
**A CASE STUDY EXPLORATION OF
THE THERAPEUTIC PHENOMENA OF
PROJECTIVE IDENTIFICATION, TRANSFERENCE
AND COUNTERTRANSFERENCE:
A Brief Therapy with a Patient with Psychotic Anxiety**

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ABSTRACT

This dissertation reviews the concepts of projective identification, transference and countertransference from an Object Relations theoretical perspective. The developmental mother-infant relationship is explored as a model for understanding the therapist-patient interaction in both its normal and pathological forms. Projective identification is used to illuminate the workings of transference and countertransference. W.R. Bion's conception of the mother-therapist as 'Container' and infant-patient as 'Contained' is presented as pivotal to understanding that interaction. Failures in projective identification - and therefore in symbolic functioning - are explored, with particular focus given to psychotic and psychosomatic manifestations in patients. The relevance of transference and countertransference phenomena to brief psychotherapy is also considered.

These concepts are then applied to a specific therapeutic case. The patient was seen as an in-and out-patient over a 5 month period 1-3 times per week. The patient's history and a brief formulation are presented, followed by a discussion of how the above-mentioned theoretical issues manifested in the therapy. The patient operated on the border between psychosis and neurosis and communicated in primitive pre-verbal and powerful symbolic ways. Case illustrations focus on the interplay between her psyche and soma, the impact of the hospital setting as well as particular transference and countertransference difficulties incurred.

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*Home is where one starts from. As we grow older
The world becomes stranger, the pattern more complicated
Of dead and living. Not the intense moment
Isolated, with no before and after,
But a lifetime burning in every moment*

T.S. Eliot, "Eos Coter, Four Quartets"

CHAPTER 1: INTRODUCTION

From an Object Relations theoretical framework of therapy, the relatedness of therapist and patient represents the rudimentary building block on which the approach is founded, just as the interrelationship between mother and infant is critical to understanding psychological development. As Brenman Pick (1988) so aptly puts it,

indeed, in so far as we take in the experience of the patient, we cannot do so without also having an experience. If there is a mouth that seeks a breast as an inborn potential, there is, I believe, a psychological equivalent, i.e. a state of mind which seeks another state of mind. (p. 35)

This, in turn, has bearing on the practice of psychotherapy which has shifted its emphasis from the intrapsychic dynamics of the patient to the interaction of the patient and the therapist (Hinshelwood, 1991). Transference and countertransference phenomena become a key focus in the process of therapeutic change, in understanding as well as shifting the patient at both an intrapsychic and interpersonal level.

This dissertation sets out to examine the concepts of transference and countertransference, with particular emphasis on primitive mechanisms including projective identification and psychosomatic symptomatology. These integral concepts are explored within an Object Relations, relational model of the ego. The term 'object' refers to another person to whom instincts are directed while the term 'relationship' refers to an interrelationship between the way the subject constitutes his or her objects as well as the way the objects shape his or her actions (Laplanche and Pontalis, 1967/1973). In the same way that subject and object are inextricably linked, so too are transference and countertransference. These concepts cannot be studied separately - indeed the inability of the literature to focus on either topic to the exclusion of the other bears testimony to this. Margaret Little (1951) confirms that "transference and counter-transference are inseparable...what is written about the one can so largely be applied to the other" (p. 33).

She goes on to remark that:

transference and counter-transference are not only syntheses by the patient and analyst acting separately, but, like the analytic work as a whole, are the result of a joint effort. We often hear of the mirror which the analyst holds up to the patient, but the patient holds one up to the analyst too, and there is a whole series of reflections in each, repetitive in kind, and subject to continual modification. The mirror in each case should become progressively clearer as the analysis goes on, for patient and analyst respond to each other in a reverberative kind of way, and increasing clearness in one mirror will bring the need for a corresponding clearing in the other. (p. 37)

I believe that a similar reflective dialectic is required when examining the concepts of transference and countertransference. For this reason, I have chosen to begin Chapter 2 with an exploration of **projective identification**. Although historically a later theoretical development than transference and countertransference, projective identification encompasses the mutuality of the therapeutic dyad, thereby offering an explanation of the dynamics involved in transference and countertransference. In particular, Bion's theory of the Container and the Contained will be used as a model for understanding the roles of therapist and patient. Abnormal forms of projective identification and their relevance to conducting therapy with psychotic patients, will also be discussed. This will have application to the case study in question.

I will then deal with the area of **transference**, starting with a historical review. A working definition will then be offered. I will examine in detail the issues involved in making transference interpretations as well as the application of transference phenomena in therapy with psychotic patients. The concept of **countertransference** will then be addressed, including the historical developments and a working definition. The following issues will also be covered: the links between countertransference and projective identification; the role of the therapist in countertransference; making countertransference interpretations; therapist neutrality; and the application of these concepts to therapy with psychotic patients.

Chapter 2 goes on to consider the application of transference and countertransference phenomena to **brief psychotherapy**. Finally, the specific area of **psychosomatic disorders** is explored developmentally in relation to projective identification. It is suggested that somatic disturbances represent a failure in projective identification. The impact this has on transference and countertransference is also discussed.

Chapter 3 reviews the **case study methodology**, its advantages, limitations and ethical considerations. The methodological approach adopted in this case study is then set out fully.

Chapter 4 provides a **brief history and formulation** of the patient as well as an outline of the **course of therapy**.

In Chapter 5, **therapy material** will be offered to illuminate these theoretical concepts. By means of case illustrations, I will share my thoughts and experiences as to how projective identification, transference and countertransference manifested in this particular therapy. Some of the difficulties encountered in the case will be considered, including the interaction between psyche and soma, difficulties in making transference interpretations, the impact of the hospital setting on treatment, triadic relationships in the transference and finally, my own countertransference difficulties.

Finally, Chapter 6 offers a **conclusion**. It draws together the key areas covered in this work and briefly looks at the challenges faced by trainee psychologists conducting therapy with borderline and psychotic patients.

Throughout this dissertation, I have referred to the therapist as female for two reasons: it fits with the developmental mother-infant conception of the therapeutic relationship and it inverts patriarchal conventions. Both patient and infant are referred to as 'he or she'.

"Freud once said that his patients had learnt to bear a part of the truth about themselves. The deepening of our knowledge of countertransference accords with this principle. And I believe we should do well if we learnt to bear this truth about each one of us being also known by some other people."

Racker, 1982, p. 126

CHAPTER 2: THEORETICAL DISCUSSION

2.1 PROJECTIVE IDENTIFICATION: THE BRIDGE BETWEEN TRANSFERENCE AND COUNTERTRANSFERENCE

2.1.1 Introduction:

Therapy is an interactive joint venture. Winnicott (1965) notes that the dependency of early infancy renders it impossible to describe an infant without describing his or her mother, thus suggesting the illogic of examining one part of the relationship to the exclusion of the other. Bion (1962) states in a similar vein that “an emotional experience cannot be conceived of in isolation from a relationship” (p. 42); this applies to all therapist-patient encounters. Klauber acknowledges the unique mutuality of this encounter:

Patient and analyst need one another. The patient comes to the analyst because of internal conflicts that prevent him from enjoying life, and he begins to use the analyst not only to resolve them, but increasingly as a receptacle for his pent-up feelings. But the analyst also needs the patient in order to crystallize and communicate his own thoughts, including some of his inmost thoughts on intimate human problems which only grow organically in the context of this relationship...It is also in his relationship with his patients that the analyst refreshes his own analysis. It is from this mutual participation in analytic understanding that the patient derives the substantial part of his cure and the analyst his deepest confidence and satisfaction. (cited in Rayner, 1990, pp. 225-26)

In relating this reciprocal relationship to the techniques of analysis, Balint and Balint observed in 1939 that “the analytical situation is the result of an interplay between the patient’s transference and the analyst’s counter-transference, complicated by the reactions released in each other’s transference on to him” (p. 228).

2.1.2 Towards Defining Projective Identification:

Historically, transference and countertransference were seen as potential forms of resistance and necessary evils largely extraneous to therapeutic progress, with the analyst’s task being one of minimization and damage control. The development of the phenomena of transference and countertransference will be explored in greater detail later in this chapter. However, it is worth noting the impact that the concept of projective identification had on these phenomena. With renewed interest in projective identification, chiefly owing to Bion, Rosenfeld and Joseph’s work in this area, transference and countertransference were reconceptualized. Transference was increasingly seen as offering the therapist direct observation of past conflicts and thus enhancing understanding of the patient. Countertransference was understood as normal, integral and valuable to therapeutic progress, rather than an internal flaw the therapist needed to analyse away. It is therefore fitting to examine Bion’s elaborations on projective identification more closely. These developed from Klein’s model of early development based on infant-mother interaction from which the patient-therapist relationship can be extrapolated.

Many of Bion's theories are based on his observations of transference-countertransference processes in the therapy of psychotic patients. In his essay, "Attacks on Linking", he describes how "the analytic situation built up in my mind a sense of witnessing an extremely early scene" from which he was able to deduce how the patient experienced his mother during infancy (1967c, p. 104). Winnicott makes a similar observation that

indeed it is not from direct observation of infants so much as from the study of the transference in the analytic setting that it is possible to gain a clear view of what takes place in infancy itself. This work on infantile dependence derives from the study of the transference and counter-transference phenomena that belong to the psychoanalyst's involvement with the borderline case. (1965, p. 54)

The mechanisms of projection, identification and introjection are used to understand the mother-infant relationship and, by extension, transference and countertransference in the therapeutic relationship: "thus the interaction between analyst and patient comes to be illuminated by the concept of projective identification" (Hinshelwood, 1991, p. 193).

Klein first employed the term 'projective identification' in her 1946 paper, "Notes on Some Schizoid Mechanisms", where she examined the process of ego splitting (i.e. division of the object into good and bad, thereby avoiding the ambivalence of loving and hating the same object), projection and identification of those split-off parts with external objects that takes place in the paranoid-schizoid position. She saw this process as being "of vital importance for normal development as well as for abnormal object-relations" (1975a, p. 9). Splitting is closely connected with projective identification in that they both represent ways of organising chaotic experiences into a primitive structure that allows a relationship with the good object to develop. When persecutory anxiety is overwhelming to the infant, both mechanisms can also lead to defensive ego fragmentation and violent projection of the fragments (Steiner, 1993).

Much debate has since arisen over definitions of projective identification, including whether it can be distinguished from projection both in theory and in practice. This debate can be attributed in part to the inherent handicap of trying to verbalise a process that arises "at a time when the infant has not yet begun to think in words" (Klein, 1975a, p. 8). While it is not within the scope of this dissertation to enter into the argument, suffice it to say that several authors (Hinshelwood, 1991; Spillius, 1988a) conclude that there is no clear distinction in the way that Klein used the terms projection and projective identification. Casement (1985) considers projective identification to be a more powerful form of projection.

For the purposes of this paper, the following working definition of projective identification will be adopted: the attribution (projection) in phantasy of a split-off part of the self to an object, in which process that part of the self is disowned (Hinshelwood, 1991). The unwanted feelings are then pushed into the object which is coerced into experiencing aspects of the self and which may feel that intrusion. By object, I am referring to another person (or some other thing) that is of interest for the satisfaction of a desire. The object is felt to have a real existence, inside or outside the subject and is related to on the basis of its supposed impulses towards the ego (Hinshelwood, 1991). Projective identification is thus "an unconscious representation of the self related in phantasy to others" (Rustin, 1991, p. 182).

Spillius (1988a) notes that the usefulness of the concept is greatly diminished when the definition of projective identification is restricted to those instances in which the recipient has feelings appropriate to the projector's phantasy and feels pressured to act on them. She suggests the use of the term 'evocatory' projective identification to represent the sub-variant of projective identification in which the recipient is pressured to have the projector's disowned feelings.

Projective identification, and the processes of transference and countertransference, are also found operating in group settings. Jacques applied projective identification to social structures: "a group that maintains a solidarity on the basis of a common external enemy is clearly projecting, as a group, into the enemy" (Hinshelwood, 1991, p. 195). Ogden (1992) briefly examines the area of group projective identifications, in which a group member unconsciously voices or enacts the feelings of the entire group. Thus the notion of scape-goating can be understood as a shared projective identification among a group of people where the intolerable feeling of vulnerability is split off, projected into an individual (or sub-group) and disavowed. The confines of this dissertation do not allow for an exploration of such group dynamics; the concepts of projective identification, transference and countertransference have rather been examined in an intrapsychic and interpersonal context.

2.1.3 Container and Contained: The Process of Maternal Reverie:

Bion expanded on Melanie Klein's groundwork in the area of projective identification to include the process whereby one person in some sense contains a part of another: "thus the link between patient and analyst, or infant and breast, is a mechanism of projective identification" (Bion, 1967c, p. 105). He describes the mother as functioning as an emotional container for the infant's projections, namely "the object that can be projected into the container...[designated] by the term contained" (Bion, 1962, p. 90). Rosenfeld (1987) stresses that the containing function is not a passive process; rather the mother (or therapist) must be prepared to enter into an intense relationship with the infant (or patient) and make sense of his or her experience.

McDougall (1978) points out that "the capacity to capture another's affect precedes the acquisition of language" (p. 252). Thus projective identification is an important communication device for the infant, the term 'infant' deriving from the Latin *in-fans*, meaning 'nonspeaking' (McDougall, 1978). In normal development, the infant projects powerful, intolerable emotions into the mother, often in a defensive attempt to disown them (or in the case of positive feelings, for safe keeping inside a protective person). Mother introjects those feelings and through a process of maternal reverie, she digests or makes sense of the infant's distress and then responds appropriately by relieving that distress, for example through feeding or language.

The infant is then able to reintroject the original feeling that has been modified by the mother. In the process, he or she acquires an experience of the mother's capacity to contain anxiety and make sense of the world which eventually is internalised: "the experience thus bears the marks of mother's understanding imprinted in the modification of the experience. It is now an understood experience and, in the interaction between these

two intrapsychic worlds, meaning has been generated” (Hinshelwood, 1991, p. 257). Good parts of the self are projected by the infant as a means of establishing good object relations and achieving ego integration (Klein, 1975a). In this way, the infant comes to feel he or she is dealing with an ideal object.

Bion (1962) calls this alpha-function. viz. the ability to assimilate raw sense impressions and emotions and generate meaningful mental concepts which form the basis of the thinking apparatus. If alpha-function is disturbed, the concrete sense impressions and emotions remain unchanged and undigested as beta-elements that are then used in projective identification. “They [beta-elements] are objects that can be evacuated or used for a kind of thinking that depends on manipulation of what are felt to be things in themselves as if to substitute such manipulation for words or ideas” (Bion, 1962, p. 6).

Reverie thus refers to the mother’s receptive state of mind in which she uses her alpha-function to contain the split-off parts of the infant’s mind - his or her projective identifications - thereby rendering them more tolerable for the infant. “The mother’s capacity for reverie is the receptor organ for the infant’s harvest of self-sensation gained by its conscious” (Bion, 1967d, p. 116). In this way, the mother shares the infant’s work of psychic integration (Rustin, 1991) and expresses her love for the infant (Bion, 1962). Winnicott notes a similar phenomenon:

I do not believe it is possible to understand the functioning of the mother at the very beginning of the infant’s life without seeing that she must be able to reach this state [of heightened maternal receptivity], almost an illness, and then recover from it...Only if a mother is sensitized in the way I am describing can she feel herself into the infant’s place, and so meet the infant’s needs. (cited in Ogden, 1979, p. 363)

When projective identification operates successfully, it serves the following functions:

1. It represents an early, non-symbolic form of communication of pre-verbal emotions, attitudes and thoughts by introducing them into the object. Ogden (1979) notes that in this process, “feelings congruent with one’s own are induced in another person, thereby creating a sense of being understood by or of being ‘at one with’ the other person” (p. 362). This “primitive form of communication ...provides a foundation on which, ultimately, verbal communication depends” (Bion, 1967b, p. 92);
2. It serves as a defence mechanism in modifying infantile frustration and fears by getting rid - albeit temporarily - of an unwanted and often threatening part of self (viz. by using beta-elements). It also affords the infant an opportunity for gaining mastery over those primitive fears by modifying that frustration (i.e. by employing alpha-elements). Thus “projective identification makes it possible for him [the infant] to investigate his own feelings in a personality powerful enough to contain them” (Bion, 1967c, p. 106);
3. It fosters empathy in that the infant becomes aware of a separate object with whom he or she is identified and becomes more able to step into another person’s shoes. This occurs in the depressive position when greater integration of conflicting feelings and split internal objects is achieved. Projective identification is thus “one of the most important mechanisms by which growth and development take place through object relations” (Malin & Grotstein, 1966, p. 31);

4. Through repeated experiences of being understood by an external object, the infant starts to acquire an internal object that is increasingly based on social reality rather than phantasy. This is a function of developing a sense of empathy. It also forms the basis of mental stability (Segal, 1981c):
5. A thinking apparatus is formed through cycles of normal projective identification and linking which becomes a container for emotional states (Hinshelwood, 1991). Segal (1981b) asserts that the process of symbol formation develops from early projections and identifications that become increasingly differentiated.

2.1.4 Placing Projective Identification on the Therapeutic Couch:

This model can be applied to the patient-therapist relationship, as follows. The patient projects into the analyst split-off parts of self (i.e. aspects of the ego) as well as objects (i.e. internalised experiences that have been identified with, and assimilated into. the ego) that may be damaged, fragmented, persecutory or idealized (Segal, 1979). The mother-therapist acts as the patient's auxiliary ego who accepts the patient's projections and struggles to make sense of them in her mind. She then returns them in a more easily digestible form to the patient, usually via an interpretation. In this fashion, the patient internalizes a sense of being understood, begins to mend the splits and develops a corresponding internal object that functions as the basis of mental stability (Hinshelwood, 1991). Segal (1979) noted that "all these steps bring him [the patient] gradually nearer the depressive position: that is, to the state of being an integrated self in relation to an integrated object" (p. 167).

2.1.5 Projective Identification Abused:

Bion (1967d) differentiates this 'normal' process of projective identification from excessive or pathological forms which can be attributed to various dynamics:

1. Mother may be unable to contain or make sense of the infant's projections which are then reintrojected by him or her with an amplified sense of despair. The infant continues to employ projective identification with increasing force and frequency to evacuate the unwanted experience which is now, for example, "not a fear of dying made tolerable, but a nameless dread" (Bion, 1967d, p. 116);
2. Disturbance can also result from the infant's poor tolerance of frustration, leading to excessive phantasies of destructive omnipotence over the object and resultant confusion of self and object (Hinshelwood, 1991). The infant may, in turn, fear retaliation from the Other, given the violence of his or her projections. In this way a vicious cycle is maintained. Paranoid anxieties may arise since "objects felt to possess the aggressive parts of the self become persecuting and are experienced by the patient as threatening retaliation" (Rosenfeld, 1987, p. 157).
3. Pathological projective identification may also result from the infant's envy in relation to the Other. This particularly occurs where good parts of the self have been excessively projected to the point that the infant's ego feels depleted of those objects, suffering ego loss and devaluation of self. Klein recognised how envy - namely the tendency to destructively attack and spoil the good object following intolerable awareness of being separate from it - plays an important role in promoting projective identification. The subject wants to be one with the object instead of having it (Hinshelwood, 1991).

This can result in clinging to, or aggression towards, the idealized Other who is perceived to control those parts and without whom, those parts of self are felt to be lost (Segal, 1979):

The re-introjection of such objects into whom massive projection has taken place gives rise to the narcissistic structure. The infant contains an object which is broken up and fragmented, controlled and controlling. To protect himself from such an object he flees to an excessively idealized internal object. This excessively idealized object is also excessively controlled and controlling, and the ego is so depleted by projections that it may become a mere shell for such internal objects. (Segal, 1979, p. 119)

The infant may envy the capacity of the mother's ability to serve as the repository for his or her feelings:

the psychotic infant is overwhelmed with hatred and envy of the mother's ability to retain a comfortable state of mind although experiencing the infant's feelings...Here we have another aspect of destructive attacks upon the link, the link being the capacity of the analyst [or mother] to introject the patient's [or infant's] projective identifications. (Bion, 1967c, p. 105)

The infant may defend against such envy - as well as act out his or her aggression - through omnipotent phantasies that he or she has entered the envied object and can control it. Rosenfeld (1987) calls this 'parasitical' object-relating because the infant (or psychotic patient) "maintains a belief that he is living entirely inside an object - the analyst - and behaves like a parasite living on the capabilities of the analyst, who is expected to function as his ego" (p. 163). In its extreme form, such parasitism represents total projective identification.

