Struggles with Empathy and Optimal Responsiveness: An Intersubjective View.

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August 1993

A minor dissertation submitted in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology.

ACKNOWLEDGEMENTS

I gratefully acknowledge the following people:

Amanda Kottler, my supervisor, for her encouragement and assistance, and for taking the risks needed to facilitate my learning experience.

Phillip Faber, my clinical supervisor, for his guidance, affirmation and acceptance.

Ian Donald, for everything. There are no words for my gratitude.

Daisy and Gerald, my parents; Orly, Guy, Alon and Eitan, my children; and particularly Gilad my husband, for their endless patience, love and support.

Rika van den Berg, Suki Jaffe and Claudia Katz, for friendship in every possible sense of the word.

Tony Frank, for his valuable comments on my theoretical understanding.

The Human Sciences Research Council for financial assistance.

Sally, whose trust, courage, determination and willingness to let me accompany her on her journey has taught me so much about the process and about myself.

ABSTRACT

This dissertation reviews the psychotherapeutic techniques of empathy and optimal responsiveness from within a Self Psychology framework. Self Psychologists view these techniques as essential for the activation of the selfobject experience, the core requirement for the restoration of a cohesive sense of self. However, numerous factors arising in the therapeutic situation mitigate against empathic listening, and there is no real consensus amongst Self Psychologists about what constitutes an optimal response. This presents a particular difficulty for trainee therapists who seek guidelines in how to use these techniques. This dissertation aims to demonstrate that empathy and optimal responsiveness are inextricably bound up with the intersubjective field, an inclusive system of which each individual is a part. A psychoanalytically informed clinical study of the intersubjective field is used to illustrate this notion. Through analysis of the patient's responses and the therapist's countertransference responses, it is shown that empathy and optimal responsiveness arise from the interface between the subjective experiences of both therapist and patient and thus include the dynamics of both. Retrospective analysis which has enabled the author to grow as a psychotherapist, is highlighted, with the hope that this may be useful to future trainee therapists.

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CHAPTER ONE

INTRODUCTION

This dissertation reviews the psychotherapeutic techniques of empathy and optimal responsiveness. Self Psychologists view these techniques as essential for the activation of the selfobject experience, which is the core requirement for the restoration of a cohesive sense of self (Lichtenberg, 1991). Thompson (1990) argues however, that while these techniques are viewed as fundamental to the therapeutic process, they are in fact extremely difficult to achieve. Numerous factors pertaining to the internal dynamics of the patient, the therapist and the unique interaction between them, mitigate against empathic listening, and there are divergent views amongst Self Psychologists about what constitutes an optimal response. These factors present a particular difficulty for the trainee therapist who seeks guidelines in how to work with patients suffering with what Self Psychologists call disorders of the self.

The viewpoint proposed in this dissertation is that empathy and optimal responsiveness are inextricably bound up with the dynamics of both patient and therapist, and are hence unique to that particular dyad. These techniques are not seen as being based on a fixed theoretical approach which may be standardized and generalized from one case to another. Rather they are viewed as arising from the interface between the patient and therapist, referred to as the intersubjective field (Stolorow, Brandschaft and Atwood, 1983). In a psychoanalytically informed clinical study of countertransference responses to one patient's dynamics, the workings of the intersubjective field are illustrated. Empathy and optimal responsiveness are seen as integral to intersubjectivity.

The aim of this thesis is to understand the workings of the intersubjective field in order to illustrate the struggles involved in being empathic and optimally responsive. It aims to show that these techniques are bound up with the concept of intersubjectivity. There is also an attempt to highlight the retrospective learning that has taken place for the author, which has facilitated the process of growing as a psychotherapist. Finally, there is the hope that this account may be useful for future trainee therapists who are grappling with these issues.

CHAPTER TWO

THEORETICAL CONTEXT

The theoretical context used in this thesis will draw on the ideas of Heinz Kohut and others working in the framework of **Self Psychology**. Some reference is made to theorists and clinicians who do not necessarily work in this way, when their viewpoints add a greater understanding to the material presented.

Self Psychologists refer to patients with a defective or weakened condition of the self as suffering from 'disorders of the self'. The aim of psychotherapy is therefore to strengthen the self, to increase its cohesion and wholeness. The core requirement for the restoration of cohesion and vitality of the self is a 'selfobject experience' (Lichtenberg, 1991). Essential to the activation of a selfobject experience is the empathic mode of listening and optimal responsiveness. However, numerous factors mitigate against empathic listening and there are differing views as to what constitutes an optimal response. This chapter therefore has two aims. Firstly, an attempt will be made to explain the centrality of the empathic mode in the Self Psychology framework, and secondly, the difficulties involved in using this technique will be highlighted.

The aims are discussed in two sections. Section one will contextualize empathy and optimal responsiveness within the theoretical framework outlined by Self Psychologists, and section two details the difficulties inherent in empathic listening and responsiveness. The sections will be divided as follows:

SECTION ONE:

- The meaning of the 'self'.
- The selfobject experience
- Disorders of the self
- Manifestations of selfobject needs in therapy
- The therapist as selfobject

SECTION TWO:

- Difficulties with empathic attunement
- Difficulties with empathic responses

SECTION ONE

THE MEANING OF THE 'SELF'

Self psychologists define the self as the core of the personality, experiencing continuity in time, space and state. It is the centre of initiative, the recipient of impressions and the repository of ambitions, ideals, talents and skills. It is the locus of relationships, and performs functions traditionally ascribed to the ego (Wolf, 1988; Lichtenberg, 1981; St. Clair, 1986). A cohesive self describes the structure of the normal and healthy functioning self (Wolf, 1988). This state is experienced as a feeling of well being, of being motivated, optimistic and energized. It is to feel "embodied, spacious and bounded" (Brooke, 1992, p. 5).

The loss of self structure when the self loses its cohesiveness is referred to as 'fragmentation'. It is experienced as a feeling of being uncoordinated and not fitting together, of being apprehensive, moody, unable to focus, disorganized, with a loss

of energy and orientation. Fragmentation occurs in varying degrees and does not necessarily imply complete dissolution of the self. The shift in experiencing the self as more cohesive, less cohesive, or fragmented, is to some degree a normal process also occurring amongst those who do not suffer disorders of the self (Wolf, 1988).

THE SELFOBJECT EXPERIENCE

It is the type of response received from the surrounding milieu that will determine the level of cohesiveness or fragmentation experienced. Those responses that are self-sustaining and promote completeness and cohesion of self-structure, are referred to as 'selfobject experiences' (Lichtenberg, 1991). Wolf (1988, p.14) emphasizes that "the self cannot exist as a cohesive structure - that is, cannot generate an experience of well-being - apart from the contextual surround of appropriate selfobject experiences".

A selfobject experience is activated through attuned responsiveness based on empathy. "To be understood can be a deeply gratifying experience and is perhaps the most important function performed for us by our selfobjects" (Bacal, 1985, p. 207). Kohut's (1977) analogy was that just as amino acids are the building blocks of proteins that provide physiological regulation, empathic human responses promote the structure of the self which provide psychological regulation. A selfobject then refers to functions of caregivers - mothers, fathers, teachers, partners, friends or therapists, who are experienced as providing empathic responses necessary for the maintenance of a stable positively-toned sense of self (Lichtenberg, 1991).

DISORDERS OF THE SELF

Patients who suffer from disorders of the self are those who were deprived of selfobject experiences throughout the early years during which the self first emerges.

This may be the result of an early development characterized by a lack of empathic attunement to the child's inner experience, and hence a lack of appropriate responses to his/her needs; or of traumatic premature loss of the selfobject.

Kohut (1971) distinguished two essential selfobject needs: the need for a mirroring selfobject which provides confirmation for a child's innate sense of vigour, greatness and perfection; and the need for an idealized selfobject which ensures a presence of calmness, infallibility and omnipotence with which the child can merge (Kohut and Wolf, 1978). The type of failure of the selfobject responses will inform the type of pathological state of the self. Failure in mirroring may result in a 'mirror hungry personality' who is impelled to display him/herself to evoke attention and admiration of the selfobject so as to counteract the experience of worthlessness. Failure of the ideal selfobject will result in the 'ideal hungry personality' who only experiences him/herself as worthwhile by finding selfobjects that s/he can look up to and feel accepted by. Kohut described other personality formations which result from either mirror or idealized selfobject failure including the 'merger hungry personality' who uses the selfobject in lieu of their own self structure, which is seriously defective or enfeebled. The merger hungry personality, with its aetiology in idealized selfobject failure, will be described in the presentation of the case material.

