the use of enactment, as it emerges from the research, will be discussed in the light of the hypothesized "strategic / structural relational psychoanalytic approach" as described in Chapter 4. The issue regarding whether the psychotherapists being researched were able to "identify" the family within the individual via their countertransference responses will be discussed, as well as whether they were able to utilize their countertransference responses, either deliberately and consciously, or inadvertently, to "join" with the patient and thereby facilitate communication. That is, the primary research question will be addressed.

7.2 THE CASE OF THANDI

The main self and object representations evident in these transcripts can be described in Fairbairn's (1952) terms and are those of a split self, seen in relation to two different types of rejecting object and an exciting object. It seems evident that one part of the self is represented as helpless and scared in relation to a chaotic, disordered and unstructured (rejecting) object. An example of this is evident in the following interaction:

T: (Nods and looks around the room.) I don't know what to do.

L: ARE YOU MAYBE WISHING THAT I WOULD TELL YOU WHAT TO DO?

T : Yes (says this with great enthusiasm). At school I know what to do, and at home if I tell my mother that I'm bored she tells me to do my homework or go and play.

L: SO YOU'RE USED TO BEING TOLD WHAT TO DO, OR YOU JUST KNOW, SO BEING HERE WITH ME AND ME NOT TELLING YOU FEELS DIFFERENT.

T: Yes, at home I play with my beads (shows me the bracelets she made) or I read a bit or play outside.

L: MAYBE ALSO BECAUSE YOU KNOW SCHOOL AND HOME AND WHAT IS EXPECTED OF YOU. THIS PLACE AND ME ARE NEW TO YOU, IT IS ALL UNFAMILIAR, SO YOU'RE UNSURE OF WHAT TO EXPECT.

T: I feel clueless.

L: THE NERVOUS FEELING IS UNCOMFORTABLE AND IF I TOLD YOU WHAT TO DO THEN IT WOULD GO AWAY.

T: Yes.

L: (I feel terrible pressure to help her out of her discomfort and am beginning to feel as if I'm being punitive.)

L: I SUPPOSE IT'S HARD TO UNDERSTAND WHY I'M BEING DIFFERENT TO YOUR TEACHERS, YOUR PARENTS AND MAYBE YOUR FRIENDS. IT'S NOT BECAUSE I WANT TO BE MEAN, OR THAT I WANT YOU TO HAVE A NERVOUS FEELING, BUT BECAUSE IN THIS ROOM, UNLIKE OTHER PLACES YOU LEAD ME AND I WILL FOLLOW YOU.

T: But what if what I want to do, you don't want to do?

L: IT'S IMPORTANT TO YOU THAT I'M O.K.

T: Yes, because what if I want to play cards and you don't want to.

L: YOU SEEM WORRIED THAT THEN I MIGHT FEEL BAD OR GET CROSS.

T: You will then feel lonely, or left out. I won't want to draw if you are just waiting there, but if you had work to do then I'd feel all right drawing.

L: SO, IT'S LIKE YOU ALWAYS HAVE TO THINK ABOUT THE OTHER PERSON FIRST BEFORE YOU CAN THINK ABOUT YOURSELF. GOSH, THAT SOUNDS LIKE HARD WORK.

T: (Laughs) I don't want you to get upset.

L: WHAT DO YOU THINK COULD HAPPEN IF I GOT UPSET? BECAUSE IT'S LIKE YOU'RE WORRIED SOMETHING BAD COULD THEN HAPPEN.

T: If you got upset then you'd tell my mother and it would be a big "gemors" (mess-up).

L: YOU'D GET INTO TROUBLE.

Another part self/object relationship that is evident in the above, is a pleasing, inadequate, compliant and very anxious self in relation to a rejecting object that is angry, punitive, withholding and uninterested (the mother or therapist as she feels in the countertransference and in terms of Thandi's expectations of her responses). A co-operative, pleasing and "good" self is seen as being in relation to an exciting object that offers help, active assistance and structure. Looking at Thandi's history, these self and object representations can be seen in terms of: (1) The initial chaotic and uncared for position of being the child of a homeless alcoholic; (2) the very anxious self in relation to the children's home environment which was possibly experienced as angry, punitive, withholding and disinterested; (3) a co-operative, pleasing and "good" self (i.e. a child who is as good as gold and never cries), seen as being in relation to an exciting object that offers help, active assistance and structure (i.e. the mother, C, who seems to alternate between taking on all of the exciting/rejecting roles

at different times). The therapist is also perceived by Thandi as either an exciting or a rejecting object, and the therapist finds herself alternating between feeling like a rejecting object and behaving like an exciting object (both of which are consistent with Fairbairn's formulation of a "bad object"). This constitutes a frame break and an enactment from the perspective of Langs' (1978) classification of communication.

Further, in the first two sessions presented, the self and object representations appear to change and reverse. In the first session it seems that Thandi enacts the "good" child/self, anxious to please the exciting/rejecting object representation (i.e. the therapist). In the next, Thandi enacts the object representations, seeming bored, withdrawn, distracted and uninterested. The therapist, L, experiences the corresponding self-representations that evoke feelings of being unsure, helpless and scared of punishment.

T: Don't stare at me.

L: YOU DON'T WANT ME TO EVEN LOOK AT YOU.

T: You're staring and it's rude. Allie (her sister) stares and I hate it.

L: I HAVE BECOME LIKE YOUR LITTLE SISTER WHO IRRITATES YOU.

T: Look over there (she points to a place in the office opposite to her).

(At this point I have already begun to feel disempowered and also helpless, like I cannot even think.)

L: IF I DON'T EVEN LOOK AT YOU, BUT LOOK OVER THERE THEN WE FEEL AS IF WE ARE FAR AWAY FROM EACH OTHER. LIKE WE COULD BE IN DIFFERENT ROOMS EVEN.

T: Get out!

Re-phrased again in Fairbairn's terms, the pathological object relationship is internalized or split off from conscious ego functioning, i.e. the splits are horizontal. So, for instance it does not seem that Thandi can remember that this is the same therapist that she so desperately wanted to please because she was afraid of rejection. The splits are also vertical in that the rejecting bad object and corresponding ego representation of a bad self are split off from the exciting object and its libidinal tie to the good or pleasing self. She also seems unable to hold on to the idea that this was the therapist who seemed promising and exciting, in that she would tell Thandi what to do. There are thus multiple dynamic entities.

From Ogden's perspective, there is no interpreting "I" (Ogden, 1994, p. 141). There is rather immediacy to experience. As described by Ogden, and as is evident in Thandi's therapy transcripts, there is a rapidly shifting sense of self and object, with little recollection of the altering feeling states. There is an absence of the sense that experience can be thought about, and the psychological defense is enactive and evacuative. In other words, impulses, feelings and thoughts are enacted or behaved. Behaviour is not thought about, and it is of the nature that it evokes intense responses in others. It also evokes a tendency to enact a response (projective identification), as is evident in the therapist's tendency to retaliate with an aggressive response to Thandi's aggression and then quickly placate and reassure, as can be seen in the examples of her interventions below:

L: DURING THE SESSION, NEITHER OF US LEAVES THE ROOM.

(Command – enactment of an aggressive object.)

L: I SEE YOU PEEKING AT ME.

(Placating/seductive? – enactment of an exciting object.)

L: I KNOW THE ONE WHERE WE EACH TRY TO HIT THE OTHER PERSON'S MARBLE (I demonstrate.)

(Reassuring – enactment of an exciting object.)

As was discussed in Chapter 2, Ogden's modes of communication can be "stretched" to accommodate those described by Langs (1978) (or vice versa). From the perspective of Langs' classification of communicative types in the therapy situation, it seems that Thandi and the therapist can be see to be operating mainly in a *Type B* field, utilizing a *Type B* communicative mode. The *Type B* communicative mode is one in which efforts at projective identification and action-discharge prevail (Langs, 1978). As seen above, Thandi enacts, as well as verbalizes her self and object representations. Analysis of the data reveals that L also tends to enact the self and object representations (see the examples above and the one that follows from session one:

L: I SUPPOSE IT'S HARD TO UNDERSTAND WHY I'M BEING DIFFERENT TO YOUR TEACHERS, YOUR PARENTS AND MAYBE YOUR FRIENDS. IT'S NOT BECAUSE I WANT TO BE MEAN, OR THAT I WANT YOU TO HAVE A NERVOUS FEELING, BUT BECAUSE IN THIS ROOM, UNLIKE OTHER PLACES YOU LEAD ME AND I WILL FOLLOW YOU.

Initially L formulates an interpretation based on *Type One* and *Type Two* derivatives: that is she bases her interpretation on the manifest content of the session (I need you to tell me what to do), and also refers to the therapeutic relationship in the here-and-now. She is, however, also drawn into the *Type B* field of action discharge, in that she

provides Thandi with reassurance that she is not mean and unhelpful and thus enacts an exciting object in relation to Thandi's helplessness.