4. One also has to account for genetic dispositions towards excessive destructiveness, hatred and envy (Hinshelwood, 1991). Similarly one also has to consider the rebound effect on the environment: the infant with poor frustration tolerance impacts adversely on Mother's capacity for reverie.

Thus pathological projective identification serves a powerful evacuatory function which leads to the infant "forcibly entering an object, in phantasy, for immediate relief, and often with the aim of an intimidating control of the object" (Hinshelwood, 1991, p. 184). This evasion by evacuation is not to be confused with normal projective identification. It represents an attack on the links between thoughts and the elements of which coherent thoughts are composed. It results in the destruction of consciousness of reality, although reality itself cannot be destroyed (Bion, 1967a). By evading rather than modifying frustration, an "apparatus for ridding the psyche of accumulations of bad internal objects", rather than a thinking apparatus, is formed (Bion, 1967c, p. 112). In this way, projective identification is used to evacuate and deny psychic reality.

2.1.6 Pathological Projective Identification Applied to the Patient-Therapist Dynamic:

Segal (1981b) explains that "in massive projective identification the ego becomes again confused with the object, the symbol becomes confused with the thing symbolized and therefore turns into an equation" (p. 56). In this way, the patient no longer sees things 'as if' they represented the object but rather as identical (i.e. equated) to the object. The patient resorts to using the symbolic equation in an omnipotent manner in order to deny the absence of the idealized object or control a persecuting object. Since all communication is based on a shared

system of symbols, this breakdown in symbol formation translates into a disturbed capacity for communication. The applications of this primitive defence will be discussed in the section dealing with the limitations of transference interpretations with psychotic patients.

Rosenfeld (1987) recognises how the omnipotent basis of projective identification in infancy is carried over into adulthood in that it remains a very powerful mental process that profoundly affects both the self and the object of the projections. He proposes that psychotic transference “provides the opportunity to demonstrate that unbearable feelings can be contained and thought about creatively” (p. 23). While it has the capacity for good, it can be dangerous if abused. Object relations dominated by projective identification tend to be manipulative, even seductive, as well as forceful and controlling. The challenge to the therapist is to transform the projection through her understanding rather than being transformed by the projection.

Inevitably, the therapist will occasionally fail to contain the patient’s projections. In psychotic and borderline patients in particular, the patient is likely to increase efforts at projection in a denial of the internal reality of the object’s separateness and the inherent loss involved in that realisation. In this manner, the patient employs a narcissistic defence against separation, need and envy. A marked degree of splitting can result in the patient experiencing ego fragmentation and associated pathologies, such as amotivation, depersonalisation, derealization, psychosomatic illness and/or psychosis. Such patients often use projective identification in order to achieve a state of confusion, merger or fusion with the therapist. In therapy, however, “the patient’s symbiotic longing turns very quickly into a dangerous feeling of being sucked or pulled into a relationship where the patient feels passive, immobilized, and trapped and is unable to find his own self again” (Rosenfeld, 1987, p. 167). This leads to feelings of persecution and rage against the ‘seductive’ object.

Grinberg (1962) draws our attention to the therapist’s own unconscious and reactive projective identification in response to the patient’s violent projective identifications. He coined the term ‘projective counter-identification’ to describe such reactions. Rather than processing the patient’s projective identification, the therapist is led into behaving as if she had acquired those projections in a real and concrete way. Another defensive response with a similar result is the therapist being overly hasty in offering an interpretation, effectively blocking the patient’s projection. These issues will be addressed further as manifestations of countertransference.

2.2 TRANSFERENCE

2.2.1 Stumbling Over the Obstacle of Transference:

When Breuer accidentally discovered his patient Anna O.'s 'romantic' feelings towards him, he reacted to this "untoward event" by abandoning the psychoanalytic profession (Hinshelwood, 1991, p. 463). Freud's response, however, was to study the phenomenon with a scientific curiosity that went beyond the individuals concerned. He named it 'transference', observing that feelings were *transferred* on to the analyst "since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is derived from elsewhere, that they were already prepared in the patient" (Freud, 1917/1963, p. 494).

Freud believed that transference derived from the patient's repressed childhood phantasies - mainly in relation to parental figures - and as such represented a form of resistance to therapeutic progress in which the patient is obliged symbolically "to *repeat* the repressed material as a contemporary experience instead of...*remembering* it as something belonging to the past" (Freud, 1920/1955, p. 18). He differentiated between positive transference (friendly, affectionate feelings on a continuum with sexualized feelings) and negative (or hostile) transference. Freud noted that mildly positive transference towards the analyst was a powerful therapeutic instrument, replacing hypnosis as a motivating lever against the very resistance which transference signalled. Sandler, Dare and Holder (1973) differentiate transference from this ability to establish rapport with the analyst. They designate the latter as a component of the treatment alliance which is anchored in the 'real' or 'non-transference' patient-analyst relationship. However, Greenberg and Mitchell (1983) point out that this bifurcation is artificial since the alliance is not independent of transference but rather is created through the interpretation of transference. In this way, "insight and relationship interpenetrate" (p. 396). Mild positive transference is still seen by object relations therapists as "the agent of continuity" (Rayner, 1990, p. 226) and as such facilitates the therapeutic relationship in its early stages.

Freud deemed that transference was resolved through pointing out its early origins to the patient and encouraging the transformation of repetition into a verbal recollection or memory. Transference thus became the means by which "the most secret compartments of mental life can be opened" (Laplanche and Pontalis, 1967/1973, p. 496) and therefore "scarcely to be overestimated in the dynamics of the process of cure" (Freud, 1923/1955, p. 247).

Ferenczi, Glover, Freeman Sharpe, Sterba, Fenichel and others took up Freud's ideas on transference and expanded them further (Greenson, 1978). Despite this recognition of the value of transference, it was Melanie Klein's approach to play therapy that truly incorporated transference into the 'dynamics of cure'. She saw transference as an enactment of current unconscious phantasy and chose to interpret it earlier in the therapy - in particular hostile transference - rather than waiting for resistance to emerge. While Freud claimed that narcissistic disorders were incapable of transference, Klein's conviction in the involvement of object relations

in every situation and mental process “led her to deny to no one the capacity for transference” (Hughes, 1990, p. 84). Rosenfeld (1987) and Searles’ (1965) work with psychotic patients bears testimony to the fundamental nature of transference (and countertransference) phenomena in all people. Similarly, the practice of psychoanalytic psychotherapy with mute, physically and mentally disabled patients bears testimony to this.

Klein also held that ‘the total situation’ reflected unconscious elements of transference:

all material given in the course of free association in an analytic session may show aspects of the immediate transference to the analyst now, even when the material does not refer explicitly to the analyst or even when it apparently consists of childhood memories. (Hinshelwood, 1991, p. 466)

Racker (1968) notes that the transference is thus not only an object relation but also a relation between parts of the patient’s ego, whereby parts of the patient are split off and placed in the therapist. The patient’s myriad splitting of aspects of the analyst into part-objects (both internal and external, past and present) reflects his or her familiar ways of dealing with conflicts and anxieties during the paranoid-schizoid position:

the patient...turns away from the analyst as he attempted to turn away from his primal objects; he tries to split the relations to him, keeping him either as a good or a bad figure: he deflects some of the feelings and anxieties experienced towards the analyst on to other people in his current life, and this is part of ‘acting out’. (Klein, 1975b, pp. 55-56)

‘Acting out’ refers to the way in which “feelings stirred up by the therapy - and particularly feelings about the therapist - get expressed in an intense way towards people or situations in the patient’s life outside” (Malan, 1979, p. 47). Brenman Pick (1988) notes that:

the analyst, like the patient, desires to eliminate discomfort as well as to communicate and share experience; ordinary human reactions. In part, the patient seeks an enacting response, and in part, the analyst has an impulse to enact, and some of this will be expressed in the interpretation. (p. 36)

Acting out in the transference can be seen as the patient’s attempt to establish a ‘real’, external relationship with the therapist (Macalpine, 1950). Greenson (1978) describes this as the patient’s search for transference gratification through seeking to satisfy libidinal urges rather than doing the analytic work. This is often effected through projective identifications aimed at getting the therapist to enact a role in the patient’s life drama. The role played by the therapist in such enactments will be examined in the section on countertransference.

2.2.2 Towards a Working Definition of Transference:

Transference has come to have the broader application of being “an expression of the particular modalities of the subject’s relations with his different types of (partial and whole) object” and not just the re-emergence of infantile prototypes, i.e. archaic relationships with the primary caregivers (Laplanche and Pontalis, 1967/1973, p. 460). For the purposes of this paper, transference will stand for the totality of the psychological attitude of the patient (including verbal and non-verbal communication) towards therapist (Racker, 1957), while taking into account the external, objective realities of that relationship. It is noted, however, that the therapist-patient relationship is developmentally a reflection of earlier relationships: the distinction between past and present is

to some extent artificial. Heimann (1950) notes that there is no clear and easy distinction between transference feelings that refer to another person in his or her own right rather than as a parent substitute. As therapy progresses, so the patient responds more realistically towards the therapist, suggesting that the patient's feelings towards the therapist go beyond transference. Casement (1990) points out that the elements of difference between the patient's past and his or her relationship with the therapist provide the security to examine the areas of overlap in the transference, while the transference exists in the misperception of similarity as sameness. This gives transference its sense of immediacy and reality (Casement, 1985). There is no sense of time in the unconscious: as Matte Blance (cited in Casement, 1990) notes, to the unconscious, the part and the whole are equivalent and interchangeable and past, present and future are identical.

Racker (1954) describes the transference as essentially "nothing but a manifestation of the relationships with internal objects" (p. 86) and as such, the past is experienced in the present. He describes both transference and countertransference as a "fusion of present and past, the continuous and intimate connection of reality and fantasy, of external and internal, conscious and unconscious" (1957, p. 310). This is substantiated by Riesenberg Malcolm's (1988) definition of transference as the immediate "expression of the patient's past in its multiple transformations" (p. 73); therefore the analyst's "understanding of the present is the understanding of the patient's past as alive and actual" (p. 75).

Thus all patient communications have some relevance to the transference situation and the therapist can never function outside the transference (Greenberg and Mitchell, 1983). In addition, transference is seen to be broadly based on projective identification (Spillius, 1988b). Malin and Grotstein (1966) hold that transference phenomena are closely related to projective identification. If this broad definition of transference is accepted, then "all object relations and all transference phenomena are examples, at least in part, of projective identification" (p. 28). Ogden (1983) validates the view taken in this paper, namely that "that projective identification is a universal feature of the externalization of an internal object relationship, i.e. of transference" (p. 236).

2.2.3 The Transference Interpretation:

Accurate interpretations are important to the patient because they communicate the ways in which his or her projective identifications have been received and acknowledged (Malin & Grotstein, 1966). James Strachey (1969) postulated that 'mutative interpretations' - namely, emotionally immediate and specific interpretations of here-and-now transference distortions in the patient's view of the therapist - are the essential ingredient of psychic change. Through such interpretations, the analyst frustrates the patient's desire for a gratifying object relationship by offering understanding instead of object-relating (Rayner, 1990, p. 226). This leads to improved reality testing.

Brenman Pick (1988) talks about the difficulty of offering a response versus interpretation. While there may be times when the patient wants a human response and the therapist wants to be human in responding to him or her, unless this is acknowledged in the interpretation, the interpretation will fail. The patient may want the therapist to share his or her pleasure or grief; the therapist in turn may want to respond instinctively by celebrating or mourning. Unless her spontaneous human response is openly acknowledged, the therapist will either respond in a sterile and rejecting manner by denying her intuitiveness and keeping out all emotions, or she will act out by responding non-interpretatively. Brenman Pick notes that each interpretation should aim at moving the patient from the paranoid-schizoid to the depressive position. The paranoid-schizoid position represents a primitive state of persecutory anxiety in which ego and object are split into good and bad. By contrast, in the depressive position, ego and object are increasingly seen as whole and therefore ambivalent, with ensuing feelings of loss, depressive anxiety and guilt (Steiner, 1993). The therapist achieves this in part by helping the patient experience that the “interpretation itself is not an ideal object” (Brenman Pick, 1988, p. 40). Such understanding implies the patient’s growing awareness of his or her separateness from the therapist (or Other) and the loss involved in that realisation.

At the same time, inaccurate interpretations are inevitable in therapy. Winnicott (1965) modestly writes that “I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers” (p. 102). Casement (1990) likens interpretations to Winnicott’s squiggle game in that they offer a halfway, collaborative step towards understanding which the patient can add to and complete, rather than the therapist having the monopoly on insight (p. 12). He states that the principal function of interpretation is to indicate to the patient the degree to which the therapist has been following him or her: “*The experience of being understood is at least as important as the detail of any insight that is conveyed*” (p. 109). Casement goes on to note that the therapist should attune her interpretations to the individual patient which may require her to remain in the background of the analytic space. Between different therapists and theorists, there is considerable debate about when, how often and whether to make past links as well as in what ‘language’ to interpret transference.

2.2.3.1 When to Make Transference Interpretations:

Greenson (1974) outlines the major difference in approach between Kleinian and Freudian therapists, drawing attention to Freud’s remarks on the “measure of self-complacency and thoughtlessness [that] must be possessed by anyone who can, on the shortest acquaintance, inform a stranger” of his or her unconscious primitive urges (1913/1958b, p. 140). He contrasts this with Hannah Segal’s statement that “I have not had a case in which I did not have to interpret the transference from the start” (cited in Greenson, 1974, p. 40). Winnicott (1965) advocates deferring transference interpretations when the patient is acting out: what is important is the therapist’s survival of the attack rather than responding in apparent self-defence.

2.2.3.2 How Often to Interpret the Transference:

Some therapists hold that patients can be overloaded with transference interpretations and that some interpretations are best not made, with silence being a more valuable response (Rayner, 1990, p. 189). Ramchandani (1989) notes that containment through silence is an appropriate response in those 'less healthy' patients who have yet to develop adequate symbolization and self-object differentiation. At the same time, too much silence can increase the patient's anxiety and lead to the therapist being perceived as persecutory and withholding. While Rosenfeld (1987) acknowledges that most patients, in particular psychotic ones, often experience the therapist's interpretations as painful reminders of their separateness, he also believes that verbal interpretations can successfully create a holding environment for such patients: "in this way the analyst's intuitive and receptive empathy is expressed in a verbal form, which has the advantage that the patient is not infantilised" through long periods of silence that re-create an 'ideal' mother-infant experience (p. 18).

2.2.3.3 Timing of Interpretations:

The timing of the interpretation can make the difference between receiving the patient's projection or returning it so quickly that the patient feels rejected, criticised and evacuated by the therapist. The patient may interpret the therapist's haste in making an interpretation as a sign of her anxiety at being able to contain his or her projection. Rosenfeld (1987) states that:

through projective identification the analyst has been experienced concretely as expelling the projected feelings and so expelling the patient as well. For this reason the analyst must learn to contain the feelings for a considerable time before he can interpret them to the patient. Such containment should not be confused with inaction. The analyst has still to identify the patient's projections and *to verbalize them to himself as quickly as possible*, otherwise he will not be able to understand the details of the patient's communication or know when and what to interpret. (p. 16)

2.2.3.4 Genetic and Transference Interpretations - Should They be Linked?:

There is debate about the value of linking transference interpretations to past relationships, with some claiming that genetic interpretations are less important than immediate, transference ones. Although Strachey (1969) values mutative, transference interpretations over extra-transference, genetic interpretations, he acknowledges that a large majority of interpretations will fall outside the transference. He also recognises the internal difficulty the therapist faces when making transference interpretations by exposing herself to the 'danger' of direct contact with the patient. Winnicott (1965) holds that "the interpretation relates the specific transference phenomenon to a bit of the patient's psychic reality, and this in some cases means at the same time relating it to a bit of the patient's past living" (p. 159).

Sinason (1991) suggests that the therapist may take refuge in making transference interpretations at the expense of broader interpretations owing to her countertransference in finding it awful that the patients' external environment cannot be altered, particularly where that reality is unbearable: "the therapist...can carry on [sic] omnipotent fear that naming is equal to making it happen....We have to think of our own shutting down of understanding, our own areas of incapacity" (p. 19). In focusing exclusively on the transference relationship

in such situations, the therapist may be guilty of disassociating from the external environment, perhaps offering herself as an ideal object. Yet she is simultaneously minimising the patient's tragedy and denying his or her sanity in the process.

Joseph (1988b) differentiates between the level of ego integration of patients in choosing whether to make transference interpretations. With those patients operating mainly in the paranoid-schizoid position, she holds that "we shall only succeed if our interpretations are *immediate* and direct....Patients capable of considerable ego integration and of good, whole object relationships may at times be able to integrate interpretations based on putting together previous material" (pp. 59-60). Riesenberg Malcolm (1988) turns the debate on its side by contending that all transference interpretations are simultaneously interpretations of past and present. She believes that here-and-now interpretations of the therapist-patient relationship are the site where "the real work of reconstruction goes on" (p. 87). According to her, 'genetic interpretations' play a secondary role in offering the patient a sense of historical continuity.

2.2.3.5 How to Word Interpretations:

Spillius (1994) remarks on the move away from using the archaic, part-object language of anatomical structure to the language of psychological functions, such as seeing, hearing and evacuating. She concludes that "both levels of expression need to be listened for together and linked with experience" (p. 351). Riesenberg Malcolm (1988) holds a different view that such symbolic language of body parts such as breast and penis, assumes a shared understanding of archaic experiences that may not be present. In addition, she criticises the use of such repetitive, non-specific and artificial vocabulary that "destroys the live contact between analyst and patient, and turns the analysis into *talking about* unconscious phantasies, rather than experiencing them in their crude impact" (p. 86). It appears that the way the therapist words her interpretations hinges on the width of the definition of transference. It should be noted that the language of interpretations is unique to each therapeutic encounter, needing to be forged anew with each patient by the therapist. Bollas notes that each analyst uses his own personal, unique idiom to invent meanings rather than discover them: "no two analysts would say the same thing to the same patient" (cited in Rayner, 1990, p. 240).

2.2.3.6 Therapist Attributes

Making transference interpretations requires certain attributes of the therapist, including active receptivity without encouragement or fear of being destroyed (Searles, 1965), self-knowledge, security, an open, non-judgmental mind and deferment of automatic human responses. The therapist needs to resist the urge of casting herself as the better parent who is providing a corrective therapeutic experience. Such an approach prevents the patient from expressing negative transference. Casement (1990) remarks that "the analytic 'good object' is not someone better than the original object: it is someone who survives being treated as a 'bad object'" (p. 87).

The psychoanalytic setting, with its strict rules and constancy, is thus ideally suited for the emergence and observation of transference. The therapist ideally has no contact with the patient's daily life, and vice versa. However, working in a hospital setting where both therapist and patient have contact and receive information about each other outside of designated therapy times breaks with this ideal setting and the implications for transference will be discussed further in Chapter 5.

Bollas (1987) notes that the therapist offers the patient a regressive space which encourages him or her to relive infantile, pre-verbal experiences in the transference; this recreation occurs "in such a determined and unconsciously accomplished way that the analyst is [in turn] compelled to relive elements of this infantile history through his countertransference, his internal response to the analysand" (p. 200).

