

**LEARNING THERAPY - SOME
REFLECTIONS ON THE
CONSTRAINTS AND DILEMMAS
INVOLVED: A CASE STUDY**

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ABSTRACT

This dissertation reviews the process of learning psychotherapy. It focuses on the second year of a two-year course work degree at the University of Cape Town, the M.A. in Clinical Psychology. In problematizing the method of teaching psychotherapy, Steiner's (1984) three essential elements for training psychotherapists are introduced (i.e. a personal therapy, abundant clinical experience with supervision and a study of theory). These are used as a structure in which to consider the training programme outlined. A suggestion is made that the learning process necessitates a difficult intellectual and emotional rite of passage, a theme referred to throughout the study. The personal process of 'growing' into a Kleinian / Object Relations orientation is described. Some theoretical concepts central to this framework are introduced. Clinical case material (derived from therapy notes collected over a period of 47 weeks) is used to demonstrate a developing understanding of these concepts. Some of the dilemmas of a trainee therapist grappling with the process are described. The constraints of learning therapy within the context described, i.e. within a course which is not focussed exclusively on therapy training are highlighted. In concluding that trainers are ambivalent about the psychotherapy component of the programme described, the study offers some useful insights for trainers, supervisors and trainees.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS.....	i
ABSTRACT.....	ii
TABLE OF CONTENTS	iii

PART I

INTRODUCTION.....	1
What is Psychotherapy?.....	1
How is psychotherapy taught?.....	2
The learning process - a rite of passage.....	3
ON LEARNING THERAPY: CONTEXTUAL ISSUES: CONSTRAINTS AND DILEMMAS.....	5
The First Year.....	5
The Second Year.....	6
Transferring patients.....	6
Patients.....	7
Fees.....	7
Case Load and Occupational Hazards.....	7
Long-term psychotherapy cases.....	8
Therapist's narcissism.....	10
Supervision.....	11
Evaluation.....	13
ON LEARNING THERAPY: THEORETICAL ISSUES.....	15
Self disclosure.....	15
The relative importance of theory.....	15
Other important elements.....	16
'Growing' into a Kleinian / Object Relations framework.....	17
Abundant Clinical experience with supervision.....	17

PART II

KLEINIAN / OBJECT RELATIONS THEORETICAL CONCEPTS APPLIED TO CASE MATERIAL.....	19
Introduction.....	19
Ethical issues.....	20
Introducing the case.....	21

	Page
PROJECTIVE IDENTIFICATION AND COUNTER-TRANSFERENCE.....	24
Projective Identification.....	24
Counter-transference.....	26
THE PATIENT WHO IS DIFFICULT TO REACH.....	29
A 'false self' versus 'neediness'.....	29
Resistance to interpretations.....	30
Effects of resistance on therapists.....	31
Passivity.....	31
Hollowness.....	31
Watchfulness.....	32
Perverse excitement at perceived anxiety.....	33
RESISTANCE, THE SCHIZOID COMPROMISE AND THE PSYCHOTHERAPEUTIC STALEMATE.....	35
Insecurity, dependance and fear of weaknesses.....	35
The terror of change.....	36
Fear of warmth and 'contact'.....	36
Compromise solutions.....	37
Dreaming.....	37
Intellectual discussions.....	38
Half in and half out relationships.....	39
The 'In and Out' programme.....	40
The dilemma of the need for a compromise.....	41
CONTAINMENT VERSUS 'DOING' THERAPY.....	43
Containing the patient: can therapists make patients go where they do not want to go?.....	43
Containing the therapist: can patients make therapists go where they do not want to go?.....	44
The desire to 'help'.....	44
Why are transference interpretations so difficult?.....	45
CONCLUDING REFLECTIONS.....	48
Thoughts for trainers.....	48
Thoughts for supervisors.....	50
Thoughts for trainees.....	51
The inevitability of narcissistic injuries.....	51
The experience of a rite of passage.....	52
Avoiding theoretical dogma.....	52
REFERENCES:.....	55

PART I

INTRODUCTION

This dissertation reviews the process of how therapy is learned. In this section, after briefly addressing the questions of "what is psychotherapy?" and "how is it taught?", the idea that learning psychotherapy necessitates a rite of passage¹ is introduced. This is a theme which is referred to throughout. Then, the training programme is contextualised and there is a description of a process of 'growing' into a Kleinian / Object Relations theoretical framework. In Part II, clinical case material is used to illustrate certain theoretical concepts which are introduced. They relate to the patient's dynamics and her process in therapy, but the material is mainly used to comment on the process of learning therapy. The study is therefore a personal account² in which I reflect on the constraints and dilemmas involved. In this sense it is a case study, but an unconventional one.

What is psychotherapy?

Herron and Rouslin (1982) comment that although numerous authors from a variety of frameworks have attempted to define psychotherapy, often in ways which are "fascinating and unclear", it is virtually impossible to do so. This is evident in their own attempt:

"..an interaction between people ... using ingredients which can only be *incompletely explained*" in which the patient has one or more problems of living and pays a fee to the other (the therapist) who is "*required to have knowledge* of how to bring about the solution of the client's problems through the ... interaction ... which includes theories of behaviour and methods for altering behaviour, *as well as an awareness of limitations in the power of the interactive therapy process*" (p.15, *my italics*).

Malan (1979, pp.1-3) describes psychotherapy in terms of maladaptive behaviour in which unexpressed painful feelings are treated by encouraging the person to

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1. To discuss this idea fully is beyond the scope of this present study. However, it is the intended subject of future research to be carried out in conjunction with Sally Swartz.
 2. As a consequence I have dispensed with the convention of never using the first person.

express them. He cautions that psychotherapy is not that easy because:

"... in most cases the patient does not reach the insight spontaneously but needs to be helped by the fact that the therapist can see into the situation more deeply".

Torrey (1986, p.1) defines psychotherapy as a profession in which there is a contract between a specialist and a client for a service, for which a fee is paid with expectations that "the mind will feel better". He cautions however, that being a psychotherapist is not the same as being a physician. Psychotherapy is difficult to study - whilst it is a human transaction, "when ... taken apart on the dissecting table, a part of the interaction ceases to exist". Casement (1985; 1990) draws attention to a learning process and an ongoing interactive procedure (if the therapist listens carefully enough and is flexible). Conceptualizations of psychotherapies are therefore affected by patients' views and experiences, in a process of mutual perception. This makes definition difficult. But, without a satisfactory definition, there can be no clear aims and objectives, both of which are important 'containers' for both patient and therapist (Herron and Rouslin, 1982, p.10). Further, without clarity, it is difficult to know how psychotherapy can be taught.

How is psychotherapy taught?

Malan (1979, p.254) introduces the principles of psychotherapy from the most elementary to the most profound entirely through case material - an empirical approach to the "science of psychodynamics". Although it is a complex way to describe procedure, as well as difficult to generalize, this seems to be the only way of learning some of the principles of psychotherapy (Herron and Rouslin, 1982, p.9).

On the other hand, Mollon (1989, p.114) alerts us to a central point of contrast between

"... 'learning from experience' (Bion, 1962) - which characterizes the culture of psychotherapy - and learning from an appraisal of the research literature - which characterizes clinical psychology ..."

He stresses the importance of the function of supervision in learning psychotherapy and argues that "clinical psychology courses give little help to the trainee in understanding the issues of [for example] transference and counter transference" (p.115). This idea is supported by Bion's (1970, p.1) belief that he will only be understood by someone who has actually experienced what it is he writes about. He remarks that the "words and verbal formulations" he has to use were "designed for a different task" and not to describe something which has been developed from a background of "sensuous" experience.

Whilst this begins to make the task of teaching psychotherapy appear impossible, it underwrites Steiner's (1984, p.55) systematized argument that there are three essential elements for training psychotherapists:

- 1) a personal analysis (the most important),
- 2) abundant clinical experience with supervision, and
- 3) a study of theory (the least important)

Each of these elements will be referred to throughout this study. In doing so, attention will be drawn to another facet in the learning process - a *rite of passage*.

The learning process - a rite of passage

Van Gennep (in Turner, 1969, p.94) defined "rites de passage" as "rites which accompany every change of place, state, social position and age". He isolated three phases in the transitional process: *Separation, margin and aggregation*. To the extent that in the course described, there is a transition - from the status of student towards another social position (clinical psychologist), trainees will pass through the three stages.

The focus of this present study is the second of a two-year internship. It misses out the first phase (separation), when symbolic behaviour signifies

"... detachment of the individual ... from an earlier fixed point in the social structure, from a set of cultural conditions (a "state") or from both" (Turner, 1969, p.94).

The study picks up when neophytes are well into the *marginal* phase of the transition or passage in which:

"... the characteristics of a ritual subject (the "passenger") are ambiguous; he (sic) passes through a cultural realm that has few or none of the attributes of the past or coming state" (p.94).

Turner (1967) describes this marginal phase as timeless, invisible, secret and hidden. This makes it difficult to study. Because of the nature and the confidentiality of the material, the marginal phase in the psychotherapy training is similar which explains why psychotherapy needs to be taught via case material and experience (Bion in Mollon, 1989).

To the extent that at the end there is the promise of passing into society with a new role (with a professional identity as a recently qualified clinical psychologist with some experience in psychotherapy), the dissertation touches on the third phase (reaggregation or reincorporation) when:

"... the passage is consummated. The ritual subject .. is in a relatively stable state once more and, by virtue of this, has rights and obligations vis-a-vis others of a clearly defined "structural" type; he (sic) is expected to behave in accordance with certain customary norms and ethical standards binding or incumbents of social position in a system of such position" (Turner, 1969, p.95).

In the final section of this study, I will point out, however, that for psychotherapists, this third phase is unlikely to ever be concluded.

ON LEARNING THERAPY - CONTEXTUAL ISSUES: CONSTRAINTS AND DILEMMAS

The process described in this study took place in 1990, in the second of a two-year course work degree at the University of Cape Town, i.e. a Master of Arts in Clinical Psychology. Psychotherapy is not the central part of this training programme, which aims also to develop competence in the fields of diagnosis, psychometric assessment and research. This section outlines aspects of the training programme, contextualising the process of 'learning therapy' and drawing attention to some constraints and dilemmas experienced as a trainee. It draws on Dickman (1983) whose account of the 1982/3 structure of the second-year psychotherapy component accords with personal experience in 1990.