It was during the missing session (taken when her car was stolen) that L blatantly enacted the exciting object in a deliberate manner, providing Thandi with structure and guidelines throughout the session. Thandi complies with this and an exciting self/object relationship is enacted (a *Type B* field – characterized by major efforts at projective identification and action-discharge. The field is not especially designed for insight, but instead facilitates the riddance of accretions of disturbing internal stimuli).

During the interview, L stated that both she and Thandi had experienced extreme relief after this action discharge. She stated that at the time she realized that this was an enactment but decided to go ahead with it anyway. She said that she knew that technically she was enacting a projective identification, a "no-no" regarding technique from within the object relations framework within which she works. However, she felt that Thandi's anxiety about her interpretative stance was related to the fact that from Thandi's perspective an interpretative stance was seen to be withholding (i.e. an enactment of the bored, withdrawn, disinterested object). She therefore decided to enact the exciting object representation. As may be seen from the transcript three, the session after the enactment, the result was the generation of a *Type B* field, where both Thandi and L enacted the angry, punitive, withholding object. Further, once again, L experiences the feeling of being "like a child", a feeling of being scared and being at loss for what to do in the face of a confrontation with an angry object. Analysis of L's communications indicates, however, that at times she may possibly

manage to "contain" the alternating projections of self and object representations. She experiences the feelings, does not say anything:

(We begin to play, but she feels aggressive and bossy and changing the "rules" to suit herself. I feel totally disempowered and feel incapable of making meaningful comments. I want to retaliate and tell her that it's no fun playing with her, and that she's actually being quite mean and hurting my feelings. I feel like a child). (Underlining in the original transcript indicating the intensity of the therapist L's feelings.)

In this example the therapist does not verbalize anything, and so may possibly be seen as attempting to contain some of Thandi's feelings of helplessness in relation to an aggressive controlling object (enacted by Thandi). On the other hand from a relational psychoanalytic perspective, to say nothing is to say something. It is difficult to tell from the session transcript whether Thandi experienced the therapist's silence as containing or whether she experienced it as an enactment of a passive helpless self representation in relation to her own enactment of the aggressive object.

Although therapy transcript four contains a clear frame break in terms of the entrance of the mother into the therapy room, it is possible that a change in communicative style from a *Type B* to a *Type A* field is evident. The *Type A* communicative mode is essentially symbolic, transitional illusory and geared toward insight (Langs, 1978). In this session, it seems that Thandi and L work together to create meaning out of events that have occurred outside the therapeutic context (*Type One* derivatives):

T: I know it was wrong, I know I shouldn't have taken the food and lied, but I can't help myself.

(This was said in a truly desperate way, and my heart went out to her.)

L: IT'S SOMETHING YOU CAN'T CONTROL, AND THAT'S SO HARD TO UNDERSTAND.

T: I don't know why, and I don't know how this has helped. I thought it would but I'm still doing it.

L: LIKE A CONFUSION AND A BIG DISAPPOINTMENT.

T: Well, I still don't know why I'm doing it and it's still there.

There are also comments that relate to the therapy (*Type Two* derivatives):

T: Then how has this helped?!

(She is more upset and desperate than angry.)

L: THIS IS WHAT COMING HERE HAS BEEN ABOUT, TO TRY AND FIGURE IT OUT, BUT THAT IT'S TERRIBLY DIFFICULT 'CAUSE IT'S TAKING LONG AND THERE'S NO SIMPLE ANSWER.

.

When asked in the interview whether she felt the enactments in the previous sessions had anything to do with the shift in the communicative modes, L stated that she liked to think that Thandi had felt very understood and contained by her enactment of the exciting object. However, she stated that she felt she should have commented on, or interpreted this more. She also stated that changes in the therapy and the communicative field may have been related to the current crisis between C and Thandi, and the imminent end of the therapy. L also commented that her tendency to

want to fix, help, and reassure, and remain a "good" or possibly "exciting" object are part of her own personality, which impacts to a large degree on her therapeutic style and something for which she has had much supervisory in-put. In other words, some of her countertransference enactments may have been due to Thandi's projective identifications, but a good measure of her reassuring and placating tactics arouse from her own need to be helpful i.e. what Grinberg (1962) terms projective counter-identification.

7.3 THE CASE OF VANESSA

Interpretation of the therapy transcripts, extensive session notes and the interview with B, in the light of the reading guide, reveals that as with the case described above, the main self and object representations evident can be seen in terms of Fairbairn (1952) – a split self, in relation to a rejecting object and an exciting object.

It seems that in the beginning stages of therapy, Vanessa's self-representations alternate. On one hand she sees herself as being compliant, needy and totally unassertive. This self feels dirty and abandoned and under attack by abusing rejecting objects. Later another self is revealed, an omnipotent and sexually seductive self, in love with an exciting, sexually seductive, omnipotent hero figure. (In his session notes, B comments that Vanessa mentioned that she has 3 personalities: Xena the warrior woman, who does not need (it was she who gave the letter to B because she is fearless); Aphrodite, an 18-year-old virgin who needs, and is seductive (who wrote the letter) and herself that wants to run away. He states that in his opinion, she has access to these splits and is not dissociative as such). In other words, B is describing that these various splits are all accessible to conscious ego functioning, that is he does

not see evidence of a horizontal split (Fairbairn, 1952) or of a vertical split, in that Vanessa is aware of the different parts of herself. In terms of Ogden's theory (1994), at times there is evidence of an interpreting "I". However, in terms of Ogden's modes of communication, it seems that Vanessa operates largely in the autistic-contiguous position, in that she uses word, intellectualisations, dreams and fantasies to form a kind of "second skin" (Bick, as cited in Ogden, 1994, p. 141).

Analysis of the data reveals that when Vanessa begins therapy she can be described as being a *Type C* narrator, operating in a *Type C* field (Langs, 1978). This is a field in which the essential links between patient and therapist are broken and ruptured, and in which verbalization and apparent efforts at communication are actually designed to destroy meaning, generate falsifications, and to create impenetrable barriers to underlying catastrophic truths. The *Type C* communicative mode is designed for falsification, the destruction of links between subject and object, and for the erection of barriers designed to seal off inner and interpersonal chaos. She can be described as a patient who utilizes the *Type C* communicative mode through the report of extensive dream material or the detailed description of events and experiences within her life or with regard to the therapeutic interaction. The material is characterized by the absence of a meaningful "adaptive contexts" (for instance, Vanessa abstracted meaning from the colour of B's shirt). Vanessa tended to use communication essentially for the generation of non-meaning and the breaking of relationship links. She also tended toward action discharge, phoning B and giving him gifts and a love letter (*Type B* communicative mode). Although thinking in the transference, analysis of the transcripts revealed that B also tended to work in a *Type B* communicative mode, working around reality testing and using educational techniques regarding the

difference between transferential and fantasy relationships versus the reality of the situation. It seems that he alternated between the enactment of the exciting, omnipotent hero figure (for instance, allowing phone calls to his home and arranging for hospitalisation), and the enactment of a rejecting father:

B: VANESSA I DON'T LOVE YOU … AND I NEVER WILL.

In the interview B stated that he had immediately regretted this enactment as he felt it was done in a cruel manner. He also stated, however, that he felt that he needed to do it to "set Vanessa free" to have other relationships, and to let go of her delusional fantasies. Further, in his interview, B describes an increase in Vanessa's self-reflective capacity. However, the external reader pointed out that B's interview material presented verbatim above has qualities of a *Type C* narrator, creating a *Type C* communicative barrier, in that there is no evidence that he himself was utilizing any *Type Two* derivatives (that is derivatives pertaining to the therapeutic relationship) when discussing the case. However, in the subsequent session presented above in full, there does seem to be an increased tolerance for *Type A* symbolic communication utilizing *Type One* derivatives in both therapist and client:

V: I just want to tell J to fuck off. I will phone that client and see if the post is still vacant, otherwise I need to get my CV out there again. I'm back where I was months ago, I should have left then.

B: IT LEAVES YOU IN A DIFFICULT POSITION. IT'S HARD FOR YOU TO FIGHT THIS, TO CONFRONT THEM ABOUT YOUR WORTH. IT'S ALSO SCARY TO CONTEMPLATE, AGAIN, THE PROSPECT OF LEAVING, OF

HAVING TO ADJUST TO SOMETHING NEW. SO YOU ARE LEFT WITH THE HISTORICAL OPTION OF JUST HAVING TO SWALLOW IT.

V: I can't do it anymore. They know it's hard for me to leave because they give me flexi time, and there are few jobs like that.

(She talks about the others saying they want to down their pencils, or just slack off. She says she can't, her work is an extension of herself, and it's part of her, a reflection of her.)

B: YOU OFTEN GET CAUGHT THINKING THAT OTHERS SHARE YOUR ETHICAL MOVES AND PLAY FAIR. YOU FEEL CRUELLY DISILLUSIONED AGAIN.

There is also evidence that the therapist may be thinking in terms of *Type Two* derivatives.