This brings us to the role played by the therapist and to the contributions of countertransference to the therapeutic setting. As Joseph (1988c) remarks, "much of our understanding of the transference comes through our understanding of how our patients act on us to feel things...which we can often only capture through the feelings aroused in us, through our counter-transference" (p. 62). Therapeutic change does not occur through transference alone. It is often through the recursive process of giving an interpretation and then observing the response of both patient and self, that its effectiveness can be evaluated and the patient's defensive structure is revealed. Fairbairn remarks that:

what mediates the 'curing' or 'saving' process...is the development of the patient's relationship to the analyst, through a phase in which earlier pathogenic relationships are repeated under the influence of transference, into a new kind of relationship which is at once satisfying and adapted to the circumstances of outer reality. (cited in Guntrip, 1961, p. 307)

2.2.4 Interpretations on the Border:

It is necessary to reexamine the issues involved in making transference interpretations with regard to very disturbed patients. The symbolization of psychotic, borderline and regressed neurotic patients is often faulty. Mere words do not always signify what was intended by the therapist: 'as if' thinking has been replaced with the use of words as 'things in themselves'. McDougall (1978) observes how some patients "frequently use language as an *act* rather than a symbolic means of communication of ideas of affect" (p. 253). She suggests this reveals early, catastrophic failures in communication that occurred when the patient was unable to contain or work through psychic experiences. She proposes that these patients' verbal communication more closely approximates actions, such as crying, screaming or growling, rather than telling something: "such communication would be a means not only of remaining in intimate contact but also a way of conveying and discharging emotion in direct fashion, with the intent to affect and arouse reactions in the Other" (p. 276). Such patients want to be understood "by mere signs" (p. 280) without having to use the normal, verbal channels of communication. They are expressing a "demand to be *heard rather than listened to*" (p. 278). McDougall highlights Bion's observation that, however satisfying symbolic communication might be, "to be *obliged* to speak in order to be understood...is a continuing narcissistic wound in everyone's unconscious. For certain people, fusion and communion, rather than separateness and communication, are the only authentic means of relating to another person" (p. 281).

In his work with psychotic patients, Rosenfeld (1969) found that “omnipotent projective identification interferes with the capacity of verbal and abstract thinking and produces a concreteness of the mental processes which leads to confusion between reality and phantasy” (p. 118).

Segal (1981b) explains this concrete thinking by way of the ‘symbolic equation’:

This nondifferentiation between the thing symbolized and the symbol is part of a disturbance in the relation between the ego and the object. Parts of the ego and internal objects are projected into an object and identified with it. The differentiation between the self and the object is obscured. Then, since a part of the ego is confused with the object, the symbol - which is a creation and a function of the ego - becomes, in turn, confused with the object which is symbolized. (p. 53)

She also notes that: “disturbances in differentiation between ego and object lead to disturbances in differentiation between the symbol and the object symbolized and therefore to concrete thinking characteristic of psychoses” (1981b, p. 52). Thus psychotic patients have a disturbed ability to differentiate between the symbol (Saussure’s ‘signifier’) and that which is symbolized (Saussure’s ‘signified’) (Lemaire, 1970/1977), as well as a confused ability to distinguish between self and object (‘me’ and ‘not me’). This in turn results in confusion between reality and phantasy and a regression to concrete thinking. It ties in with Bion’s (1967c) observations of disturbances in dream function in psychotic patients.

Rosenfeld (1969) links infantile expressions of aggression to the way in which the therapist’s interpretations arouse separation anxiety and envy in the patient and disrupt his or her omnipotent phantasies of merger. Ogden (1983) expounds the dilemma facing such disturbed patients with regard to therapist interpretations: listening entails risking being transformed into the therapist while not listening entails risking severing all ties with the therapist. “Either way, the patient’s existence is threatened” (p. 237).

Spillius (1988b) notes that far more is involved in transference and countertransference than explicit verbal communication. However, Sinason (1991) points out that even when non-verbal cues are utilised, the therapist ultimately relies on words: “however silent, our thinking process is in the medium of verbal language” (p. 12). The patient’s concreteness impacts on both the therapist’s role as well as the form of the transference. Bollas (1987) acknowledges his open struggle to verbally articulate his subjective experiences of non-verbal transference (i.e. projective identifications) with disturbed patients. He gives the term “the unthought known” to these “heretofore inarticulate elements of psychic life” (p. 210). Bollas concludes that “the transference-countertransference interaction, then, is an expression of the unthought known” (p. 230). He has observed how this process leads to the patient’s enhanced ability “to speak elements of himself” (p. 207). This corresponds closely to Bion’s theories of projective identification as a means of developing alpha function.

Steiner (1994) remarks that words are used “not primarily to convey information, but to have an effect on the analyst, and the analyst’s words are likewise felt as actions” (pp. 406-407). Joseph (1988b) recognises that these ‘difficult to reach’ patients are often “doing a great deal of acting, sometimes in speech itself” (p. 49). The difficulty this poses to the therapist is exemplified in Cycon’s (1994) account of her analysis of a patient using paranoid-schizoid defences: “it became clear to me that she was not listening to my interpretations in order to understand and think critically about their content. She seemed to wrap herself in my words and my voice as if they were a warm blanket” (p. 445). At the same time, the patient experienced critical interpretations as cutting, saying that “a good interpretation was ‘like the blade of a knife that you plunge into me with satisfaction.’” (p. 445). For this patient, words functioned on a pre-linguistic level as soothing or persecutory things-in-themselves rather than as symbols that carry meaning. This is the likely explanation for Cycon’s finding that even non-critical and non-collusive interpretations drew painful awareness to the patient’s separateness in relation to the therapist, arousing “primitive and destructive envy of the analyst’s ability to understand, help and satisfy her” (p. 440).

Bollas (1978) describes a similar response from a patient with a schizoid ego structure who was “trying to share a secret with me, in the transference, but it was a secret utterance that was prior to language” (p. 101). He concludes that the patient appreciated the sound of the therapist’s voice: “the analyst’s interpretations are far less important for their content, and more significant for what is experienced as a maternal sound - a kind of verbal humming” (p. 102).

McDougall (1989) elaborates the underlying dynamic:

Disaffected patients, unable to represent mentally an idea linked to its emotional quality, and equally unable...to repress such presentations, must instead have recourse to the more primitive mechanisms of splitting and projective identification to protect themselves from being overwhelmed by mental suffering. The individual then ejects from consciousness the idea with its accompanying affect, instead projecting these onto the representation of another person in his internal world. A representative of this internal world is subsequently sought in the external world. (p. 104)

In ‘normal’ or neurotic transference, the focus lies on the interplay between the patient’s experience of an imaginary, projected therapist and a real therapist. With psychotic transference, McDougall (1978) points out that such differentiation is rarely perceived. For such patients, neither partner in the therapeutic dyad possesses a clearly defined identity and the patient is likely to eliminate any perceptions that do not fit in with his or her preconceived notion of the Other. By means of projective identification, “traumatic thoughts and feelings are in this manner controlled through immediate evacuation from the subject’s own psyche, to be played out in the external world, an attempt at magical fulfilment and narcissistic reparation” (p. 295). The deployment of primitive defence mechanisms reflects psychotic anxieties of the self and the maintenance of identity mobilized by the face of disintegration and fusion (McDougall, 1978).

Projective identification represents a major form of non-verbal communication, which is crucial to understanding the immediate transference situation. That understanding is achieved by taking in and closely tracking the patient's projections until their transference implications become apparent. It becomes important, therefore, for the therapist to work through countertransference feelings and reactions in order to fully understand the transference. Joseph (1988b) points out that "these patients provocatively 'misunderstand' interpretations, take words out of context and attempt to disturb or arouse the analyst" (p. 53), thereby unconsciously coercing the therapist to enact their projective identifications. She suggests that by increasing awareness of the split-off, needy parts of the patient, the therapist's capacity for tolerating and containing without responding is also increased. Rosenfeld (1987) considers the capacity to detect the patient's non-verbal projections as essential in the treatment of psychotic patients. It may require the therapist to "remain quiet and allow oneself to open further so that the projection of the patient does not get blocked by one's personal defensive reaction" (p. 15).

Steiner (1994) discusses the dilemma facing the psychotherapist of such patients, namely whether interpretations should focus on the patient or the therapist's contribution to the transference. According to him, patient-centred interpretations are often experienced as critical, intrusive and persecutory and can arouse anxiety about the therapist's ability to contain his or her projections. On the other hand, analyst-centred interpretations can be taken up as an admission of the therapist's countertransference difficulties in coping with the patient. They can also be experienced as the therapist's self-absorption at the expense of the patient's well-being as well as an attempt to evade, rather than confront, the issues. Ultimately Steiner concludes that the aim of interpretations of these disturbed psychotic and borderline patients should be to contain the patient's projections rather than achieve insight.

2.3 COUNTERTRANSFERENCE

2.3.1 Introduction:

Freud first introduced the concept of countertransference in 1910 and noted that it arises "as a result of the patient's influence on his [the physician's] unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it" (pp. 144-145). Thus countertransference was seen as the psychotherapist's pathological, unconscious feelings towards the patient which represented an obstacle to treatment that should be removed through the therapist's further analysis. Annie Reich (1952), for example, saw countertransference in its 'proper sense' as the therapist's transferences on to the patient, which she concluded was a necessary prerequisite of therapy yet "has to remain shadowy and in the background" (p. 31). At the same time, she acknowledged that the therapist's tool for understanding is her own unconscious.

Freud's work on countertransference was extended by Ferenczi and others (Rayner, 1990). In a series of lectures on psychoanalytic techniques given in 1930, Ella Sharpe noted the need for the analyst to enter into a "profound *dialogue with her own feelings* and hence have them available for her use as possible" (cited in Rayner, 1990, p. 183). Michael and Alice Balint's 1939 paper "On Transference and Countertransference", both broadens and normalises the concept of countertransference. They state that anyone would be expected to respond emotionally to the emotions transferred on to him or her by another person: "the analytical situation is the result of an interplay between the patient's transference and the analyst's counter-transference, complicated by the reactions released in each by the other's transference on to him" (p. 228). In writing on the meaning and use of countertransference, Racker (1957) similarly notes that:

the first distortion of truth in 'the myth of the analytic situation' is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities...and each of these whole personalities...responds to every event of the analytic situation. (pp. 308-309)

On the other hand, Winnicott (1965) argued for the definition of countertransference to be restricted to the therapist's "neurotic features *which spoil the professional attitude* and disturb the course of the analytic process as determined by the patient" (p. 162). He suggested that Margaret Little's term - 'the analyst's total response to the patient's needs' - be used instead of 'objective countertransference', namely the therapist's emotional responsiveness to the actual personality of the patient and based on observation. Winnicott believed that the term had been broadened such that its meaning was being compromised and asked "would it not be better at this point to *let the term countertransference revert to its meaning* of that which we hope to eliminate by selection and analysis and the training of analysts?" (p. 164).

2.3.2 Towards a Working Definition of Countertransference:

Paula Heimann (1950), in her seminal paper "On Countertransference", re-vitalized the concept by moving away from the narrower definitions and applications of countertransference as a hindrance to viewing it as a useful therapeutic tool for understanding the patient. She notes that countertransference is more than the therapist's transference towards the patient, in that it "is an instrument of research into the patient's unconscious" (p. 81). Heimann explains that "the analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's *creation*, it is part of the patient's personality" (p. 83). As such, countertransference can be understood to represent a specific occurrence of projective identification.

I will draw on Heimann's (1950) definition of countertransference as representing "all the feelings which the analyst experiences towards his patient" (p. 81). However, for the purposes of clarity, I will take countertransference to mean the distinctive feelings aroused in the therapist by the *specific* qualities of a patient. This excludes general aspects of the therapist's personality and psychic structure which play a role in all her clinical work (Sandler, Dare and Holder, 1973) and which therefore represent her own transference. Margaret Little (1951) expresses the view that countertransference represents an amalgam of that which is specific to the individual patient and individual therapist concerned: "every counter-transference is different from every other, as every transference is different" (p. 33).

2.3.3 Countertransference as a Facet of Projective Identification:

While Heimann did not expressly mention projective identification in her 1950 paper, her definition identifies the key role played by projective identification in countertransference. She later went on in 1980 to make the connection explicit:

Projective identification occurs as a counter-transference phenomenon, when the analyst fails in his perceptive functions, so that, instead of recognizing in good time the character of the transference, he on his part unconsciously introjects his patient who at this point acts from an identification with his rejecting and intruding mother, re-enacting his own experiences in a reversal of roles. (cited in Rayner, 1990, p. 216)

Although Klein disagreed with Heimann's views, they were taken up by Klein's followers who saw countertransference as "the manifestation of projective identification as an interpersonal phenomenon" (Rayner, 1990, p. 217). Bion, Rosenfeld and others drew on their own emotional responses in the therapeutic setting as a source of information about the patients' state of mind. The link between projective identification and countertransference is borne out in Spillius' (1988b) definition of countertransference as "a state of mind induced in the analyst as a result of verbal and non-verbal action by the patient, thus giving effect to the patient's phantasy of projective identification" (p. 11). She further observes that "arousing the pathology-in-the-analyst is often the means by which the patient effects his projective identification" (p. 11).

Rustin (1991) comments in a similar vein that:

much of what is taken note of and used in the countertransference are the mental phenomena associated with projective identification. That is to say, the countertransference provides the evidence, in the form of the effects on the analyst's thinking and feeling, of patients' states of mind and being....what is significant is that analysts see their mental processes in certain circumstances as liable to be unconsciously 'taken over' by their analysands. (p. 65)

The therapist's need to reflect on and identify personal feelings and reactions to the patient's material has often been written about. Heimann (1950) goes so far as to state that "if an analyst tries to work without consulting his feelings, his interpretations are poor" (p. 82). In such instances, intuition is replaced by theory. She notes:

Our basis assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'counter-transference'. This is the most dynamic way in which his patient's voice reaches him. (p. 82)

Freud (1913/1958c) observed that "everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people" (pp. 320). Heimann (1950) views the therapist's "unconscious perception of the patient's unconscious...[to be] more acute and in advance of his conscious conception of the situation" (p. 82). McDougall (1978) remarks that "*a baby's earliest reality is his mother's unconscious*" (p. 251) which the infant discharges through primitive defences such as projective identification. She suggests that the therapist's countertransference may be the only way to gain access to the patient's experience of pre-verbal, traumatic events.

Heimann (1954) explains the process by which the analyst becomes aware of countertransference, namely when her former state of free-floating attention is replaced by worry, tension or confusion: “what has happened...is that the patient has succeeded in projecting his own resistance, anxiety, and wish to escape from facing his psychic reality into the analyst. The analyst’s freedom of thought has ended, because at this moment his ego has become like his patient’s ego” (p. 166). Thus countertransference reactions are a useful means of detecting projective identifications as well as identifying the patient’s most urgent issues and therefore, the most appropriate interpretations.

Considerable debate has arisen over the difficulty in distinguishing between those countertransference feelings that result from the patient’s transference and those that are defensive against the patient’s transference. Hinshelwood (1991) cautions against applying projective identification too loosely to the transference-countertransference relationship, noting that:

to interpret projective identification in clinical material on the basis of the analyst’s reactions can lead to the suspicion that the analyst is merely attributing his own feelings, without further thought, to the patient, and omnipotently ‘knows’ the patient’s feelings in this directly intuitive way. (pp. 202-203)

This warning is reminiscent of the dangers with which Melanie Klein considered the therapist could misuse countertransference. These included inducing or grafting her own neurosis on to the patient (Racker, 1968) or being preoccupied with her internal feelings at the expense of making emotional contact with the patient. In this way, the therapist is guilty of enacting the narcissistically involved parent to the infant-patient, a common pattern of pathology among narcissistically disturbed patients (Ogden, 1979).

Sharpe noted in 1947 that “to say that...an analyst will still have complexes, blind spots, limitations is only to say he remains a human being. When he ceases to be an ordinary human being he ceases to be a good analyst” (cited in Sandler, Dare and Holder, 1973, p. 67). The more self-awareness the therapist has, the less likely she is to make false attributions towards her patients. Heimann (1950) recognised the danger of employing a wider definition of countertransference and cautioned that “it does not represent a screen for the analyst’s shortcomings” (p. 83). Spillius (1988b) observes that “in spite of Klein’s doubts, her colleagues continued to use her idea of projective identification as an important factor in counter-transference” (p. 10).

2.3.4 The Facilitating Environment of the Therapist:

The therapist functions as container for the patient’s intolerable experiences. This occurs through repeated cycles of projective and introjective identifications. The therapist’s role is to resist discharging and enacting countertransference feelings by becoming increasingly able to sustain and reflect on those feelings. This is akin to Winnicott’s (1965) notion of the mother representing the infant’s facilitating environment as well as Bion’s concept of the mother’s optimal use of reverie (and therefore alpha-function).

The therapist has to listen on a number of different levels to what is being overtly said, what is being covertly implied, how the message is being delivered as well as what is being omitted. Since much of the patient's communication is unconscious, the therapist requires emotional sensitivity rather than reactivity. This aspect of countertransference corresponds with Racker's 1957 concept of "concordant identification" whereby, through patterns of introjection and projection, the therapist recognises the resonance of the patient's material with her own, and vice versa. At the same time, the therapist also experiences "complementary identification", whereby in response to the patient treating her as an internal object, she identifies herself with that object. Unless the therapist develops an internal "ego observer" (Racker, 1953, p. 323) or an "internal supervisor" to use Casement's (1985) term, she will probably act out in the countertransference. Thus, the therapist's self-awareness must be well developed to allow her to tease out the patient's transference from her own unconscious phantasies and defences.

In addition, the therapist needs to be able to tolerate extended periods of 'not knowing', during which time conscious thought processes can catch up with unconscious intuitions. Bollas (1987) observes that "the most ordinary countertransference state is a not-knowing-yet-experiencing one" (p. 203). This requires the clinician to have a well-established sense of identity which can then be temporarily lost in the patient's projective identifications and transference. In this way, the therapist permits herself to be used as an object by the patient (Winnicott, 1971) who can gather together his or her bits, thereby facilitating ego integration.

Winnicott (1958) notes that while hate is part of the normal range of emotions felt by the therapist in relation to her patients, it is particularly challenging to contain those angry and murderous impulses felt towards psychotic patients. He likens the analyst of the disturbed patient to the mother of a newly born infant, stating that both must learn to tolerate hating the infant-patient without acting on those impulses. This may require the mother-therapist to resort to masochistic absorption of the infant-patient's attacks on her until greater ego separation and differentiation is possible:

the most remarkable thing about a mother is her ability to be hurt so much by her baby and to hate so much without paying the child out, and her ability to wait for rewards that may or may not come at a later date. (p. 202)

Winnicott (1958) takes this a step further by suggesting that the patient's ability to tolerate feelings of hatred towards the therapist is contingent on the therapist being able to hate him or her. Ultimately, the therapist will inevitably fail to contain the patient's projections from time to time. It is useful to refer to Winnicott's concept of the 'good-enough mother' (1971) in which disillusionment is implicit. The mother disillusiones the infant (and vice versa) as part of preparing him or her to meet his or her own needs in a realistic way. However, she cannot succeed unless there has been sufficient opportunity for illusion: "for this illusion to be produced in the baby's mind a human being has to be taking the trouble all the time to bring the world to the baby in understandable form, and in a limited way, suitable to the baby's needs" (1945, p. 142). Similarly the therapist needs initially to provide that illusion to the patient through receiving his or her projective identifications. She can then gradually disillusion the patient who may hold an idealized view of her as someone who can intuit her unspoken, and even as-yet-unknown, feelings and thoughts.