Patients suffering from disorders of the self feel varying degrees of fragmentation most of the time, and seldom feel a cohesive sense of self. Brooke (1992, p. 5-6) describes patients who suffer from fundamental self-pathology as feeling split, unstable, with persecutory anxiety, and emotions that are labile or dead. They often feel disembodied and hence depersonalized and unreal. Disturbances in memory and concentration make everything feel discontinuous and fragmented. With little capacity for fantasy and imagination, solutions are immediate and concrete, and

behaviour is therefore often impulsive and destructive. There is a longing to be understood, yet a terror of it. There is a longing for independence and autonomy, but a terror of being abandoned. The pain of separation and loss is unbearable.

In therapy these patients present with a vague and ill-defined set of symptoms which include: problems with work and relationships, sexual problems, hypochondriacal complaints, irritability, anxiety, and pervasive feelings of emptiness and depression (Wolf, 1988). They are characterized by a specific vulnerability: "their self-esteem is unusually labile and in particular they are extremely sensitive to failures, disappointments and slights" (Kohut and Wolf, 1978, p. 413). However, it is not through the symptomatology that these patients can be diagnosed, but rather through the emergence during psychotherapy of the 'selfobject transferences' (Kohut, 1977).

MANIFESTATIONS OF SELFOBJECT NEEDS IN THERAPY

The therapeutic situation provides an arena where regression can occur, and these repressed and disavowed selfobject needs can be mobilized and exhibit themselves in the selfobject transferences. The selfobject transferences are the manifestation in the clinical therapeutic situation of the "distorted archaic needs, and the defenses against them, that were acquired during childhood in interaction with the earliest selfobjects" (Wolf, 1988, p. 124). With the mirror hungry personality the 'mirror transference' will be activated, and the ideal hungry personality will develop an 'idealizing transference'.

In the 'idealizing merger transference' there is a need for merger with the idealized selfobject. The patient experiences a sense of self structure through the selfobject, i.e. - the therapist. The fluidity of boundaries interferes with this type of patient's ability to discriminate his/her own thoughts, wishes and intentions from those of the

selfobject. Thus there is a wish that the therapist be attuned to the patient's needs and thoughts without having been told them by the patient and an expectation that the therapist be the centre of initiative. Because these patients experience themselves through the selfobject, they are very sensitive to separation from the needed selfobject and go to great lengths to ensure the selfobject's continuous presence (Wolf, 1988; Kohut and Wolf, 1978). This was evident during the therapy described in this dissertation, and explains much of the patient's behaviour. Sometimes the merger transference manifests first with a defense against it, by an excessive need to remain at a distance from the selfobject. Wolf (1988, p. 125) explains that:

> the defense is necessary to protect against the overwhelming trauma that would be experienced if the needed merger with the selfobject should miscarry because of the selfobjects's reluctance to become enmeshed and be controlled.

It is this clinical picture that emerged in the case presented.

THE THERAPIST AS SELFOBJECT

What is required of the therapist is to adopt an empathic mode which consists of two stages. Firstly, listening, attuning to and understanding the patient's inner experience; and secondly responding in a manner that conveys this understanding. Kohut (1977) explains that empathy is a mode of observation of psychological phenomena which allows one person to observe and understand the other's subjective experience, and to communicate this understanding to the other in an interpretive form in the clinical situation.

Empathy is defined as "a particular listening position, a vantage point from within the patient's own point of view....an immersion into a patient's inner life" (Ornstein, 1986, p. 22). The therapist tries to understand how and why the patient feels and behaves as s/he does, and communicates this in a way that allows the patient to feel

understood, rather than blamed. Empathic listening aims at making sense of the patient's feelings and behaviour instead of confronting what might from the therapist's perspective, appear to be distortions or pathology (Chernus, 1988).

The point that has been highlighted and emphasized in this theoretical exposition is that the empathic mode is fundamental to the activation of a selfobject experience. Repeated early empathic failures are seen as having brought about the disorder of the self, and repeated empathic responses are needed for its restoration. However, while this concept is central to Self Psychology, functioning in the empathic mode is actually very difficult. The formation of an empathic bond and how to respond appropriately, are often taken for granted by Self Psychologists, without enough discussion of the struggles that are involved. These difficulties constitute the focus for the next section.

SECTION TWO

DIFFICULTIES WITH EMPATHIC ATTUNEMENT

Critics of this viewpoint state that there is no need to stress empathy since analysts have always been empathic. Ornstein (1986) argues that this is not a valid criticism as empathizing is not easy. She emphasizes that it is difficult to achieve and maintain an empathic immersion into the patient's inner life over a prolonged period. Thompson (1990) found that in trying to account for his struggle to attune to certain patients he became aware of factors emanating from the patient, from the therapist, and from the mutual construction which developed in the dyad, the 'intersubjective field' (Stolorow, et al., 1983).

From the patient's viewpoint, there may have been a long history of empathic failure through mismatching and disrupted attunement, or through a traumatic selfobject loss. These patients therefore, enter therapy needing to be very cautious. They are in constant conflict between desperately needing selfobject responses, and the fear that the selfobject will again fail and lead to further injury. Bacal (1981, p. 36) described this conflict: the patient's

> **hope for 'a new beginning' corresponds to what he had always needed but what he learned he must never dare look for in his childhood, because of the early, pervasive deprivation. The experience of emerging trust and hope, even in a subliminal or preconscious way, is reacted to by the patient as a danger signal of impending trauma, since it was precisely in this state that the repetitive let-down by the life-giving and hoped-for responsive selfobject was able repeatedly to traumatize the patient.**

Hence the patient is ambivalent, and may exhibit this ambivalence with powerful resistance and defensive withdrawal. Guntrip (1962), working from an Object Relations framework, refers to this dynamic as a schizoid defence. The patient mobilizes an "in and out programme" (Guntrip, 1962, p. 274) whereby for the preservation of his/her selfhood, the patient is "bound to be on the defensive against the very person whose help he seeks" (Guntrip, 1962, p. 273). When the patient is mobilizing a lifetime of learnt defenses to keep the therapist out, it becomes very difficult for the therapist to connect with the patient's inner state. This dynamic was clearly evident in the case material presented in Chapter 5.

Therapists bring their own countertransference issues to the therapy which can make it difficult to listen in the way that is required for empathic attunment. It is widely accepted that patients of this type elicit powerful feelings in the therapist either as a realistic reaction to the patient's behaviour, or due to the therapist's own unresolved narcissistic conflicts (Kohut, 1977; Gorkin, 1987; Kernberg et al., 1989). Reactions can range from feelings of rage, hopelessness, despair, the sense of being driven

crazy, boredom and sleepiness; to feelings of love, fondness, admiration, sexual arousal, omnipotent concern for and neediness of the patient (Gorkin, 1987). When the therapist is struggling with these emotions, empathic listening can be hindered. In addition, there can be the constraint imposed by trying to understand a patient within a theoretical model or from a diagnostic framework. This may result in therapists listening and responding only to certain material, and may prevent them from understanding the totality of the patient's individual experience (Ornstein, 1986; Schwaber in Thompson, 1991). The role of this kind of unresolved narcissistic conflict, and the struggle with theoretical issues will be highlighted in Chapter 5.

The difficulties of therapy do not reside solely within the 'mental apparatus' of the patient but rather arise from "the inclusive therapist-patient system" (Stolorow, et al., 1983, p. 117) referred to as the intersubjective field. In the same way that infant and maternal care together form an indivisible unit, so the patient and therapist together form a "indissoluble psychological system" (Stolorow and Atwood, in Bacal, 1990, p. 362). Both patient and therapist are involved in the process, hence the patient's therapeutic experience depends on contributions from both the patient and the therapist. As patients fear injury to the self and design defenses to protect the self's structure and boundaries, so therapists have their areas of vulnerability and are similarly fearful of narcissistic injury (Kohut, 1971; Wolf, 1988). Patients are often aware, if only on an unconscious level, of therapists' vulnerabilities and conflicts. Their "transference antennae" (Thompson, 1990, p. 33) pick up the therapist's personality and behaviour. This "not only interferes with the unfolding of the selfobject transference but may also create a vicious cycle of misunderstanding (empathic failure)" (Ulman and Stolorow, 1985, p. 39). Efforts will be made to illustrate this interactive process with case material.