B: (I am wondering about this, how it relates to what had preceded it, what it means about deception and acknowledgement, about projection or displacement, but she has moved on. She tells me her sister is asking for advice on her relationship, which is in trouble… I'm now thinking of the transference. I'm thinking how she didn't want to talk initially.)

At this stage it still seems that B is reluctant to introduce these thoughts into the therapeutic interaction. In other words, B chooses not to interpret the theme of anger, disappointment and "relationships in trouble" in terms of her feelings toward him. As with the case referred to above, it is difficult to tell whether Vanessa experiences this reluctance to interpret "in the transference" (*Type Two* derivatives), as "containing" or

whether she experiences his lack of interpretation in terms of *Type Two* derivatives in terms of an absent/rejecting object. However, her request that he:

V: Say something…

… and the fact that this is a common occurrence may mean that she requires something more from him. On the other hand, it seems that B's concerns that she may slip away and become psychotic may also perhaps be justified:

V: I'm feeling very tired, a little dizzy. I'm slipping away.
B: (I nod understandingly – this is usually a defensive manoeuvre – I fear preceding something dissociative.)

The possibility of *Type A* communication "tails off". Again there is evidence of a *Type C* narrator operating in a *Type C* field.

7.4 THE CASE OF HAZEL

Hazel's therapy began with a frame break in that her psychotherapist had also been her family therapist, and so from a strictly psychoanalytic perspective, it was flawed. The frame breaks continued, however, as will be pointed out below.

In terms of question one of the reading guide, a number of split self and object representations can be identified (Fairbairn, 1952). Superficially, Hazel presented herself as pleasing, clingy and needy, in relation to an exciting object who was tantalizingly available, but also evasive. Excerpts from the case notes provided by the

therapist S suggest that she also enacted this needy versus tantalizingly available, but evasive, self-and-object relationship. For example:

S: H said she had her monthly appointment with Dr Q at the Outpatients' Department (OPD) next week, so could she come on Thursday, after the appointment, instead of Wednesday. I said I could see her on Thursday but only at 11.00 a.m. before OPD rather than afterwards. She said she'd try to get there on time but she might be a bit late. I said that as she booked her appointments at OPD a month in advance could he make it to fit in with our Wednesday's session as it would not always be possible for me to move her time to her doctor's appointment. She said she would try to do that.

This constitutes an enactment of Hazel's relationship with her father whom she idealized, and tried to please, but who seems to have been available, but indirectly rejecting (e.g. ringing the nurse's bell "by mistake" to remind her that visiting time was over). From the session notes and transcripts, however, it also seems that Hazel also makes herself "tantalizingly available", thus the therapist's initial positive feeling about the therapy and about Hazel in general. However, she constantly misses sessions, arrives late and perusal of the data reveals that Hazel does not really make herself available for therapy, undermining its importance and discounting the therapist. It seems that initially, both the therapist S and Hazel are out of contact with each other and their own feelings. The alternating enactment is thus of a clingy, pleasing self and an exciting, tantalizing other. Anger, and more destructive feelings are thus cloaked under this "pretty" exterior. Underlying this façade, however, is an actively destructive, persecuting, bombarding and attacking (rejecting) object, and a helpless, desperate, victim self, probably representing the internalization and re-

enactment of a rejecting mother/child unit. This reversal of roles (Hazel enacting the object and the therapist enacting the self), is evident in the missed sessions, and Hazel's manner of bombarding S with information, her consistent interruptions of the process, her negation of or twisting of any input provided by S and her comments about S being unavailable. Her positive comments about S's holidays seem, on the other hand, to be rather spiteful and to be full of envy. There is evidence of a preoccupation with somatic complaints (albeit those of her husband), to the exclusion of other issues. S's helplessness is evident in her difficulty in being assertive and her passivity regarding changing sessions, both of which she remained unaware of until the follow up interview with the researcher.

After becoming aware of these enactments, S became more confrontational regarding the appointments. In the interview S stated that she did not usually allow changes in appointment time to go unchallenged (although there is sometimes a difficulty with this as she works in a state institution). She was also very surprised by her own evasion and lack of assertiveness when this was pointed out to her (e.g. being unable to say "no" to the demands to phone Hazel's husband's doctor). S stated that she now recognized these apparent over-sights as enactments, but that they were not deliberately thought out. She stated that she did not consider any of the enactments to have been useful. However, she did state that she did not think that Hazel would have been at all receptive to an interpretative stance, particularly transference interpretations. She stated that she felt that she had not made contact with the patient, and considered the quality of the relational bond to be "at an all-time low".

In terms of Langs' (1978) classification of modes of communication, therapy thus remains in an "out of contact stage", with the patient, Hazel, operating in a *Type C* mode where the detailed description of events and experiences within her life is utilized essentially for the generation of non-meaning and the breaking of relationship links. Initially it seemed that the therapist participated in this mode of communication, becoming equally evasive. For example:

S: She thought M actually had time for Dr X, seemed to like him and didn't want to take that away. But she did feel worried, could I please call him? I said that professionally I didn't think I was allowed to. I would check with my professional body and let her know. She asked if I might call them now ... She nodded and said she had better go up to see Dr Q (a few minutes before the end of our session, which had been moved a day to fit in with this appointment). She said she would come by afterwards to find out about me calling Dr X. I said I would be unavailable but would telephone her to let her know, if I didn't see her.

She returned just before my next appointment. I let her know I hadn't been able to reach someone but would call her. She said Dr Q suggested family therapy again, but she didn't think M would agree. I called later that day to reiterate I could only call Dr X with M's permission.

Subsequent to the investigation of the researcher, it seems that S is more aware of the symbolic nature of Hazel's communications. However, she still considers Hazel unreceptive to interpretation and lacking in self-reflective capacity. Analysis of the transcripts and session notes supports this notion.

7.5 THE USE OF ENACTMENT IN TERMS OF THE HYPOTHESIZED "STATEGIC / STRUCTURAL RELATIONAL PSYCHOANALYTIC APPROACH"

> I have finally come to realise that it is an unavoidable task of the analyst: although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetuated against the patient.
>
> (Ferenczi, as cited in Aron, 1996, p. 168)

As a reminder, the research question reads:

Does countertransference responding (replication of existing bad object relationship patterns) lead to changes in the types of communication used, as defined by Langs (1978)?

The secondary questions formulated to explicate the research question were as follows:

What are the self and object representations evident in the narrative? What communicative fields and types of communicative modes, as defined by Langs (1978), are evident? Are the changes in the communicative fields and modes of communication used by patient and therapist? Does the therapist work with Type One or Type Two derivatives, as defined by Langs (1978)? What frame breaks and enactments are evident?

As indicated, the three cases presented in the research contained evidence of enactments on the part of the therapist. In terms of the secondary research questions proposed in Chapter 5, the self and object representations have been explicated above, as has the therapist's use of *Type One* and *Type Two* derivatives.

The hypothsized approach suggests that deliberate countertransference enactment may facilitate communication in psychotherapy. In the three cases investigated, two of the psychotherapists were aware of, or could "identify" the family within the individual that they were working with. In both cases, the therapist was aware of the pressure to enact. In both cases the therapist made conscious decisions to enact the patient's relational constellations. For instance: when interviewed, B stated that although he realized that he had enacted a rejecting paternal object he had wrestled with the idea of saying this to her. In saying it he had felt pulled out of his usual role as therapist. But he felt it was cruel not to say it to her. By not telling her, he was keeping her fantasy of a marriage relationship with him alive. He also felt that this enactment had somehow set Vanessa free.

Both psychotherapists stated during their interviews that they were of the opinion that this enactment would and indeed did facilitate the therapeutic process. Both the first two psychotherapists presented, however, were unhappy with the way that they made the intervention. For example: during the interview, B stated that he realized that what he had said to Vanessa was not the truth. He said that he realized that, in fact, he did care for her very deeply, but in a paternal way, although he did have some erotic feelings at times. He said that as he told her that he did not love her, he regretted it and apologized to her for what must have seemed to her like cruel and sadistic rejecting behaviour.

In terms of changes in communication styles, there is some evidence in the first case (Thandi) of a change in the communicative mode. There is evidence that the therapist

begins to think more symbolically and eventually a *Type A* communicative mode between therapist and patient is temporarily achieved (see above).

In the second case, the therapist, B, was of the opinion that there had been increased capacities in the patient (Vanessa) to self-reflect. As mentioned above, however, it is the opinion of the external reader that B's interview data contains evidence of a *Type C* narrative in that he provided detailed descriptions of events in Vanessa's life without referring to the therapeutic interaction at all (that is, he did not utilize any "adaptive contexts" within the therapy situation when describing her life and did not use any *Type Two* derivatives). It was the opinion of the external reader that B was using the *Type C* mode as a defense against intimacy, which had been confused by the patient, Vanessa, and B himself, as sexual intimacy. For example, in the research interview, B elaborates:

"She is actually a very amazing person. Her psychiatrist is very taken by her progress. For one – that she has been able to work all the way through a psychotic process. She is able to regulate her moods. She is able to use a psychodynamic understanding in a kind of cognitive way … Then she will think about … 'OK when did it happen? I did notice that there was a white Mazda that drove past me … the white Mazda is the same car that is driven by my uncle, and I saw my uncle this morning. I had a conversation with my uncle and he said that he had seen my first boyfriend and he …' blah … blah … blah… so she understands that her anxiety at that moment is about her first boyfriend. She is able to make links all the way and find out what the anxiety is about!"