Thus, it is one of the therapist's primary functions to allow herself to be the container of the patient's projective identifications: "the infant within the adult person cannot find a voice, however, unless the clinician allows the patient to affect him, and this inevitably means that the analyst must become disturbed by the patient" (Bollas, 1987, p. 204). Ogden (1983) likewise states that "it is not possible to analyse the transference without making oneself available to participate to some degree in this form of [induced] identification" (p. 236). He points out that being a container does not imply that the therapist is an empty receptacle for the patient's projective identifications (1979). It is precisely because the therapist comes with her own past, conflicts and unconscious phantasies that containing those projections requires considerable effort and skill on her part. Essential to therapeutic progress is the clinician's understanding of that induced role, without which the therapist is merely repeating the patient's existing interactional patterns.

2.3.5 Making Countertransference Interpretations:

There has been some dissension about whether or not to reveal countertransference feelings to the patient. Heimann (1950, 1954) believes it is the therapist's private affair and ought not to be shared: "such honesty is more in the nature of a confession and a burden to the patient. In any case it leads away from the analysis" (1950, p. 83). Rustin (1991) points to the contrast between the patient who is encouraged to share all his feelings and thoughts with the analyst and the analyst whose understandings and mental work relating to countertransference is largely hidden from the patient: "this is a highly self-reflective activity, and one which must by and large take place as a solitary process in the analyst's mind, only its outcome in decisions to say this or that being known to the patient" (p. 98).

Some therapists believe that the use of countertransference information by the therapist should be restricted to formulating transference interpretations. Therapists such as Bollas (1987), Little (1951) and Winnicott (1958) believe it is useful to share these responses. Little notes that "not to refer to counter-transference is tantamount to denying its existence, or forbidding the patient to know or speak about it" (p. 38). Winnicott (1945) argues that it is important that the patient is aware of the negative countertransference reactions in order to be able to experience his or her own hateful feelings: "the patient who is asking for help in regard to his primitive, pre-depressive relationship to objects needs his analyst to be able to see the analyst's undisplaced and co-incident love and hate of him" (p. 138). Winnicott likens aspects of the therapeutic frame, such as the end of the hour, as important manifestations of hate, just as good interpretations are symbolic of love and good nurturing.

Bollas (1987) argues convincingly that through indirect and, less often, direct sharing of countertransference, the therapist is able to help the patient find lost, split-off parts of himself or herself - that which he refers to as 'the unthought known'. In this manner, she can re-engage the patient in the free (verbal) associative process: "in many patients the free associative process takes place within the analyst, and the clinician must find some way for his internal processes to link the patient with something he has lost in himself" (p. 205). Bollas explains that "by direct use of the countertransference I mean that quite rare occasion, one which may be of exceptional value to the effectiveness of the analysis, when the analyst describes his experience as the object" (p. 210). By

indirect countertransference, he refers to tentative statements made by the analyst which are offered into the transitional space to be considered and tossed around by patient and clinician. Such interpretations are heralded by statements such as ‘It occurs to me’, ‘I wonder’, and ‘I’m thinking that’.

Bollas (1987) believes that “the psychoanalytic understanding of the transference-countertransference discourse is a way of thinking the unthought known” (p. 230). Thus he seems to be arguing for the unique value of countertransference in assisting with analysing patients who have had pre-verbal traumata, in particular psychotic patients. This is corroborated by Bion’s (1967a) account in Second Thoughts of how he relied on countertransference in order to gain an understanding of the mental state of psychotic patients who were unable to communicate that state verbally. The curative process of therapy involves being used by the patient in the transference as an object and making sense of that usage in the countertransference as the subject. Little (1951) suggests that “the more disintegrated the patient the greater is the need for the analyst to be well integrated” (p. 35) and that work with psychotic patients relies entirely on the therapist’s countertransference. Rosenfeld (1987) concurs, stating that:

contact with one’s own hidden psychotic areas is an essential part of being in touch with the patient and the psychotic transference relationship... We have to realise that in treating psychotic patients (even more so than ordinarily) both the analyst’s personality and his intellect are his tools in the treatment, and therefore his mental health is an extremely important factor. (pp. 18-19)

2.3.6 Abnormal Forms of Countertransference:

Money-Kyrle (1988) distinguishes between normal and disturbed countertransference. In the former, the therapist feels empathy for the patient’s welfare without becoming emotionally involved with him or her. He notes that therapists are motivated by scientific curiosity as well as the parental and reparative drives. The parental drive refers to the analyst’s concern with the patient’s unconscious child part and the way in which this part of the patient often relates to the analyst as a parent. The reparative drive reflects that “in some degree, the patient must stand for the damaged objects of the analyst’s own unconscious phantasy, which are still endangered by aggression and still in need of cure and reparation” (p. 23). He suggests that “it is just because the analyst can recognize his early self, which has already been analyzed, in the patient, that he can analyze the patient. His empathy and insight, as distinct from his theoretical knowledge, depend on this kind of partial identification” (p. 23). It is through insight that the analyst is able to partially identify with the patient and employ her unconscious to understand the patient.

However, normal countertransference cannot be sustained because the analyst is not omniscient, the patient is not always cooperative and he or she may have difficulty sustaining contact. Money-Kyrle (1988) believes the breaks in understanding occur when the patient too closely resembles an incomprehensible part of the analyst. Once there is a break in understanding, the therapeutic relationship is altered. The anxiety aroused in the analyst has to do with the limited therapeutic tools at her disposal: all she has to offer the patient is her interpretation and when that fails, the resultant anxiety in turn diminishes her understanding. The therapist has to deal with her emotional distress internally before being able to disengage sufficiently in order to deal with the material.

The degree to which the therapist will be disturbed by not-understanding depends on the extent of her need for continual reassurance of success and the severity of her superego, which may make it difficult for her to tolerate her limitations. Where the therapist's reparative drive is thwarted, it may result in positive or negative countertransference. She may reassure or attack the patient respectively. The patient in turn may be facilitating this process by trying to provoke such a feeling in the therapist. Little (1951) describes how positive countertransference can operate destructively in long-term therapy. The therapist's narcissism leads her to treat the patient as an object of reparation: "it becomes necessary to make that same patient well over and over again, which in effect means making him ill over and over again in order to have him to make well" (p. 34).

When the countertransference is positive, it can result in the patient splitting the therapist from the bad objects, thereby preventing expression of his guilt and working through the depressive position. If it is overly hostile, the patient may come to stand for the analyst's bad and persecutory objects which she would like to get rid of, thereby perpetuating the cycle of persecution and despair.

Money-Kyrle (1988) suggests that therapists tend to get stuck in either an introjective or projective position. In the former symbiotic pattern, the therapist feels burdened with the patient and with her own immature aspects. This may, on the one hand, represent self-punishment for having unconsciously intended to hurt the patient. It also represents the patient's attempt at projecting himself or herself into the therapist in order to punish her and prevent separation. In the latter case, she defensively returns the patient's projections (even projecting parts of herself) with the result that "the patient remains an incomprehensible figure in the external world" (Money-Kyrle, 1988, p. 25). Money-Kyrle notes that such disturbed countertransference

probably take[s] up a lot more analytic time than we readily remember or admit. Yet it is precisely in them, I think, that the analyst, by silently analysing his own reactions, can increase his insight, decrease his difficulties, and learn more about his patient. (p. 31)

2.3.7 The Therapist as Mirror:

This brings us to the issue of therapist neutrality. Freud (1912/1958a) wrote that "the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p. 118). Annie Reich (1952) remarks that "it is, indeed, not an easy task to be able, on the one side, to feel oneself so deeply into another person as the analyst has to do in order to understand, and, at the same time, to remain uninvolved" (p. 25). Brenman Pick (1988) employs the analogy of the therapist "walking the tightrope between experiencing disturbance and responding with interpretation that does not convey disturbing anxiety" (p. 34). She has to find the balance between remaining in contact with the importance of personal experience while at the same time, remaining loyal to the value of technique. The clinician faces the difficult task of being both analytically neutral as well as emotionally in-tune with the patient.

It seems that Freud's use of the mirror metaphor has led to some confusion about where on the continuum the therapist should lie, with some concern about whether the therapist should be emotionally detached. Greenson (1978) understands Freud's mirror image to imply the need for opacity on the part of the therapist such that

only the patient's conflicts are reflected, without any distortion of the therapist's personal values or feelings. The less the patient knows about the therapist, the better. Notwithstanding that, Greenson acknowledges that this is relative since everything in the office and routine reveals something of the therapist. The patient's intuition further enables him or her to get to know the therapist.

Winnicott (1965) notes that "the analyst's own analysis was in effect a recognition [by Freud] that the analyst is *under strain in maintaining a professional attitude*" (p. 160). He states that the therapist must remain emotionally vulnerable while at the same time retaining a professional stance. He goes on to liken the professional attitude to symbolism "in that it assumes a *distance between analyst and patient*" (p. 161).

Bollas (1987) speaks of the need to establish "countertransference readiness", by which he means maintaining an internal potential space that allows the patient to re-experience infantile life without the impingements of the clinician's judgement (p. 201). He values the therapist's spontaneity and authenticity in the therapy situation and remarks that:

No analyst is ever neutral once he has met the patient...no two patients ever use the analyst's personality elements to achieve specific functions in the same way...The patient's unconscious use of the analyst's true conviction is vital to his eventual well-being. (cited in Rayner, 1990, p. 242)

Winnicott (1965) claimed to be truly professional in making interpretations:

On the one hand I may have stomach ache but this does not usually affect my interpretations; and on the other hand I may have been somewhat stimulated erotically or aggressively by an idea given by the patient, but again this fact does not usually affect my interpretative work, what I say, how I say it or when I say it. (pp. 161-162)

Winnicott (1965) does make a case for dropping this professional attitude with anti-social and borderline/psychotic patients. In the latter category, patients are likely to break down during treatment, allowing the hidden, true self to emerge. He states that "the analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient" (p. 163). He acknowledges that the borderline psychotic patient breaks through the therapist's professional attitude and "forces a direct relationship of a primitive kind, even to the extent of merging" (p. 164). Here Winnicott appears to be talking about the operation of projective identification.

Greenberg and Mitchell (1983) point out that the therapist not only participates in the patient's transference patterns but also precipitates them. This reflects the interactional and inherently dyadic nature of psychotherapy:

The analyst's participation exerts a pull on the patient, and the analyst serves as co-creator of the transference. Similarly, the patient's experience of and behaviour towards the analyst exert pulls on the analyst, who can usefully employ his awareness of these pulls in the service of understanding the patient's *relational* patterns. Thus, countertransference provides the crucial clues to the predominant transference configurations, since transference and countertransference reciprocally generate and interpenetrate each other. Countertransference is an inevitable product of the interaction between the patient and the analyst rather than a simple interference stemming from the analyst's own infantile drive-related conflicts. (p. 389)

In this way transference and countertransference are viewed differently in the relational model than in the drive model of therapy. The analyst's task is not to remain outside the process but rather to actively engage the patient and to participate, with the aim of transforming pathogenic relationship patterns.

In focusing on the role of the therapist, Greenberg and Mitchell (1983) point out the different roles demanded of the different psychoanalytic models: the drive model requires neutrality while the relational model requires participation. The decision about where one falls on that spectrum is influenced by several factors including personality, personal experience in therapy and supervision and individual clinical judgement. The relational model (within which this paper is located) emphasises the therapist's attentiveness to patterns of mutual influence in the therapeutic dyad and encourages the use of countertransference as an empathic tool.

2.4 BRIEF THERAPY AND THE APPLICATION OF TRANSFERENCE-COUNTERTRANSFERENCE PHENOMENA

This section examines the applicability of transference and countertransference phenomena in relation to brief psychotherapy. When considering brief therapy, we need to evaluate the degree and intensity to which transference and countertransference phenomena occur as well as whether to interpret or avoid these phenomena. A cursory review of the research (Frances, 1986; Malan, 1979; Mann, 1986; Perry & Michels, 1986; Schafer, 1986) failed to provide a definitive answer.

Mann (1986) draws our attention to the lack of clarity as to what constitutes brief therapy, suggesting that anything from one session to two years could be defined as such. He believes there is increased emotional intensity in brief therapy: "the emotional life of the patient is at a substantial boil from the first session to the last" (p. 125). Malan (1979) concludes that brief and long-term therapy exist on a continuum, with little or nothing to differentiate them. He regards transference interpretations - both positive and negative and particularly those linking transference feelings to parental relationships - as the most important procedure in producing enduring psychodynamic change in *all* forms of psychodynamic therapy.

Frances (1986) leaves it up to clinical judgement as to whether transference interpretation is crucial, irrelevant or potentially harmful in each focal therapy. He suggests that transference needs to be addressed in brief therapy in the following instances:

- where it represents a form of resistance;
- where it develops rapidly;
- where it mirrors the patient's main complaint;
- where such interpretations are seen to strengthen the therapeutic alliance;
- where the patient's has sufficient ego strength; and
- where there is sufficient time to explore transference in a manageable way.

It emerges from the literature that the real attributes of the therapist (namely age, gender and culture) play a larger role in either triggering or suppressing transference reactions in short- as opposed to long-term therapy (Frances, 1986, p. 112). Against this, we need to consider the assertion of psychoanalysts such as Ella Sharpe that “transference begins with the very first analytical session” (cited in Sandler, 1983, p. 39). Certainly in my limited experience, strong transference (and for that matter countertransference) reactions are present prior to the therapist and patient even meeting. These can occur in response to factors such as a person’s name, imputed ethnic background or physical address. I saw a patient who developed a very strong negative transference from the moment I introduced myself. She believed that her husband was romantically involved with a woman who shared my first name. In a highly emotional moment that occurred early in her treatment, she screamed, ‘And I hate your name!’ . Up until then, she had ‘protected’ me by concealing her reaction to my name. This can also be understood as a defensive manoeuvre on her part in order to deny the existence of the other woman.

In conclusion, it appears that the key issue is not whether or not transference phenomena are present in brief therapy; rather it is the degree to which that transference is taken up by the therapist on the one hand, and the regression that occurs in the patient, on the other. This also brings into question the suitability of brief therapy as the elected treatment method for each patient. Malan (1979) suggests the following criteria for brief therapy:

- (i) a clearly identifiable life problem which offers a discrete therapeutic focus;
- (ii) evidence of patient responsiveness to trial interpretations around this theme;
- (iii) patient motivation; and
- (iv) considering the possible dangers of brief therapy as well as ruling out or minimizing them. Such dangers could include destructive acting out and risk of suicide.

To this list can be added:

- (v) realistic financial considerations which often rule out long-term therapy; and
- (vi) the high or limited case loads of therapists offering subsidised treatment.

There is a dearth of information on countertransference in brief therapy which Mann (1986) suggests may be owing to a subtle devaluing of brief psychotherapy by therapists who respect the analytic process. Schafer (1986) relates how brief therapy can impede the therapist’s reparative needs as well as enhance her sense of helplessness and imperfection. She may feel apologetic about the limitations of treatment and seek reassurance from the patient as to its usefulness. Countertransference zeal arising from the therapist’s need to be omniscient can result in identifying the treatment focus overly quickly. This places the patient at risk of being exposed to unwarranted or restrictive interventions or being abandoned as a poor therapy candidate. In this way, “through what may be called countertransference therapeutic zeal, the therapist tries to deny how difficult it is to bring about change based on true and insightful modification of defenses [sic]” (Schafer, 1986, p. 155). Schafer reports that countertransference guilt can result in the therapist introducing an apologetic or defensive tone, by demanding cooperation from the patient and/or punishing him or her for not making progress. These issues peak around termination with its issues of separation and loss. The difficulties are compounded with increasing brevity of therapy duration.

Schafer (1986) proposes that the therapist is likely to cope with this difficulty through defensive detachment or aloofness and working more by formula than by feel. Alternatively, the therapist may be intent on achieving manic endings to therapy, such as a shared illusion of cure. Mann (1986) also relates the increased pressure on the therapist working in a time-limited manner to countertransference resistance around termination:

Uncertainty about one's competence to do this [rapid work] creates a readiness to feel guilty as treatment goes on. A positive transference usually makes treatment sufficiently comfortable to make one wish to continue, whereas negative transference stimulates guilt and the feeling that one must do more and give more. (p. 125)

This seems to align with Money-Kyrle's (1988) observations about the therapist's reparative drive, own narcissism and need to feel useful. Schafer (1986) notes that "brief therapy inherently thwarts these reparative needs....From the patient's standpoint, however, the guilty therapist is a narcissistic manipulator, one who burdens them with his or her own needs for reassurance" (p. 153). Mann (1986) endorses the view that in brief therapy "the narcissistic gains in having patients become dependent on us are felt to be aborted from the start" (p. 126).

Thus it appears evident that transference and countertransference issues are prominent in brief therapy. There are particular difficulties that the brevity of treatment poses, including the need to make sense of transference and countertransference under pressure of time and with a less complete knowledge of the patient. It is evident that an understanding of the phenomena of transference and countertransference is essential. The extent to which the therapist will apply these concepts ultimately depends on the particular needs of each therapy case.

2.5 PSYCHOSOMATIC MANIFESTATIONS AS FAILURES OF PROJECTIVE IDENTIFICATION

Winnicott (1988) states that:

the basis of psyche is soma, and in evolution the soma came first. The psyche begins as an imaginative elaboration of physical functioning...Human nature is not a matter of mind and body - it is a matter of inter-related psyche and soma, with the mind as a flourish on the edge of psycho-somatic functioning. (p. 16-26)

It is not surprising, therefore, that psychological distress has its physical counterparts, and vice versa. Furthermore, it follows that primitive psychic phenomena are important in understanding psychosomatic disturbances. For example, Winnicott (1988) describes how a person's pain threshold would be lowered were he or she to identify that pain with a persecutory internal object. He explains the psychiatric term 'depersonalization' as the loss of relationship between psyche and soma. Conversely, integration and well-being are achieved when the psyche resides in the body.

McDougall (1978) notes that it takes the infant some time to achieve unity between psyche and soma, i.e. to dwell in his or her body: “the feeling of identity is structured around the conviction of being contained in one’s skin, and the certitude that the soma and the self are indissociable” (p. 426). She observes that babies respond to emotional pain psychosomatically since they lack the ability to verbalise such pain. Thus “the infant’s earliest psychic structures are built around nonverbal ‘signifiers’ in which the body’s functions and the erogenous zones play a predominant role” (1989, pp. 9-10).

Projective identification represents one of the non-verbal means of communication that the infant has at his or her disposal. However, McDougall (1978) seems to imply that psychosomatic symptomatology embodies an earlier level of disturbance that precedes projective identification. Rather than communicating distress, psychosomatic symptoms serve to deny any awareness of psychic pain by Self or Other. Projective identification requires some differentiation between ‘me’ and ‘not me’: as such it represents the start of a dyadic relationship. On the other hand, psychosomatic symptomatology seems to be situated in an archaic, “one-body relationship” (p. 392) with an undifferentiated merger of the infant’s inner and outer world. In psychosomatic illness, “the symptoms are signs, not symbols, and follow somatic and not psychic laws” (p. 348).

Psychosomatic symptomatology is precipitated by the disruption in relationships to others who are omnipotently perceived as being a part of the infant or patient’s self and who are used as transitional objects for soothing or as objects to attack and master. McDougall (1989) observes that the thought processes of psychosomatic sufferers often seem to have drained language of its emotional meaning. The body rather ‘over-functions’ to the point of madness: “there is a dissociation between word-presentations and thing-presentations, so that the bodily signals of anxiety (that is the *somatic* pole of affect) becomes equivalent to a thing-presentation, severed from the word presentation that would give meaning to the experience” (p. 102). She likens this process to psychotic thought which uses language in a delusional manner to give meaning to existence and combat the fear of personal annihilation. Both methods of communication seek “to restore the primary mother-child unity, to be understood through and in spite of one’s way of communicating” (1978, p. 291). However, the two processes differ in that psychosomatic thought represents an empty space of nothingness that short-circuits both primary and secondary processes, thereby eclipsing - even refusing - any self-awareness of the presence or meaning of psychic pain. McDougall (1978) elaborates:

To come back then to the striking *differences* between psychosomatic and psychotic creations, we might say that whereas the psychotic child clutches at a delusional ‘monster’ to palliate the lack of the internal object brutally projected outward, the psychosomatic sufferer has precociously laid his monster to rest. He has *lost* them. I would suggest that there are deeply buried archaic fantasy elements encapsulated somewhere in the unconscious, but that these are unarticulated linguistically and thus have no access to preconscious or conscious thought. (pp. 370-371)

This is in keeping with Bion’s concept of beta elements, namely those aspects of psychic experience which cannot be thought about in a meaningful way and which find expression in somatic states. He remarks that “hypochondriacal symptoms may therefore be signs of an attempt to establish contact with psychic quality by substituting physical sensation for the missing sense data of psychical quality” (1962, p. 53).