DIFFICULTIES WITH EMPATHIC RESPONSES

The second stage of the empathic process is to respond in a way which conveys that the therapist has understood the archaic selfobject needs as they emerge in the transference. This does not imply that the therapist responds in accordance with the need, or tries to play a role which s/he considers to be the opposite of the pathogenic parent, and hence offer a "corrective emotional experience" as described by Alexander (1956). Indeed this is not possible, as the therapist is never able to meet the idealized standards of perfection desired of the selfobject by the patient.

There is a dispute among Self Psychologists as to how to convey this understanding to the patient; i.e. how to respond in an appropriate way. According to Goldberg (in Wolf, 1988, p. 133) interpretation of needs is fundamental. He expressed this succinctly:

> The analyst does not actively soothe; he interprets the analysand's yearning to be soothed. The analyst does not actively mirror; he interprets the need for confirming responses. The analyst does not actively admire or approve grandiose expectations; he explains their role in psychic economy. The analyst does not fall into passive silence; he explains why his interventions are felt to be intrusive.

Ornstein (1986) agrees, explaining that empathy includes both understanding and interpretation. The empathic process is only complete with explanation, which enables the patient to develop insight into the nature of the difficulty.

Bacal (1990) argues that insight per se is of questionable value and is by no means the only therapeutic communication that can convey understanding. "Words will often fall woefully short of constituting a therapeutic offering" (Bacal, 1990, p. 66) particularly when working with regressed patients. He insists that for a selfobject experience to occur, the therapist must respond in a way that is therapeutically useable for that particular patient. This includes non-verbal behaviours, alteration in

attitude and the way in which things are said more than the actual content. The therapist must be flexible and willing to extend beyond normal classical analytic neutrality if that is what is required. A response that enables the patient to feel understood is referred to as an "optimal response" (Bacal, 1985). Ashbury (1990) supports this view, but says that in certain instances optimal gratification of needs is required. She questions whether empathic attunement is in itself curative, and whether the empathic bond can substitute for the fulfilment of the patient's original need. In some cases words alone are insufficient, actions more effectively convey the therapist's caring and understanding. For example, working out a way to meet the patient's need for connection during a vacation (a letter or phonecall), may be more meaningful than interpreting the need for that connection.

Further debate exists amongst Self Psychologists as to how the selfobject experience is used to benefit the patient. Kohut (1971; 1977) and Kohut and Wolf (1978) describe empathic failures as essential to this process. They termed these temporary breakdowns in the self/selfobject relationship "optimal frustration", and considered them to be fundamental to the process of "transmuting internalization" which are essential to the process by which a cohesive self structure develops. Others (Bacal, 1985; Terman, 1988; Ornstein, 1988; Ashbury, 1990) disagree. They see deficits in self structure as being ameliorated primarily through the process of optimal responsiveness, whereby affective attunement and empathic understanding are conveyed repeatedly. Frustration is simply one more context in which the therapist responds in an attuned manner, and then is able to re-establish the disrupted relationship. It is the repetitive experience of the therapist's empathic responsiveness which is seen to be the therapeutic factor. Thompson (1990) found that achievement of selfobject experience could often not be reached in the short term, and even when successful, persisted only for short periods. Offering an experience of optimal

responsiveness is in fact so difficult that there is no need to introduce "frustrations" into the analytic experience. Frustration and empathic failure are inevitable (Bacal, 1985) and need to be kept to a minimum. The case material presented in Chapter 5 provides evidence of such a struggle to be optimally responsive.

Despite discrepancies in approach Self Psychologists are united in the view that the therapist is an active participant in the therapeutic process. The empathic mode, whereby the therapist attempts to enter into the subjective experience of the patient, includes the subjective experiences of the therapist. The therapist's responses directly impact on the patient and inform the process of therapy. Thus the therapist is viewed as "more than a mere observer and interpreting commentator, but an active participant in the analytic dialogue. His or her thoughts, feelings and actions have an influence on the analytic process and on the patient that can usually be controlled but not altogether avoided" (Wolf, 1988, p. 137). This interactive process is integral to the empathic mode.

The aim of this thesis is to explore the workings of particular psychotherapeutic techniques: namely, empathy and optimal responsiveness. In other words: how is the subjective experience of the patient understood and responded to by the therapist, and how does this understanding and response impact on the therapeutic process? What are the contributions of the patient and of the therapist in the construction of the intersubjective field? In order to answer these questions, a methodology is required that reflects the subjective experiences of both the therapist and the patient, as well as the interaction between them. A psychoanalytically oriented clinical study which focuses on intersubjective field will be used for this purpose. This methodology will be discussed in the next chapter.

CHAPTER THREE

METHODOLOGY

The aim of this chapter is to describe the methodology that has been adopted for this study: namely a clinical study of the intersubjective field. The differences in methodological approach used for research of psychotherapeutic technique will be outlined, with the aim of illustrating that the notion of intersubjectivity is integral to the empathic mode. This argument stems from Kohut's (1977) belief that theory and technique cannot be imposed upon clinical material, but must arise out of the process through an empathic immersion in the subjective experience of the patient.

In attempting to find a suitable methodology for investigating these therapeutic techniques, it is useful to consider the distinction made by Wolf (1988) as to the position of the researcher in relation to the observational field. Researchers who are positioned outside of the observational field, emphasize careful observation of the object with the aim of gathering data that is consensually verifiable and replicable. This is exemplified in studies which focus on technique in relation to outcome. A second group of researchers position the researcher inside the observational field, whereby the observational field includes the "subjectively experienced mental states of the analytic team, that is, the analyst and analysand" (Wolf, 1988, p. 18). This approach is unique in that the observer is also the observed (Thompson, 1992). Being psychoanalytically informed, these researchers consider therapeutic technique to be bound up with countertransference responses and the intersubjective field. In keeping with these ideas, it is this approach which will be utilized in the thesis.

An explanation why this approach is appropriate for the present study requires a brief outline of the differences between the above mentioned distinct methodological positions. In studies where the researcher is positioned outside the observational field, therapy is viewed as composed of discrete variables which exist in their own right, and which must be isolated, in order to be measured and observed. These variables include: the patient, the therapist, the relationship and the different techniques or theoretical expositions (Henry, Schacht and Strupp, 1986). In the exploration of therapeutic technique, the focus of investigation is on the effect of one set of variables upon another with the aim of providing evidence which is generalizable and valid. This is seen in outcome studies where patient change is linked to particular therapeutic operations (Strupp, 1977). Results are then evaluated either through group comparisons, or through a single case study. However, whether doing a group comparison, which is underpinned by a rigorous positivistic methodology or a case study which uses a more qualitative approach, the quality of the research is dependant upon the degree to which the variables can be isolated, controlled and observed. The essential feature of this approach is that the researcher, even when s/he is also the practitioner, attempts to remain independent of the variables being examined and employs various methods to control for experimenter bias (Alderfer, 1985).

With the emphasis on the isolation of discrete variables which are observed from outside the observational field, it is argued that a crucial element of therapeutic technique is not addressed: namely the therapeutic interactions which occur as one variable impacts upon another and informs its development in the process of therapy. In order to explore these interactions, a shift in focus is required which places the researcher inside the observational field, and views the variables as interlinked. In light of this shift, technique cannot be considered a discrete variable which arises

from the therapist's theoretical perspective, it is not viewed as a component which the therapist brings to the interaction, but is rather seen as arising out of the interaction between the particular patient and the particular therapist. The ability to empathize is not a skill which the therapist either has or does not have, but is rather viewed as a development in the interface between the therapist's capacity to understand and the patient's willingness to be understood, and as such, includes the dynamics of both therapist and patient. In the same way there are no standardized optimal responses. The therapist's responses are seen to be informed by the interaction between the internal dynamics of the therapist and the specific selfobject and developmental needs of the patient at a given point in the therapy. Technique is then inextricably bound up with the intersubjective field, an inclusive system, of which each individual is a part (Thompson, 1991). It is argued therefore that through an examination of the workings of the intersubjective field that these techniques may be better understood.