The First Year

Students spend the first year at the university's Child Guidance Clinic where, detached, they encounter unexpected 'first contact' difficulties. In learning that therapists "do not behave like other people" (Ignatieff, Spillius, Glasser and Pedder, 1987, p.28), they discover that an essential part of psychotherapy involves the radical subversion of some conversational rules (Swartz, 1988, p.59). Secondly, an unfamiliar "acute kind of listening and taking in, with great [empathic and analytic] curiosity" is necessary (Spillius in Ignatieff et al., 1987). Thirdly, they discover the importance of boundaries³ (Langs, 1973) and the difference between empathy and sympathy. Therapists also have to learn to cope with patients' conflict over this disconcerting style of conversation. The anomalous feelings associated with this alien behaviour are typical of a separation phase in which neophytes, ill formed, feel naked and vulnerable (Goffman, 1961; Turner, 1967).

3. Each requires non-compliance with conversational rules, a point to be explored more fully in future research (see note 1).

The Second Year

In the second year, interns spend a maximum of 4 months in 3 or 4 different training units (within the Groote Schuur - Valkenberg teaching complex). Here they gain the adult experience required by the Professional Board for Psychology. Two of the units are therapeutic milieus in which re-educative therapy techniques such as role plays aim to define and resolve specific presenting problems. Both units run a structured programme (one has a time limit of 12 weeks).

Interns in the 2 therapeutic milieus facilitate group therapy for at least four weeks of their stay. They also see from one to eight patients, for 'individual therapy' either weekly (at one unit) or twice weekly at the second unit - although this is flexible. Interns may join other activities - doing so provides important diagnostic and psychodynamic information.

Transferring patients

Patient's movements do not coincide with interns rotation between units. Transfers of patients to new trainee therapists are therefore common. When S whose case material is presented in Part II, became the author's patient she had been in the unit for 9 of 12 weeks. In keeping with the accepted procedures (without having fully recognized the clinical significance of the history taking procedure), I did not take a full history in her last 3 weeks at the unit, nor did I do so when she began long-term psychotherapy. I assumed that the details recorded in the clinical summary would be adequate. In retrospect this was clearly unsatisfactory. It highlights the idiosyncrasies of recording information and formulating. Although trainees present (at ward rounds and in supervision), patient's histories and psychodynamic formulations as if they are 'the truth', they are little more than a subjective construction of a text (Harre, 1985). The gathering of information takes place between two people, and when a third enters the landscape, the picture changes (Bion, 1970; Sless, 1986). The formulation left behind by S's previous therapist did not therefore 'speak to me' and, in spite of modification, a satisfactory formulation seemed impossible to construct - there were large gaps

that needed filling for me. The transfer of patients also contributes towards ambivalent bonding and an unsatisfactory therapeutic alliance. Whilst S's extreme ambivalence was a crucial psychodynamic aspect, it was not helped by the transfer, as the case material will show.

Patients

Most patients seen at the Child Guidance Clinic in the first year have tended to seek help before a crisis. Hospital patients, like S, have often reached a particular kind of crisis and have unreliable or inaccessible support systems. In the second year then, interns are more likely to encounter patients who have attempted suicide, for example. Many more of the hospital patients have diagnostically and therapeutically significant personality traits and a relatively large number have diagnosable personality disorders (see Dickman, 1983). Many have a prior psychiatric history and the hospital is often a last resort. This has implications for long-term psychodynamic psychotherapy, discussed later in this section.

Fees

In 1990, hospital fees generally equalled those charged by private psychotherapists (although unemployed patients paid only R3-00 per session). The fees office sends accounts to patients. Thus, trainees can avoid an important aspect of the therapeutic relationship. This might provide them with a false sense of being the "helper, the giver, the devoted person who truly cares about the patient" (Herron and Rouslin, 1982, p.77) which has implications for psychotherapy, particularly with a patient like S who was charged the standard rate but recovered 100% from medical aid.

Case Load and Occupational Hazards

Case loads vary at different units (up to 15 cases a week) and the daily programme is generally extremely full. There is a conflict between the service, research and teaching aspects of the course - the training appears to be largely determined by the service demands of the hospital (Lazarus, n.d.). In certain

units the work involves only diagnosis and case management (often via interpreter) of acute psychotic patients. The focus at the therapeutic units is also on diagnosis and case management, but short-term psychotherapeutic intervention is central. In addition, all interns are expected to have two long-term psychotherapy cases (discussed below). Interns placed at the therapeutic units spend one afternoon a week carrying out, and fully reporting on, two psychological assessments. This might include a neuropsychological assessment to determine the extent of cognitive impairment after injury in a motor vehicle accident, followed by an assessment of a working class woman for mental retardation to recommend a disability grant, sterilization or referral to sheltered employment. In addition, in 1990, interns attended lectures for 5 hours per week. Towards the end of the year interns were expected to spend this time on the thesis component of the course.

This broad exposure is consistent with the aim of a programme designed to train clinical psychologists (Eysenck in Mollon, 1989). It does not, however, provide the experience necessary for trainee psychotherapists (Steiner, 1984; Mollon, 1989). Further, the volume of work causes fatigue (which becomes an accepted fact) and leaves little time or energy for the psychotherapy component of the course. The variety of work does not allow for the paradox that as the therapist "does more clinical work it actually becomes easier" (Steiner, 1984, p.58). The fatigue means that therapists are struggling with something besides the patient's problems (Herron and Rouslin, 1982, p.69).

Long-term psychotherapy cases

The process of acquiring long-term patients varies. Occasionally it is possible to carry over a client from the first year. As long as there are sufficient numbers of referrals, long-term patients are allocated to interns on a first-come, first-served basis at the beginning of the second year. They are seen at the intern's unit and therefore move with interns (unless unusual arrangements can be made with consultants in the various units). This is uncontainable for patients and trainees

(Herron and Rouslin, p.74). Interns place a value on reconstructive psychodynamic psychotherapy and there is an expectation that they will acquire some experience and knowledge of it (Dickman, 1983). However, as hospital patients are unlikely to be motivated for ongoing psychodynamic psychotherapy; many would be considered unsuitable for psychotherapy in terms of Hildebrand's Excluding Factors (Malan, 1979, p.225). Further, whilst a comprehensive assessment *may* be carried out, the pressure to gain 'experience' means that interns do not take sufficient stock of what kind of patient they have (Mollon, 1989). Patients are not therefore adequately assessed for long-term psychotherapy (Dickman, 1983).

Assessment is a complex process requiring considerably more skill than interns have at this stage of training. It also requires supervision of the kind not available in the hospital system (Dickman, 1983, pp.135-7; Lazarus, n.d.). Also, in terms of the theoretical framework discussed, the title 'long-term therapy' is a misnomer. At best, patients are seen for two years but interns see most long-term patients for about nine to twelve months, once a week (Dickman, 1983 and personal experience) i.e., for approximately 36 - 48 sessions. This is not comparable with the periods discussed in the Kleinian / Object Relations framework (whose practitioners see patients for periods of longer than five years, usually three to five times a week). The time spent with one patient in the training then, might be better considered short-term psychotherapy given the fact that there is a deliberate limitation of therapeutic time imposed by the course structure⁴. But, short-term psychodynamic psychotherapy would entail clinical experience not available to trainees at this early stage in the learning process. And again, it requires intensive supervision of a kind not available in the hospital setting (Dickman, 1983; Lazarus, n.d.)⁵.

4. An unfortunate constraint that affected therapy with S.
5. Malan's idea of short-term therapy, i.e. 15-40 sessions, once a week, requires a specific and clearly defined goal with explicit and early termination (in Dickman, 1983, pp.102-5).

These issues highlight the tension between training needs and appropriate treatment for patients and the lack of clarity over this component of the training programme (Lazarus, n.d.). A decision to withhold therapy is a legitimate and important option. If recommended it would be consequent upon informed assessment (Dickman, 1983, pp.96-100) but, such a decision would mean forfeiting the opportunity for the clinical experience so sought after by interns, and required by the structure of the course.

Before going on to discuss supervision it is necessary to briefly consider a central, but largely hidden aspect of all therapists, with which trainees have to grapple.

Therapist's narcissism

Herron and Rouslin (1982, pp.85-99), in discussing the "therapist's narcissism," refer to "the self-involved use of self with patients - the defensive use of self ... couched in psychoanalytic terminology."⁶ They comment on the obtuse ways in which authors have explained the concept of therapist's narcissism that makes them:

"... wonder about therapists (including us) who choose to write about narcissism. All we can say is we will try to be clear without being simplistic and complex without being convoluted, and to the degree we accomplish that task we will consider that our interminable analyses have paid off" (Herron and Rouslin, 1982, p.87).

Briefly, obsessional defences are the most common manifestations of narcissism and are frequent components of psychotherapy. They include the need to feel in control, power struggling (because of a fear of being influenced, but also a fear of compliance) and are central to the case material presented in Part II. Early in training, defensive grandiosity (against feelings of helplessness and a lack of adequate self-confirmation) is common. Later, possibly in a rationalized defence, there are likely to be feelings of powerlessness until ultimately feelings of being able to help emerge in the use of "healthy narcissism" (Herron and Rouslin, 1982).

6. This of course refers to concepts such as counter-transference - discussed later.

Therapists often suffer from "chronic helpfulness" - a compulsive need to help (Herron and Rouslin, 1982). If stopped, the resultant "space" (Bion, 1970) is filled with guilt (Herron and Rouslin, 1982, p.99). This makes the therapist's task extremely difficult for a trainee to maintain realistic expectations and goals for therapy (Dickman, 1983, p.135) or to provide a "corrective emotional experience" (Malan, 1979). Further, thrown into the deep end and beginning from a position of ignorance and naivety, they will inevitably suffer injuries to self-esteem and self-image when floundering. When it becomes clear that warmth, empathy, a friendly approach, interpretations and behavioural advice are not necessarily gratefully received (Mollon, 1989), this will be experienced as a narcissistic blow which has implications for supervision.

In raising the sensitive issue of therapists' narcissism, Herron and Rouslin do not intend to indict the therapist. Instead, they attempt to acknowledge its reality and to encourage healthy and open discussion. They observe that in supervision "it is the *patient's* narcissism and self-absorption that gets most of the attention, not the *therapist's*". This, like the belief in the truth of patients' texts (as if they are objective and exist independently of time, space and the observer), makes supervision a complicated process. Herron and Rouslin (1982) argue for "frank and open discussion" as an essential aspect of psychotherapy training and argue that avoiding discussion of the therapist's narcissism impedes the therapeutic process. This also has implications for supervision.

Supervision

In the second year, clinical psychologists employed by the hospitals supervise interns. Much of the teaching takes place in ward rounds headed by psychiatrists whose focus and aims are different to those of clinical psychologists. In each unit there are also members of allied professions i.e., psychiatric nurses, social workers, occupational therapists. This broad exposure can be extremely beneficial but there is a danger in confusing too many models (Steiner, 1984, p.59).

The long-term therapy supervision in 1990 took place in groups (of 2 to 3 interns) once a week for 2 hours. For those in groups of 3, with 6 patients to discuss, 20 minutes could be spent on each. This is not adequate for training as a psychotherapist (Dickman, 1983; Steiner, 1984; Mollon, 1989), and underwrites the overt message that psychotherapy is only a small component of the course.