In reflecting on Bion's theories, Rustin (1991) surmises that when the infant fails to develop a thinking apparatus, "an alternative 'solution' to the problem of sensory and sentient bombardment is found in fragmentation, splitting, or the atomization of experience; *or perhaps simply experiencing this mental pain in somatic ways, by being ill* [italics added]" (p. 208). Thus psychosomatic symptoms can be understood as a failure of projective identification, which in turn represents a failure in symbolization. Segal corroborates this by noting that "the degree of bodily concreteness of projective identification depends on the degree of disturbance in the patient; the more the patient uses defences characteristic of the paranoid-schizoid position, the more concrete and bodily his projections will be" (cited in Spillius, 1988a, p. 85).

McDougall (1989) states that where there is a profound split between psyche and soma:

psychic pain and mental conflict arising from inner or outer stress are not recognized at the level of verbal thought and discharged through psychic expressions such as dreaming, day-dreaming, thinking, or other forms of mental activity; rather, they may lead to psychotic solutions of an hallucinatory kind or find discharge in psychosomatic manifestations, as in early infancy. (p. 43)

The split between psyche and soma leads to a break in the links between primary and secondary processes, with the psyche having to regressively resort to using preverbal, somatic forms of expression: "the psyche has done what it can without words" (p. 66). McDougall (1978) proposes that the risk of somatic discharge is reduced when beta elements begin to find expression both verbally and affectively:

it is possible that constructive (that is protective) fantasy, for dealing with absence and difference, can only be 'stored' as a psychic treasure to the extent to which it is held through words and the early elements of 'thinking,' in the sense of Bion's research. (p. 386)

Patients with borderline personality disorders often present with somatic problems (Giovacchini, 1993). Giovacchini feels that such patients suffer from 'psychic discontinuity' in that "there is not smooth continuum from primitive, unconscious primary-process structures to higher reality-oriented secondary process ego organizations" (p. 232). He describes how a patient is able to free himself or herself of somatic disturbances when he or she is able to bridge that disjuncture (i.e. to make contact with his or her unconscious). He surmises that such somatic symptoms may result from the lack of connecting bridges. Giovacchini concludes that "the empty spaces that characterize psychopathology are somatically organized and devoid of psychic content" (p. 233). Both McDougall and Giovacchini's ideas seem to concur with the views expressed in Bion's (1967c) paper, "Attacks on Linking".

It is through the countertransference whereby the therapist's unconscious apprehends the patient's painful experiences, that somatic embodiments can start to be converted into psychic, symbolic expressions. In this sense, the therapist-mother functions as the thinking apparatus in making sense of the infant's psychic distress (beta elements); she facilitates its expression symbolically and emotionally, rather than somatically.

Kafka (1969) describes ways in which the patient's own body can be treated by him or her as a transitional object and functions as a way of establishing an unfinished body scheme. The patient considers his or her body as a 'not-me' object and enters into a sado-masochistic relationship with it. Kafka concludes that "in analysis the ebb and flow of sadomasochistic transference and countertransference may be conceptualized as a factor contributing to the re-formation of a more integrated, more bodily-ego-syntonic membrane, and thus contribute to the eventual elimination of the symptom" (p. 212). In Macaskill's (1982) exploration of transitional phenomena in relation to borderline patients, he notes that a patient's negative self-image or grandiose phantasy can serve as transitional phenomena that protect him or her from meaninglessness or fragmentation. Psychotic experiences, suicide attempts and self-destructive behaviours can also serve a transitional purpose and this may account for the ego-syntonic quality such phenomena often have in borderline patients. The ideas of both authors can be extended to other forms of somatic expression.

McDougall (1989) recognises that psychosomatic illness acquires a secondary, beneficial significance as both reassurance of the patient's bodily limits as well as proof of his or her psychic survival. It functions in much the same way that psychotic symptoms do: "both states serve an underlying reparative aim in the face of an overwhelming, though often unrecognized, sense of danger" (p. 29). She feels that it is in the patients' telling and sharing of his or her body's unique dialect, that the psyche can directly reclaim the soma's complex translation of its message. "In so doing, the body becomes relieved of its repetitive attempts to find a solution to psychic pain" (p. 171).

"Unlike the laboratory, the psychoanalytic consulting room does not immediately connect with the army recruiting office, with the factory and the advertising agency. It appears situated outside the busy day-time world where definite tasks constantly demand attention, where we are drawn from one practical assignment to the next. This new site strangely draws toward the world of sleep and dreams, of affections, of desires and passions, even of demons, angels, and visions."

Jager, 1983, p. 172

CHAPTER 3: METHODOLOGY

This chapter elucidates the methodological approach adopted in this study and attempts to address some of the methodological difficulties that this type of research typically incurs. It also contextualizes the case study under consideration. I have adopted Clyde Mitchell's (1983) working definition of the case study as "a detailed examination of an event (or series of related events) which the analyst believes exhibits (or exhibit) the operation of some identified general theoretical principle" (p. 192).

Case study methodology was the nucleus of research in psychotherapy as well as many other related fields:

There can be no doubt that most of what the field has learned about psychotherapy since Breuer treated his famous patient Anna O. a century ago has come from astute and creative clinical observations....As participants in and observers of immensely intricate human interactions, we have the opportunity - if we are sufficiently ingenious, perceptive, and sensitive - to make observations, discern connections, form hypotheses, and within limits, test them....In an important sense, as the advocates of single case studies reconfirm, each therapeutic dyad constitutes an experiment, albeit an experiment with built-in limitations. (Strupp, 1981, p. 216)

Notwithstanding its origins, psychology began to imitate nomothetic research methods of the pure sciences, losing sight in the process of the intrinsically scientific nature of careful case study research and of psychotherapy:

in contrast to the highly intuitive insight of the founders of psychotherapy, psychotherapy research tends to involve persistent and excruciating attempts to objectify and quantify experiential and behavioural data in order to isolate variables which supposedly would make up what psychotherapy is. (Kruger, cited in Edwards, 1990, p. 6)

Case study research represents an alternative to such positivistic attempts to research psychotherapeutic processes and outcomes. Kiesler (1981) states that "single case study methodology functions both as an excellent practitioner-training framework as well as a living integration of the basic scientific attitude into out clinical work" (p. 214). Not only is the psychotherapist privy to data that cannot be easily accessed outside the therapy room, but many of the research topics of interest to practitioners cannot be studied by other experimental approaches. This dissertation, examining the processes of transference, countertransference and projective identification, is a case in point. Indeed, experimental methods can even be seen to "obscure the very phenomena which must be understood in psychotherapy research and that constitutes its essence" (Strupp and Hadley cited in Barlow, 1981, p. 150).

The very nature of psychotherapy with its foundation in the unique and multi-determined relationship that is established between therapist and patient does not render it amenable to standardized experimental scrutiny under the laboratory microscope; nor would such 'controlled results' have automatic generality or reliability beyond the individual case. Psychotherapy defies such detached scrutiny; it is not made up of the sum of its parts and therefore alternative methods of research need to be used.

Casement (1990) points out the inescapable conflict facing practitioners:

On the one hand, we need to be familiar with whatever can be established as common clinical experience: without a sufficient framework we would be relying too much upon guesswork and intuition. On the other hand, we are constantly being challenged to discover what else may apply better to the individual patient. Because the diversity of human interaction goes so far beyond the strictures of any science, what we do as analysts will not always be manifestly consistent or without its contradictions. (p. 167)

Kratochwill, Mott and Dodson (1984) stated that “single case study methodologies...are uniquely suited to evaluation of treatments involving a single client” (p. 55). As Yin (1984) puts it, “the distinctive need for case studies arises out of the desire to understand complex social phenomena. In brief, the case study allows an investigation to retain the holistic and meaningful characteristics of real-life events” (p. 14).

The case study has been criticized for being an ‘N=1’ study. However, as further cases are added over time, the sample size increases and approximates nomothetic research (Kiesler, 1981, p. 213). In addition, as Yin (1984) points out, “case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes” (p. 21). Statistical generalizations based on frequencies are of little use to the practitioner. Put antithetically, theoretical principles do not apply uniformly to individual cases. The clinician cannot mechanically apply research results and bodies of theory to patient treatment; the idiosyncratic nature of the psychotherapeutic relationship requires the therapist to gain an understanding of the individual patient’s dynamics and to forge a unique relationship with him or her. Clyde Mitchell (1983) who stresses the intrinsically heuristic nature of the case study, underlines this point by stating that “the presentation of a case study is significant only in terms of some body of analytical theory” (pp. 203- 204) and its generalizability depends on the adequacy of that theory rather than the particular instance itself.

For the above reasons, it was considered appropriate to employ a phenomenological, single case study design in order to illuminate aspects of transference and countertransference mechanisms. It is hoped that this case study will render these theoretical principles quickly accessible and comprehensible to the reader.

A proposal was submitted to the Multi-Disciplinary Research Committee at Tara, the H. Moross Centre and approval was granted. The committee considers, among other things, any additional demands made on patients or hospital staffing, the ethical nature and the academic value of the research. It was proposed that case material would be drawn from those individual therapy patients seen during my six month rotation at Tara’s Wards 4 and 5 from July through to December 1995. Since the research fell within the requirements of the psychology internship, no additional work was imposed on either hospital staff or patients in conducting this research. The research further complies with the American Psychological Association’s ten ethical principles in the conduct of research with human participants (Christensen, 1980).

By way of background, Tara the H. Moross Centre is a government psychiatric teaching hospital situated in Johannesburg's exclusive northern suburbs. Wards 4 and 5 are male and female in-patient adult psychotherapy wards holding 10 and 18 beds respectively. The average length of hospital treatment is 4-6 weeks. The patient profile on these wards constitutes a majority of white, English-speaking women ranging in age from their late teens to mid-sixties, with a mean age of 32 years. On the whole, patients are relatively well educated and psychologically minded. The patient diagnostic profile reflects predominantly Substance Abuse, Adjustment Disorder and Major Depression on Axis I (representing clinical disorders according to the multi-axial classification of the 1994 Diagnostic and Statistical Manual of Mental Disorders-IV), with Cluster B and C Personality Disorders making up the bulk of Axis II diagnoses (representing personality disorders). Personality variables were an important factor in the referral of patients to wards 4 and 5. The above statistics are based on demographics collected by an occupational therapist between March and August 1994 (refer to Appendix 1) and have been corroborated as well as supplemented by my own observations during my internship in 1995.

The thrust of the treatment is psychotherapy-based, with pharmacotherapy as an adjunct. A range of therapeutic approaches is employed, depending on the patients' needs and staff expertise. These wards have an egalitarian and unified team-based approach to treatment. The multi-disciplinary team consists of a consultant psychiatrist, psychiatric registrar, clinical psychologist, social worker, occupational therapist, psychiatric nursing staff, two intern psychologists as well as a variable number of students from all disciplines.

It is worth commenting on certain aspects of the ward set-up which have potential bearing on treatment. Ward rounds were held in a room that also served as the patients' lounge. During these meetings, patients could overhear staff laughing. Staff would walk through the women's ward in order to reach the room, in the process encountering patients in their beds or getting dressed. I once observed a therapist stop and encourage her patient to get out of bed *en route* to ward round. After assessing new patients, the team typically has a lavish tea which one of the team members provides and it is customary for patients (as part of their ward duties) to prepare and lay out the food. This process seems to represent some kind of reciprocal feeding, whereby the patients are required to sustain the therapists who have been nourishing them. Some patients elaborately decorate trays of food while others express resentment at this duty. A process of group transference and countertransference can be seen to operate which falls outside the realm of this paper yet would be interesting to investigate further.

Patients were allocated to me by the usual ward procedure, namely at biweekly ward rounds following a brief presentation of the patient's history by the referring professional and a face-to-face interview with the patient and the entire multi-disciplinary team. Details about the research were explained to all my patients at the outset of therapy and all questions raised by the patients were answered. Patients were asked to sign a declaration agreeing to be part of a research project in fulfilment of the requirements of the internship that looks at the process of therapy. I explained that I was asking all my patients to be part of the research, however, I would select one or two therapies which I would then write up. It was made clear to patients that their participation

was voluntary and that they would not be disadvantaged should they elect to withhold consent. In addition, they have the option of withdrawing from the study at a later stage without any consequences. Termination of therapy would constitute debriefing. Patients were assured that confidentiality of their personal details would be protected by changing personal details in such a way that it is difficult to identify the patient. Finally, patients were asked to sign a consent form, agreeing to the above (Refer to Appendix 2).

While this meets ethical requirements, it probably has some impact on the patient's perception of the therapist. All patients were made aware of the internship status of the therapist. However, being asked to participate in university research highlights the student-role of the therapist and could be seen as contaminating her neutrality.

The therapy that forms the basis of this case study took place over a period of 5 months. I saw the patient three times a week during her 7-week admission. Her in-patient treatment program included pharmacotherapy, closed and open group therapy, occupational therapy as well as therapy with an assigned nurse therapist. The open group therapy was facilitated once a week by another intern and myself. These blurred boundaries in the therapist-patient relationship posed certain challenges which will be explored in the following chapter. After discharge, I continued to see the patient for therapy twice a week. The patient then elected to reduce her sessions to once a week for the remaining two months. Termination was prompted by the end of the internship and the South African Medical and Dental Council's ruling that interns are prohibited from seeing patients until they have completed their course requirements and registered with the Council.

I received individual clinical supervision twice a week with two different supervisors. One of those sessions was dedicated to supervision of this case. Detailed process notes were kept of all sessions. In addition, some sessions were tape recorded and verbatim transcripts were prepared. I was also in my own therapy twice weekly which was the forum for dealing with countertransference issues evoked by the case.

The patient readily agreed to signing the consent form. Every care has been taken to conceal her biographical details and protect her confidentiality. I would like to express my gratitude to the patient for giving her permission and it is hoped that the benefits of making the material public will justify this encroachment into the private sphere. Background information was taken from several sources, including the student nurse who admitted the patient, myself who obtained a history from the patient, various psychiatric nursing sisters who were involved in other aspects of the patient's treatment, the consultant psychiatrist who saw the patient privately on several occasions and the patient's husband who was interviewed by nursing staff for collateral. All this adds weight to the validity of the history yet by no means implies that it represents an 'absolute truth'. Rather, it allowed me to track the nuances in the patient's 'storying' of herself, nuances that reflected her varying levels of distress and insight.

Given the focus of this dissertation, case material has been restricted to illuminating those aspects of the therapy that are relevant to the theoretical principles being discussed. As such, the density and rich interconnectedness of the therapy material may not be adequately or validly reflected in the account that follows; neither does the account of the therapy reproduce the chronological unfolding of material. As Clyde Mitchell (1983) notes, “in interpreting the events in any particular case theoretically the analyst must suppress some of the complexity in the events and state the logical connections among some of the features which are germane to the interpretation” (p. 205). This is one of the shortcomings of this type of research.

"A body that suffers is also a body that is alive"

McDougal, 1992, p. 152

CHAPTER 4: HISTORY AND FORMULATION

The patient, Loretta, a married, childless woman in her early 40's, presented as underweight and petite with long blonde hair and a carefully made-up face. She was expressive, animated and displayed a high level of anxiety. This was her first psychiatric admission. She had called the consultant psychiatrist asking for urgent admission. Loretta had been referred by an endocrinologist who had seen her once for numerous physical complaints, including hypoglycaemia, dextrose and lactose intolerance. She had no history of substance abuse but her surgical and medical history was substantial. She noted that people do not seem to believe her physical symptoms which she found irritating because she did not know how to convince them otherwise.

Loretta initially reported suffering from panic attacks with associated physical symptoms, including anxiety, shivering, hyperactivity, abdominal pain, tachycardia, nausea and blurred vision. Much of this could be accounted for medically in terms of hypoglycaemia. These symptoms had intensified three weeks prior to admission when she received the news that her mother was supposedly dying of cancer and rushed off to be with her. This was later discovered to be unfounded - Mother had a serious gastric condition which could become cancerous and life-threatening at a later stage. She had had suicidal ideation for the first time. On admission, she denied feeling depressed. However, on later reports it was evident that she had neuro-vegetative and cognitive features of depression, including marked weight loss. A further precipitant appeared to be a recent diagnosis of early menopause by her gynaecologist who recommended a hysterectomy for her prolapsed uterus. Loretta was distressed to think of "losing my womanhood".

Loretta also displayed fixed ideas about food that seemed to approach delusional proportions. She had been on a self-inflicted, extremely restrictive diet for the past few years and claimed that these foods were now "antagonistic" towards her. She was markedly underweight and made a strong connection between the present time when she could see herself "disappearing" from weight loss and her last pregnancy where she felt as if she were disappearing under the "rising water level" of oedema; she had also experienced panic attacks. She appeared to have suffered from clinical depression at that time. The day after admission, Loretta developed an appetite and gradually began eating a wider range of foodstuffs.

In terms of her psychiatric diagnosis using the 1994 Diagnostic and Statistical Manual-IV (DSM IV) multi-axial system, Loretta met the criteria for the following Axis I disorders:

- Depressive Disorder, Recurrent with postpartum onset
- Anxiety Disorder Due to a General Medical Condition (Hypoglycaemia)
- Eating Disorder Not Otherwise Specified
- Somatization Disorder

On Axis II, she displayed features of Mixed Cluster B personality disorder, with prominent Narcissistic and Histrionic features. Such labels ultimately obfuscate a dynamic understanding of the patient. I found it hard to fit this patient neatly into a DSM IV pigeon-hole for personality disorders. Loretta appeared to exist on the border between psychosis and neurosis, with considerable resilience and resourcefulness alongside her “mad” moments. At times she was proficient, receptive and actively verbal in individual therapy while on other occasions she employed defence mechanisms associated with Klein’s paranoid-schizoid position, in particular splitting and projective identification.

On Axis III, Loretta had a mitral valve prolapse (which is associated co-morbidly with Panic Disorder) as well as a prolapsed uterus and possible early menopause. She was underweight with hypoglycaemia and had a long history of candidiasis.

Loretta related a history of anxious and withdrawn behaviour dating back to early childhood. She was a planned baby born to European parents in a war-torn North African country. She grew up in primitive conditions. English was not her first language and while she could express herself fluently, at times she mispronounced words or used neologisms. Loretta described having a conflictual relationship with Mother whom she depicted as “a robot”, withholding, perfectionistic, self-preoccupied and demanding. Mother, who was abandoned emotionally by her own mother in her infancy (the maternal grandmother was widowed when Mother was an infant and had to work in order to support the family), could only perfunctorily meet Loretta’s needs for food and cleanliness. Even then, she often missed her child’s needs by cramming her with food until her stomach hurt. Loretta’s early experiences of feeding were often intrusive, excessive and invasive. Mother was unaffectionate and withheld her love once Loretta attempted to separate. In her words, Mother had “a passion for things that didn’t move much...so I suppose she stopped loving them (the children) as they grew up because they were not little dolls”.

Father, in turn, was a loner, passive and “intellectual”, preoccupied with his own studies and emotionally unavailable; he discharged his duty towards his family by supporting them financially. Loretta claimed to be fast developer and to be able to read by age 4; she retreated into a world of reading and isolation. She once said in therapy: “Give me anything that seems to be isolated. I can deal with it. But when it comes to the social point of it, I get exhausted”. As a child, she was unable to play with dolls or other children, modelling herself rather after Mother and Father by ‘playing’ with books as well as pots and pans.