As mentioned above, this style of communication can be seen in terms of a *Type C* communicative barrier. It can also be seen in the light of a *Type B* communicative mode (action discharge). However in the session conducted subsequent to the research interview there does seem to a shift toward the use of *Type A* communication and the use of *Type One* derivatives and the therapist thinking in terms of *Type Two* derivatives.

In the third case researched, enactment by the therapist was evident throughout the six-month therapeutic process. However, there was no change in the type of communicative style used by therapist and patient.

It seems then, that of the three cases researched, there is only some slight evidence of a shift in communicative style following enactment in the first and second cases presented. It is also difficult to attribute any causality in terms of change in communicative style directly to the enactment. The hypothesized approach, which recommends deliberate enactment to facilitate communication, is one possible interpretation of the events; other interpretations may be just as viable. For instance, the external reader suggested that the change in the therapist L's stance might have been due to both her own internal, and her external supervision. She suggested further that it was the change in the therapist's understanding of the enactments, and her change in the mode of intervention that led to a change in the dominant mode of communication between Thandi and L. The therapist L herself, indicated that she thought that factors extraneous to the therapy, including the fact that Thandi's family was moving to another city, might have contributed towards the shift.

It is possible that researching a greater number of cases may illuminate a trend of changes in communication style following enactments. However with the three cases researched in the current study, this trend is not evident.

Further, there is some evidence of countertransference pathology in that all three psychotherapists researched were to some extent unaware of their enactments before they occurred, although all three psychotherapists had had training and input regarding the nature of transference/countertransference phenomena. All three reported having had ongoing therapy and to being in therapy supervision, and indeed two reported having provided supervision for others. It seems that the awareness of the psychotherapists of their own countertransference enactments varied.

In the cases presented, the psychotherapists became aware of the pressure to enact and their tendency to do so, either via their own self-reflection or through outside input. In at least one of the cases it seems that the questions asked by the researcher may have resulted in awareness of the enactment by the therapist. This point highlights the concern of Ivey (1992) regarding countertransference enactment and its possibly pathological dimensions. Also, as mentioned in Chapter 4, McHenry (1994) refers to the well-known archetype of the "wounded healer". Many therapists become caught in a cycle of trying to "heal the self" by "healing others" and thus become enmeshed in their patient's problems. Two of the psychotherapists presented made a conscious decision to enact the intra-psychic structure of the patient. The research is equivocal in that it does not demonstrate that this definitely led to any change in communication patterns between therapist and patient.

None of the psychotherapists involved in the research were working from an interactional perspective or even from a relational psychoanalytic perspective. All claimed to work from within a more traditional object relational perspective (although psychotherapists B and S had had some interactional training). Although in the first two cases, the enactments were thought about, it seems from the data that they were carried out in a rather tentative way, with some guilt, defensiveness and apology from the therapist. The strategic / structural notions (described above) of an expert therapist deliberately altering his style to "join" with the different object relational constellations identified by the psychotherapists concerned, were not evident.

It would be interesting to investigate the suggested hypothesis further utilizing psychotherapists who are conversant with both frameworks theoretically, and who endorse the flexibility of technique espoused by relational psychoanalysis. As mentioned above, the approach suggested here takes relational theorizing regarding technique one step further, as it advocates not only the judicious deliberate self-disclosure of countertransference at times, but also the deliberate re-enactment of countertransference responses. As suggested in Chapter 4, it is possible that by processing the patient's need for a "bad object" and by "publication" (Bion, 1959, 1962a, 1962b), or giving it back to the patient in a modified form (i.e. enacting a "bad object" who is also thinking and reflecting about what the patient needs), the therapist is also being a "good object", thus linking together the possibility of "good" objects and "bad" objects. In this way it is suggested that Fairbairn's (1952) "closed system" of internal object relations is breached. However evidence for the success of this hypothesized alternate approach was not found in the current research study. It is

possible that other methods may be useful to investigate the hypothesized approach further.

7.6 POSSIBLE ALTERNATE APPROACHES TO RESEARCHING THIS HYPOTHESIS

It would be interesting to conduct research on a larger number of psychologists to find out what their views of enactments are and how they relate enactments to changes in communicate patterns between themselves and their patients. In other words, the type of interview conducted in the pilot study (described in Chapter 5) could be extended as in the research conducted by Schön (2000), on psychotherapists' modes of dream interpretation, and Thorpe (1989), on psychotherapists' experiences of processing projective identification. The focus would thus be on analyzing an increased number of *therapist's experiences* of enactment and changes in communication styles. Given the findings of the pilot study, however, the difficulty with this approach may possibly be finding enough psychotherapists to participate, particularly if they were asked to provide back up data, i.e. obtain informed consent.

As mentioned above, it would also be interesting to conduct research on a broader range of types of therapist and to include those working from within a relational psychoanalytic framework, or those working from within even more broadly integrative frameworks. It is possible that these psychotherapists may not have as much hesitancy regarding the obtaining of informed consent. Nor would they be so reluctant to introduce techniques that alter the "basic frame" and therefore they might not be so tentative in their acknowledgement of, and deliberate use of, countertransference enactment.

An alternative approach might include an investigation into *the experience of the patient* when psychotherapists enact their internal relational constellations. This approach was used by Kelly (1994) to investigate patient's experiences of interpretations in "conversation-based, insight orientated therapy" (Kelly, 1994, p. 71). In his research Kelly (1994) utilized tape-recorded data obtained directly from sessions and interview data from both psychotherapists and patients.

Kelly does not specify from which particular theoretical frameworks his research participants were drawn. However, this procedure would be difficult to replicate within the psychoanalytic psychotherapist community in Johannesburg, given the fact that gaining *indirect* access via therapy session transcripts, therapist interviews and session notes proved difficult enough.

From within a more strictly psychoanalytic framework again, predictably, given the strong reservations that psychoanalytic psychotherapists have regarding frame breaks, the difficulty would be in gaining direct access to patient material. It may be possible, however, to do this type of research by eliminating the therapist and approaching patients through other sources, e.g. newspapers or magazines. In this case, however, the researcher would need to rely entirely on the patient's version of the therapist's therapeutic approach and types of intervention. Such studies abound and seem to have a phenomenological structure. For instance, Gratton (1983) examined the client's experience of trust in the therapeutic relationship from the point of view of the client and Bachelor (1988) described how clients perceive therapist empathy.

Other studies on the therapeutic process that can be cited include those by Barber, Connolly, Crits-Christoph, Gladis and Siqueland (2000); and Raue, Goldfried and Barkham (1997). These studies focused on patients' experiences of the therapeutic process. They did not mention difficulties in accessing data because of confidentiality and frame break issues but seemed to use therapist/patient couples specifically co-opted by health care workers and advertisements for the purposes of the study.

Possibilities for researching the hypothesized approach come from outside of the psychoanalytic and relational frameworks utilized as organizing conceptual frameworks for this thesis. They are, therefore, not mentioned in the literature review, but include studies relating to the therapeutic relationship, which have focused on the "Working Alliance Inventory" (WAI). The measure is based on Bordin's (1976) pantheoretical, tripartite conceptualization of the therapeutic alliance in terms of bonds, goals and tasks. For instance, Hovarth and Greenberg (1989) worked on the development and validation of the working alliance inventory by administering the inventory to 29 counsellor-client dyads. The therapists are described as experienced professionals who identified themselves as adherents to various frameworks such as "client-centred, analytic, Jungian, behavioural and cognitive". Again, these studies did not mention difficulty in obtaining informed consent as was found in the present research. Perhaps to avoid this problem, other studies such as those presented by Samoilov, Goldfried and Shapiro (2000), and Martin, Garske and Davis (2000) utilized archival material and conduced "meta-analyzes", or studies of studies, a procedure similar to that described above (e.g. Schön, 2000; Thorpe, 1989) where the study is conducted "one-step removed" and the patient's direct participation in the study is not required.

Other possibilities for researching the phenomenon of therapist enactment and patient communication styles come from within the framework of attachment theory, also not described in the literature review. Although the details of the theory are strongly associated with, but beyond the scope of this thesis, attachment theory pre-supposes contrasting pathways of development arising out of either secure or insecure attachment. Different infant patterns of attachment have been linked to varying parental handling behaviour and to different communication styles and pathology in adults (e.g. Ainsworth, Blehar, Waters & Wall, 1978; Hopkins, 1990; Stern, 1977, 1985). Attachment theorists measure adult attachment styles and their corresponding communication patterns using measures such as the "Adult Attachment Interview" (George, Kaplan & Main, 1985) and investigate the implications of this for the therapeutic process (e.g. Dozier, 1990; Holmes, 1997; Mace & Margison, 1997). Debates in attachment literature centre on the capacity to reflect and self-reflect, depending on attachment circumstances (e.g. Fonagy, 1996, 2001; Eagle, 1997). Issues pertain to the establishment of a "secure base" and the capacity for "self exploration". From an attachment theory perspective, attachment and exploration operate in a reciprocal manner. From this perspective one of the important consequences of secure attachment and the availability of a secure base is the facilitation of an individual's range of exploration. There is much evidence in the attachment literature that secure attachment is positively related not only to exploration of the external world but also to meta-cognitive functioning and exploration of one's inner world. The therapist and the therapeutic situation serve as a secure base from which the patient may feel freer to confront and explore warded off anxiety-laden aspects of his or her inner world.