Whilst supervision in groups provides a forum where peers can learn from each other's experiences in a relaxed atmosphere (Mollon, 1989), there are constraints. First, the atmosphere may not be relaxed (see below). Further, it is possible that neither peers nor the supervisor is comfortable in the theoretical frameworks into which each intern begins to grow. The necessity to translate between frameworks can impede progress. For example, in any single case discussion it was not unusual to encounter four people speaking completely different languages, imposing their own theory (or interpretation of it) on the material. On the other hand, it also might expose interns to a variety of models, which at this early stage in training is commendable. On the negative side, supervisors not versed in the chosen framework might be unable to refer trainees to appropriate literature. This requires interns to find additional precious time to consult with outside resources.

This latter point raises a further important issue. Steiner, 1984, p.58) argues that, coming from an academic background:

"... sometimes, paradoxically, helps to infantilise the trainee who ... demands supervision not primarily with the needs of his patient in mind, but thinking first of his training and career ..."

Part of this demand involves an expectation to be taught. Because of the containing aspect of theory, this expectation increases whenever trainees feel insecure and needy. When the demand is not met, supervisors can be experienced as withholding and uncaring. Unless these dynamics are addressed supervision is likely to become a pedestrian process and is unlikely to be growthful.

Evaluation

Throughout the second year, the hospital staff who perform the role of supervisors also evaluate trainees. For university purposes, at the end of the year there is an examination in which the therapy case counts 50% of the marks (which is not consistent with the idea that therapy is only a small component of the course). Examiners can include those who have supervised interns during the year. So, throughout the year there is pressure to demonstrate competence. But, with limited clinical experience and supervision (Dickman, 1983; Lazarus, n.d.) this is obviously difficult. Given the therapist's narcissism, it is not surprising that in this context, trainees avoid both self disclosure and discussion of "troublesome issues" such as those encountered with someone like S (Herron and Rouslin, 1982).

Resistance to discussion of counter-transference can arise from the possibility of unresolved dynamics between peers which may or may not relate to competition⁷, which is common amongst therapists. The inevitable comparisons make trainees particularly cautious about sharing personal feelings (Herron and Rouslin, 1982, p.76). In this kind of setting, the most important aspect of supervision is missed i.e., the creation of "a 'space for thinking' - a kind of thinking which is more akin to maternal reverie, as described by Bion, than problem solving" (Mollon, 1989, p.113). This means that instead of elucidating the hostile transference and encouraging interns to address it directly, attempts to negotiate around transference obstacles are fostered (p.119). Important aspects of the psychotherapy (and training) process are missed. For example, interns might mention feelings of anger towards a patient, but only in terms of what it means in relation to the patient. The fear of the patient returning the anger and stirring up therapist's residual rage would not be discussed (Herron and Rouslin, 1982, p.96).

7. Competition is fostered in the university system, particularly in psychology where large numbers of students compete for few places in post-graduate courses.

This raises an important point. Supervision is about *the therapist and the patient*, not only the patient's dynamics. This point is frequently forgotten, particularly it seems in the company of trainees for whom all the material is initially intriguing. But, the point is missed also because of the fear of narcissistic injuries and shame (Herron and Rouslin, 1982; Mollon, 1989) which, as a vital part of supervision, demands attention from supervisors.

ON LEARNING THERAPY: THEORETICAL ISSUES

In this section, a brief commentary on the issue of self disclosure is followed by a discussion on the relative importance of theory to learner therapists. The possible influence which personal therapy, other academic endeavours and clinical experience have on the growing theoretical orientation of trainees is also discussed. Thereafter, the process of 'growing' into a Kleinian / Object Relations model is described. Steiner's (1984) argument for three essential elements in the process of training is referred to throughout this section, i.e. a personal analysis, abundant clinical experience with supervision and a study of theory.

Self disclosure

Herron and Rouslin (1982) and Casement (1985) argue that exposing material where psychotherapy has "gone wrong" in both supervision and in a more public forum is an important part of learning therapy. Personal experiences and dynamics then, are addressed in the study but only to the extent that they relate directly to case material and the process of learning therapy covered in this dissertation. It is not intended to draw attention to the full range of my personal dynamics which will be recognized by clinicians; the ability to introspect critically, although significant, is not a particular focus of this study.

The relative importance of theory

According to Steiner (1984, p.59), theory is the least important of three essential elements in the process of training. It can "give a false sense of understanding of a bookish kind". It's most important function is to help create order out of the chaos experienced in a therapy session, i.e. to provide some containment for the therapist (Bion, 1970; Herron and Rouslin, 1982; Casement, 1985). Such containment can only be effective if the theoretical concepts make sense to the therapist. The theory then, must be *understood* in more than just an academic sense (Bion, 1970). Although Herron and Rouslin do not support this, it is possible that if therapists

have been, or are themselves in therapy, they will draw on a framework which helps to create some order out of their own chaotic psychodynamics. 'Growing' into a framework in this way has had a significant impact on my own learning process.

Other important elements

It seems that in addition to Steiner's three elements, it was useful for me to have been exposed academically to both the Lacanian idea of nonunitary subjectivity and multiple and contradictory discourses (Henriques, Hollway, Urwin, Venn and Walkerdine, 1984) and to the "otherness of others" (Casement, 1990). Psychology and social anthropology⁸ comprised the major part of my own earlier studies. Interest in clinical psychology was fired by the fascination of cross-cultural psychology, medical anthropology, discourse theory and, of course, issues in my own (broadly based psychodynamic) therapy. Drawn to ethnomethodology at an early post-graduate level, research assumed nothing - socially based assumptions were avoided (Harre and Lamb, 1986). 'Depth psychology' aroused some skepticism. In the first year of the clinical psychology course this meant a struggle to understand and accept many of the theoretical concepts and ideas expressed in lectures and in the prescribed literature. Much was assumed and presented as 'the truth'. Further, much (if not all) had a western, middle-class and androcentric bias (Lykes and Stewart, 1986). Since many of these so-called truths did not seem to 'fit' with subjective experience nor with the way in which patients seemed to present their difficulties, skepticism prevailed. This caused much discomfort since it affected the ease with which patient's texts could be written⁹ (Harre, 1985; Sless, 1986). Confidence in the role of therapist was negatively affected and anxiety increased. At that time theory was almost certainly being used in a "bookish" sense, not necessarily for the good of the patient.

8. Studied by both Bott Spillius and Casement, who are drawn on in this dissertation.

9. I am referring to recording a patient's case history and psychodynamic formulations.

'Growing' into a Kleinian / Object Relations framework

The process of experiencing theory as liberating rather than as stifling began when some of the theoretical concepts began to facilitate an understanding of what was happening in my own therapy. At these points, engaging was unavoidably powerful; some concepts remain landmarks in my 'passage'. This sudden, extremely intimate, understanding was a "sensuous" experience (in Bion's (1970, p.1) sense). Klein's (1951) paper on *The origins of transference* is one such example. A second is Malan's (1979, pp.140-143) discussion on the "Corrective Emotional Experience" which provided illumination of a sort difficult to describe and one which made a significant difference to working therapeutically with patients.

This growing understanding provided increasing impetus to read more in the area of Object Relations and accelerated an increasing understanding of what had previously seemed to be an alien language. It is noteworthy that, in terms of a rite of passage, this is the time when 'secret knowledge' is passed on to those in the marginal phase. The mystification, and then the de-mystification, are necessary, to prepare neophytes for re-incorporation or assimilation into society, having acquired a new 'status'- different because of an understanding of the mystical language (Turner, 1967).

The process outlined thus far underwrites Steiner's (1984) idea that theory alone is of limited use and that personal therapy is an important component of the learning process. It also draws attention to the possible influence that academic development in other contexts might have on trainees (Casement, 1990). In the next section Steiner's third essential element will be addressed.

Abundant clinical experience with supervision

In the second year of the training, self-consciousness and difficulties with 'first contact' issues have decreased markedly - struggles are differently focused. Whilst there are ongoing, perhaps more intense efforts to engage with theory,

there is also an increase in clinical work, with patients of a different sort. One such personal challenge involved 'reaching' S.

The possibility that there was at issue some over-identification and miscommunication (Bion, 1970) on account of the negative aspects of countertransference and projective identification, (to be introduced later) was mostly avoided in supervision (for reasons set out earlier) and there remained a profound sense of misunderstanding. Drawing on a resource outside of structured supervision, Levett suggested that Joseph (1988) might be useful. This marked another phase in the process of 'growing' into the Kleinian / Object Relations framework. Initially the paper was interesting but difficult to "experience" (Bion, 1970); its value was purely academic. Later, coupled with intensifying amounts of clinical experience and a patient who appeared difficult to reach, Joseph's (1988) points took on an "emotional" life (Bion, 1970). What was happening in sessions became clearer; struggles with the patient's dynamics could be understood in terms outside of (and in addition to) personal shortcomings and failures as a therapist. Of course, this was extremely containing.

This experience supports Steiner's (1984) argument for the necessity of "abundant clinical experience with supervision" in the training of psychotherapists. Further, discussion has supported the notion that all three elements are interdependent, each significantly facilitating the other.

This section has outlined a process of growth into a Kleinian / Object Relations framework. Part II will focus on the theoretical concepts used in attempts to understand and work with the patient whose case material is also presented (to illustrate the concepts being discussed). Some of the constraints and dilemmas involved as a therapist-in-training, given both the patient's dynamics and the context outlined earlier, are also addressed.

PART II

KLEINIAN / OBJECT RELATIONS

THEORETICAL CONCEPTS APPLIED TO

CASE MATERIAL

Introduction

Particular theoretical concepts within the Kleinian / Object Relations framework are introduced in this section. They are illustrated with case material - the aim being to demonstrate a developing understanding of the concepts applied. It must be noted that contributions to the development and applications of these concepts are extensive and varied but, are covered only to the extent that they proved useful for present purposes. The reference to the Kleinian / Object Relations framework encompasses a recognition of the central role that early relationships, in combination with the phantasy life of the individual, play in shaping later emotional responses and patterns of relating. In this model the focus of psychotherapy is on transference phenomena.

This is not intended to imply expertise in the Kleinian / Object Relations model nor to suggest adherence to all the opinions of the individual theorists mentioned.

This would be impossible for at least two reasons. First, it takes more than two years of training (and analysis) to gain the kind of identity and understanding required to work strictly in a psychoanalytic framework (Joseph and Widlocher in Weiss, 1986), and second, this is not the aim of the training described here.