The intersubjective field includes the subjectively experienced mental states of both therapist and patient. It is possible to obtain data with regard to the therapist's subjective experience from his/her own account. Data related to the patient's subjective experience may be gathered both through careful observation of the patient, as well as through empathy and vicarious introspection (Kohut, 1977). Observational data is gathered by monitoring the patient's responses, silences, body language and behaviour. Empathy and vicarious introspection requires an examination of the associations, memories and affects that are evoked in the therapist. This obviously does not mean that the therapist assumes that the patient's mental state is the same as his/her own, but that this information together with knowledge of the patient, theoretical background, previous experience and numerous unconscious clues are used as a springboard for hypotheses about the patient's

mental state. "The analyst attempts to put himself into the analysands's shoes, so to speak, not by asking what he, the analyst, would experience under these circumstances, but by asking himself what this particular patient - about whom he knows so much - would be apt to experience in this context" (Wolf, 1988, p. 20).

The fundamental tool used for this exploration is, by definition, the therapist's countertransference. Through careful analysis of the therapist's countertransference responses in relation to the material brought by the patient, and the subsequent responses of the patient to the therapist's conscious and unconscious interventions, the intersubjective field can be explored. This thesis is therefore a psychoanalytically informed clinical study of countertransference in relation to a patient's dynamics, which aims to understand the workings of the intersubjective field.

The method used follows that of Thompson (1990, 1991), a Self Psychologist who, in his clinical studies positioned himself inside the observational field and explored his own countertransference responses in order to understand the workings of the intersubjective field. Instead of reviewing a case as a whole process and examining themes as they developed longitudinally, he reviewed a four month cross-section of an ongoing therapy. As in Thompson's study, this investigation attempts to examine countertransference experiences, together with the minute and subtle effects of the therapist's real presence and interventions as subjectively experienced by the patient (Thompson 1991).

Analysis of countertransference presents the researcher with methodological difficulties of reliability (Wolf, 1988) and validity (Thompson 1991), and is a field that has been largely ignored in the literature (Gorkin, 1987; Hayes, 1981). This could possibly be attributed to the research/practitioner split, and the "irrelevance of the

traditional research enterprise to clinical practice" (Hayes, 1981) as well as the fact that in most training programmes methodological courses are taught by non-clinicians (Hayes, 1981).

The empathic mode of data collection is deemed by critics of this approach as unreliable (Wolf, 1988). Their concern is that the therapist's projections and countertransference reactions may distort the data (Wolf, 1988, p. 20) and that subjectively biased and selective accounts are given (Bromley, 1986). As in any scientific data collection methods have been developed for keeping distorting intrusions to a minimum. Casement (1985) has emphasized the therapist's ongoing capacity for critical introspection, the 'internal supervisor', as a crucial component of this process. In addition, the role of supervision, personal therapy and therapeutic training have served as controlling factors (Wolf, 1988) in this study. Nevertheless, despite these controlling measures, this thesis is based on the premise that the interaction of two particular individuals is by its very nature a subjective account. Another clinician would almost certainly have had a different experience.

In this type of investigation researchers are unable to claim that their knowledge, theory or interpretations have any ultimate validity (Thompson, 1991). The data that is collected attempts to explain the way in which the individual patient is organizing his/her experience of the analyst and the particular meanings which the experiences have come to encode (Brandschaft and Stolorow, in Thompson 1991). Thus focus is on subjectivity, rather than objectivity; on meaning rather than cause and effect; on attempting to understand phenomena in their complexity, wholeness and uniqueness rather than exemplars or instances for generalization about relations between isolated variables (Edelson, 1985). Nevertheless, it is felt that this dissertation serves an important function. Firstly, as this is a relatively new theoretical approach there is a

dearth of clinical examples which illustrate the concept of countertransference and intersubjectivity (Thompson, 1991). This study adds to the body of literature. Secondly, following Kottler (1991) it is an account of the struggles common to trainee therapists, and therefore it is hoped that it will be useful for future interns. And thirdly, it has provided a personal opportunity for the author to integrate theory with clinical practice in the arduous process of becoming a psychotherapist.

The therapy that is described is not psychoanalysis, but rather intensive psychodynamic psychotherapy informed by psychoanalytic principles. Data is drawn from 95 sessions held over a period of nine months, three sessions per week. Detailed notes were kept, 5-10 pages per session, recording a verbatim account rather than a thematic account. Notes on countertransference responses, and therapist's dreams were also kept. In keeping with Steiners (1984) requirements for learning psychotherapy, clinical supervision and personal therapy were received during the entire period. Clinical supervision took place weekly with some phonecalls between sessions when this was required. This supervision was not informed by a Self Psychology framework, it followed a psychoanalytically oriented Object Relations model. Personal therapy was attended twice a week and played an important role.

For purposes of this dissertation data has been selected to illustrate the kind of difficulties experienced with empathy and optimal responsiveness referred to in Chapter 2. This narrow focus is imposed by the space limitations of the thesis at the expense of fully conveying the dynamics of the case and the richness of the experience. Data is presented in Chapter 5 in two sections. Firstly, three issues are outlined as they emerged in the therapy and related to the dynamics of the patient; namely the idealized transference, the suicidal ideation and the periods of silent withdrawal. The emphasis is upon describing the manifestations of these dynamics

rather than their development over time, therefore presentation of material does not follow any chronological order. In the second section the therapist's countertransference responses to these three issues are described with an emphasis on how they interacted with the patient's dynamics to make empathic listening and optimal responsiveness difficult.

As this is a clinical study ethical issues of confidentiality are especially significant. The patient was not asked for permission to use the material for this paper as it was felt this that would present an unnecessary intrusion and could alter the course of the therapy. The decision to use this material draws on the ideas expressed by Malan (1979) and Casement (1985) who both published material without the permission of patients, whilst ensuring that it was carefully disguised. Every attempt has been made to disguise the details of this case so that they will not be recognisable to anyone other than possibly the patient herself. If however, she does happen to read it, it is hoped that she will accept that this has been written with the respect, compassion and care that has characterized our shared experience.

CHAPTER FOUR

HISTORY AND FORMULATION

Sally is a single, 25 year old, semi-skilled artist, sharing a flat in Observatory. She is currently unemployed and supported by her parents. She sought help because she "just couldn't go on any more". She was very vague and non-specific about what this meant, but described herself as being depressed and unhappy, unable to continue at work, and struggling with her relationships.

She presented as a tall, slim, attractive, young woman with long, black hair and blue eyes. At times she made inappropriately long eye contact, while on other occasions she stared vacantly at the floor. She described herself as unattractive and wore big and loose fitting clothes that concealed her body, which she despised. She carried herself in an upright and almost stately manner which, she said, led others to perceive her as aloof and snobbish. Her mood was depressed. She suffered with numerous somatic complaints, including a dermatological condition, headaches and chest pains. In the therapy room she was quiet, withdrawn, and found it difficult to express herself. History taking proved difficult and was an anxiety-provoking experience for her. She was guarded in her responses, taking a long time to reply. Although she would answer specific questions, she found it difficult to elaborate and give details. Consequently a very limited picture emerged of her past and of the significant personalities in her life. She was sharp and quick-witted with a dry, cynical sense of humour and her intelligence was estimated to be in the superior range. In retrospect the vagueness of the symptoms, as well as the lack of clarity regarding the history could have alerted the clinician to an underlying disorder of the self (Wolf,

1988). However at the time of history taking neither the clinician nor the supervisor were thinking in this theoretical paradigm.

Sally came from a privileged home and while her material needs were met in abundance, it seemed that her emotional needs were neglected. There was little place for the expression of feelings in the family, and little open communication. Mother was a housewife, but active with numerous charities and committees. Sally's feelings about her mother were ambivalent. She felt she was kind, yet she felt her mother's caring was never genuine, but was cultivated to prove to others that she was a good mother. Sally experienced her as anxious and intrusive. Almost no relationship existed between Sally and her father, a successful computer analyst and an "abusive, hypercritical swine". She had little connection with her two younger brothers. The motto of the home was "if you can't say anything good don't say anything at all", consequently she hardly spoke to either of them.