Perusal of the literature reveals that some studies have explored what type of patient may be suited to what type of therapy and how the attachment experiences of the patient and therapist may influence their handling of the patients' attachment issues and communication styles (e.g. Dozier, Cue & Barnett, 1994; Leiper & Casares, 2000).

It may be interesting, however, to pursue some of these ideas in terms of the current research question and hypothesized approach, and investigate whether the therapist can actually change his communication style and whether a change in style has an impact, or whether this change is merely superficial posturing. Further, it would be useful to ask whether the therapist's self-reflective ability influences the attachment of the patient and therefore alters the communicative patterns between the therapeutic dyad.

Further discussion of these issues and others related to this topic is well justified, but beyond the scope of this thesis. Again, however, regarding investigation of attachment, the issue would be how to access patients and the therapeutic process without breaking the "frame" of the therapy for psychotherapists and patients who work from within a strictly psychoanalytic framework (see discussion of "informed consent" in Chapter 5).

CHAPTER 8: CONCLUDING REMARKS

> ... on weighing the anchor, every sailor must take with him the best possible technical and cultural equipment for coping with the perils of the sea, but the expert sailor knows that he must adapt his techniques to the sea and the weather and that every voyage will be to some extent unpredictable and at any rate different from its predecessors. It is precisely this awareness, no less than the skills acquired that distinguishes his approach from the rigid illusions nurtured by the beginner.
>
> (Holmes, 1998, pp. 236-237)

8.1 CONCLUDING REMARKS

This thesis suggested that psychoanalytic approaches to therapy can supplement their armamentarium of techniques by utilizing "joining" and "accommodation" techniques described by interactional theorists such as Minuchin (1974) and adapting to "fit" the intra-psychic structure of their individual patients.

Based on interpersonal notions that we cannot not communicate and the relational notion that the therapeutic process is a process of negotiation, and accepting that modification of technique is required when working with more regressed patients or patients who are attached to "bad objects", this thesis endorsed the inevitability and usefulness of re-enactment.

The thesis used Fairbairn's notion of psychopathology as an "attachment to bad objects". From a Fairbairnian perspective psychopathology is characterized by the return to exciting/rejecting objects or their substitutes. These "bad objects" are seen as the only possible source of nurturance and validation, and as a consequence, other potential "good objects" are ignored. There is thus a reversal of the normal process of

going towards "good objects" and away from "bad" ones. As mentioned in Chapter 2, Fairbairn likens the situation to one of demon possession and the task of the analyst to that of exorcism and the casting out of devils. He states that the release of bad objects from the unconscious is one of the chief aims of psychotherapy. He emphasizes though that the *bad objects can only be released if the analyst has become established as a sufficiently good object for the patient.*

The thesis suggested that by behaving in a manner similar to the patient's "bad objects" the therapist becomes a "good object" for the patient. A "strategic / structural relational psychoanalytic approach" was proposed and investigated. It was suggested that the therapist utilize his countertransference responding to "identify" the family within the individual. Further it was suggested that psychoanalytic psychotherapists utilize the strategic / structural approaches to therapy described in Chapter 4 and then deliberately and strategically "join" with this family. This constitutes enacting various relational constellations of the patient, i.e. enactment of "bad" object relationships. It was suggested that the therapist deliberately enact the "bad" relational constellations that he has been able to identify via his countertransference responding, in order to enter the "closed system" of internalized object relations units described by Fairbairn. As suggested in Chapter 4, it is possible that by processing the patient's need for a "bad object" and by "publication" (Bion, 1959, 1962a, 1962b), or giving it back to the patient in a modified form, i.e. enacting a "bad object" who is also thinking and reflecting about what the patient needs, the therapist is also being a "good object", thus linking together the possibility of "good" objects and "bad" objects. It was the contention of this thesis that the intentional resonance of the therapist to the "bad" self and object representations (i.e. the intra-psychic structure of the patient) provides a

positive realization to the preconception of the existence of a "good" object (a thought about a good object) and to the possibility of links (Bion, 1959) between "good" and "bad" objects, which had not been available previously. In this way it is suggested that Fairbairn's (1952) "closed system" of internal object relations is breached.

Weich (1990, p. 128) quotes Henry David Thoreau: "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music he hears, however measured or far away".

It has been suggested here that the therapist should march to the beat of the patient's music, changing step when the patient does, but also at times deliberately altering his step when he thinks the time is right, to see if the patient follows. The therapist should be aware of his own missed beats and his tendency to "dance to other drums".

The researcher has found this approach to be successful in her practice of therapy; however, evidence of the success of this hypothesized alternate approach was not found in the current research study. There was not a clear demonstration that enactment of the patient's internal object relational constellations by the therapist leads to a change in the communication style of the patient. Therefore, other ways of investigating the proposed approach were suggested.

Minuchin cites the poet Jimenez, "the road is not the road, the road is how you walk it." (Minuchin, 1974, p.119). It is clear from the literature review and the research, that the "road walked" by psychoanalytic psychotherapists, is road of enactment. It seems to this researcher that this road is valuable and can be used in ways beyond

those already suggested by relational psychoanalysis. The success of this “road” depends upon “how you walk it”.

REFERENCES:

Addison, R. B. (1992). Grounded hermeneutic research. In B. F. Crabtree & W. L.Miller (Eds.), *Doing qualitative research: multiple strategies. Research methods for primary care* (Vol 3). Newbury Park, CA: Sage.

Ainsworth, M. D. S., Blehar, M. C., Waters, E. & Wall, S. (1978). *Patterns of attachment. A psychological study of the strange situation.* Hillsdale: John Wiley & Sons.

Alexander, F. (1956). *Psychoanalysis and psychotherapy.* New York: Norton.

Alexander, F. and French, T. M. (1946). *Psychoanalytic psychotherapy: Principles and application.* New York: Ronald Press.

Aron, L. (1996). *A meeting of minds – mutuality in psychoanalysis*. London: The Analytic Press.

Aron, L. (2000). Ethical considerations in the writing of case histories. *Psychoanalytic Dialogues, 10,* 231-245.

Bachelor, A. (1988, Summer). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy, 25* (2), 227-240.

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, L. & Siqueland, L. (2000). Alliance predicts patient outcome beyond in-treatment change in symptoms. *Journal of Counselling and Clinical Psychology, 68* (6), 1027-1032.

Bion, W. R. (1959). Attacks on linking. *International Journal of Psychoanalysis, 40,* 308-315.

Bion, W. R. (1962a). A theory of thinking. *International Journal of Psychoanalysis, 43,* 306-10.

Bion, W. R. (1962b). *Learning from experience.* London: Karnac.

Bleger, J. (1990). Psychoanalysis and the psychoanalytic frame. In R. Langs (Ed.), *Classics in psychoanalytic technique (*pp. 419-427). Northvale NJ: Jason Aronson.

Bleicher, J. (1980). *Contemporary hermeneutics.* London: Routledge & Kegan Paul.

Bordin, E. S. (1976). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice, 16,* 252-260.

Bouchard, M. and Guerette, L. (1991). Psychotherapy as a hermeneutical experience. *Psychotherapy, 28* (3), 385-394.

Britton, R. (1998). *Belief and imagination*. London: Routledge.

Brown, L. M., Tappan, M. B., Gilligan, C., Miller, B. A., & Argyris, D. E. (1989). Reading for self and moral voice: A method for interpreting narratives of real-life moral conflict and choice. In M. J. Packer and R. B. Addison (Eds.), *Entering the circle: Hermeneutic investigations in psychology* (pp. 141-165). Albany: State of New York Press.

Casement, P. (1985). *On learning from the patient.* London: Routledge & Kegan Paul.

Celani, D. P. (1993). *The treatment of the borderline patient: Applying Fairbairn's object relations theory in a clinical setting*. New York: International University Press.

Dell, P. (1982). Homestasis and family therapy: A brief history. *Family Process, 21*, 21-44.

Dell, P. (1985). Understanding Bateson and Maturana: Toward a biological foundation for the natural sciences. *Journal of Marital & Family Therapy, 11* (1), 1-20.

Denzin, N. & Lincoln, Y. (1994). Introduction: Entering the field of qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-17). Thousand Oaks: Sage.

Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology, 2,* 47-60.

Dozier, M., Cue, K. L. & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Counselling and Clinical Psychology, 62* (4), 793-800.