The clinical details of S and the concepts have been selected for two reasons: Firstly, to illustrate central theoretical issues relating to S's dynamics and her process in therapy. Secondly, they were found useful to understand the case material. Much of the understanding is retrospective¹⁰. In the early states of the therapy, whilst struggling with the process described in Part I, I was unable to

10. The volume of psychometric assessments and case management generally, together with the relatively little time spent in supervision, leaves minimal space for reflection of this kind.

assign labels to the experiences. Many of the sessions left me floundering and feeling insecurely supported. This is not to suggest that the present insights are final. Analysis of data such as this is a fluid process due to the therapist's ongoing learning - referred to in the last section of this study.

In the spirit of both Herron and Rouslin's (1982) and Casement's (1985; 1990) argument for frank discussion there is some commentary on troublesome issues and introspective feelings. But first, other matters need to be addressed.

Ethical issues

Case material is presented in this section which makes it necessary to consider some ethical issues. The question of confidentiality in reporting on clinical cases is not to be taken lightly. Patients have an absolute right to expect total confidentiality (Steere and Wassenaar, n.d.). This of course means that whilst therapists are able to share their work in small supervision groups, they cannot do so in larger, more public forums. Valuable "spaces" (Mollon, 1989) in which therapists can share aspects of their work which would be growthful both to themselves, but also to others, are therefore lost (Herron and Rouslin, 1982; Mollon, 1989; Casement, 1990). Ideally, then case material should be written up and shared with colleagues.

Within the theoretical framework drawn on in this dissertation, to ask for the patient's permission to share material can introduce an intrusive factor into the psychodynamic therapeutic process. If permission is sought after treatment, the patient's right to be left free from continuing contact with the therapist is violated (Casement, 1985). This poses the dilemma of whether or not a therapist may present case material without permission from the patient.

Malan (1979, p.vi) carefully disguised the material he used. He apologizes to anyone who recognizes themselves, stating that the material is "published with sympathy and respect; and that the ultimate aim is for psychotherapy to be more

understood and generally accepted, and hence for more people to be helped by it". Casement (1985, p.226) also published patient's material in a similar belief that to do so is in the interests of "promot[ing] an analytic atmosphere in which patients can expect to be better listened to". He, like Malan, took great care to disguise the material to the extent that patients are unlikely to recognise themselves or, at worst are unlikely to be identified by anyone else.

S was not asked for permission to use the material presented in this study. It is therefore carefully disguised; the basic structure of S's history and family patterns has been radically changed to the extent that it is unlikely that anyone, other than perhaps those who have been involved in her treatment, will recognise her. S may recognise herself because the content of therapy sessions has not been altered, but only fragments are used. Furthermore, S is not in any way connected with the university and is therefore unlikely ever to read this dissertation. If she does, unexpectedly, it is hoped that she will accept that it has been written with compassion and in the hopes of offering useful insight to both trainers and trainee psychotherapists working with patients like herself.

*Introducing the case*¹¹

S was a single, 23 year old woman who was referred following a para-suicide. She was a student and worked at a local hotel during vacations and on several nights a week. The fifth child in a large family, S described her parent's relationship as "distant". She came from a middle-class background in Johannesburg. She presented her father, an actuary, as "critical and undemonstrative". He had died six months earlier of a heart attack (aged 60). Her mother (49), an actress, was paradoxically described as "shy and insecure". S was very close to her until age 5 when a younger "sickly" sister had been born. S described her relationships with all her siblings as "distant". Gordon (26), a "hard act to follow", was her

11. The summary of S's process in therapy is based on therapy notes used for supervision purposes (approximately 7 pages on average for each weekly session). Therapy comprised 34 sessions over a period of 47 weeks between February and December, 1990.

"hero". All her older siblings are married, live outside of the country and are successful professionals. Her older sister was the only family member to ever show any emotions (at times of stress jokes were made) and was ridiculed for her repeated shows of emotions. These were considered "weak and typically female behaviour".

S was a planned baby. She described herself as a quiet child who had been happy until the age of 5 when her sister was born and required mother's undivided attention. S was rebellious in high school and was sent to boarding school in her mid-teens. She matriculated with one distinction but had "gained no recognition for it".

S had had two intimate relationships with women (each lasting approximately 12 months - they ended due to circumstance rather than from active choice). She defined herself as homosexual but was secretive about this, convinced that she would be ostracized. She had been in a three year relationship with P, a 20 year old hairdressing student, until shortly before admission. S described P as "undemonstrative and unsupportive".

S described herself as "quiet" and "socially inept". On admission she appeared controlled, self-assured and forthright. There was no past psychiatric history. Her premorbid personality was recorded as "depressed on and off for about 18 months during which time there had been suicidal ideation". S had felt worse since her father died. She reported loss of weight, sleep problems, poor concentration and motivation, and a noticeable lack of energy. She described a social support system consisting of one "close friend". Pre-admission stressful events included 1) the death of father six months earlier, 2) perceived abandonment by mother (plans to spend that Christmas with S in Cape Town had been changed; instead she had travelled overseas with S's younger sister), 3) the break-up of relationship with P, and 4) the failure of an examination.

S presented as casually dressed and self assured, but as a defensive and guarded young woman with above average intelligence. Her clinical diagnosis included both Major Depression (Single episode) and Dysthymia (primary type, late onset) on Axis I¹², with Dependent traits on Axis II. On Axis IV her clinical summary records "severe psychosocial stressors".

When I became S's therapist she was three weeks away from the end of her stay at the unit. Her previous therapist, the therapist's supervisor and the consultant in charge, were of the opinion she would benefit by ongoing individual work and I agreed to continue to see her¹³. S was agreeable to this but not convinced it was necessary, believing that after her intensive "treatment" she should be able to cope alone. No formal history was taken by me and this became problematic, in spite of but, also because of the argument that patient's texts are relative, subjective and by no means static (Bion, 1970, pp.72-3). This of course illustrates a tension between discourses, the implications of which are profound, given the discussion in the following sections. This is addressed in the final section.

12. Using DSM-III-R criteria

13. At the time I had no long-term therapy cases - in terms of the course I was required to see two such cases.

PROJECTIVE IDENTIFICATION AND COUNTER-TRANSFERENCE

Both projective identification and counter-transference are frequently referred to in this study and now warrant some discussion. The patient who is difficult to reach often uses projective identification. But, it is extremely hard to recognise because it is difficult to separate from transference and counter-transference issues, particularly by an inexperienced therapist. This has implications and demands particular care in thinking about case material. Whilst it may be containing for the learner therapist, there is the danger in unselfconscious 'understanding' of a patient's dynamics in terms of one of these mechanisms¹⁴. This further supports Steiner's (1984) argument for the central part played by his three essential elements in the training process.

The concept of projective identification cannot be simply described and it is used differently by different theorists (e.g. Grotstein, 1981; Kulish, 1985-6; Bruss, 1986). It is not intended to enter the debate here, but the way in which the concept has been understood and used in this dissertation will be set out briefly, followed by a brief discussion on the concept of counter-transference.

Projective identification

Projective identification is an intense method of communication used by patients like S. It occurs at a time when either patients have no words to describe their feelings (if indeed they are consciously aware of them) or when they unconsciously need to disown an aspect of themselves or their feelings. They 'communicate' through a process of splitting within themselves. For the mechanism to be considered as projective identification, the recipient of these powerful projections

14. Klein's always emphasised the patient's material, not the analyst's feelings which she believed affected his or her proper functioning as an analyst. She always suggested more self-analysis on the part of the analyst. This is illustrated by Segal's story of "a young analyst who told [Klein] that the patient had projected confusion into him to which she replied 'No, dear, *you* are confused'" (in Bott Spillius, 1988, p.10).

(the therapist), must experience an "affective resonance [in which their] feelings take on a 'sameness' based on identification"¹⁵ (Casement, 1985, p.81).

In session 35, in the transference, S needed me to care for her (on a conscious level she wanted a husband). She complained that like her teacher, I was unfair and uncaring (being unavailable at an alternative time) and like her flat-mate, she could not get rid of me because she liked me. Finally, she would not ask me for help in the same way as she would not ask her mother for help. I was left feeling dreadful. S had launched an "alarming attack on [my] professional and personal identity" (Mollon, 1989) which was experienced as a narcissistic blow. But, whilst in earlier sessions I had not had any idea as to how to make sense of the murderous feelings, and the paralyzing confusion and guilt, later I was able to do so in terms of projective identification. In this example it is not clear if this feeling (put into me by S) related to S's actual feelings or if they had been split off because she could not experience them and then had left them with me. The latter is a likely explanation, given S's comment in the next session (36) that when she leaves therapy she always feels "elated".

The degree of identification distinguishes projective identification from projection. If the mechanism being used is a projection, the therapist can empathically observe without feeling intruded on and without any of the intense feelings induced (through counter-transference) by a patient using projective identification (Bruss, 1986). It is noteworthy that it is not only psychotic patients who use this form of intensive communication (Casement, 1985). When projective identification is used as communication, an urgency is felt (Apprey, 1985-6). In session 35 (described above), the intensity with which I felt my failure was such that it could not have been understood in terms of projection. The power of these subjective experiences

15. It is extremely difficult in reporting fragments of case material to convey this resonance or the effect that the patient's words produce on oneself and the atmosphere that is created by this process (see Bion, 1970).

can only be felt in a clinical setting and renders them explicable only in terms of projective identification (Bion, 1970; Casement 1985).

Obviously, from what has just been stated, projective identification cannot take place without recognising the part played by counter-transference. Whilst what is felt by therapists might be 'purely' that which the patient is 'putting into' them, what they do with the feeling, or how they understand it, is likely to be mitigated and contaminated by their own, often intense (Kernberg, 1965) counter-transferential reactions.

Projective identification cannot be separated from the transference situation. In patients difficult to reach, we will see that, as a result of projective identification the therapist, having received the patient's projection of his or her active, concerned part feels the pressure of it and acts out the desire to "get something achieved" (Joseph, 1988). The infantile part of the patient is thus kept hidden, demonstrating how projective identification is an aspect of transference in which pressure is exerted on the therapist to experience themselves in a way that is congruent with the patient's unconscious phantasy (Ogden, 1982).

Segal (1967) draws attention to the use of projective identification in which the patient is silent and withdrawn, inducing in the therapist all the childlike feelings of helplessness, rejection and lack of understanding with which the therapist can identify, contain (Bion, 1967) and alleviate in a "holding environment" (Winnicott in Casement, 1990). This was experienced when, in session 36, every interpretation I made was rejected, making me feel those feelings - helpless, rejected and misunderstood.