Father’s work meant the family moved frequently. Once her schooling began at age 5, Mother lived separately from Father. Loretta was left with neighbours over the ensuing five years when Mother visited Father. During that time, a sibling was born with whom Loretta had a distant relationship. During Mother’s absences, Loretta claimed to have been abused “not physically, not quite sexually but rather emotionally” by the neighbours’ older son. The parents’ marriage was always troubled and their separation became permanent. Father isolated himself further from the family. He had a second family with his common-law wife. Loretta had no contact with Father after she married; he died of alcoholism and lung cancer. Mother never remarried.

When Loretta was 10 years old, Mother returned with her children to live with her mother in Europe for a number of years. Loretta claimed to have first developed anxiety symptoms from this age because she was pushed to achieve scholastically. She appeared to have difficulty establishing appropriate interpersonal relationships throughout her schooling. Loretta obtained her matric certificate as well as a diploma in alternative medicine.

Thus it appears that Loretta was prematurely pushed into a position of self-reliance and pseudo-adult ways from an early age. It is likely that her ego had difficulty 'hatching' (Mahler, 1986, p. 224) both from an emotional and somatic perspective. She also displayed somatic complaints as a young girl which can be understood as an internalisation of distressing affect while her symptoms of anxiety can be seen as reflecting her sense of feeling unsafe in the world.

Loretta had few relationships before marrying Ricardo 17 years ago and showed little interest in sex. The couple moved to South Africa from North Africa about 5 years ago. Her husband had the same ethnic background as her; she found him to be unsupportive and emotionally detached. Their marriage appears to replicate familiar, bad object relationships of her upbringing. Their sexual relationship was - and continued to be - poor and she described sex as "consented rape". She had several miscarriages during her twenties, which included pregnancy-induced hypertension (or toxæmia which is potentially life-threatening to the mother and foetus) and a premature baby who died a few hours after birth. These losses had a profound effect on Loretta who related how her body kills lives. The series of miscarriages reinforced her sense of internal badness yet she quickly disconnected from these painful feelings, which were displaced into various bodily symptoms. She and her husband never spoke about the deaths and she never fully mourned them; rather her grief was expressed several years later via the death of a beloved pet. Loretta had begun to feel ambivalent about the future of their marriage, vacillating between wanting to leave him on the one hand, and reconciling herself to her future and the history that they shared on the other.

In later years, Loretta began working in a part-time capacity in the field of alternative medicine and established an emotionally intimate relationship with a work colleague, Neville who was twenty years her senior. Her ambivalence in both wanting and fearing a good personal contact is encapsulated in this relationship: she feels strong longings for Neville when he is absent but his actual presence evokes fears of being smothered and of losing her freedom and independence, resulting in turn in her emotional withdrawal from him. She seems to have set up a triangulated relationship with herself at the apex, her husband, who allowed her sufficient space yet from whom she felt disconnected, and Neville at the other, who was caring and concerned to a point which threatened her autonomy and was experienced as intrusive. By vacillating between these extremes in an 'in and out' fashion, Loretta appeared to have established for herself a degree of comfortable distance, as did the porcupines in Schopenhauer's parable: they huddled together because they were cold but found they pricked each other with their quills and so drew apart again...until they found just the right distance for comfort (Guntrip, 1994, p. 166).

I saw Loretta 3 times a week for individual therapy during her in-patient stay at Tara which lasted just over six weeks. She was concurrently receiving closed and open group therapy as well as seeing a nurse therapist once to twice a week. Individual therapy initially focused on Loretta's unresolved grief around the death of the babies and the way in which her presenting physical symptoms mirrored earlier emotional states. Themes of food and nurturance were prominent and these were linked to a strong sense of early object loss. During this time, her physical symptoms largely resolved themselves and were no longer the primary focus of attention.

After discharge, I saw Loretta twice a week for therapy. As treatment progressed, her interpersonal relationships became the focus, including her marriage, relationship with Neville and the transference relationship. She tested my ability to contain her emotions in a variety of ways. Loretta's deep sense of loneliness and sadness became increasingly apparent in the sessions and there was greater congruence between her emotional expression and content. This was accentuated by a growing awareness of pending termination which brought into relief her earlier losses. She reacted defensively by electing to reduce her therapy attendance to once weekly. A refocusing on somatic preoccupations was noted.

"The sorrow that has no vent in tears makes other organs weep"

*Henry Maudsley, 19th century anatomist,
cited in McDougall, 1992, p. 139*

CHAPTER 5: CASE STUDY APPLICATION

5.1 Introduction

Chapter 2 explored the concepts of transference and countertransference, with particular emphasis on primitive mechanisms including projective identification and psychosomatic symptomatology. In this chapter, clinical material is presented to illuminate the application of these theoretical phenomena as well as the ways in which Loretta's intrapsychic and interpersonal dynamics manifested in the therapy. I have focused on several themes that emerged in the course of the therapy and have illustrated these with relevant case material, as follows:

- Somatic Preoccupations (Case Illustrations 1-4);
- Making Transference Interpretations (Case Illustration 5);
- The Impact of the Hospital Setting on Treatment;
- Triadic Relationships in the Transference (Case Illustrations 6-9); and
- Countertransference Difficulties (Case Illustration 10).

5.2 Somatic Preoccupations:

As described in the previous chapter, Loretta presented initially with numerous physical symptoms, including a heart condition, gynaecological and gastric disturbances, ulcer, anorexia and hypertension. She had recently seen a gastroenterologist and the results of numerous tests revealed that she had hypoglycaemia which was probably a function of being markedly underweight. Loretta appeared to disregard the test results and demonstrated some ambivalence towards ridding herself of these symptoms. This seems to suggest that her somatic symptoms served a comforting purpose. In addition, she appeared to derive a secondary gain from them: her husband and Neville gave her much attention and the pain served to remind her that she was alive. The onset of an escalation in her symptoms appears linked to Mother's threatened death. This is in keeping with McDougall's (1989) observation that her psychosomatic patients frequently fell ill and/or suffered dramatic weight loss when faced with threatened or actual separation or abandonment by key people who represented the enmeshed mother figure in whom their self-identity was interwoven.

Her body and its somatic symptoms appeared to function as transitional objects in the absence of a genuine transitional object that could assist her in becoming independent of her mother (McDougall, 1989, p. 158). During childhood, Mother seemed to have used Loretta narcissistically, thereby impeding her ability to individuate. Loretta's psychotic anxiety found expression in somatic forms when she was unable to verbalise her psychic pain.

5.2.1 Case Illustration 1:

In response to the many somatic complaints Loretta gave as her presenting problem in the first session, I asked her why she thought she had come to a psychiatric hospital rather than a medical hospital. I pointed out that I was not a medical doctor and so wondered what she would like to use the therapy for. Loretta replied that if she sorted out her physical problems, she could get her mental problems into perspective. She noted that the

physical part affects her mentally. I remarked that it also worked the other way round. She did not reject my comment. It appeared that Loretta showed a degree of insight into her difficulties and the interrelationship between psyche and soma. I felt there was some space for her to think about the psychological aspects of her situation.

5.2.2 Case Illustration 2:

There was often a gap between the content of what Loretta spoke about and her affect in the room. This was most marked when she spoke about the death of the babies. She related with apparent pride how the day after her first miscarriage, she told her husband to bring a bright red dress to hospital because they were going out to celebrate. At dinner they bumped into friends who inquired about the pregnancy. Loretta recalled how shocked they were to find out how recently she had miscarried. It appeared that her feelings of grief were cut off, denied and projected into others, including the friends and later, myself. At the same time, her choice of a blood red dress appears to represent a graphic attempt to communicate the pain of her experience. Her husband seemed equally unable to contain their grief: they never spoke about their losses.

This difficulty in processing painful emotions appeared to be related to environmental failures and impingements (Winnicott, 1965) in her infancy and childhood. Mother functioned as a faulty container, leading Loretta to remove all knowledge of pain from her consciousness. These emotions appear to find expression somatically and through projective identification. In therapy, it appeared Loretta required a maternal object to think for her and contain her pain. This pain represents not only the death of the real babies but also the loss of the baby parts of Loretta that had to grow up prematurely.

There are parallels between Loretta and a patient described by Casement (1985) who lost two infants and presented with a gynaecological disorder. He concludes that “to survive these intolerable experiences, she may have converted the psychic pain belonging to them into gynaecological pain. Perhaps this symptom continued to express, somatically, the repressed feelings related to these unbearable losses, which had been so closely associated with that part of her body” (p. 79). Once the abovementioned patient was able to get in touch with her psychic pain rather than split it off and project it into others, her somatic symptoms subsided.

5.2.3 Case Illustration 3:

The split between psyche and soma expressed itself graphically in the third week of therapy. At the start of her ninth session, Loretta complained of perceptual disturbances, dizziness and feeling ‘out of her body’. This aroused some anxiety in me that her symptoms would result in her being unable to continue in the session and that she might even collapse. It crossed my mind that she could have Temporal Lobe Epilepsy and be manifesting ictal phenomena, including depersonalisation. Internally I reviewed my options, one of which was to cancel the session and walk her back to the ward. I managed to contain my anxiety and chose to proceed with the session by exploring with her what may have happened to bring on these symptoms now. I later voiced my concerns at the next ward round where the team decided to book her for an electroencephalogram to rule out a possible co-diagnosis of Temporal Lobe Epilepsy; this was ultimately not necessary since no other supporting symptomatology emerged.

Loretta's response to my questioning the onset of her symptoms was one of amusement. She pointed out how the doctors and psychologists see these things so differently. I acknowledged the validity of both perspectives but said that I was interested in what triggered this reaction now and why it had happened during her therapy session. Loretta could not consider this, suggesting an inability to contemplate the possibility that she might have brought the symptoms on herself. During the session it emerged that Loretta had also experienced depersonalization following her last miscarriage. I tried to link these experiences with her current experience of threatened loss, in particular her fear about going home for the pending weekend and facing the emotional distance in her relationship with Ricardo as well as her concerns about discharge. In retrospect, this also pointed to her anxiety about threatened loss in the transference relationship which I could have addressed directly. Notwithstanding that, my ability to contain Loretta's projective identification and return it to her in a more comprehensible form allowed her to get in touch with her sense of loss with regard to her marriage and the session became unstuck. Up to this point in the therapy, she had primarily related past events: this session marked a shift in focus on current difficulties and concerns. It also involved a greater degree of risk-taking and engagement in the therapeutic process.

In reflecting on this session, I understood my countertransference to be an indication of the powerful projections Loretta could force into her objects. By responding to her in the way that I did, I was both communicating my ability to function as a container for her distress as well as providing a focus for that psychic distress by refusing to concentrate entirely on her somatic symptoms. This brief interlude can be understood as an enactment in the therapy of longstanding coping mechanisms. As described earlier, Loretta had difficulty 'hatching' and differentiating from Mother and the boundaries between 'me' and 'not me' appeared to be confused. By shifting the focus from the psychological (or symbolic) to the somatic (or pre-verbal) realm, she circumvented the process of thinking about and making sense of her losses. This adversely affected her ability to mourn, a process that is connected to Klein's depressive position. McDougall (1978) remarks how "it is impossible to mourn the loss of an object one has never possessed, or whose existence has never been truly recognized as distinct from one's own, or as an integral part of one's inner world" (p. 298). Steiner (1993) similarly notes that mourning entails recognition of the differentiation between what belongs to the self and what belongs to the object; "in the process the lost object is seen more realistically and the previously disowned parts of the self are gradually acknowledged as belonging to the self" (p. 61). Projective identification is critical to the process of mourning in that it involves the detachment of parts of the self from the object. Steiner goes on to say that:

if mourning can be worked through, the individual becomes more clearly aware of a separateness of self and object and recognizes more clearly what belongs to the self and what belongs to the object. When such separateness is achieved it has immense consequences, because along with it go other aspects of mental function which we associate with the depressive position, including the development of thinking and symbol formation. (p. 61)

It was interesting that Loretta focused less and less on her physical symptoms as the therapy progressed. Occasionally she would report that they had abated. It appeared that as she gained an outlet for discussing and considering her anxiety and pain, which could be contained by the therapist, so her somatic symptoms diminished. McDougall (1989) describes how “*bio*-logic” comes to be replaced by “*psycho*-logic” (p. 171). By having access to symbolic means of expression, it is possible that the somatic symptoms were able to abate. Loretta gained some insight into her focus on these symptoms at the expense and neglect of emotions.

It was not surprising, therefore, that with termination came a regression to the pre-admission intensity of physical symptoms. She complained of premenstrual worsening in her mood, with some suicidality and a feeling of wanting to climb the walls. This coincided with the end of a visit from her mother and a reawakening of her desire to have a child. As discussed earlier, this recurrence of psychosomatic symptomatology was probably precipitated by the disruption in relationship to others who are omnipotently perceived as a part of her.

5.2.4 Case Illustration 4:

At this point, I will describe a session in detail to further illustrate some of these themes. It was her fifth session on a Monday, immediately following her first weekend home since her admission to Tara. Loretta arrived with a small yellow flower that she had found growing outside my office. She expressed surprise to find the identical flower that her grandmother used to feed to her rabbits in Europe. Loretta went on to describe her physical symptoms in great detail, saying she had “a headache between my brain and my thoughts”. This eloquently describes the disturbances in symbolization and alpha functioning to which Bion and McDougall refer. She appeared to have been unable to hold on to the good experiences at Tara. Her attachment and subsequent separation anxiety found somatic expression through her body weight: while she had put on weight during her first 10 days at Tara, she felt she was losing weight over the weekend and had bad stomach cramps. I reflected her feeling of frustration to which she responded by talking about how her body gives up on her. I noted her physical frustration but the meaning of the flower was prominent in my mind. I said that I wondered what she was feeling emotionally and whether the flowers pointed to some desire of hers for nurturance.

This allowed the session to progress: Loretta considered how her grandmother was able to nurture rabbits but not her grandchild. She postulated that her grandmother had “created” the rabbits’ desire for the flowers, thus portraying the picture of a mother who meets her own needs rather than the infant’s. From this, Loretta moved on to relate a dream she had the previous night that she had murdered a strange man. Despite the amount of blood in the dream, she reported feeling no distress yet woke up exhausted. I understood her dream in terms of the initial focus of the therapy, namely unresolved mourning around the dead babies and I chose to share that link. I felt I was giving voice to awful, unspeakable things when I said that I wondered whether in some way she felt she had murdered the babies. I was also aware of not wanting to appear to be indicting her. Loretta responded by speaking about the terrible choice with which she had been faced: to abort the babies or risk her own life in carrying them to term. I responded by noting that in a sense the babies were murdering her.

Loretta related how unprepared she felt for motherhood. She then recalled a repetitive dream she had had for the past few years in which she keeps killing her mother by hacking her to death with an axe. In the dream, Mother continues to look at her with a hurt yet passive face which fans Loretta's anger. It emerged that these recurrent murderous dreams were occurring against a backdrop of Mother pressuring Loretta to allow her to live with her and Ricardo, which Loretta was resisting.

It appeared that Loretta's external and internal object relations both reflected murderous instincts. Loretta's destructive response to Mother's threatened merger with her in the external world is expressed internally through attacking her own internal mother, which leaves her in no emotional state to mother a baby. Her object world is one of either consuming the object or being consumed. This brings to mind Henri Rey's (1994) discussion of an anorexic patient, in which he reflects that the core meaning of food and eating lies in the universal law of 'devour or be devoured': "eating is the way food is obtained. For the 'foetus-baby' and the mother it means eating each other: you can either eat or you are eaten" (p. 65). While Rey does not explicitly make the link to projective identification, I feel it is self-evident. Loretta's primitive anxiety can be understood by a theoretical appreciation of the phantasies involved in abnormal projective identification. Her inner world is populated with murderous instincts and fear of being annihilated through symbiotic merger with the other. She annihilates the other through her forceful projections in which the object becomes an extension of herself. At the same time, she feels the projected parts of self to be incorporated by, and lost to, the other and she fears retaliatory destruction by her objects.

I had not reached this understanding of the patient at this early stage of the therapy: even if I had, it probably would not have been opportune to share it. I responded to the dream by suggesting that perhaps it pointed to her sense of extreme rage towards Mother. I linked this to her comments about Grandmother's inability to care for her and suggested that the person who should have loved and nurtured her, namely Mother, was also unable to do so. My response allowed Loretta to express her anger at Mother's failures and impingements. She painted a picture of a mother who was so busy keeping the house clean that she had no time to make emotional contact with her children.

At this point in the session, I found myself working hard at making links with the prolific material Loretta had given me about her experiences. I also became more active in offering interpretations. I connected Mother's inability to nurture her to Loretta's subsequent ambivalence towards her unborn babies. Loretta's anxiety was aroused when I pointed out the parallels in her current physical symptoms to the time of the death of the babies and wondered about whether the symptoms were now evoking similar feelings. She acknowledged the similarities then asked if I thought it was "all emotional" rather than physical, thereby insisting on maintaining a split between the two. I was taken off-guard by her directness and side stepped her question by asking what she thought. Loretta repeated her original belief that once her physical problems were resolved, her emotional problems would be sorted out. I responded by saying that I did not see it as 'either/or'; rather that we had to think about and account for both aspects of herself. This interpretation attempted to help her begin to integrate a fundamental split between psyche and soma. Loretta despaired, saying she thought she had "left all this behind".

She immediately related another recurrent dream in which she is on a desert island and the water level begins to rise and rise. She associated this with her experience during pregnancy. I returned to commenting on the awful choice facing her, to which she replied by stating how young she had been and how she did not want to be pregnant. In denying how much she wanted the babies, she was disallowing herself to mourn the losses. Instead, she began crying about all the years she had lost because of the babies. Her anger at the devouring babies took me by surprise and I was also struck by how self-involved her response was. My reaction points to an empathic distance in the countertransference. I responded by stating what I hoped to see happen: I said that she seemed to be mourning the loss of the babies as well as the loss of her own time and opportunities and I remarked how she had cut herself off from those feelings at the time. Loretta took this further, relating how incapable her husband was of understanding her.

There were probably implications for the transference relationship in what she was saying, namely a sense of my failing to understand her. I did not pick up on this, responding rather to a sudden insight I had into the possible link between her physical and emotional states. I said I wondered whether her bodily state of being undernourished, weak and fragile evoked for her the feeling state of being a child who felt needy and helpless. Loretta replied sharply that she was not having these symptoms in order to attract attention. She then stated that it might all be emotional. I felt my interpretation had been taken up as a criticism to which she responded by first attacking, then disengaging. I responded by affirming that there is a physical component in that she is so thin and weak because she has been starving herself. I noted that food is the earliest form of nurturance and love that a mother shows her baby and how hard it was for Loretta to feed herself. At this point, it would have also been appropriate to include her difficulty in allowing herself to be fed.

Loretta's response indicated that perhaps my interpretation touched an overwhelming area of psychic pain. Instead of considering this further, and perhaps in light of the approaching end of the session, Loretta rather chose to ask me how she can get rid of the pain that she feels. I responded by commenting on how she has split off her hurt and pain from others by presenting a busy, brave façade. I ended by returning to the flower she had found outside my office and wondering whether it expressed her hope of finding nurturance here. Loretta immediately noted that the flower is yellow and yellow symbolises jealousy. By way of this rejecting, spoiling response, she deals with her envy that an Other could offer her something she is unable to give herself. I asked whether she felt there were feelings of jealousy in the room. In retrospect, it would have been more appropriate to acknowledge that the jealousy - or to be more accurate, envy - was very much present. She also seemed to be rebuking me for all the rabbits I had been feeding instead of her. However, it was hard at the time to reconcile her envy and neediness with the denigration which I was experiencing. Loretta responded by denying any jealousy, saying she is not a jealous person and that to be jealous is to be demanding. She then associated the yellow flower with her favourite colour, gold, and recalled that she used to describe herself as the golden girl. Thus, the session ended with Loretta reasserting a narcissistic self-focus and her phantasy of omnipotence.