Eagle, M. (1997). Attachment and psychoanalysis. *British Journal of Medical Psychology, 70,* 217-229.

Edinger, E. F. (1985). *Anatomy of the psyche. Alchemical symbolism in psychotherapy.* La Salle: Open Court Publishing.

Edwards, D. J. A. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology*, *38* (3), 36-70.

Ehrenberg, D. B. (1992). *The intimate edge. Extending the reach of psychoanalytic interaction.* New York: Norton.

Eissler, K. R. (1990). The effect of structure of the ego on psychoanalytic techniques. In Langs, R. (Ed.), *Classics in psychoanalytic technique* (pp. 397-414). Northvale, NJ: Jason Aronson.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality.* London: Routledge & Kegan Paul.

Fairbairn, W. R. D. (1958). On the nature and aims of psychoanalytic treatment. *International Journal of Psychoanalysis, 39,* 374-385.

Fisch, R., Watzlawick, P., Weakland, J. & Bodin, A. (1977). On becoming family therapists. In P. Watzlawick & J. H. Weakland (Eds.), *The interactional view.* (pp. 308-324). New York: Norton.

Fonagy, P. (1996). *Attachment and theory of mind: Overlapping constructs?* Conference on "Bonding and Attachment: Current issues", organized by the Association for Child Psychology and Psychiatry, Regent's College, London.

Fonagy, P. (2001). *Attachment theory and psychoanalysis.* New York: Other Press.

Gabbard, G. O. (2000). Disguise or consent. Problems and recommendations concerning the publication and presentation of clinical material. *International Journal of Psychoanalysis, 81,* 1071-1086.

Gabbard, G. O. & Lester, E. P. (1995). *Boundaries and boundary violations in psychoanalysis.* New York: Basic Books.

Gadamer, H. G. (1975). *Truth and method.* New York: Crossroads.

George, C., Kaplan, N. & Main, M. (1985). *Attachment interview for adults.* Unpublished manuscript, University of California: Berkeley.

Ghent, E. (1992). Foreword. In N. J. Skolnick & S. C. Warshaw (Eds.), *Relational perspectives in psychoanalysis.* (pp. xiii-xxii). Hillsdale, NJ: Analytic Press.

Gilchrist, V. J. (1992). Key informant interviews. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research: multiple strategies. Research methods for primary care* (Vol 3). Newbury Park, CA: Sage.

Giovacchini, P. L. (1990). Interpretations, an obscure technical area: Comments on Winnicott's "interpretation in psychoanalysis". In P. L. Giovacchini (Ed.). *Tactics and techniques in psychoanalytic psychotherapy III: The implications of Winnicott's contributions.* Northvale, NJ: Jason Aronson.

Gratton, C. (1983). Phenomenological and traditional views of trust between clients and therapists. In A. Giorgi, A. Barton & C. Maes (Eds.), *Duquesne studies in phenomenological psychology* .Vol. 4. (pp. 90-104). Pittsburgh, PA: Duquesne University Press.

Greenberg, J. R. (1991). *Oedipus and beyond.* Cambridge, MA: Harvard University Press.

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

Grinberg, L. (1962). On a specific aspect of countertransference due to the patient's projective identification. *International Journal of Psychoanalysis. 43,* 436-440.

Grotstein, J. S. & Rinsley, D. B. (Eds.) (1994). *Fairbairn and the origins of object relations.* New York: Guilford Press.

Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. *International Review of Psychoanalysis, 2,* 145-156.

Haley, J. (1963). *Strategies of psychotherapy.* New York: Grune & Stratton.

Haley, J. (1977). Toward a theory of pathological systems. In P. Watzlawick & J. H. Weakland (Eds.), *The interactional view* (pp. 31-55). New York: Norton.

Holmes, J. (1997). Attachment, autonomy, intimacy: Some clinical implications of attachment theory. *British Journal of Medical Psychology, 70,* 231-248.

Holmes, J. (1998). The changing aims of psychoanalytic psychotherapy. An integrative perspective. *International Journal of Psychoanalysis, 79*, 227-240.

Hopkins, J. (1990). The observed infant of attachment theory. *British Journal of Psychotherapy, 6* (4), 460-470.

Hovarth, A. O. & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counselling Psychology, 36* (2), 223-233.

Ivey, G. (1992, Spring). Countertransference pathology in South African psychotherapy. *Psychoanalytic Psychotherapy in South Africa,* 31-45.

Ivey, G. (1998). *Interpretation: Why, what, how, and when?* Unpublished lecture notes, Psychodynamic Adult Psychotherapy Workshop, Johannesburg.

Ivey, G. (1999). Transference-counter-transference constellations and enactments in the psychotherapy of destructive narcissism. *British Journal of Medical Psychology, 72,* 63-74.

Jackson, D. D. (1977). The study of the family. In P. Watzlawick & J. H. Weakland (Eds.), *The interactional view* (pp. 2-19). New York: Norton.

Jacobs, T. J. (1999). Countertransference past and present: A review of the concept. *International Journal of Psychoanalysis, 80,* 575-594.

Keeney, B. P. (1983). *Aesthetics of change.* New York: Guilford Press.

Kelly, K. J. (1994). *Hermeneutics in psychotherapy: A study of interpretation in the context of psychotherapeutic dialogue.* Unpublished doctoral dissertation, Rhodes University, Grahamstown.

Kernberg, O. F. (1976). *Object relations theory and clinical psychoanalysis.* New York: Jason Aronson.

Kernberg, O. F. (1980) *Internal world and external reality: Object relations theory applied*. New York: Jason Aronson.

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies.* New Haven, CT: Yale University Press.

Kernberg, O. F. (1994). Fairbairn's theory and challenge. In J. S. Grotstein & D. B. Rinsley (Eds.), *Fairbairn and the origins of object relations.* New York: Guilford Press.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis, 27,* 99-110.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Kvale, S. (1994). Ten standard objections to qualitative research interviews. *Journal of Phenomenological Psychology, 25* (2), 147-173.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

Langs, R. (1978). *The listening process*. New York: Jason Aronson.

Langs, R. (1982). *Psychotherapy: A basic text.* Northvale, NJ: Jason Aronson.

Lebow, J. (1997). The integrative revolution in couple and family therapy. *Family Process, 36* (1), 1-17.

Leiper, R. & Casares, P. (2000). An investigation of the attachment organization of clinical psychologists and its relation to clinical practice. *British Journal of Medical Psychology, 73,* 449-464.

Lichtenberg, J. D. (1989). *Psychoanalysis and motivation.* Hillsdale, NJ: Analytic Press.

Mace, C. & Margison, F. (1997). Attachment and psychotherapy: An overview. *British Journal of Medical Psychology, 70,* 209-215.

Malcolm, J. (1980). *Psychoanalysis, the impossible profession.* Northvale NJ: Jason Aronson.

Maroda, K. J. (1991). *The power of counter-transference: Innovations in analytic technique*. Chichester: John Wiley.

Martin, D. J., Garske, J. P. & Davis, M. K. (2000). Relation with the therapeutic alliance with outcome and other variables: A meta-analytic view. *Journal of Counselling and Clinical Psychology, 65* (3), 438-450.

Masterson, F.J. (1990). Psychotherapy of borderline and narcissistic disorders: Establishing a therapeutic alliance (A developmental, self and object relations approach). *Journal of Personality Disorders, 4* (2), 182-191.

McHenry, S. S. (1994, Winter). When the therapist needs therapy: Characterological countertransference issues and failures in the treatment of borderline personality disorders. *Psychotherapy, 31* (4), 557-569.

Merleau-Ponty, M. (1982-1983). The experience of others. (F. Evans & H.J. Silverman, Trans.), *Review of Existential Psychology and Psychiatry, 18* (1-3), 33-63.

Miles, M. B. & Huberman, A. M. (1994). *Qualitative data analysis. An expanded source book* (2nd ed.). Thousand Oaks, CA: Sage.

Minuchin, S. (1974). *Families and family therapy.* London: Tavistock Publications.

Mitchell, S. A., & Aron, L. (Eds.), (1999). *Relational psychoanalysis. The emergence of a tradition*. Hillsdale, NJ: Analytic Press.

Ogden, T. H. (1982). *Projective identification and psychotherapeutic technique.* Northvale, NJ: Jason Aronson.

Ogden, T. H. (1990). On potential space. In Giovacchini, P. L. (Ed.), *Tactics and techniques in psychoanalytic psychotherapy III: The implications of Winnicott's contributions* (pp. 90-112). Northvale, NJ: Jason Aronson.

Ogden, T. H. (1992). *The matrix of the mind. Object relations and the psychoanalytic dialogue*. London: Maresfield Library.

Ogden, T.H. (1994). *Subjects of analysis.* London: Karnac Books.

Ogden, T. H. (1996). Reconsidering three aspects of psychoanalytic technique. *International Journal of Psychoanalysis, 77,* 883-899.