Counter-transference

Just as transference cannot be separated from projective identification, so the therapist's response to projective identification cannot be seen as anything other than as an aspect of the counter-transference (Ogden, 1982). The following

illustrates the difficulty of separating the two concepts. At the end of session 10, in which S had ambivalently discussed immediate termination, it felt as if I had been played with. I wondered with guilt, if my own counter-transferential disturbance with S, and hence my own ambivalence, had been experienced by S and wondered if *she* had felt played with (Money-Kyrle, 1988, p.25). Later, I was able to think of this in terms of projective identification in which I was experiencing the fullness of S's ambivalence and the insecurity she felt in any relationship.

Historically, counter-transference has been used variously but again, it is not intended to deal with the concept in great depth. The term is used to refer to "the feelings aroused in the therapist" (Joseph, 1988b, p.62). It was initially considered an obstacle to psychotherapy but is recognized today as an invaluable tool for understanding the unconscious mental processes of the patient, so long as the therapist understands and can tolerate the reactions as part of "his early self, which has already been analysed" (Money-Kyrle, 1988, p.23). Once more, this draws attention to the central role played by personal therapy in learning therapy (Steiner, 1984).

Counter-transference used to be thought of as "mainly ... a personal disturbance to be analysed away in ourselves" (Money-Kyrle, 1988, p.22). There is evidence to suggest that therapists still have ambivalent feelings about the concept even though it is particularly useful in understanding the transference and in making transference interpretations. For trainee therapists, counter-transference issues are difficult to acknowledge and discuss, mainly because counter-transference reactions are often unexpected. Discussing them invariably draws attention to the self-involvement, or narcissism, of the therapist. This may lead to unconscious avoidance of raising the issues in supervision - often true for me.

Not all counter-transference is useful or "normal". There are some conditions under which it is disturbed, particularly "whenever the patient corresponds too closely with some aspect of [the therapist] which he has not yet learnt to

understand" (Money-Kyrle, 1988, p.24) and which requires further personal therapy. This is illustrated in the following example. In session 35, possibly because of my own pre-occupation with forthcoming exams, I chose to focus on S's exams. Attempting to show concern for the problems S had to cope with whilst studying I commented on this. She misunderstood the caring and felt criticized for not concentrating on her studying. She then became distant. For the rest of the session, I felt a failure. This extended into session 36, when in her characteristically distant and superior way, S continued to reject anything I said. My response was 'to give up' and I wondered if I should be doing this kind of work at all. The "resultant feelings of shame, as well as guilt, may make it difficult to seek supervisory help" (Mollon, 1989, p.119). Such a response is characteristic of beginners without the breadth of experience to work with this kind of patient. But, the response also came out of my own unresolved personal issues not yet understood - an example of "disturbed" counter-transference. This prevented me from hearing what S was trying to communicate to me in the only way she knew how.

This section has outlined briefly two concepts which are referred to frequently and which are both central in a Kleinian / Object Relations framework (Kulish, 1985-6). The following section considers a specific kind of patient, i.e. one who is difficult to reach. It draws almost exclusively from Joseph (1988), a paper which first drew attention to the possibility that S was indeed difficult to reach.

THE PATIENT WHO IS DIFFICULT TO REACH

Joseph's (1988, p.48) central thesis is that it is difficult to give "real emotional understanding" to a patient who is difficult to reach with interpretations. This was apparent with S throughout therapy. The patient's "schizoid mechanisms" (p.60) keep one part of the ego completely apart from the therapist¹⁶ and from the psychotherapeutic work as a consequence. In successfully keeping another part away they create a form of "anti-understanding". The hidden part is extremely needy and is potentially responsive, hence it is essential but very difficult for the therapist to reach it. I may have been more able to understand S in terms of this concept if I had felt safe enough to raise the issue in supervision but, my apparent lack of feeling troubled me - I experienced it as a failure on my part and, as a counter-transference issue, best kept for my personal therapy.

A 'false self' versus 'neediness'

The part of the ego which is brought to therapy presents itself as the 'rational', 'coping', 'independent' self - Winnicott's (1960) "false self" (in Joseph, 1988, p.49). In what might have something to do with competitive controlling (p.51), the "false-self" ensures that no real contact is made. This is demonstrated by S, who in the first 4 sessions reported that things were going well, confirming the 'coping' self she was at pains to present throughout therapy. She denied having feelings about losing her individual therapist and we agreed to meet until May, 1990, to focus on her father's death and her relationship with P. At the end of the training programme I can now recognise that this 'rational', 'coping' self points to S's unconscious concern about her ability to cope and her repressed neediness and dependence.

16. Joseph uses the term 'analyst' but, since this dissertation addresses the process of learning *therapy*, the term 'therapist' is substituted. This does not imply that I see no distinction between the two. Real differences exist but this is not the place to address this issue.

The 'coping' part of S was more evident at some times than at others. It frequently followed difficult sessions and occurred following the particularly demanding sessions mentioned above (35 and 36) when an attempt to show concern over S's exams had been experienced as criticism. In the next session (37), she presented the 'coping independent adult' who had decided to give notice on her flat and to move into a boarding house pending purchase of a flat.

Throughout much of the therapy, such patients relate in a slightly superior way. Yet, there is an appearance of a therapeutic alliance, it feels as if the patient is assisting the therapist with the work. In fact, they are successfully keeping the "patient part" split off. The success with which S achieved this with me is demonstrated by the fact that, only in session 13 did S say she had been afraid to tell me how bad she had been feeling throughout because she feared I might send her to Valkenberg (which would mean she was not coping). She seemed to fear that if she showed her feelings she would be bundled off somewhere as she had been as a child, first when her younger sister was born and later when she was sent to boarding school. Clearly, S feared that there were bad persecutory aspects to me. The only way she could keep these aspects of me at bay was to bring to therapy the 'coping', 'false self', thereby splitting off the needy part which Joseph (1988) suggests is true of patients such as S, who are difficult to reach. This also allowed her to avoid dealing with her neediness on a conscious level.

Resistance to interpretations

Patients who are difficult to reach are impervious to interpretations. In session 10, after S ambivalently had decided to leave therapy I said we had formed a "relationship" which S flatly denied. A conflict followed: I said she seemed sad; she asked how I knew. I said there were tears in her eyes, she said they were not tears, her eyes were sore. She then agreed to come the following week. I asked if she meant that next week would be her last week and she said "maybe". I commented on how it seemed there was some conflict between us. I said it was

as if she was punishing me for having pushed her out. She replied "No, I am humouring you". I linked this kind of behaviour to P, suggesting that maybe I had come too close to her which is why she wanted to end now. She denied this even though, as will become clear in the next section, S did struggle with intimacy.

Effects of resistance on therapists

Passivity

This resistance to being understood has a variety of effects on the therapist. Through projective identification, the patient can be experienced as feeling extremely passive (Joseph, 1988). This passivity occurred with S when, having slept with P again and feeling "euphoric", P ended the relationship claiming S had "seduced her". S "suppose[d she had] to accept that the relationship had ended and need[ed] to think about what [she] should do with [herself]". In a monotone, she offered a few options, for example, calligraphy classes and catering for a "gay evening". Misled by her apparent positivity, I became excited. I commented on each seeming like a very good idea but the comments "fell flat". I could not understand this at the time but was later able to make sense of it in terms of S's unconscious attempts to manipulate me into pressing her into action. I then became the active, interested, coping part of S. This use of projective identification of parts of the ego "can very easily pass unnoticed and bring a very subtle pressure on the (therapist) to live out a part of the patient's self instead of analysing it" (p.59). As a consequence I was precluded from getting in touch with the cut off part of S, the apathetic, passive, needy and dependent part.

Hollowness

The blocking of understanding can also give the therapist a feeling of "hollowness" even though it appears as if contact is being made. Following an extremely ambivalent series of sessions (9-12), S agreed to continue with therapy (session 13). She had apparently recognized that she was conducting her relationships on a "hot/cold" basis and it felt for the first time that therapy was 'working', that we had, at last, formed a proper 'therapeutic alliance' and that S was at last an ally

rather than someone "creating anti-understanding". However, there was the intangible feeling of "hollowness" (p.49) surrounding what had begun to look like ongoing psychotherapy. At these times:

"... it all feels a bit too easy ... [any] signs of conflict ... are somehow quickly dissipated ... free associations are absent and the analyst has to work very hard to understand what is being asked of him (sic)" (p.49).

This occurred frequently with S; in supervision I reported a feeling of "walking through syrup".

Watchfulness

Whilst it felt that 'therapy' had begun in the session following S's understanding of the 'hot/cold' way in which she conducted her relationships, paradoxically, I also began to wonder if S was intelligent enough for this kind of psychotherapy and discussed this in supervision. Later, discovery of Joseph's (1988, p.54) remark on how the watchfulness of the split off, needy part of a patient prohibits meaningful communication and makes the patient seem "dull and stupid" was therefore extremely useful.

The watchfulness which occurs is illustrated in session 16, which followed a session in which S's ambivalence to therapy had been very evident in the transference (but on which I had not remarked). She commented that we had covered something "very important" in the previous week. It had "something to do with self-esteem". Since I remembered no such reference I wondered with alarm, if I had experienced a counter-transferential block. Later, there were similar experiences which were disturbing for me. In retrospect they illustrate the power of S's splitting, i.e. she was conducting the therapy with an extremely watchful observer which had understood something in the previous session which had not been shared with me - it was happening elsewhere so to speak.

Although the needy part cannot be reached, it may be talked about (Joseph, 1988). This is clearly illustrated in session 19, in which S consciously admitted to wishing

to avoid having to acknowledge her needy part. She made an understatement of the kind which always made me want to laugh. Earlier, I had struggled to subvert conversational rules by not laughing in response to S's attempts to lighten 'talk about troubles' (Atkinson and Heritage, 1984), a style characteristic of her family's way of dealing with emotion. Later, I was able to recognise this as "diagnostic" (Casement, 1985). In this session, I commented on how, when something was painful for her she turned it into a joke. She agreed, saying she did not want to make things "too gloomy". I remarked that people would never know how she was feeling and she said she did not want them to. I said this must make her feel very lonely. Tears welled up in her eyes and in what was possibly an error, I remarked on how something appeared to be upsetting her. Immediately her tears drained away and I commented on this. She said she was doing it intentionally and that whenever she succeeded she considered it to be a "victory". I remarked that this made me wonder how she understood therapy and what she was getting out of it. She said she was getting a lot out of therapy: It made her feel good, it was her space and one in which she could say how she is feeling without having to control her feelings. This apparent contradiction again illustrates how successfully S was able to keep a split off part away from me, i.e. the part she claimed was "not having to control her feelings" whilst the watchful observer observed, clearly acting the role of a 'rational' person of the type acceptable to S's family.