Sally was unplanned. Her parents were forced to marry, leaving mother under considerable strain at that time. She felt depressed, sick from the pregnancy and unsupported. Sally was born with a congenital heart defect, and was a sickly, frail, unsettled and anxious infant. Mother seemed to have difficulty attuning to Sally. She struggled to nurse her, to manage her, and to calm her, yet she resisted receiving help from family or a domestic worker. She was an anxious mother, over concerned about her infant's eating, sleeping and excrement patterns, making numerous visits to the clinic and paediatrician. At 17 months Sally was hospitalized for the heart defect. Until age six she had 14 subsequent admissions and spent up to four months at a time in hospital. Hospital policy discouraged parental intervention and visits were limited, so there was no single continuous caregiver, but a rotating nursing staff who were unable to meet Sally's selfobject needs. She remembered the experience as

being lonely, cold, painful and frightening. Sally described lying in her cot screaming for somebody to come to her, until eventually she would fall asleep unattended, in her own mess. The message given by the hospital staff was "sweets are given to children who don't cry". She learnt not to cry during this period. She also stopped talking, and even after discharge spoke very little.

Primary school was a fairly settled period of her life. She excelled academically, revealing a particular talent for writing and artwork. As her mother was artistic this became an area where Sally could please her. She developed an idealized relationship with her art teacher, who was both gentle and affirming, and remembers this relationship as significant. Socially, she was "painfully shy", and was described as being "quiet as a frightened little sparrow". She preferred to have one close friend than move in a group, but these relationships were intense and shortlived. Initially Sally would feel very close to the friend and would spend as much time as possible with her. Gradually, however, she felt the friend would become "too clingy and demanding" and then she would withdraw from the relationship. This type of 'in and out programme' (Guntrip, 1962) characterized her relationships from an early age.

High school ushered in a reign of terror as father clamped down on what he considered to be rebellious behaviour. As Sally would not communicate her difficulties to either of her parents, mother began to intercept her mail, read her diary, speak to her teachers and friends in order to understand Sally's behaviour. Academically she deteriorated and socially she felt hated and ostracized by her contemporaries. "I intimidated them", she said, "it's my eyes, no one could read them, they didn't know what to make of me". In matric she had her first homosexual relationship. Although this experience gave her some measure of comfort and

pleasure, it brought a torrent of scorn and criticism from her contemporaries, teachers and family.

University was a difficult experience. Her parents felt it would be wise for her to leave home, so she registered as a student of Fine Art at WITS, in Johannesburg. She has few memories of the year spent there: "I was drunk most of the time". Her dropping out of university enraged father, who said he was "washing his hands of her" and told her to "get out". Sally described the next four years as "a haze". She either felt completely numb and unable to do anything, or she would be overwhelmed by feelings of anxiety and fear, which would send her into "a frenetic spin of clubbing, partying and drinking". She supported herself with numerous jobs including painting props for theatres, selling in the markets, and waitressing.

At 23 she met Cindy, an outgoing, friendly young woman with an unstable pattern of relationships and employment. As Cindy was unemployed, she moved in with Sally, took control of the relationship and introduced some calm into Sally's life. Again the relationship followed a similar pattern (Guntrip, 1962; Bacal 1981). Initially they were very close. Sally's selfobject needs were met and she felt cared for and understood. However within a short time she felt overwhelmed with the intimacy and would withdraw saying she couldn't breathe, she couldn't bear to be touched and needed her space. Cindy responded with ongoing threats to leave. Finally, after two tumultuous years, Cindy left saying: "I love you, but you are destroying me, you're hurting me too much".

This constituted a traumatic loss of a selfobject which was overwhelming and precipitated referral. The therapist that she saw, however, became ill and had to terminate the therapy after three months. With this second selfobject loss Sally

began to break down, she could not stop crying, lost 10 kilograms in weight, couldn't sleep, think, or function and had strong suicidal ideation. Her therapist referred her to a psychiatrist who diagnosed a Major Depression and recommended hospitalization.

On admission I became her individual therapist. She formed a close and idealized relationship with me and although she had difficulty sharing, she appeared to draw comfort from the sessions and looked forward to them. In hospital she was quiet and withdrawn participating minimally in groups. After approximately 6 weeks, however, she gradually appeared to respond to treatment, felt less anxious, more contained, and became more interactive with other patients. She explained that she had never felt such "kindness and warmth from people" in her life. It appeared that in the safety of the hospital environment her selfobject needs had been activated, and that through the care and affirmation of the therapist, staff and patients her selfobject needs began to be met, allowing her to feel a more cohesive sense of her self (Wolf, 1988). However, as discharge date approached she began to fragment. With impending loss of these selfobject experiences, she became increasingly anxious and fearful of returning to the outside world. She hoarded her medication, and a week before her discharge date she made a very serious suicide attempt. Two weeks after this she was discharged, and I have continued to see her as an outpatient.

Sally's clinical diagnosis (using DSM-111-R criteria) included both Major Depression (single episode) and Dysthymia (primary type, early onset) on Axis 1, Dependant traits on Axis 2, with moderate psychosocial stressors on Axis 4. However, as the therapy unfolded this diagnosis proved inadequate as her Axis 2 pathology began to dominate the picture. It became clear that she fitted more in the cluster B group, as

strong borderline traits began to emerge, and that her Axis 1 pathology was secondary to this.

From a Self Psychology perspective Sally could be described as suffering from a disorder of the self. She existed in a state of varying degrees of fragmentation, functioning erratically despite considerable talents. She seemed only able to experience some sense of cohesion when in relationship with a selfobject who she could idealize and merge, and who could act as a calm and soothing presence. In Kohutian terms she could be described as an 'ideal hungry personality' (Kohut and Wolf, 1978) as described in Chapter 2. The rapid emergence of an idealized merger transference in the therapy could be seen as confirmation of this.

Her history offers ample evidence for the roots of this disorder. It appears that there was an absence of early empathic responses and affective attunement, resulting in a faulty early selfobject experience. Mother, possibly due to her own personality and circumstantial difficulties, seemed unable to attune to Sally, and Sally, being ill, seemed constitutionally endowed with her own anxious and unsettled temperament. While this mismatch resulted in repeated narcissistic injuries for Sally, it must have been similarly experienced by mother. It seems that mother compensated for her own narcissistic rage with reaction formation, becoming overprotective, overintrusive and anxious. This led to further empathic failure, and deprived Sally of a calm and soothing idealized selfobject with whom to merge. Father, having difficulty with his own emotional needs seemed unable to support mother through this period, and could not be used by Sally as an alternate idealized selfobject.

The experience of being hospitalized at 17 months was undoubtedly overwhelming and laid the foundation for her ongoing terror of abandonment. Continually changing

caregivers left little opportunity for the attuned responses that she longed for, and she soon learnt that asking for these responses led to further empathic failure. She withdrew into a detached, depressed silence as described by Bowlby in his studies on hospitalized children (1969, 1973). Her belief that there was something intrinsically bad about her and that she could never be understood, left her isolated from shared human experience (Terman, 1988).

As a consequence of her early history, Sally failed to develop a cohesive internal self, and hence was unable to function as an autonomous and separate individual. Her subsequent history reveals an ongoing search for selfobjects with whom she could merge and use in lieu of her own self structure which was seriously defective and enfeebled (Kohut and Wolf, 1978). When her archaic selfobject needs were activated within these relationships it signalled impending trauma that the hoped-for selfobject experience would again result in failure. This can be seen in the 'in and out' pattern of intense but shortlived relationships, where emotional closeness was reacted to by withdrawal and rejection (Guntrip, 1962; Bacal, 1981).

This pattern was also reflected in the transference activated within the therapy. Efforts were made to merge with the therapist with the wish that the therapist be attuned to, and know her needs and thoughts without having been told them. This was followed by anger and frustration when this did not occur. There was the expectation that the therapist be the centre of initiative, the active agent, and that she be allowed to passively follow. This merged state enabled her to feel some internal cohesion, but as a consequence it left her very sensitive to separation from the therapist. The merged state signalled the possible trauma of being abandoned and hence would be followed by periods of withdrawal and detachment as described in Chapter 2.