Ogden, T. H. (1997). Reverie and metaphor. Some thoughts on how I work as an analyst. *International Journal of Psychoanalysis, 78,* 719-732.

Ogden, T. H. (1999). The analytic third: Working with intersubjective clinical facts. In S. A. Mitchelle & A. Aron (Eds.), *Relational psychoanalysis. The emergence of a tradition* (pp. 459-492). Hillsdale. NJ: Analytic Press.

Orange, D. M., Atwood, G.E. & Stolorow (1997). *Working intersubjectively. Contextualism in psychoanalytic practice.* Hillsdale, NJ: Analytic Press.

Packer, M. J., & Addison, R. B. (1989). *Entering the circle: Hermeneutic investigation in psychology.* Albany: State of New Jersey Press.

Palmer, R. E. (1969). *Hermeneutics.* Evanston: Northwestern University Press.

Ponsi, M. (2000). Therapeutic alliance and collaborative interactions. *International Journal of Psychoanalysis, 81,* 687-704.

Raue, P. J., Goldfried, M. R. & Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive-behavioural therapy. *Journal of Counselling and Clinical Psychology, 65* (4), 382-387.

Reis, B. E. (1999). Thomas Ogden's phenomenological turn. *Psychoanalytic Dialogues, 9* (3), 371-393.

Renik, O. (1993). Analytic interaction: Conceptualising technique in the light of the analyst's irreducible subjectivity. In S. A. Mitchell & L. Aron (Eds.), *Relational psychoanalysis. The emergence of a tradition* (pp. 407-424). Hillsdale, NJ: Analytic Press.

Renik, O. (1998). The analyst's subjectivity and the analyst's objectivity. *The International Journal of Psychoanalysis, 79,* 487-497.

Ricoeur, P. (1981). *Hermeneutics and the human sciences. Essays on language, action and interpretation* (J. B. Thompson, Trans. & Ed.). Cambridge: Cambridge University Press.

Ricoeur, P. (1984). *Time and narrative* (Vol 1). Chicago: University of Chicago Press.

Safran, J. D. & Muran, J. C. (2000). *Negotiating the therapeutic alliance.* New York: Guilford Press.

Samoilov, A., Goldfried, M. R. & Shapiro, D. A. (2000). Coding system of therapeutic focus on action and insight. *Journal of Counselling and Clinical Psychology, 69* (3), 513-514.

Schön, J. (2000). *Elements of dream interpretation: Laying the foundation for a basic model for clinical practice.* Unpublished doctoral dissertation, Rhodes University, Grahamstown.

Segal, H. (1964). *Introduction to the work of Melanie Klein.* New York: Basic Books.

Smith, J. H. (1988). Psychoanalysis and psychotherapy: Comments on the analytic attitude. *Journal of Psychotherapy, 4* (4), 401-411.

Stern, D. (1977). *The first relationship.* United States of America: Harvard University Press.

Stern, D. (1985). *The interpersonal world of the infant.* United States of America: Basic Books.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research. Grounded theory procedures and techniques.* Newbury Park, CA: Sage.

Sullivan, H. S. (1940). *Conceptions of modern psychiatry.* New York: Norton.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Sullivan. H. S. (1964). *The illusion of personal individuality. The fusion of psychiatry and social sciences.* New York: Norton.

Summers, F. L. (1999). *Transcending the self. An object relations model of psychoanalytic therapy*. Hillsdale, NJ: Analytic Press.

Thorpe, M. R. (1989). *A phenomenological investigation into the psychotherapist's experience of identifying, containing and processing the patient's projective identification.* Unpublished doctoral dissertation, Rhodes University, Grahamstown.

Valle, R. S., King, M. & Halling, S. (1989). An introduction to existential-phenomenological thought in psychology. In R. S. Valle & S. King (Eds.), *Existential phenomenological perspectives in psychology.* New York: Plenum Press.

Watzlawick, P., & Beavin, J. (1977). In P. Watzlawick & J. H. Weakland (Eds.). *The interactional view* (pp. 274-299). New York: Norton.

Watzlawick, P., Beavin, J. B. & Jackson, D. D. (1967). *Pragmatics of human communication.* New York: Norton.

Watzlawick, P., & Weakland, J. H. (Eds.) (1977). *The interactional view: Studies at the Palo Alto Institute,* 1965-1974. New York: Norton.

Watzlawick, P., Weakland, J. H. & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: Norton.

Weakland, J. H., Fisch, R., Watzlawick, P. & Bodin, A. M. (1977). Brief therapy: Focused problem resolution. In P. Watzlawick & J. H. Weakland (Eds.). *The interactional view* (pp. 274-299). New York: Norton.

Weich, M. J. (1990). The good enough analyst. In P. L. Giovacchini (Ed.), *Tactics and techniques in psychoanalytic psychotherapy III: The implications of Winnicott's contributions.* Northvale: NJ: Jason Aronson.

Winnicott, D. W. (1965a). The capacity to be alone. In D. W. Winnicott, *The maturational processes and the facilitating environmen*t (pp. 29-37). New York: International University Press.

Winnicott, D.W. (1965b). Ego integration in child development. In D. W. Winnicott, *The maturational processes and the facilitating environment* (pp. 56-64). New York: International University Press.

Winnicott, D.W. (1965c). From dependence towards independence in the development of the individual. In D. W. Winnicott, *The maturational processes and the facilitating environment* (pp. 158-169). New York: International University Press.

Winnicott, D.W. (1990). On transference. In R. Langs (Ed.), *Classics in psychoanalytic technique* (pp. 415-427). Northvale, NJ: Jason Aronson.

Winnicott, D. W. (1992a). Hate in the countertransference. In D. W. Winnicott, *Through paediatrics to psychoanalysis. Collected papers* (pp. 194-203). New York: Brunner/Mazel.

Winnicott, D. W. (1992b). Transitional objects and transitional phenomena. In D. W. Winnicott, *Through paediatrics to psychoanalysis. Collected papers* (pp.229-242). New York: Brunner/Mazel.

APPENDICES

APPENDIX A: LETTER TO PSYCHOTHERAPISTS

Dear

I am currently doing research on the process of psychotherapy as part of a PhD (Psychotherapy) degree through Rhodes University and I am seeking to recruit participants, psychotherapists with at least five years experience in clinical practice. I am interested in finding participants who subscribe to the object relations conceptual framework and who practise within the parameters defined by this approach.

At this stage I would prefer not to divulge the detail of the aspect of the therapeutic process to be researched in order to prevent the contamination of data to be collected. However what I can say here is that I am researching, in particular, an aspect of projective identification and therapy with patients who can be described as operating in a predominatingly paranoid-schizoid mode.

I require two levels of participation in the research:

- Firstly, as part of a pilot study, I would like to interview suitable psychotherapists to glean general information about their values regarding participating in research and their approach to working with patients who seem to be operating in a predominatingly paranoid-schizoid mode. This would involve either a telephone call or an interview, which will take about a half an hour or an hour of your time.
- Secondly, in order to investigate some specific aspects of processing of projective identification, I am looking for a smaller sample of participants who would be prepared to provide transcripts of sessions that have already been transcribed for the purposes of supervision. Psychotherapists who would be prepared to participate in the second stage of the research, would be required to negotiate consent with their selected patient, an issue which would be discussed during the initial interview. They would then be required to participate in one or two further follow-up interviews with me. This would therefore require another one or two hours of your time.

Complete anonymity is assured in all phases of research.

My background in brief is as follows:
After completing my training at RAU and internship at Sterkfontein Psychiatric hospital in 1989 I have worked as a clinical psychologist in private practice. In 1997 and 1998 I did an Integrative Diploma in object relations under the auspices of Sherwood Training Institute U.K. at Wits with Prof G. Straker, Dr C. Smith and Dr J. Watts. I have been involved in doing the course work section of the PhD (Psychotherapy) through Rhodes since 2000. This has involved courses, essays and written exams on the following topics:

- Object Relations
- Phenomenology and Hermeneutics
- Self Psychology
- Jungian Analysis
- Intersubjectivity.

The course work section also included an oral exam and a case study. I have completed this section of the degree.

The research in which I am asking you to participate, is part of a thesis required for the completion of the entire PhD. Completion of the PhD will also allow completion of the Integrative Diploma.

The Rhodes University Humanities Higher Degrees Committee has accepted my research proposal.

If you are prepared to participate in the first stage of the research, could you contact me by e-mail and leave phone numbers and times when it would be convenient for me to contact you to make further arrangements? Please note that participation in the first stage is part of a preliminary investigation and does not bind you at all to any further

participation. It also does not involve any direct participation in publication and so there is therefore no necessity for patient consent at this stage.

I would really appreciate any assistance and participation in the above, even if it only involves telephone contact. I realize that your time is valuable and I am prepared to reimburse you for any time spent with me on research.