Perverse excitement at perceived anxiety

It is not uncommon for patients to use their split off parts to become perversely excited, for example, at perceived anxiety in the therapist. This enables them unconsciously to avoid understanding interpretations or provides a controlling mechanism in which to disturb or arouse the therapist through "violent acting out" (Joseph, 1988, pp.52-3). This part remains so effectively split off that it is extremely difficult to understand. Acting out in response becomes almost unavoidable. Hence, it is extremely difficult to truly reach the patient in a way in which the patient's needs are accessible to both therapist and patient in a healthy

way. Personal therapy (to work with the apparently unresolved counter-transferential aspects) and active listening in Casement's (1990) sense is imperative but extremely difficult for a trainee. An example of both acting out and of not listening follows.

When S. decided to terminate in session 10 (after I had said we could continue until January, 1991), it was completely unexpected. Instead of exploring her fear of contact I asked, defensively, if she felt she had dealt with all the issues she had wanted to. My response indicates a failure both to listen to what S was really communicating and to deal with my counter-transference reaction to what was probably experienced as a "narcissistic injury" (Mollon, 1989). That personal therapy and abundant clinical experience is an essential part of learning is illustrated by the fact that in session 46 this same pattern recurred - i.e. in both S's presentation and my reaction. This underlines the importance of Steiner's stipulation for personal therapy and abundant clinical experience with supervision, and also illustrates how effectively S was using her split off part - making it extremely difficult for me to understand and hence to avoid acting out.

This section has dealt with the manifestations of the problems of working with a patient who is difficult to reach, together with some related technical issues. Aspects of the psychodynamics of such a patient are addressed briefly in the next section. This includes an attempt to indicate why the patient is at such pains to ward off the therapist.

RESISTANCE, THE SCHIZOID COMPROMISE AND THE PSYCHOTHERAPEUTIC STALEMATE

This section draws almost exclusively on Guntrip (1962) who, unlike Joseph (1988), discusses the psychopathology of patients who are difficult to reach. Important to note at the outset is that the kind of patient described is not consciously attempting to hinder the process. Guntrip (1962, p.274) suggests that all patients are "at bottom" schizoid and argues that the "reality ego ... want[s] to be finished with the illness ... as soon as possible". But, he makes the point that this is a "regrowing" process and, like a healing process of the body, "there is no quick and easy way of making a mature and stable adult personality out of the legacy of an undermined childhood" (p.273).

Insecurity, dependance and fear of weaknesses

As a child, the schizoid personality has not been treated as a person. Consequently they feel extremely insecure. Fearful of their weaknesses, they attempt to defeat them. In truth, the patient is weak but in believing it is their fault, they cannot accept that their "emotional ego development has been arrested at the deepest levels" (p.277). This is illustrated in session 16. Referring to her low self-esteem, S said she felt as if she was "prostituting" herself at work whenever she failed to assert herself. She felt "feeble" and wanted to use the rest of the time we had together to "practice giving my opinion". Apparently having had to be silent and invisible at home as a child, this illustrates Guntrip's (1962, p.277) description of a person with "a chronically anxious infantile dependence (which) craves all the time for a good parent figure with whom he can make a new start". Patients like this remain emotionally infantile, believing nothing will ever be worthwhile unless the lost parental influence is restored (Balint, 1968, p.89). In the belief that they cope with life inadequately and that their needs make them dependent, these patients despise the needy part of themselves. As adults they are at great pains to defend their independence, and their right to

self-determination. But, in their (false) independence (with loss of ego) they experience "a sense of utter and hopeless aloneness" (Guntrip, 1962, p.285).

The terror of change

Whilst this kind of patient wants to feel better then, change is terrifying. They cannot give up a lifetime of inadequate solutions or defences for what "feels to be the uncertain promise of a real solution" (p.285). This is illustrated by S's frequent insistence on a "guarantee that crying would make [her] better" without which she "did not see the point".

Some patients can risk the experience of the kind of regression necessary to reach the needy self in sessions, whilst the adult copes outside. Those like S, who cannot, continue to tolerate the familiar anxieties because they seem less terrifying than the idea of over-dependence and the fear of all that comes with it. This would include "the loss of identity, becoming stifled and sub-ordinate, and submissive clinging to the protector" (p.274). S's terror was demonstrated in her fear of being sent to Valkenberg. The patient is thus trapped. In their hopeless (false) independence, they seek help but, the need for regressed dependence means losing self-determination, independence and individuality (p.285); so the person the patient turns to for help becomes the person from whom they must flee (p.274). When S finally terminated prematurely (session 46), it was in the belief that if there was a real solution to be had, its promise was too uncertain and indeed, change and admission of her dependence was too terrifying for her to even acknowledge.

Fear of warmth and 'contact'

Joseph (1988) and Guntrip (1962) point out that when some warmth and 'contact' is established, further progress is blocked. The patient becomes helplessly passive (though not actively unco-operative) and loses interest in the work which appears to be going on. The shifts to passivity often follow experiences of having been truly understood. This entails 'contact' which, for this kind of patient is

terrifying. They fear not only that they will be expected to talk and "to perform" (Joseph, 1988, pp.55-56) but also the consequences of the closeness. This happened repeatedly with S's tears which always followed 'contact'. If I commented on them or showed some empathy they would drain away instantly and she would become immediately remote. Also, in session 38, S spoke of a friend at the hotel with whom she had "cut contact". I asked her why and she replied (as if she had read Guntrip) that she had "come too close and asked too many personal questions".

Compromise solutions

The need to hold on to a false self precludes an acceptable relationship with any other human being. But, this kind of patient needs people as much as they fear, and does not trust, them. This forces them to seek "compromise solutions" (Guntrip, 1962, p.273) which, of course, puts psychotherapy at risk.

Throughout therapy the patient is "tossed about between his or her fears of isolation and simultaneous fears of emotional proximity" (p.273). The patient's ability to tolerate separations will be affected by these contradictory needs. They need to be certain they will never be deserted and can acknowledge feeling some anxiety at the thought of a break from therapy, but find it impossible even to recognize the humiliating and intolerable, needy self. S cancelled sessions following those in which there had been 'contact' and warmth - this never seemed to bother her. But, following a cancellation by me there was some acting out. This illustrates aspects of the 'half in and half out programme' (addressed below) but, other forms of schizoid compromise are first discussed.

Dreaming

Guntrip (1962, p.280) describes dreaming as a schizoid compromise "par excellence". Given this, and the tendency of these patients to withdraw after warmth and contact, it is interesting to note that S brought a dream to session 25. This followed a series of sessions in which she had talked about feeling "special"

because sometimes we went beyond the 50 minutes and one in which there had been a successful transference interpretation:

She remembered waking up with a feeling that someone "who feels like a lover" is leaving her (she had the same feelings about the person as she did for P). But, she thought the person looked like her father. She is "imploring" and "pleading" with him not to go. They are in the house she grew up in, with father going from room to room slowly. He is leaving the house when S wakes up. On waking she was not distressed but had a strong sense of loss. It was not a physical dream. Throughout, there was a conversation going on. S was a "big person" but she was talking irrationally, "like a child". Father was responding rationally. She kept asking questions. She was unable to remember any of the details of the conversation.

According to Guntrip (1962, p.280) discussing dreams intellectually rather than emotionally maintains the patient's schizoid defence: Dreams are a way of struggling to solve problems independently. They are rivals to psychotherapy, in that the patient will be only half in touch with the therapist. We did not deal with the dream in transference terms (for reasons which are addressed later). We looked at the lack of choice S had in both her father's death and P's departure at the end of the year and linked it to how her earlier intimate / sexual relationships had always ended due to circumstance rather than through active choice on her part. The fact that the person in the dream represents a depriving, rejecting father/lover/therapist seems clear but, by drawing on her characteristic superior air, S made it impossible to address her obvious distress at being abandoned by P, or by me in the transference.

Intellectual discussions

Another way of maintaining a compromise is by attempting to control the analysis by trying to turn it into an intellectual discussion. One of Guntrip's patient's considered analysis as "a valuable course in psychotherapy" (1962, p.279). S repeatedly said she wanted lectures on how to conduct herself in various situations. (It is noteworthy that in the therapeutic milieu she had consistently refused to take part in the role plays).

Whilst intellectualising might not be useful for a patient because of the lack of real change, Guntrip advises against rejecting this material as a defensive manoeuvre;

these patients are likely to value their intellect as the one *functioning* part of their personality. If "he (sic) is just ruthlessly stopped from using it in sessions he may well feel ... reduced to a non-entity" (p.279). Therapists then must support this grown up part of the self, as well as the child. If they do not, the original unsatisfactory environment is being re-created. Perhaps I achieved this with S when, in session 46, she insisted on premature termination. She agreed that maybe there was some work she needed to do at some later point but for the moment she felt she needed to be able to cope alone.

Half in and half out relationships

In schizoid patients there is a sense of non-committal, true of all relationships with friends, family, organizations, etc. Their relationships generally represent a child's struggle to overcome infantile dependence by disguising it in semi-adult form (Guntrip, 1962, pp.282-3). Such patients sometimes maintain a 'half in and half out relationship' with someone outside of therapy, often secretly for fear of being told to give it up by the therapist (p.278). Prior to seeing me, S told her therapist that she had "broken up" with P. However, she maintained a half-in and half-out (or, to use her own terminology, a "hot and cold") relationship with P throughout her therapy with me. It is noteworthy that she terminated therapy immediately after P left Cape Town to work for her parents in Port Elizabeth. This strategy served the purpose of ensuring that both relationships (with P and with me) were half-in and half-out.

In session 9, I had said that we were 5 weeks away from the time we had agreed to terminate therapy and needed to talk about whether we were to go on beyond that time. In the following session (10) S announced it was her last. She was "tired of coming and was coping fine". As a result of discussion in supervision, it occurred to me that raising the issue of continuing therapy had paradoxically made her feel rejected. In the following session (11) I said I wondered if she felt "pushed out" of therapy as she had felt with P and when sent to boarding school. She had. I again explained that we could continue but that if she did want to

end, we should meet about 3 more times to say good-bye properly. In session 12, S arrived saying the session was to be her last but then agreed to "maybe come once more". This ambivalence put me in touch with how both she and P must have felt in their half-in and half-out relationship. I drew to S's attention the on/off nature of our exchanges. I said I never knew if she was or wasn't going to come to therapy and wondered if this is what happened between P and herself. She introduced the words "hot/cold" and said if she was doing this here and with P, she was maybe doing it everywhere and should probably "look at this".

In another instance suggesting that she was becoming more aware of her fear of intimacy, S said she feared that therapy was replacing P. In sessions 20 and 21, after I had told S that I would be away for a week in 3 sessions time she described an 'In and Out' encounter with a man at work. At first, she had been very attentive but when he became "aroused" she lost interest. However, when he came back to the hotel and did not greet her she was indignant. Also, after my leave (which coincided with P being away as well) S related several incidents in which she had considered "seducing" women.