This schizoid dynamic elicited strong countertransferential responses ranging from omnipotent protectiveness to frustration, anger and hopelessness. The way that these feeling affected the therapist's ability to empathize, as well as how they informed the type of responses given will be discussed in the next chapter. The role of supervision, the therapists own personal therapy and the struggle to find a comprehensible theoretical paradigm (Steiner, 1984) will be emphasized as key features of this process.

CHAPTER FIVE

THE THERAPY

In this chapter clinical material is presented to demonstrate the difficulties involved with empathy and optimal responsiveness through an examination of the intersubjective field. The chapter is divided into two sections.

SECTION ONE:

- Sally's dynamics as they emerged in the therapy.

SECTION TWO:

- Countertransferential responses and difficulties with empathy and optimal responsiveness.
  - Countertransference Response to the Idealized Merger Transference
  - Countertransference Response to the Suicidal Ideation
  - Countertransference Response to her Silent Detached Withdrawal

The first section describes three dynamics of the patient as they emerged in the therapy, namely the idealized merger transference, the suicidal ideation and the periods of silent withdrawal. In the second section the countertransferentail responses to these dynamics will be described with an emphasis on how they impacted on the process of therapy to hinder empathy and optimal responsiveness.

SECTION ONE

SALLY'S DYNAMICS AS THEY EMERGED IN THE THERAPY

An idealized merger transference (Kohut and Wolf, 1978) began to emerge in session 9, four weeks after therapy began, after I returned from a weeks holiday, as Sally hesitantly acknowledged the difficulty of the separation. From this time, I found myself feeling as if I was carrying her around with me all the time, like the mother of a young child who is always conscious and aware of the whereabouts and welfare of her youngster. She was ambivalent about therapy and presented with a "queer mixture of distancing and immediacy" (Bacal, 1981, p. 37) : "I wait for two days for the session, then I have to smoke three cigarettes before we start, and now I'm just watching the clock until we finish". She never missed a session, usually arrived early, and from the second month she had difficulty ending the sessions and would often ask for a few minutes to gather herself together. However, she often spoke about her discomfort in being in the room, how she wished she could get out, and her difficulty in talking to me. As the rapport deepened the ambivalence became more pronounced. There were sessions of closeness, a merged state where I was idealized and allowed to share her area of experience, followed by a sharp, angry withdrawal which left me feeling as if I had been thrown across the room.

Six months into the therapy (session 65), prior to my vacation, Sally became anxious that the relationship would terminate. I asked her how this would be for her: "I would fragment, bust up into a hundred pieces". She described a similar experience in her relationship with Cindy: "I gave part of myself to her, and then whenever she wasn't with me I hardly knew what to do with myself because there was a huge chunk of me missing". Sally was aware that her own sense of self was so enfeebled that she could only experience some degree of cohesion when merged with an idealized figure.

However she also knew the trauma involved in losing that idealized selfobject and hence she resisted the merger. The ambivalent, schizoid, 'in and out' programme (Guntrip, 1962) dominated the therapy. Effort was invested to promote merger, which consequently increased her terror of abandonment and was defended against by rejection and silent, passive aggression. However, this again left her without the needed selfobject experience, and the archaic need for merger was again activated, leading to renewed efforts to promote merger.

Her efforts to promote merger manifested in different ways. Following her suicide attempt I had been to visit her in a medical ward. We had shared a moment of closeness wondering if we were breaking hospital rules by smoking. Soon after this she began the session (39):

Sally: Can we break the rules again?

Micky: You want a cigarette?

Sally: Yes, do you want one?

Micky: There's something that pulls us together when we smoke together, like we're partners in crime. You ask if we can break the rules? I wonder if you are wanting to pull us closer together?

Sally: I suppose so because last session was so horrible.

She brought numerous small gifts which were very meaningful within the context of the therapy and made concrete her feelings of closeness to me. Soon after the smoking incident she gave me a cigarette lighter. Occasionally she would give me her poems or drawings to keep for the weekend, taking some comfort that I would take parts of her home with me. She gave me a hand-carved sparrow for Christmas. This figure emerged from a dream of hers in which I, the wise hawk, had been

invested with omnipotent powers to help her, a frightened and hungry little sparrow, to make a long and perilous journey.

But the most effective effort to promote merger was her ongoing suicidal ideation which was ever-present and was a source of great anxiety for me in the countertransference. The fact that she had made a very serious suicide attempt increased this anxiety, as well as the fact that she had detailed plans of how and when to do it. Consequently, I worried about her continuously. She had a powerful and unrelenting pull towards death which she described as being "suspended in a state of oblivion where reality can't touch you" (session 57). Death was seen as an escape from the overwhelming suffering which she experienced. "I can't take this pain any more, I feel like I'm choking in my own blood, please, believe me I really can't take it much longer" (session 59).

Her efforts to promote the merger seemed to increase her terror of abandonment. She was continually preoccupied with thoughts about my leaving her (session 28):

Sally: I'm afraid to attach because I know its temporary. You tell me otherwise but I can't believe it. You'll go away somewhere, you'll be transferred to another town, you'll get a job where you can't see me. I just want to nail you to the floor.

She feared her own feeling of destructiveness would bring about an abandonment (session 74):

Sally: I am not a person to have a relationship with, I destroy everyone who comes into my life and I will destroy you. Or if I don't destroy you I'll drive you away, you'll wash your hands of me, everyone does.

Micky: And then?

Sally: Then all hope is destroyed.

Her defense against the anxiety of abandonment was to withdraw into a detached silence which at times had a strong paranoid flavour to it. She would enter the room, sit, stare intensely at the floor, making no eye contact at all and smoke one cigarette after another, totally excluding me. Sometimes she could be drawn into a brief conversation where she might answer specific questions, but on other occasions her replies were monosyllabic and gave a strong message of: "don't come near me".

Closeness seemed to imply abandonment as was evident when she brought me her drawings (session 84). It took great courage to show me her drawings as she felt "you'll know me too well, you'll know how messed up I am, and you won't stick around, then you can really hurt me". But when she did finally bring them she shared openly, and there was a deepening of rapport. The next session brought a stark withdrawal. She began the session (85) with a long silence:

Micky: Where are you today?

Sally: I'm not opening my mouth.

Micky: You feel something will happen if you do?

Sally: I'm in a danger zone, I don't want to talk about it.

Micky: Sounds like you feel pretty unsafe with me today.

Sally: It's not safe anywhere.

Micky: You experience me as a danger.

Sally: Everyone.

Micky: I wonder if I came too close on Friday and now you are needing to withdraw to get a bit of distance.

Sally: In some ways you were too close, but I used some of the pictures to keep you at a distance, you know like talking about the weather.

These periods of withdrawal would then reactivate her need for a selfobject, leading to renewed efforts to promote merger. Her suicidal ideation would increase and my anxiety would rise. Indeed, she was extremely sensitive to me, finely attuned to my moods and energy levels. If for a moment she sensed some withdrawal on my part, her suicidal ideation would increase, with the effect of jolting me abruptly back into having her at the forefront of my mind (session 87):

Micky: How suicidal are you?

Sally: Silence.

Micky: Don't worry I won't slap you into hospital, you can tell me.

Sally: Pretty badly, it's there most of the time.

Micky: In the front, the middle or the back of your mind?

Sally: In the front.

Micky: Actively, do you have a plan?

Sally: Pretty actively, I know how I'll do it.

This would be followed by rediscussing the suicide contract, extra sessions or arranged telephonic contact between sessions.

Although the schizoid defense is needed to prevent further narcissistic injury (Wolf, 1988), it is designed to exclude others from entering the inner area of experience, prohibiting empathic attunement. Thus the patient denies for him/herself the much needed selfobject experience. Through repeatedly empathizing with the need for the defense it is hoped that some cohesion of the self will occur, thereby slowly diminishing the need for this defensive structure. However, limited theoretical knowledge of this dynamic left me with little understanding of her behaviour. Strong countertransference feelings further limited my ability to empathize. The interaction of her dynamics and my countertransference will be described below.