Regards,

APPENDIX B: GENERAL INTERVIEW (PILOT STUDY)

1. How long have you been practising as a psychotherapist?
2. Do you subscribe to a particular conceptual framework?
3. Which theorists have had the most influence on your clinical practice?
4. Do you have experience of making written verbatim transcripts of the therapeutic dialogue in sessions based on memory?
5. How often do you do this?
6. Do you work with patients who seem to operate from a predominatingly paranoid-schizoid position?
7. Are you aware of making any changes to your basic technique when working with such patients?
8. What is your opinion regarding research and psychotherapy?
9. What is your opinion regarding obtaining informed consent from a patient?
10. Would you be prepared to participate in a research project that required you only to divulge your own experiences during psychotherapy with a specific patient, in other words, informed consent would not be required?
11. Would you be prepared to consider obtaining informed consent from a specific patient if anonymity is assured at all stages of the research process?

APPENDIX C: INSTRUCTION TO PARTICIPANTS (PHASE ONE)

1. Please could you provide your notes regarding all sessions with the selected patient, and written memory transcripts of the therapeutic dialogue? As much detail as possible is needed, including your thoughts, feelings and associations to the material, which we can discuss during a subsequent interview.
2. You will need the patient's consent. A "letter to patients" is attached and would need to be handed to a suitable patient, so that they can decide if they would be amenable to your sharing some of their information with me. I would not want any contact with the patient and would ask you to disguise any possible identifying data.
3. Your choice of patient is important. It would need to be a person who, in your judgement, would not be unduly affected by the intrusion into the therapy.
4. A consent form for the patient to sign is also attached. This will need to be retained by you. A consent form is also attached for you to sign. This form will be kept by me.
5. After you have provided me with the requested data, I would like to discuss the context of the transcribed session with you, as well as relevant details of the patient's history and the course of therapy.

APPENDIX D: LETTER TO PATIENTS

To Whom It May Concern:

I am a Clinical Psychologist in private practice and am currently doing research on psychotherapy as part of a PhD (Psychotherapy) degree through Rhodes University. In order to investigate the process of psychotherapy in detail, I need to have access to material from some of your therapy sessions with your therapist. I am writing this letter to see whether you would be prepared to consent to this access. If you are, I would like to assure you of the following precautions which will be undertaken to protect your anonymity and the confidentiality of your therapy:

1. Your therapist will not give me your name or any other identifying data.
2. In event of any of your data being used in the completion of the thesis or any future publication, I will provide your therapist with a draft of the text in order that he or she can ensure that your anonymity is guaranteed.
3. You are free to withdraw your consent at any stage of the research.
4. I do not wish to have formal or informal contact with you about the research. I would not like to intrude into your therapy in any way and will be examining the therapy from the therapist's perspective.
5. Any notes and information given to me by your therapist will be returned to him/her at the end of the research project.

If you are interested in helping with the research, please discuss it with your therapist and if you remain willing, kindly sign the consent form attached and give it to your therapist. I will be sending this letter to a number of people who are in psychotherapy and wish to stress that your participation is voluntary.

Yours sincerely,

APPENDIX E: CONSENT FORM FOR PATIENTS

(Consent form to be retained by the psychotherapists)

I agree to my psychotherapist discussing my therapy and selected sessions with Penny Webster as part of a research project on the process of psychotherapy. I understand the purpose and nature of the study and my consent is voluntary. I grant permission for data to be used in the completion of a PhD (Psychotherapy) thesis and any other future publication. I understand that (1) any identifying data will be changed by my therapist so that my anonymity will be maintained; (2) this consent form will be kept by my therapist; (3) I may withdraw my consent at any stage of the research and this will be honoured by the researcher with immediate effect; and (4) all communication in relation to this project will take place between the researcher and my psychotherapist. (5) Any notes or written information will be returned to my therapist at the end of the research project.

Signature

Date

APPENDIX F: CONSENT FORM FOR PSYCHOTHERAPISTS

(Consent form to be retained by the researcher)

I agree to discuss the biographical data and details of therapy with a consenting patient with Penny Webster, in order to assist in the research of aspects of the process of psychotherapy. I understand the purpose and nature of the study and my consent is voluntary. I grant permission for data to be used in the completion of a PhD (Psychotherapy) thesis and any other future publication. I understand that (1) I will change any identifying data so that the patient's anonymity will be maintained; (2) this consent form will be kept by the researcher; (3) I may withdraw my consent at any stage of the research and this will be honoured by the researcher with immediate effect; (4) all communication in relation to this project will take place between the researcher and myself, she will have no formal or informal contact with my patient; (5) Any notes or written information will be returned to me at the end of the research project; (6) I will be assisted with further supervision by the researcher or another experienced clinician at any stage if I feel that the research has impacted on the therapeutic process.

Signature

Date

APPENDIX G: THERAPIST INTERVIEWS (PHASE THREE)

1. In the course of therapy with the patient whose details you have shared with me, have you as therapist experienced a thought, feeling, fantasy, or manner of relating, which took you some time to come to terms with?
2. Please reflect on some of the interventions that you made. Did you act or behave in a manner that felt unusual or inauthentic for you?
3. Describe the process whereby you first became aware of what you were experiencing.
4. Did you, at any stage, become aware that your experience was related to the patient and not purely an aspect of your own countertransference?
5. Did you attempt to hold or contain the feelings, or did you continue to enact them, even though you were aware of doing so?
6. Did this have any effect on you? If so what?
7. Did it have any effect on the patient?
8. Was there any change in the quality of the patient's narrative?
9. Was there any change in the quality of the relational bond between you and the patient?

APPENDIX H: LANGS' COMMUNICATIVE TYPES (1978)

ADAPTIVE CONTEXT

The specific reality stimulus that evokes an intra-psychic response.

TYPE A FIELD AND *TYPE A* COMMUNICATIVE TYPE

A bipersonal field and communicative style in which symbolism and illusion play a central role. Such a field is characterized by the development of a play space or transitional space within which the patient communicates analyzable derivatives of his unconscious fantasies, memories, introjects and perceptions, ultimately in the form of *Type Two* derivatives. Such a field requires a secure framework, and a therapist or analyst who is capable of processing the material from the patient toward cognitive insights which are then imparted through valid interpretations. Such endeavors represent the therapist's capacity for symbolic communication. The *Type A* communicative mode is essentially symbolic, transitional illusory and geared toward insight.

TYPE B FIELD AND *TYPE B* COMMUNICATIVE TYPE

A bipersonal field characterized by major efforts at projective identification and action-discharge. The field is not especially designed for insight, but instead facilitates the riddance of accretions of disturbing internal stimuli. The *Type B* communicative mode is one in which efforts at projective identification and action-discharge prevail.

TYPE C FIELD AND *TYPE C* COMMUNICATIVE TYPE

A field in which the essential links between patient and therapist are broken and ruptured, and in which verbalization and apparent efforts at communication are actually designed to destroy meaning, generate falsifications, and to create impenetrable barriers to underlying catastrophic truths. The *Type C* communicative mode is designed for falsification, the destruction of links between subject and object, and for the erection of barriers designed to seal off inner and interactional chaos.

TYPE C NARRATOR

A patient who utilizes the *Type* C communicative mode through the report of extensive dream material or the detailed description of events and experiences within his life or with regard to the therapeutic interaction. Such material is characterized by the absence of a meaningful adaptive context, the lack of analyzable derivatives, and the use of communication essentially for the generation of nonmeaning and the breaking of relationship links. It is not uncommon for the *Type* C narrator to interact with a therapist or analyst who makes extensive use of psychoanalytic clichés, generating a therapeutic interaction falsely identified as viable analytic work, while its primary dynamic function falls within the *Type C* communicative mode.

DERIVATIVES

Manifest communications, verbal and nonverbal, which contain in some disguised form expressions of unconscious fantasies, memories, introjects and perceptions. They are then the communicative expression of neuroses and the basis on which they are maintained.

***TYPE ONE* DERIVATIVES**

Readily available inferences derived from the manifest content of the patient's associations, without the use of an adaptive context. These inferences constitute one level of the latent content, arrived at in isolation and without reference to the dynamic state of therapeutic interaction and to the adaptive-dynamic function of the material at hand.

***TYPE TWO* DERIVATIVES**

Inferences from the manifest content of the patient's material that are arrived at through the abstracting-particularizing process when it is organized around a specific adaptive context. These disguised contents accrue specific dynamic-adaptive meaning when so organized, and are the main medium for the therapist's or analyst's interpretations, primarily in terms of the therapeutic interaction.

FRAME

A metaphor for the implicit and explicit ground rules of psychotherapy and psychoanalysis. The image implies that the ground rules create a basic hold for the therapeutic interaction, and for both patient and therapist, and that they create a distinctive set of conditions within the frame that differentiate it in actuality and functionally from the conditions outside the frame. The metaphor requires, however, an appreciation of the human qualities of the frame and should not be used to develop an inanimate or overly rigid conception.

APPENDIX I: READING GUIDE QUESTIONS

Identify the following in the case narratives:

1. Self and object representations (me/not me interface) (Langs, 1978).
2. Communicative fields.
3. Changes in communicative fields.
4. *Type One* and *Type Two* derivatives.
5. Frame breaks and enactments by the therapist.