The 'In and Out' programme

The following experience of Guntrip's illustrates the 'In and Out programme', characteristic of the schizoid patient (Guntrip, 1952, pp.36-7; 1962, p.274). It also highlights the tensions found in these patients, i.e. dependence/independence, trust/distrust, acceptance of/resistance to treatment. These contradictory tensions make such patients attempt to establish a persistent compromise, halfway between the two extremes which, in psychotherapy will obviously result in "a therapeutic stalemate" (Guntrip, 1962, p.275): His patient unyieldingly needed to keep herself going without help. She found it impossible to trust or rely on him and complained that she had to fend for herself outside of sessions. She did not therefore see how he could be useful to her. Guntrip states that she was mentally dismissing him as soon as she left a session and then, panic stricken at the thought of isolation, was forced to carry on long conversations with him in her

head. However, on entering his rooms for the next session she had nothing to say until the end of the session when she would suddenly have much to say (p.275).

In the compromise relationship then, full emotional response is not involved. Patients are 'In and Out' of the relationship which they keep going while keeping the inner self withdrawn (pp.277-279). This is achieved for example, by arriving at therapy every week but, whilst support is being obtained, real understanding of themselves and their way of dealing with relationships remains unchanged. This was evident when S herself said in session 41 that she did not see the point of continuing in therapy; it was "all very well coming each week and dealing with a crisis but a new one will always arise and so [she] needed to be given skills in a lecture format, to learn to deal with these crises alone". She felt she could not keep coming for ever "just to be alleviated for a week".

The dilemma of the need for a compromise

The dilemma of the need for compromise means that if one cannot be found, the patient will have to leave therapy. But, if one is found there will be a 'blocked analysis'. This is likely to break down but, until it does, there is a chance of "analysing the forms of compromise the patient sets up and promoting some progress" (p.278) - a seemingly impossible task since, as Joseph (1988) asserts, these patients keep emotional indications of their chronic dependency needs hidden - evident in much of the material presented thus far¹⁷.

In their compromise these patients attempt to be content in becoming cold and emotionally neutral. This is demonstrated when S, in a more conscious battle with the needy/dependent part of herself, said she was too sensitive (a part I only fleetingly experienced); she admired, and was striving to be a "coper" - "a hard, cynical person who feels nothing" (notably, the part she brought to therapy).

17. If S had not recovered 100% of the cost of therapy, it is not certain that she would have continued to come for as long as she did.

In denying any feelings, such patients are unable to effect stable and happy human relationships. This is evidenced by the 'half in and half out' relationships described above. However, being unable to tolerate the 'half in and half out' solutions often leads to a "point of volcanic eruption" (Guntrip, 1962, p.286). S's para-suicide could be understood in these terms. At these points patients need a genuine therapeutic relationship which offers an opportunity to experience the trust and security so far never experienced. This will be a step towards finding a way out of their "trap" (p. 286). But, it is hard for them to accept, as is demonstrated in S's premature termination. (Although the uncertainty surrounding termination, together with the repeated moving of our meeting place, might also have meant that the relationship was not reliable enough for S).

This section has addressed the fears and strategies of patients either attempting to find a compromise or who have effectively reached a point of 'blocked analysis'. In the next section the various tensions between whether or not to "expose" a patient to the issue of blocked analysis will be addressed. The particular dilemmas presented in such situations for a trainee are discussed.

CONTAINMENT VERSUS 'DOING' THERAPY

Containing the patient: Can therapists make patients go where they do not want to go?

Guntrip (1962, p.285) states that a psychotherapeutic stalemate:

"... is a necessary stage through which a patient must pass ... [because] ... the emergence of the ultimate withdrawn infantile self is the hardest of all ordeals for the patient"

This must be borne in mind in considering that in some instances it is not possible for patients to be in therapy for a reasonable length of time (as is true of patients seen by interns). There may also be other constraints which leave the patient with no option but to maintain the compromise. In such cases Guntrip advises therapists to be practical. A useful compromise should be accepted and the patient should be helped to accept the fact that they cannot go beyond this point (p.286).

The "resistance" is not coming out of perverseness, it is a struggle to maintain stability - a courageous act (Guntrip, 1960). In S's family there was a strong "taboo on weakness" (Guntrip, 1962, p.286) which left her with little choice but to be courageous. These kinds of patients are 'coping' within the limits of what is possible for them. A compromise is "preferable to opening up devastating conflicts in order to seek real solution". Thus, whilst it may be an:

"... evasion of the real solution, ... it is not for us to say lightly whether a patient should or even can lay himself (sic) open to the radical cure" (p.279).

The compromise, then should not be too "ruthlessly exposed" (p.285) by, for example, irresponsible interpretations. However, it is noteworthy that if patients can deal with their problems they will, and if they cannot "no amount of analysis will make [them] do so" (p.279) (except perhaps unintentionally, as a consequence of an extra-therapeutic circumstance). Guntrip then suggests that therapists generally cannot make patients go where they do not want to go. This is a relief for a trainee. But conversely it is extremely difficult for trainees to support a patient in a compromise situation. I suggest that in this situation patients can certainly make trainee therapists go where they do not want to go.

Containing the therapist: Can patients make therapists go where they do not want to go?

To justify the statements made in the last section, it is necessary to return to some of the constraints imposed on trainees by their narcissistic need to 'help' people, the context and the lack of experience, all described in Part I.

The desire to 'help'

Lack of clinical experience and aspects of the trainee therapist's narcissism perpetuates naive use of theory. There are times in the early stages of learning (but later too), when there is a grandiose sense, but also a rationalized fear of what can be done (Herron and Rouslin, 1982). Langs (1973) and Malan (1979) draw attention to the possibly detrimental effects of "irresponsible interpretations". Possibly as a result, in the early phases of the training described in this dissertation, discussion in lectures and in supervision regularly focused on the (grandiose) fear of offering interpretations which will be damaging to patients (particularly in view of the explicit termination). Whilst trainees do not want to be irresponsible then, there is a tension between the narcissistic desire to 'help', the obsessional need to 'perform well' and of course, the (often forgotten) needs of the patient. This uncertainty, together with increasing amounts of clinical experience contributes to uncontainable feelings of helplessness, ignorance and hopelessness. At these times it is difficult for trainees to believe that what is being 'done' can be of any use to patients, particularly in a schizoid compromise when the 'doing' feels like 'nothing'. Whilst training, this is hard to admit. Yet, paradoxically this very admission is a necessary step towards learning to work effectively as a therapist i.e., one which frees therapists to the extent that they can "learn from the patient" (Casement, 1990). Once a trainee reaches this point of acceptance, 'doing' therapy feels less hopeless. When, in session 46, S expressed a wish to end therapy I had still not learnt enough myself to listen to her, to accept that she was right and that I should support her. On reflection, some three months later, I have been able to recognise this.

I am not intending to suggest that the feelings experienced in working with patients like S are ever comfortable. Within the framework discussed, transference interpretations are essential for this kind of patient (Joseph, 1988) but they are difficult for all therapists to give¹⁸, particularly for trainees with little clinical experience.

Why are transference interpretations so difficult?

Difficulties in giving transference interpretations obviously do not only stem from conflicts within therapists. They arise as a consequence of the patient's dynamics as well, some of which were described earlier. For example, when patients unconsciously manipulate the therapist into pressing them "live out a part of the patient's self instead of analysing it" (Joseph, 1988, p.59). However, there are a range of reasons why trainees find transference interpretations difficult. Much of the difficulty is likely to relate to therapists' unresolved object relations, which may be similar to those of the patient who is difficult to reach. It might also be consequent upon issues of control and difficulty in accepting:

"... a position of a subjective object in the client's life [and] at the same time ... [being able to] keep both feet on the ground" (Winnicott in Herron and Rouslin, p.130).

This was never acknowledged in supervision, where transference interpretations (when discussed) were considered in terms of 'opening up too much too soon'.

This might have been fuelled by, for example, Kernberg who, critical of premature transference interpretations, suggests that they contribute towards a "lack of deepening of the analytic relationship" (in Herron and Rouslin, 1982, p.131)¹⁹.

However, such fears are common in learner therapists (Salzberger-Wittenberg, 1970; Langs, 1973) and the anxiety is illustrated in session 25 when S brought a dream to therapy. In not necessarily agreeing with Guntrip's assertion that they are always, and only a form of schizoid compromise, I considered S's dreams in terms of a working psyche. But, I did not deal with it in terms of the transference. I

18. It is not only trainees who experience this difficulty. Strachey (in Pick, 1988, p.34) implies that "the full or deep transference experience is disturbing to the analyst".

19. It is to be noted that Kernberg is talking of a different kind of patient.

felt S would not be able to cope with this way of understanding the material. On reflection and with more clinical experience, it is apparent that I was overwhelmed by it myself. At the time I justified avoidance in the belief that the same material would return (given that this was what was happening in S's Unconscious). This was not completely true - she never brought another dream nor did she respond in anything but a superficial, uninvolved way to any reference to the transference material in the dream which I tried to introduce in later sessions. I later discovered that this was contrary to Bion's advice (in Casement, 1990), that therapists "forget" material from past sessions,

Joseph (1988 and 1988b), as a Kleinian, argues that interpretations should be immediate and direct because everything in the therapy situation can be seen in terms of the transference. She comments that if she finds herself making an interpretation which does not relate immediately to what is going on in the present session:

"... (unless it is very near a reasonably successful termination) ... [she] usually assumes [she] is not in proper contact with the part of the patient that needs to be understood or that [she] is talking more to [herself] than to the patient" (1988, pp.59-60).

This of course, underwrites Casement's (1985; 1990) entire thesis of the importance of listening and Steiner's (1984) discussion that without abundant clinical experience, theory is used in a bookish sense rather than for the benefit of the patient. It also illustrates the possibility that, through schizoid mechanisms, a patient can make the therapist go where they do not want to go i.e., by colluding with the false self and supporting the patient in their endeavour to keep the dependent needy part hidden. I did this in the dream session but also in numerous other sessions. There is a particularly poignant example which followed a week in which I had been on holiday (session 33). Uncharacteristically, S said it felt like a long time since we had met and that it had been important for her to know that she would be seeing me again. She had phoned her mother and had had the best conversation with her for a very long time. It felt good that she would have somewhere to be for Christmas. At the end of this session S described how,

over the weekend she had experienced a strong need to "curl up and stay" at P's house, something she surely wanted to do then, in my office.

Perhaps, for whatever reasons, I had in fact supported S in her compromise by not interpreting in the transference. This is advocated by Guntrip (1962) in his warning against ruthless exposure of a patient to their need for a compromise and of the need for therapists' to support the patient in it. However, noting his statement that if schizoid patients are not ready to work with certain issues they will not 'hear', begs the question of whether the fear of transference interpretations is justifiable. Whilst they may not achieve anything for the patient if they are not ready to hear, are transference interpretation so irresponsible?