5.3 Making Transference Interpretations:

Making transference interpretations at times left me doubting whether I could ‘take up’ such a position of importance in Loretta’s world, a reservation which was often fuelled by the responses given to those interpretations. Loretta would deny the significance or importance of the therapy relationship. In this way, I felt at times that such interpretations were met with great resistance, as illustrated in the above extract. This was further compounded by the brief duration of the therapy in which it was not possible to tease out the elements of the transference. In a longer therapy, the nuances of such resistance could be identified and worked with over time in order to gain insight. My doubts can be understood as a function of both my limitations in seeing the transference implications in some of her more general comments as well as a manifestation of Loretta’s transference. I was being made to experience the shifty ground on which she often found herself in relation to others, her own unstable object relations. In the countertransference, I often found myself feeling that I had to watch what I said and that it was likely to be dismissed or rejected. I felt that my ‘contributions’ were often side-lined and that I was continually ‘put into my place’ by Loretta. I think that in this way she was striving to give me a sense of her own helplessness and ineffectiveness in relation to her husband and more fundamentally, her parents. I tended to respond to this by absorbing the experience without trying to retaliate. In this way, it would be possible for Loretta to absorb a different outcome and perhaps to re-introject a sense that such attacks could be withstood by an Other.

5.3.1 Case Illustration 5:

This pattern was clearly illustrated at her final session. In the lead up to termination, Loretta had commented on the progress of a litter of wild kittens that often played outside my office. In the last few sessions, Loretta walked right up to the window at the back of my office to look for the kittens. In thinking about her behaviour, I understood it as an expression of her wish to penetrate into the depths of the therapist, thereby avoiding termination. I also wondered about the symbolic meaning of the wild kittens: perhaps they represented the wild parts of her which she had kept outside the room. At the final session, Loretta commented on how my babies (namely the kittens) had grown up and gone away; she later related how she had found a little bird that fell out of its nest and had helped feed it so that it could fly back to its mother where it would be taken care of.

I understood the material to relate clearly to her feelings around termination, and responded that Loretta felt she too was having to grow up and leave. The anecdote about the bird reflected a more hopeful and thoughtful side to her, with the possibility that she could feed her own baby bird, if only for a moment. It also represented an inversion on her part, in which she looks after me. Perhaps it further expressed her injunction against the mother-therapist leaving her baby-patient. I was aware of feeling a sense of relief that this demanding therapy was coming to an end and found it hard to acknowledge her unspoken hope that she could remain in touch with me. This was made explicit later in the session when Loretta felt the need to reverse the dependency by stating that the “baby Debbie” was also growing up and leaving Tara, referring to my intern status.

Being a trainee psychologist results in much psychic energy being deployed into an evaluation of one's own performance and at times, the difficulty in acknowledging one's mistakes. This can occupy so much internal space as to block the flow of transference-countertransference communications. The impact it has on the patient must also be taken into account. By way of anecdote, a mature-aged intern saw a patient in her mid-twenties. In the course of her therapy, the patient related that during an earlier admission to Tara she had been acutely aware that her young therapist was in training and had therefore made a considerable effort to be the 'good patient', thereby attempting to ensure her therapist too was 'good', i.e. well regarded and graded. Thus, one cannot underestimate the role of being a fledgling therapist in the patient's phantasies.

In this case, it is possible that Loretta used the writer's student status as a defensive means of equalising the therapy relationship. While her comment about the "baby Debbie" may reflect a role reversal achieved through projective identification as well as her feelings of abandonment by the mother-therapist, I also experienced it as a slight, putting me in my place as well as discounting the therapy. It appeared to be intolerable to her to think of needing to rely on another person, particularly when such a person was leaving and would be unavailable to her. By denying any such need, she also cut off the pain of leaving. This seemed to reenact her coping mechanisms for dealing with other losses in her life.

When I spoke about therapy coming to an end, Loretta substituted her phantasy that we would bump into each other at a later date and so she refused to concede that it was ending. I pointed out that even though we might encounter each other, the therapy and the time we had spent together were over and how difficult that was for her to accept. She replied how it was a small world and she was certain we would see each other again. I noted that it was easier for her to think about ending in this way. It seemed like her illusion was necessary for her. Termination ultimately encapsulated all of Loretta's struggles and mastery of it would take her a much lengthier therapy. Rather than strip her of her defences, I felt it was appropriate to leave this one intact. Perhaps it also had to do with my own guilt at abandoning her and wondering how she would cope after termination: her illusion served to ease my own sense of destructiveness.

The above illustration further demonstrates how throughout the duration of the therapy, Loretta continued to tend to denigrate my interpretations and overtly deny or devalue the therapeutic relationship. At the same time she was giving other messages to the contrary. One way in which I attempted to deal with transference interpretations was by referring to the value of the 'therapeutic space' as opposed to the individual therapist and by recognising her transference to the institution, Tara. Loretta seemed more able to accept my interpretations about her difficulty leaving Tara and what being in hospital meant to her, as opposed to referring to the therapeutic dyad. The in-patient does develop this broader transference to the institution with its therapeutic milieu, different practitioners and therapeutic modalities, which needs to be recognised.

5.4 The Impact of the Hospital Setting on Treatment:

I had brief contact with Loretta outside of therapy sessions and was also privy to additional sources of information about her. I was aware that this had the potential to contaminate my feelings towards her as well as complicate her transference towards me. The therapeutic relationship inevitably cannot be kept 'pure' in an in-patient hospital setting. Ogden (1992) recognises that attempts to maintain an "illusion of 'analytic purity'" (p. 112) never truly succeed; rather individual therapy is one facet of hospital treatment that must be integrated with the overall therapy program. In my experience, there were always other practitioners involved in giving therapy in different contexts. Patients were acutely aware that they 'shared' the therapist with several others on the ward. No doubt phantasies about therapists were shared between patients. The hospital setting seems to invite potential feelings of envy, with subsequent devaluing or idealizing of the various therapists. Such an environment of sibling rivalry further complicates the individual therapist-patient relationship, with patients externalizing their phantasies by splitting their transferences towards the therapist or by projecting fragmented transferences on to various staff members. *All* patients will phantasize about sharing their therapist with other patients, in this way echoing - if not replicating - earlier traumas. However, the hospital in-patient setting concretizes unconscious phantasies in a very real way and this continually needs to be accounted for.

At the same time, Gabbard (1992) postulates that the mutative ingredient of hospital treatment may lie in the patient's experience of a network of therapeutic relationships from multiple treaters, both clinicians and non-clinicians. The hospital further serves as a holding environment for clinicians working with disturbed patients. In writing about the in-patient hospital setting, Gabbard notes that "many patients can be treated only in a hospital environment precisely because the fragments they project into any one therapist are too burdensome for a single individual to contain without considerable support" (p. 16). I derived support from the team and found that with regard to Loretta, we were thinking and working in similar directions.

It is also possible that the patients' access to a variety of people, both fellow patients and therapists, could enhance an understanding of the transference. Gabbard (1989, 1992) acknowledges the multiplicity of transference and countertransference reactions that emerge between the patient and clinical staff as well as the tendency for a patient to recapitulate his or her internal object world in the hospital milieu via splitting and projective identification. Indeed, a very disturbed patient of mine once commented with surprise how every person in the hospital reminded her of a family member or friend, saying that it seemed as if they had been 'selected' with her difficulties in mind. While this multiplicity may make the transference more complicated to unravel in the individual therapy setting, it also represents a short cut in understanding the patient's inner world. Gabbard (1992) notes that "staff meetings in inpatient work serve a container function, where the [patient's] projected fragments are identified and integrated into a coherent picture of the patient's psyche" (p. 11). In this way, staff can function as a cohesive whole in containing both the patients' projective identifications as well as their countertransference reactions rather than acting on them (Bateman, 1995), with the result that "the patient's internal split often begins to mend at the same time the staff's external cleavage heals" (Gabbard, 1989, p. 450).

In this case, there were instances in which the hospital setting facilitated my understanding of Loretta's transference. For example, in relating details about group therapy, she cast Sarah, the closed group facilitator, as tough and pushing her towards insight. I was left to infer that she saw me differently and could explore the transference relationship in this way. Later in the therapy, she saw a psychiatrist to whom I had referred her for ongoing follow-up. Again she saw the two of us differently, with the doctor being depicted as harsh and Loretta having to struggle more to express herself. This time, her feelings about termination were being expressed. With both the nurse-therapist and psychiatrist, there was probably an element of reality in our different personal styles and modus operandi. At the same time, I was able to use her discussion of the doctor's style to point out her sense of loss of the way in which I had worked with her.

At other times, the hospital setting muddled the transference. A patient from Loretta's group therapy committed suicide shortly after discharge and the nurse-therapist informed the remaining group members of her death. Loretta arrived 5 minutes late at therapy on the Friday afternoon in her last week before being discharged. She claimed not to be surprised at the news because she had seen through the patient's pretence at coping. During the session, Loretta responded in a narcissistic manner to the suicide, expressing distress at her ability to "see the worst in others". She expressed concern for one of the remaining group members, Joanne, who hides her feelings and pushes away support from others. I explored her identification with the Joanne part of herself as well as possible links to her pending discharge. An hour after the session, I encountered Loretta on the ward and she uncharacteristically asked if she could have a word with me. She told me that Joanne was suicidal and she had encouraged her to talk to her nurse-therapist. Loretta wanted me to know so the team could make a decision about her weekend leave. I thanked her for notifying me and said I would bring it to the attention of the team. However, I was puzzled as to the meaning of her communication: was this an expression of her own suicidal feelings that were stirred up by the patient and spilled out of the session? Was this an attempt on her part to repair both the patient's death as well as a perceived deficit in the therapeutic team? She never returned to this incident in subsequent sessions and its meaning remained enigmatic to me.

Given the impact of the hospital setting, it is interesting to reflect on the impact on the therapy of Loretta's change in status from in-patient to out-patient. While I was able to obtain useful corroborating information from other team members regarding Loretta, I felt this hampered my thinking processes at times, as did my own experiences and knowledge of patients and clinicians about whom Loretta spoke. It became more difficult to stay with her internal world given these additional experiences that were independent of the therapy. I felt it was easier to understand Loretta's internal situation once she was an out-patient since it helped keep the transference pure.

5.5 The Transference and Triadic Relationships:

Loretta recreated the triadic relationships of her past and present relationships in the transference. It seemed to me that these triads stemmed from early difficulties in relating to an Other in a dyadic relationship rather than representing a reenactment of later, Oedipal conflicts. By introducing a third person into the dyad, she seemed

to be using a schizoid defence in her struggle to attain closeness to others. Loretta's ambivalence towards relating to people expressed itself in an 'in-out' relationship towards me. At times she felt excited, even titillated, by transference interpretations while at other times she withdrew from the perceived symbiosis that such intimacy threatened, to the point of denigrating the therapeutic relationship. This left me feeling I was being either seductive or redundant, with Loretta helping me out in the therapy, rather than the reverse.

5.5.1 Case Illustration 6:

This was most clearly illustrated in a session during her fifth week of therapy in which feelings of omnipotence were predominant. She spoke about the eccentric, crazy part of herself and seemed intent on shocking me. This appeared to reflect her early object relations in which the infant had to resort to outrageous behaviour in order to get Mother's attention. This manifested in the transference through her belief that unless she shocked me, she will be unable to have an impact or find a place with me. She related how she used to parade naked in front of Mother and Ricardo, sitting down to a meal while watching their embarrassment. I pointed out how powerful she must have felt and how in this way, she could give them a sense of the discomfort she often felt in relation to them. Loretta rationalised how natural nudity is and that unlike flowers or animals, we humans cover ourselves as if we are covering our feelings. I felt it was important to point out to her that there was something very provocative about being naked in front of Mother and her husband at the same time. Loretta spoke about deriving pleasure from how upset they became. She related how Ricardo probably felt she was showing Mother "what was his" but went on to explain that her nakedness was a communication that neither one could touch - it was her property. In this tangible way, Loretta seemed to be expressing her struggle with the boundaries between 'me' and 'not-me'. I understood her need to display her nudity not as a sexualized act but rather as a vivid expression of the dissociation between her body and feelings.

She went on to connect the way in which exposing her body was akin to expressing her feelings. I noted that she was speaking about having to keep feelings under wraps. Loretta spoke at length about how difficult she finds it to share feelings of success and failure. She noted, "If you talk about your good points, others will say you have a big ego and if you talk about your bad points, they will tell you to keep quiet because they are afraid it will be contagious". She seemed to be concerned with my reaction to her as well as what material she could bring to therapy. When I related this to the transference by pointing out that Loretta may expect me to also want to "squash" and disallow aspects of herself in the therapy, she replied "You surprise me, Debbie, because believe me, I seem to shock almost everybody. I shock doctors". She went on to relate how she had seen a young Jewish doctor in his early thirties who had asked her to take off her clothes and get on the bed. She stripped and "jumped" on the bed, then realised how shocked he was: "he looked like a baby in a panic". At a subsequent visit, she noticed that he relaxed after she put on a robe. She asked him whether he thought she would rape him and he was "totally shocked". Loretta then said he was going to see her totally naked so what was the use of covering herself piece by piece.

I felt this anecdote had definite transference significance and responded by noting that therapy was a place in which Loretta had been emotionally naked and had spoken about painful and secret parts of herself that others had disapproved of. I said I wondered whether she expected me to be shocked or overwhelmed.

Loretta noted that while professionally I should not be shocked, I am “still a person”. I observed how it appeared easier for her to think about it as a purely professional relationship. I understood that Loretta’s experience of a robotic mother, who merely went through the motions of caring for her children’s physical needs, had been transferred on to me. She acknowledged that she used to think about it as a professional relationship but now thinks of me as a human being as well. She then added: “So you see me naked”. I remarked that those who had seen her naked (about whom she had spoken during the session) had told her to cover up, that it was not okay. Loretta noted how they did not want to see her naked in any form - not just the body - because it was too uncomfortable for them. She related how Mother had told her that she had to take painkillers because Loretta drives her “insane” when she talks to her. This demonstrates a repeated pattern in the family of somatizing rather than thinking. Both mother and daughter had difficulty distinguishing between an open body and an open mind. I was aware of the session flowing nicely, with Loretta responding directly to my comments. This gave me an indication that my interpretations were on the mark.

She went on to relate how Mother was “not ready” to acknowledge her feelings. She added that Father used to say Mother went to bed with an overcoat and qualified that she did not take this literally. Rather, he meant that Mother was very reserved. However, her next comment reverted to a concrete, rather than symbolic, understanding. She noted how Ricardo is similar to Mother in that he always goes to bed wearing his underpants.

There appear to be two levels of understanding operating in the session: clothing as a thing-in-itself and clothing as a metaphor for emotional defensiveness. In interpreting within the patient’s metaphor, one faces the danger of the patient reducing the symbolic level of understanding to the concrete. I responded within Loretta’s metaphor by acknowledging that there were many ways in which Mother would not see her and wondering whether in order for Loretta to feel she could be seen, she felt she had to strip off more and more. Loretta’s comment, “Become more outrageous”, indicated that she was still following me. However, she quickly went on to talk about her pleasure at embarrassing Ricardo by telling people she was at Tara. She described herself as coming from a place where to be naked is to be “out the mould”, where people have no feelings - they just do what others want to be seen.

I noted that when Loretta wants to be noticed or seen, it felt like she had to break the mould and be outrageous in some way; that there is some pleasure in being seen as well as sadness at having to do that in order to be seen. She replied that she is naturally outrageous and went on to philosophize about Nature which has “no such thing as freaks”. She spoke about analogies in the animal kingdom: “even if you have three fingers, cry or are retarded, you are still acceptable”. She felt her behaviour was outrageous because she does not want to be

wanted for conforming but rather for her uniqueness. She continued to talk in this philosophical manner and concluded that she prefers others to see her at her worst. In this way, she can ascertain whether a person “can stick” as opposed to someone who sees the “nice part of Loretta” and when the bad part comes, they “are not there any more”.

Loretta’s comment has direct transference implications for what was being enacted in the immediacy of the session, namely she seemed to be testing me in order to ascertain whether I could “stick” with her. I responded on a more general note that her eccentricity appeared to be a way of testing people, to see if they would accept or reject her. I noted that there was a part of her that felt a bit like a freak that did not fit in and that she wondered whether those parts of her could be accepted. In using her earlier word, “freak”, I hoped to give voice to her unspoken fears of madness, thereby containing them. However, Loretta replied defensively that she is “absolutely mad about life” and how perfect and natural life is. She went on to describe how people turn their face away from dogs coupling, yet she can “make a big party about it”. Others think she is crazy but she does not agree. I was disturbed by her image of the dogs, which led to my speculation about whether Loretta had been witness to a primal scene or was perhaps referring to an experience of abuse. I was unable to take up the implications given her subsequent remark that our senses “degrade” us and this is why a mother will never give love to a child because it is too degrading to be an animal.

I repeated her words about the mother not giving love to a child and Loretta clarified that a mother would probably not give as much love to a child as to reduce herself to the same level as a “baboon mother” would give to her “gorilla child”. She said it was natural for animals to kiss and hug and have a real relationship whereas the mother and child never seem to be like that, it never came to the point where “it really boils over with excitement”. I then said that Loretta never appeared to have experienced her mother in *that* way, that she was always wearing her overcoat and keeping things inside. In bringing back Loretta’s comments to her own situation, I reverted to using the clothing metaphor at this point.

Loretta replied that there is nothing wrong with the love an animal can express; it is natural. I linked this to her walking around the house naked as a way of showing them that they should have loved her in a natural way. Loretta agreed and went on to share her observations about how animals can give innocently and honestly while humans cannot. She said she found that hard to accept despite having “lived in the mould for 17 years” (the duration of her marriage) as well as occasionally “breaking the mould” and then conforming again. She said “It’s the story of my life”, sighed, then looked at the clock and said “Three minutes, Loretta”. The end of the session was approaching. Her tendency to dramatize things and use disturbing images can be understood as a way of parading herself naked in front of me during the session. I later came to understand Loretta’s sense of drama in which things either boiled over or felt dead, as operating as a defence against depression.

I remarked on how difficult it had been for her initially to think about filling the session. Loretta interrupted me, saying she had had the material in her mind but did not know if I was “strong enough” to listen to it. She said “The professional, yes - but the other person, no. I don't see you, Debbie, doing it”. I reflected how she saw me in an overcoat. There was a lot packed into what I was trying to convey, perhaps too much. I was trying to link her perception of me with that of her mother. Loretta chose, however, to respond at a concrete level. She began to list my clothing: “A T-shirt, blouse and jersey with the skin over” - then corrected herself - “under everything”. At this point, I felt uncomfortably like I was being stripped by her. I attempted to contain her projection and return it to her in a more comprehensible form, by saying that it sounded to me as if she had been testing me to see what I could contain, what I could take.

Loretta replied that she could not see me coming to her house for dinner and her answering the door and saying, ‘Come inside. take your clothes off, let's have tea’. She felt I would run away. I again felt pressured into either “boiling over with excitement” or responding sadistically. I once more attempted to return her projection in a way that contained it within the therapeutic setting rather than ‘acting in’. I noted that we were talking here about my ability to hear and take in her experiences, to react without running away from that or being judgemental about it. Loretta remarked that I would not sleep very well tonight, that I would go home and think about it. She laughed then said it gave her no satisfaction, pleasure or pain to think about it but she felt I would definitely go and think to myself - even if just for a split second - about “the contradiction between two people in one person - oh man, one person in two people - should I say two people in one person”.

Loretta appeared to be describing a fundamental split in her ego and grappling with the normalcy of this. Her preoccupation with Nature and nakedness during the session seemed to reflect her concern about her own madness. I noted there were these two sides of her and that while the one side felt more acceptable to be here in this room, another side of her had come today. I continued that it was hard for her to believe that I would be able to hold both sides together, that this side would be so shocking and so outrageous that I would be very disturbed by it and would be unable to look at it; as if I would say, ‘There is the first part of Loretta and that is all we will focus on’. Loretta responded by saying that there is a very crazy part of her that loves life, that can really become involved in life and can feel very alive. There is the other part that is dead, frustrated.