SECTION TWO

COUNTERTRANSFERENTIAL RESPONSES AND DIFFICULTIES WITH EMPATHY AND OPTIMAL RESPONSIVENESS

Countertransference refers to "the therapist's emotional responses to the patient" and includes cognitive and affective responses, fantasies and associations about the patients and the material they present (Gorkin, 1987, p. 54). Although until mid-century analysts were cautious, perhaps even phobic (Little, in Gorkin, 1987) about their own responses to the patient, today it is widely accepted that countertransference is not a hindrance to the process, but actually a valuable tool (Maltsberger and Buie, 1974; Nadelson, 1977; Epstein, 1979; Giovacchini, 1981; Bollas, 1983). However, this requires ongoing vigilance on the part of the therapist about what of his/her own issues are being brought into the process, and what is being elicited by the patient.

Bollas (1983), of the British Object Relations School, shares the view with proponents of Self Psychology that the therapist is an active participant in the therapeutic process. "There are two 'patients' in the session and therefore two complementary sources of free association" (1983, p. 5). When working with disturbed patients, the clinician must allow the patient to affect him/her, and become disturbed by the patient. The analyst must be willing to be receptive to varying degrees of "madness" and thereby become "situationally ill", yet at all times must be present as an analyst, observing, assessing and holding the part that is necessarily ill. Bollas claims that the state of countertransference is one of not knowing, and yet experiencing and being willing to sustain this not knowing for a long time. The capacity to bear and value this necessary uncertainty, defines one of the most important clinical responsibilities to the patient.

The fact that I did not fully comprehend this possibly constituted my initial difficulties in understanding Sally. I could not understand why I was being so powerfully affected by this patient, and I could not bear not knowing what was going on for such a prolonged period. My response was to feel a sense of shame and inadequacy that left me reticent to bring these issues to supervision or even to my personal therapy. However, as I read about countertransference experiences of other clinicians, I gradually began to use supervision and therapy to contain my feelings and to gain some insight. Through this I could achieve some degree of objectivity.

Kohut (1971) writes that analysts' major reactions in the analysis of narcissistic disorders are rooted in their own unresolved narcissistic disturbances. It was through my own exploration of how Sally was either gratifying or injuring my narcissistic strivings, that I was able to gain some clarity about the process. It was only then that I could begin to attune to her needs and empathise with her experience. I will attempt to show how the developmentally arrested psychological structures of both the patient and the therapist interacted to codetermine the specific intersubjective field (Ulman and Stolorow, 1985). In order to describe something of this process I will outline my countertransference responses to the three issues mentioned above: idealized merger transference, the suicidal ideation and the silent detached withdrawal.

Countertransference Response to the Idealized Merger Transference

My response to the emerging idealization and merger was mixed, it was both resisted and welcomed. Both of these responses influenced my ability to empathise and respond.

Kohut (1971) maintains that when the analyst is idealized, there emerges a painful narcissistic tension experienced as embarrassment, self consciousness and shame, which stem from the analyst's repressed fantasies of his/her grandiose self. This is especially so when the emergence of the narcissistic transference occurs at a rapid pace and the analyst is "caught by surprise and has no time to prepare himself emotionally for his own reactions to being suddenly invested by an onrush of the patient's narcissistic-idealizing libido" (Kohut, 1971, p.262). Consequently, the analyst tends to fend off the idealization in small and often unconscious ways. This impacts on the patient and informs what happens in the intersubjective field. In the first months of the therapy I found this occurring (session 19):

Sally: I felt good after Thursday's session, I felt you were listening to me.

Micky: You felt heard, but you really made yourself heard.

Sally: No I've tried to explain to people before, but no-one has understood. I'm grateful.

Micky: If it wasn't me it would have been someone else.

Sally: Silence (withdrawal).

Influenced by a more Kleinian framework, I felt suspicious of the idealization, interpreting it as a defense against her underlying rage and devaluation. When I tried to suggest this to Sally, she recoiled as if she had been attacked and withdrew into silence. My imposition of a particular theoretical understanding on her experience reflects my trying to find my own feet theoretically, but was experienced by her as an empathic failure and led to periods of painful withdrawal. Eventually, without being consciously aware of what I was doing, I began to adopt what Kohut (1971) suggested was the only correct attitude to a germinating idealized transference: to accept the admiration. This passive acceptance could be seen as optimally responding to the patient's needs.

The idealized merged transference stirred my own unmet narcissistic needs. In this role I felt good and useful and needed. In fact, in some ways she had become my selfobject (Thompson 1990). Maltsberger and Buie (1974) working from an Object Relations framework, write that the three most common narcissistic snares for the beginner therapist are the aspiration "to heal all, to know all, and to love all" (p. 627), and indeed I fell into this trap. The idealized transference elicited in me an omnipotent concern and protectiveness, and the need to shield her from suffering. However, it also stirred in me my own fears of being abandoned and my own anxiety of losing my selfobject.

My countertransference possibly limited my ability to tolerate her intense feelings, particularly about abandonment. Although I understood her fear, my response to her terror of loss and abandonment was not to interpret it, but to gratify her need for contact by trying to take away the intolerable experience. Thus when she expressed fears of being separated for short periods I would give her my telephone number and tell her I could be contacted if she felt the need. When she said that it felt much too long between sessions, I responded by increasing her number of sessions or maintaining daily telephonic contact. When she expressed doubt about whether I would return after a holiday, I offered her potentially unrealistic reassurance and provided her with transitional objects.

With these interventions Sally was able to tolerate these separations with some sense of cohesiveness, but it also made it easier for me. The question arises, however, whether interpretation of her needs and fears would have been sufficient, or perhaps of greater benefit in the strengthening of the self. As mentioned earlier, some theorists (Kohut, 1971; Wolf, 1988; Goldberg in Wolf, 1988) argue that interpretation of the need is of primary importance and that the empathic failures are necessary for

transmuting internalization. Others (Bacal, 1990; Ashbury, 1990) say that words and explanations will not always enable the patient to feel understood. What is required is the provision of an experience that conveys this. Although I acknowledge that gratifying her needs relieved some of my anxiety, it is my feeling that her anxiety was so high that interpretation alone would not have been sufficient to hold her during these separations, and I am therefore in agreement with proponents of the latter school. Gratification of her needs through the above mentioned experiences as well as repeated provision of continuity of care and commitment was the optimal response at this stage of the therapy, and constituted a selfobject experience. Perhaps in time when she is less regressed and I am more able to tolerate the intensity of her feelings, empathic interpretations and insight will become more useful and take the place of gratification of needs.

This illustrates the notion of intersubjective field, whereby the dynamics of a particular therapist and a particular patient interact to codetermine the progress of the therapy. My approach to the suicidal ideation illustrates the same concept but shows that instead of trying to gratify her needs I tried to control, which impacted on my ability to empathize and respond appropriately.

Countertransference Response to the Suicidal Ideation

Whilst the idealization fed my narcissistic needs, the suicide attempt was experienced as a severe narcissistic injury. When I heard that Sally had in fact been hoarding her medication for some time before her suicide attempt, I felt confused, used, rejected and angry. It put me in touch with my own rage and confronted me with my own hopelessness and despair.

The suicidal ideation was (and continues to be) the most prominent feature of the therapy. The feelings elicited in me made it difficult to empathize. Instead of listening, I wanted to argue, and instead of entering into her subjective experience, I wanted to monitor and control. It led us to a struggle, a battle of wills:

Micky: You seem angry with me.

Sally: I'm not angry, I'm numb.

Micky: That's easier than being angry.

Sally: I'm angry with mankind in general.

Micky: What's mankind in general doing to make you so angry?

Sally: They are saying that there are things that I can't do, that my life is not my own.

Micky: I have said that concretely and have made that message very explicit. I have said "you may not kill yourself", and I have bound you to a contract.

Sally: You have no right to do that.

Micky: That may be, but I have done it. It seems as if you feel that this contract is more for my needs than for yours.

Sally: It feels like I'm being kept alive because of what everybody else wants. Like a person on a heart lung machine who can't decide when they want the machine turned off. Well I've had it, its enough.