With ongoing supervision, clinical experience and a growing orientation towards a Kleinian / Object Relations framework, the truth in Guntrip's claim was recognized clinically time and time again. It became increasingly clear that transference interpretations were more containing and therapeutically useful for the patient than not attending to what is happening in the transference (Casement, 1990) and instead, linking what was happening to the past in terms of the pre-conceived road-maps posited by some of the great theorists. But, as I have argued, transference interpretations are uncontainable for the therapist. Until Steiner's three essential elements for the training of psychotherapists have been integrated sufficiently, patients *will* therefore be able to take therapists to uncomfortable places to which they do not want to go.

CONCLUDING REFLECTIONS

This study has focussed on the process of learning psychotherapy within a Clinical Psychology course that aims at developing competence also in the fields of diagnosis, psychometric assessment and research. Some theoretical concepts derived from the writings of Kleinian / Object Relations psychoanalysts have been discussed and applied to the experience of learning psychotherapy. To show a developing understanding of the concepts applied, case material was used. The study introduced some dilemmas of a trainee therapist grappling with the process itself, and in a particular context. Various points were made, some of which will be summarised here. Those chosen are personally significant; others would not necessarily consider them to be the most important concerns. They are however likely to be useful for trainees and for possible implementation of changes by supervisors and trainers.

Thoughts for trainers

In comparing the 1989/1990 psychotherapy component of the clinical psychology training with Steiner's (1984) three essential elements for training psychotherapists, two issues become clear. First there is a great deal of ambivalence towards the component, and second, there is little clarity over the aims and expectations. Not surprisingly, given the academic base of the course, Steiner's least important element, "a study of theory" was given ample attention in the first year (1989). In the second year (1990), appropriately this aspect received less attention mainly because of the expectation that theoretical input will be gained in ward rounds and in supervision.

The disadvantages of exposing interns to too many models and members of differently focussed professions at ward rounds have been discussed. Exposure to too many theoretical orientations in supervision has also proved to be a potential impediment in that interns miss valuable input from clinicians working in the framework into which they may have 'grown'. The system, adopted for the second

year in 1991, in which case conferences are held instead of lectures, may address this problem, provided that psychotherapy cases are presented in this forum. Interns will be able to consult a range of people for theoretical or clinical input. (Of course, the fear of narcissistic injury in such a large forum could impede this process).

In contrast, Steiner's most important element, i.e. personal therapy, is not given appropriate recognition. Whilst it may seem surprising that not every intern is in personal therapy, this is conceivable. Therapy is costly, and this demands a commitment and some sacrifice. Interns also have to arrange therapy times outside working hours which is not always possible. This may influence a decision not to begin therapy, or to terminate prematurely. It is noteworthy that Steiner's second most important element: "abundant clinical experience with supervision" is also given insufficient recognition. This is mainly because of the broad exposure, demands of the course and the hospital requirements, which leaves little time for seeing therapy cases and minimal time for supervision.

These observations underwrite the idea that the psychotherapy component is not a central focus of the course. This in itself may be acceptable, but the ambivalence, borne out by the following contradictions, is not. In spite of the little time allocated to long-term psychotherapy supervision, the psychotherapy assessment counts for 50% of the marks at the end of the second year. Further, there is an unstated expectation (and a personal investment on the part of most interns to do so) that interns acquire experience and knowledge of reconstructive psychodynamic psychotherapy (Dickman, 1983). Since reconstructive psychodynamic psychotherapy is not always appropriate for the patients seen in the hospital setting, this is problematic, particularly since patients are not always adequately assessed and might be unsuitable for so-called long-term psychotherapy.

Whether interns are doing long-term or short-term therapy is unclear. Dickman (1983) raised this issue but it remains unresolved and contributes towards the

ambiguity of the psychotherapy component. Clarification may resolve the problems surrounding assessment for psychotherapy, also raised by Dickman (1983).

Whilst the problem of inadequate assessment may in part be due to lack of experience at this early stage in training, there *is* a reluctance to withhold therapy. This highlights and perpetuates the tension between trainees' requirements and patients' needs. For as long as the ambivalence towards the psychotherapy component exists, interns are likely to chose to 'do' therapy rather than to withhold it, even if such a decision is more appropriate on the basis of a well informed assessment. They are also unlikely to suggest an alternative treatment plan, for example, a brief behavioural or cognitively oriented intervention, even if it would be more effective. Clarification of the aims and objectives of the course would free interns to make well-informed decisions. For example, it might facilitate a specific request for supervision from someone who works only in another model, who might be prepared to offer appropriate and intensive supervision. Whether this is feasible needs exploration.

Thoughts for supervisors

Whilst it is impossible to avoid the emotional difficulty inherent in the learning process, the intensity of the narcissistic injuries and shame experienced by trainees can be alleviated in supervision. This can be achieved by fostering healthy and open discussion. It is particularly important given the kinds of patients seen in the second year internship. Many may be hostile which is likely to be genuinely damaging to the trainee's mental state (many naively assuming that "well intentioned applications of scientifically respectable techniques will be appreciated" (Mollon, 1989, p. 116)).

Supervisors must aim to provide trainees with a safe 'space for thinking'. Admittedly, this is difficult for at least two reasons. First, the evaluative role of supervisors in end of year university examinations could make the space extremely threatening for some; and this demands serious thought. Second, is the limited

time available for supervision and the fact that it occurs in groups. As discussed, this can worsen already existing unresolved peer dynamics, and possible hostility directed at supervisors (because they are experienced as withholding parents). If these issues are avoided by supervisors, attempts to negotiate around negative transference issues will be fostered, impeding both the therapy being supervised and the training process. Just as avoidance of transference issues in therapy makes patients feel uncontained, so are trainees likely for to feel uncontained in supervision. Instead of a safe 'space to think', supervision could be experienced as hostile or uncaring.

Viewing supervision in this dynamic way is of course controversial. Not all supervisors will necessarily agree, depending on their theoretical orientation. Some may be uncomfortable with transference issues. On the other hand, they may, like Klein, hold the view that these dynamics should be dealt with "somehow in personal therapy." This raises two points, both of which should be considered seriously by trainers and trainees. First, there are implications if the 'dealing with it' takes a long time (Herron and Rouslin, 1982) . Second, the intern may not be in personal therapy.

Thoughts for trainees

The inevitability of narcissistic injury

This dissertation underwrites the central significance of the combination of Steiner's (1984) three essential elements for training psychotherapists. It has also shown how a combination of these elements involves a rite of passage which can be experienced as extremely difficult. Everyday conventions and values, once clear, become unclear in the process. This is uncontained but unavoidable. Interns have to be "thrown in at the deep end and begin[ning] from a position of ignorance and naivety" (Mollon, 1989). The inevitability of narcissistic injury to self-esteem and self-image has been shown. This, and the possibly difficult insights gained in personal therapy, has to occur if psychotherapy is to be 'understood', not from appraisal of the research literature but from experience

(Bion in Mollon, 1989). And, as much as trainers may wish to make it easier for trainees, they can only be 'good enough' - they cannot make the process easier for interns.

The experience of a rite of passage

The rite of passage, by definition, entails insight and growth which change social relationships. There is also a changing relationship with theory, as I hope I have shown. Initially it is often used defensively, in a bookish sense (as Steiner, 1984, suggests). But later, even with increasing amounts of clinical experience and personal therapy, whilst there may be more of an 'emotional' understanding, it can remain "sterile" (Casement, 1990) if trainees continue to use it defensively to contain them. Recognising a phenomenon and assigning "a name to it immediately relieves anxiety and allows observations to be assembled into meaningful concepts" (Steiner, 1984). The belief in the objective and static truth of clinical histories and psychodynamic formulations is likewise containing for trainee therapists. The consequences of not having personally taken S's history has illustrated the problem of this assumption.

A rigid adherence to theory and objective truth seems then to be a necessary and containing part of the process. But I hope to have shown in this study that this is not the goal towards which trainees should strive. Adequate understanding of theory does not compensate for a lack of other essential elements. I suggest that the point at which trainees can use the theory more flexibly, and can truly listen and learn from patients, is an ultimate goal.

Avoiding theoretical dogma

This idea is drawn from Casement (1985; 1990) who, like Joseph (1988), Malan (1979), Klein (1951) and others mentioned in this dissertation, profoundly affected both the learning process described, and my growing choice of theoretical orientation. To the extent that Casement *listens* to patients without attempting to impose theory on what they are saying (1990), he appears to be working within an

ethnomethodological framework. Drawing on the work of Bion (1970) and his anthropological background²⁰, Casement assumes nothing; he treats everything a patient presents to him as anthropologically strange. This discovery was personally both containing and exciting for me because my earlier skepticism which had felt like intellectual inadequacy and defensive acting out could now be viewed as apparently healthy. There was, after all this, a place for my persistent belief that many individual's own subjective contradictions do not fit readily into the great theorists' developmental stages and "road maps" for treating patients (Herron and Rouslin, 1982, p.2).

Casement (1985; 1990) therefore provided both an authoritative source from which I could draw, and permission to listen to the patient and to discover his or her "otherness". This can only occur when the therapist has "considerable knowledge of himself and his own propensities" (Steiner, 1984, p. 57). Predictably within the context of what has been addressed in this study, his arguments were only truly 'experienced' and therefore 'understood' towards the end of my training.

At this point the passage is nearing its end (if it ever really ends). The trainee is in a relatively stable state by the end of the training and is expected, by virtue of the professional status outside of the training institution, to behave according to the norms and ethical standards of the Institute of Clinical Psychology (Steere and Wassenaar, n.d.). It is at this stage that it seems possible once more to be positioned in the discourses for which, at the beginning of the rite of passage, there had seemed to be no place. But, with a difference - exposure to Steiner's three essential elements, combined with earlier academic influences, has made the discourses richer in all their multiplicities and their contradictions. But, the subject matter of the training and the theoretical orientation described, keeps the

20. Whilst studying anthropology Casement (1990, p. 4) discovered "the 'otherness' of others - far beyond my previous imaginings ... [it helped] me to realize that, in any attempt to understand ... people different from ourselves - we have to approach that task without preconception".

therapist marginal²¹, in a position of perpetual student, "learning from the patient" (Casement, 1985; 1990). It is therefore imperative that all three of Steiner's (1984) essential elements continue. In particular, as Dickman (1983) advises, trainees entering private practice as psychotherapists must continue training with adequate supervision of psychotherapy cases.

21. Theorists from without a Kleinian / Object Relations framework might find this idea precious. However, it is a point which cannot be discussed in the present dissertation but will be pursued in later work with Swartz, mentioned in footnote 1.

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