I said that it was up to me, in a sense, to hold both parts. Loretta interrupted to say, “If a human being - yes; that we can't disregard that a person is a human being and not a robot”. She laughed then said that she thinks essentially everyone is the same, that maybe I will not be able to discard my clothes and walk around naked or have tea naked with her but inside of me there is a fantasy that it would be nice if I could do it, in the same way that there is a fantasy inside her that it would be nice if she could be more conformist, and conform to certain goals without feeling rebellious about it which she cannot do. She seemed to be referring to her belief in my capacity to identify with her and receive her projections.

I responded that I could see that she was concerned about whether I could accept this life-loving side of her. Loretta replied that it was not just me, that it was all other people. They are worried that this side of her will cause her to go away, that they do not understand that this is the side that will cause her to stay. The session ended there, with her denying my transference interpretation and putting me in my place. She was right: at some level she had projected herself powerfully into me and there was a sense in which parts of her stayed with me in my mind long after the session ended.

5.5.2 Case Illustration 7:

As has been illustrated, Loretta tended to act out her intrapsychic difficulties on a concrete level. Her propensity towards introducing a third person into the transference relationship was graphically demonstrated in the following interlude. At Loretta's first appointment as an out-patient following her discharge from the ward, I arrived at my room to find her waiting for me with Neville. She was dependent on him to drive her to and from therapy. Loretta introduced him, saying she thought I would not mind if he came into the session. I was taken aback but asserted that we needed to discuss it first and that he should wait outside.

Loretta entered the room without him and began talking about how strange it was to be back at Tara since her impression of the place as quiet and peaceful had changed: she was struck today by how noisy it was. She was avoiding returning to the ward. She related how a client of hers had reacted positively to her at work and how this had felt like a role reversal since she was used to being the therapist. I was very aware that Loretta was avoiding talking about Neville joining the session. I noted how she might be feeling uncomfortable at returning to Tara in the patient role and wondered whether her suggestion of bringing Neville into the session was her way of dealing with her discomfort, but she denied it. I reflected the ambivalence she had expressed towards being at the hospital and in therapy today, her concern about how things might have changed and her anxiety about whether I could hold her in mind. This seemed pertinent given the change in therapy arrangements from in-patient to out-patient.

I seemed to have struck a chord because Loretta responded that I had lots of patients who took up this space. I noted how it was different in that she was no longer a patient on the ward and I recognised her desire to still have a place here. She could then discuss her phantasies around the change in the therapeutic relationship, returning to her previously expressed wish to invite me to tea with her. I clarified the limitations of the therapeutic relationship which remained in the room. Loretta expressed relief at how other people might discuss her socially were we to mix in the same circles. I explained that the nature of the therapeutic relationship protected her confidentiality. It appeared that this 'new phase' of therapy brought with it its own anxieties for Loretta who required the therapeutic contract to be renegotiated.

I was still mindful of Neville's presence outside the room. At times I had imagined that he could overhear what we were saying and in that sense, he *was* present. Given my failed first attempt and the lack of an opportune link to the current therapeutic material, towards the end of our time, I chose to ask Loretta directly what had motivated her to include him in her therapy. She said she felt it would be easier not to repeat herself to him

after the session - he could be a fly on the wall. I explored whether she felt it might affect the therapy but she denied that his presence would interfere in any way. Loretta asked me what I thought and I responded that this was a space for the two of us; I felt that having a third person in the room would affect the way I would respond to her. This in fact had been happening to me during the session. Loretta appeared pleased with my response while I felt somewhat manoeuvred into taking a position in the transference. I felt I had been tested by her and was left with the impression that I had passed. I understood this episode as an indication of how concretely she attempted to prevent closeness in a relationship. When Loretta left the room at the end of the session, I noted that Neville was not sitting outside the door but appeared to be waiting for her in the car. I was aware that he had effectively been excluded and wondered what consequences there might be.

5.5.3 Case Illustration 8:

The issue reemerged a week later when Loretta cancelled a session at short notice. When she called, I responded calmly that I would see her at our scheduled session later that week. However, I was left with a disquieting feeling that something had happened to her. At the subsequent appointment, she revealed that Neville had had a fainting spell and was unable to drive her to Tara. It emerged that she had telephoned to cancel the appointment at the moment when she found him lying on the floor yet did not know what was wrong with him. I recalled how she had described things as “frantic” in the surgery during our conversation. She noted how Neville had replied, while lying on the floor, that there was no need for her to cancel the session. I noted how she wanted me to know how frantic she felt by calling me at that instant. She appeared to have been using the telephone as a means of discharging her feelings in the moment. I was left with some of her projected distress while she, in turn, seemed to have introjected my calm response. It is interesting to note that Loretta had apparently found in Neville someone who could receive her powerful projections and who, in turn, seemed to use a similar way of communicating through the body.

She reported that after this incident, Neville was very distressed and cried because he was upset and jealous about her coming to therapy. He could not understand how she could “open up” and talk to me for two hours a week when she could not do so to him. She explained to Neville that the reason she can talk to me is because I am a psychologist and ask lots of questions, then she thought about it and had to admit that I do not actually ask any questions. She remarked that this made him feel worse. In exploring with Loretta what it was about therapy that made it easier for her to share herself, she described how invaded she feels by Neville when he wants her to share her experiences: she felt as if he wanted to know every detail and that she could never meet his insatiable need for information. I related how it appeared safer for Loretta to share herself here because she could share as much as she felt comfortable with and had been able to do so at her own pace. In retrospect, I may have cut off her negative transference to me, including her feelings of being pressured to ‘produce the goods’ in therapy as well. I was able to return to this later in the session.

Loretta continued to relate ways in which Neville was demanding. She felt she was used to giving “the skeleton” of herself to Ricardo, who would tell her to get to the point if she took more than five minutes. For the first time, she was directly expressing a sense of comfort in her husband’s detachment. I linked this material to her feelings of sadness and loneliness at being cut off from others that she had expressed in last week’s session. Loretta began speaking about how self-contained she had had to be in relation to her parents. She described Father with his head in his books: so intellectual yet inaccessible. She related how Mother was disinterested in the children and would furiously rearrange the furniture at night but never had enough energy for them.

I reflected that in having to contain her own emotions, Loretta had shut herself off from others. Perhaps she was now recognising how it was affecting her in relation to others as well as finding it difficult to start opening up to people. Loretta repeated that she does not understand why she can “open up” here. Loretta’s use of the phrase “open up” indicated that for her, sharing feelings was more of a physical action than an emotional communication. I remarked that her parting words at the end of our last session had stayed with me. I was interested to see if she had remembered them; she had not. I recalled her saying that she had had nothing to say at the start of therapy yet had “filled” the session so I must “have the power”. Loretta responded that she felt I must have some kind of power for her to have felt okay about talking to me. I reflected that she needed to imagine that I was powerful enough for her to open up to me and for me to be able to contain what she had to say.

Loretta went on to talk about how Neville invades her and she feels as if he wants to pry. She was reminded of the nurse-therapist, Sarah’s analogy to life being like an onion with layers that one keeps peeling off. She linked this in some way to being in therapy. I explored with her whether it sometimes felt like I was also invading her but she denied this. Our time was up and the session ended with my acknowledging the complexity of this issue. I said that I was left wondering about her request for Neville to come into the session, that perhaps it felt like an easier way for her at the time to address this issue.

At the end of the session, I was left feeling powerful as well as somewhat flattered that Loretta and Neville were ‘fighting’ over therapy time and that I constituted a threat to him. Perhaps Loretta needed to create an omnipotent therapist to contain her projective identifications and to diffuse her envy; inevitably this resulted in spoiling. It was also one of the few direct indications I had that she experienced therapy as creating the possibility for a response of a difference. From this session, I had a clearer understanding of how the dynamic between Loretta, Neville and Ricardo was reenacted in the therapy with her, myself and Neville as the competing outsider. The incident also gave me insight into Neville’s fragility in relation to Loretta as well as highlighting the psychological purpose served by introducing a third person into the dyad. By vacillating between two people, Loretta maintained a fragile balance in interpersonal relatedness: she was alternatively detached or symbiotically merged.

5.6 Countertransference Difficulties:

The preceding illustrations of Loretta's therapy should give the reader a sense of how powerfully she employed projective identifications at times as well as how concretely she could express herself. Such disturbed patients often have an equally disturbing effect on the therapist. My potential as a recipient for Loretta's projections was enhanced when I discovered I was pregnant early in the therapy. The impact of my pregnancy on Loretta was of concern to me. In writing about special problems in psychotherapy, Bellak (1981) deals with the matter of the therapist's pregnancy and concludes that:

if the patient does not see anything when she [the therapist] has come to show her pregnancy markedly, it is only appropriate to raise the question as to why the patient has not remarked on it, and one can learn a good deal about denial and related problems. It is certainly only reasonable to acknowledge the pregnancy, if the patient remarks on it again, giving the patient sufficient chance to fantasize and conjecture. (p. 228)

Bellak is writing about long-term therapy in the above extract. In this case, I took the decision that given the imminent termination of the therapy, I would not raise the issue of my pregnancy but would be on the look out for any signs of Loretta's awareness of it. Such awareness never appeared to reach consciousness. I was not noticeably pregnant and none of my other patients had detected it. With such an atmospheric patient as Loretta, however, I could never be certain whether she had intuited my pregnancy. At one of the final sessions dealing with termination, Loretta's own desire to have a baby was aroused and she spoke of the possibility of adopting a child before dismissing it as a viable option. While this may have been evoked by my own pregnancy and Loretta's envy of it, it seemed more closely connected to the visit and recent departure of Mother, her sister and nieces which had aroused Loretta's earlier losses.

Rosenfeld (1987) observes how the therapist may experience physical symptoms with patients using excessive projective identification:

even physical symptoms can be experienced by the analyst with such patients because the patient's expulsions may be so concrete; he may feel sick just as the patient may actually vomit. Such concrete rejection of the analyst's help can often be clearly understood as a re-enactment of some earlier rejection of the mother's food and care, now repeated in the analytic situation. (p. 163)

5.6.1 Case Illustration 9:

At Loretta's penultimate session, I was overcome early in the session with a strong sense of nausea. I had received the results of my amniocentesis the previous evening and with my relief came a letting down of my physical defences. Throughout the session, I struggled to focus on her words since I was afraid I would be physically ill. In my mind I was preparing a contingency plan should I feel the urge to vomit. The session focused on termination and Loretta's referral to the psychiatric consultant. She spoke about her anticipated difficulties with the new clinician and how she experienced her as self-preoccupied and invasive in prescribing drugs. Loretta felt, however, that she had enough strength now to be able to stand up for her rights as a patient. I considered her observations about the clinician to be relatively accurate and this left me wondering what else she was able to perceive. I began to phantasize that Loretta would 'drop the bombshell' of being aware of my pregnancy on leaving the session, thereby leaving me with the baby, so to speak.

On reflection, many of Loretta's concerns about the new clinician reflect transference feelings around termination which I failed to pick up during the session. Some of this appeared to be conveyed non-verbally through my phantasy of anticipated attack by her as well as my real impatience for the session to end. Minutes after Loretta departed, I found myself being physically ill. On reflection, I understood this both as a powerful projective identification as well as my own countertransference. It appeared to be an unconscious communication by Loretta of her painful feelings of rejection and abandonment: she was experiencing being violently expelled from therapy and conveying that experience to me in a real way. At the same time, I was having to face my own guilt at ending the therapy with Loretta and my sense of how damaging the experience could be for her, with all her unresolved endings and unfinished mourning. I also felt guilt at my relief at therapy ending since it was increasingly painful to be with her while containing my secret pregnancy.

"The other source of the analysand's free association is the psychoanalyst's countertransference, so much so that in order to find the patient we must look for him within ourselves."

Bollas, 1987, p. 202

CHAPTER 6: CONCLUSION

This dissertation explores the fundamental, integral phenomena of projective identification, transference and countertransference in relation to therapeutic practice. Using Bion's notions of the Container and the Contained, the functions of projective identification in both the mother-infant and patient-therapist relationship, are examined in both normal and pathological forms. These concepts are then specifically applied to the areas of transference and countertransference. Special attention is given to the difficulties of working with psychotic patients. The application of theory to the case study aims to convey the process that is involved in working with, and understanding, a patient with psychotic anxiety. The case illustrations were chosen to illuminate the graphic and primitive ways in which the patient communicated her inner world to the therapist, employing conscious and unconscious, pre-verbal and symbolical means. I have discussed how the therapy process was both enhanced and mired by the hospital setting within which therapy took place. Similarly, my own experiences during the therapy, including being a trainee and falling pregnant, facilitated as well as complicated the treatment and my countertransference.

In applying these concepts to the specific case in question, I further hope that the reader gained a sense of the difficulties and challenges encountered in the process of learning to be a therapist. However, it is worth noting that the learning process does not end with the internship: it is ongoing. The challenges I encountered were further intensified by the level of disturbance of the patient in question and the primitive means of communication she employed at times.

Winnicott (1965) cautions against trainee therapists treating psychotic or borderline patients: "In the training of psycho-analysts and the like we must not place the students in the position of being related to the primitive needs of psychotic patients, because few will be able to stand for it, and few will be able to learn anything from the experience" (p. 164). Margaret Little (1951) also notes that "one of the major difficulties of the student in training or the analyst who is undergoing further analysis...[is that] he is having to deal with things in his patients' analysis which have still the quality of present-ness, or immediacy, for him himself, instead of that past-ness which is so important" (p. 35).

Despite these caveats, trainees in the clinical psychology masters program in South Africa are inevitably exposed to very disturbed patients in their training; trainees are often simultaneously in their own therapies. However, and as Little (1951) goes on to observe, beginners often experience successful results: they are "not afraid to allow their unconscious impulses a considerable degree of freedom because, through lack of experience, like children, they do not know or understand the dangers, and do not recognize them" (pp. 36-37). Trainee therapists may be more receptive to patient projective identifications as a result. Thus therapist inexperience can have its advantages for patients who benefit from the enthusiasm, optimism and drive which trainee therapists apply to their first therapy cases. It can further be argued that such disturbed patients afford the best training ground from which to learn about psychological dysfunction.

At the same time, intern psychologists are also more vulnerable to the abuse of such projective identifications by patients. Staff have observed the uncanny ability of disturbed patients to seek out the weakest link in the team and project powerfully into him or her. That 'weak link' is often the intern psychologist or registrar, who is being evaluated during his or her brief rotation through the unit. The effects of such projective identifications could manifest in trainees as psychosomatic illness or acting out in the transference or countertransference in ways that are destructive to both the patient and therapist, such as grandiose phantasies of making reparation or behaving sadistically or masochistically in relation to the patient. The issues involved in learning to be a therapist have been explored in detail by Koller (1991) in her Masters dissertation. The difficulties cannot be avoided and are best dealt with by establishing good support structures for trainees, in particular: thorough supervision of clinical work by experienced psychologists trained in the art of supervision; inclusion of trainees in ward rounds, team meetings and decision-making; formation of peer support groups; and insistence on attending personal therapy.

In conclusion, I owe a debt of gratitude to Loretta, as well as all the other patients I saw during my internship at Tara, for offering me such fertile ground for learning.

APPENDIX 1

AN INVESTIGATION INTO THE NUMBER OF MALE AND FEMALE PATIENTS TREATED ON WARDS 4 AND 5 FOR 6 MONTHS FROM MARCH TO AUGUST 1994, THE NUMBER OF MALE AND FEMALE PATIENTS WITH EACH AXIS 1 AND 2 DIAGNOSIS TREATED ON THE WARDS AND THE AVERAGE AGE AND LENGTH OF STAY OF THE MALE AND FEMALE PATIENTS.

[This study was conducted in November 1994 by Occupational Therapist, Brendaley Danin who was working on Tara's wards 4 and 5 at the time of the study. It has been reproduced here.]

PURPOSE OF THE STUDY: The purpose of the investigation is to document the above-mentioned information, in order to support the continuation of wards 4 and 5 by substantiating how many patients, and what diagnoses, are treated on the wards.

HOW THE INFORMATION WAS OBTAINED: The information was obtained from the patient registers, which are updated for each patient admitted onto wards 4 and 5. The numbers were added for gender, Axis 1 diagnosis and Axis 2 diagnosis and added and averaged for age and length of stay.

SUMMARY OF INFORMATION OBTAINED:

The total number of male patients:	23
The total number of female patients:	100
The total number of patients:	123
The youngest and oldest male patient:	20 years and 58 years
The average age of male patients:	35.22 years
The youngest and oldest female patient:	17 years and 66 years
The average age of female patients:	31.24 years
The youngest and oldest patient:	17 years and 66 years
The average age of patients:	32 years
The shortest and longest length of stay for male patients:	1 day and 86 days
The average length of stay for male patients:	35.9 days
The shortest and longest length of stay for female patients:	1 day and 106 days
The average length of stay for female patients:	28.74 days
The shortest and longest length of stay for patients:	1 day and 106 days
The average length of stay for patients:	30.01 days

Table 1: Number of Male and Female Patients Treated Each Month

MONTH	No. of Male Patients	No. of Female Patients	Total No. of Patients
March	5	29	34
April	4	25	29
May	5	26	31
June	9	26	35
July	9	28	37
August	8	32	40
TOTAL	40	166	206

The average number of male patients seen per month: 6.67

The average number of female patients seen per month: 27.67

The average number of patients seen per month: 34.33

Table 2: Number of Male and Female Patients With Each Axis I Diagnosis

AXIS 1 DIAGNOSIS	No. of Male Patients	No. of Female Patients	Total No. of Patients
Substance Abuse	6	29	35
Adjustment Disorder	4	18	22
Major Depression	2	16	18
Bipolar Affective D.	1	8	9
Schizophrenia	2	3	5
Anxiety-Based Disorder	1	4	5
Organic Disorder	1	2	3
Dysthymia	0	2	2
Eating Disorder	0	2	2
TOTAL	17	84	101

Table 3: Number of Male and Female Patients With Each Axis II Diagnosis

AXIS II DIAGNOSIS	No. of Male Patients	No. of Female Patients	Total No. of Patients
Cluster B Personality Disorder	8	37	45
Cluster C Personality Disorder	7	36	43
Cluster A Personality Disorder	4	0	4
Mixed Personality Disorder	0	1	1
TOTAL	19	74	93

PROBLEMS EXPERIENCED: The problems experienced with the investigation were that not all the necessary information was recorded, that the study did not indicate the amount of individual and group treatment that each patient underwent and the effectiveness of the treatment offered on wards 4 and 5, the difficulties with diagnosing patients accurately and the use of broad diagnostic categories, especially with respect to Axis II diagnoses, in diagnosing patients.

CONCLUSION: This study indicates how many male and female patients, with each Axis I and II diagnoses, are treated on wards 4 and 5 over a randomly chosen six month period, from March to August 1994.

It also indicates the need for further investigation into the effectiveness of the intensive psychotherapeutic and occupational therapy programme run on the wards.

APPENDIX 2**CONSENT FORM**

I have been fully informed as to my possible participation in a research project looking at the process of therapy and it has been explained to me that my participation will not affect the therapy in any noticeable or significant way. I understand that my personal details would be kept confidential and my identity would be concealed.

In signing this consent form, I give my permission to be included in the research project. I understand that I am free to refuse to participate or to withdraw my consent and discontinue my participation in this study at any time and that should I choose to do so, my treatment during my stay at Tara, The H. Moross Centre will not be affected.

I also consent to therapy sessions being tape recorded to assist with the research project. I understand that only Intern Psychologist, Debbie Abrahams, will listen to the tape recordings and that they will be deleted on completion of the project.

Patient: _____

Date: _____

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