Micky: Sally, our suicidal contract is non-negotiable, but I think I am aware of how difficult it is for you to keep the contract. I have offered you something in return for keeping your side of the contract: my availability, so that when you are feeling overwhelmed, like you can't hold it any more, you can call me and I will try to help you get through that unbearable hour.

In exploring the reasons why it was so difficult for me to attune to Sally and to hear what she was trying to communicate, I had to consider a few factors. Firstly, my

personal view of suicide; secondly, the narcissistic injury sustained by her utter hopelessness; and thirdly, my fear of abandonment.

In working with suicidal patients the therapist's point of view regarding the acceptability of taking one's own life, is a vital issue (Gorkin, 1987). Binswanger (in Gorkin, 1987), accepts the inevitability and appropriateness of the patient's wish to die, but I was not a proponent of that view. I could find no comprehensible place in my world view for suicide. Stolorow, Brandschaft and Atwood (1987) comment on the therapist who feels that the mainstay of their sense of reality is threatened, that their psychological world is endangered by the patient whose experience fundamentally contradicts the perceptions and beliefs of the therapist. The result is a "struggle between therapist and patient that stems not from wishes to 'drive each other crazy' (Searles, 1959) but from their efforts to preserve the integrity of their respective psychic realities. To the extent that the therapist is drawn into such a struggle any inquiry into the patient's subjective truth becomes thereby precluded" (Stolorow, R.D., Brandschaft, B., and Atwood, G.E., 1987, p. 136). This was my experience. I found that this issue polarized us into camps, I carrying the life force while she was pulling towards death. I tried to prevent her from killing herself, either by enforcing the suicide contract, or by trying to convince her that life actually was worth living, or could be in the future (session 57):

Sally: I want to die, I don't want to live like this any more. Please, understand, I cant take it much longer.

Micky: You say you can't live like <u>this</u> any more. If you could choose between dying and having some other kind of life would you choose to live?

Sally: That's fantasy talk.

Micky: Well let's fantasize a bit. What could you imagine would be worth living for?

Sally: I can't think of anything.

Micky: If you had a place of your own, a job you enjoyed, some friends you could talk to and connect with - would that be worth living for?

Sally: If there was some sense of meaningfulness. But what's the point of talking about it. I can't attain any of those things. The way I feel I don't have the strength to create anything.

Predictably, encounters of this nature did little to shift her experience. I could feel my own frustration and anger underlying the struggle, as I could sense her rage in not being heard.

Sitting with her ongoing hopelessness and despair made it difficult to regulate my own narcissistic equilibrium and to feel any measure of self esteem. This was particularly difficult being a therapist in training. Nadelson (1977) suggests that in situations like this, counteridentification replaces empathic responses. When the patient expresses loss of hope in the process, the therapist begins to feel that the patient is quite correct. He writes that on one such occasion his thoughts ran as follows: "I feel that I have not helped the patient, I am repetitious, perhaps I help no one" (Nadelson, 1977, p. 750). At these times, I was filled with self doubt and feelings of inadequacy and would unconsciously express this to her:

Sally: I think you're disappointed in me, you feel I could do better. You're probably quite angry that I'm not doing enough.

Micky: I wonder if its the other way around that you are angry with me for not doing enough.

Sally: I haven't thought of that, I know you're doing as much as you can. You're not wonderwoman.

Micky: I wonder if it feels like you're wasting your time here.

Sally: Sometimes it does, like is it bloody worth it, its not really helping. What does it help to talk about my feelings, I just carry on feeling it all at home anyway.

Ruvelson (1990) suggests that when working with patients of this type the clinician must maintain a delicate balance between empathizing with the patient's despair, whilst always maintaining a sincere conviction in his/her ability to improve. She refers to this as the tightrope between hope and hopelessness. If therapists are overoptimistic they fail to achieve adequate empathic attunement with their patient's subjective state of despair and hence could leave the patient feeling that his/her pain has been minimized. If, on the other hand, the therapist becomes enmeshed and absorbed by the patient's hopelessness, therapeutic aspirations are equally forfeited (Ruvelson, 1990, p.146). Maintaining the balance between hope and hopelessness, was extremely difficult, particularly when I doubted myself and my abilities. Hence empathic understanding was compromised.

I think, however, that what made me resist and struggle against her suicidal ideation more than anything else was my own fear of being abandoned. As Sally had regressed, something of a regression had occurred in me and I too found myself holding on to her. As she had claimed that she had given part of herself to Cindy, and then couldn't exist without it, I experienced something of this myself. It was a non-separateness which may have been experienced by her as intrusive. She told me this in indirect ways. Prior to the Christmas vacation, her suicidal ideation had been particularly strong, and she had set herself a suicide date. This had resulted in my phoning her between sessions, and arranging an extra session. The following session she arrived and told me that a friend was wanting to be in a relationship with her (session 67):

Micky: How do you feel about her?

Sally: I just want to run. Feels like she's coming too close. I don't want her to feel anything for me because I'll hurt her.

Micky: How?

Sally: I just do that in my relationships. They want something which I can't give, then I withdraw, then they want it even more then I withdraw even more and they get hurt.

Micky: What does she want that you can't give?

Sally: She wants me. Total commitment.

Micky: What does that mean to you?

Sally: Its like being shut in a box and put on the mantlepiece. You can't move, or do what you want, you have no space, you have to be there all the time. Like you're stuck, you can't breathe, you choke.

Micky: Do you ever feel like that here?

Sally: Sometimes, then I just want to get out of here and run a mile.

Micky: Why don't you?

Sally: Because you won't let me back. If I left then you'd get hurt, so I have to stay.

Micky: So you stay in order not to hurt me. Sounds like you'd like the freedom to move in and out but that I shouldn't take it personally or get hurt by it.

Sally: I would like that.

Micky: Would you like to test it out?

Sally: Maybe, but not now.

Micky: Its difficult to trust that this relationship will be flexible enough to accommodate your needs. Like if you are not meeting my needs, then I'll end the relationship.

Sally: I don't even know what my needs are.

Micky: Sounds like you need to have a relationship that is flexible, or elastic enough so that you don't feel trapped or choked.

Sally: Sometimes I think you're superwoman.

Micky: Who me - why?

Sally: I don't know - (she laughs and blushes).

It is possible to see this encounter as an indication of Sally's mother transference. I represented her intrusive and narcissistic mother whose needs were of primary concern. However there was a reality component to Sally's experience of me. I was controlling, holding on very tightly, and I would have been very hurt had she abandoned me. Stolorow, Brandschaft and Atwood (1987, p. 114) hold that "the patient's fear of the analyst's vulnerabilities, and of being held responsible for the analysts feelings of frustration, constitute a severe resistance to free association and a prominent motive for defense" .

In this instance I was able to recognise my part in her experience and therefore to empathize more easily. Her feeling of being understood enabled her to feel a greater sense of self cohesion, which lowered her anxiety. However, on many occasions I felt unable to offer any explanation that she could use. Once, I gave a lengthy interpretation based on a theory that I had read. She looked up at me as though through a haze and said: "I'm sorry, what did you say?"

And yet, somehow, she has been able to survive this far although the suicidal ideation still dominates the therapy and recurs with each threat of separation or withdrawal. Perhaps the fact that I kept trying to understand conveyed that I felt that there was hope. Perhaps my struggling with her, enforcing the suicide contract against considerable anger and resistance, conveyed that she was worth fighting with and fighting for. Her selfobject need was to be with me and to ensure that I did not leave her. It is possible that my presence - to come consistently and reliably to the sessions, to remain in contact with her, to be available, to believe in her and not to abandon her no matter how crazy she makes me feel, is the optimal response.

My countertransference response to her detached silence was intense and will be discussed below. The role of supervision and personal therapy were crucial in enabling me to work with this issue.

Countertransference Response to her Silent Detached Withdrawal

Sally described this withdrawn state as being "safe but isolated within my ivory tower". Indeed during these periods she cut herself off with huge impenetrable walls where she could not be reached with words. I shall attempt to describe one of these periods of withdrawn silence, how it impacted on me preventing me from attuning to her, and how in dealing with my own "situational illness" the silence shifted.

In the eighth month of therapy (session 92) I informed Sally that in two months time I would be going on holiday. Initially she did not respond to this and continued as normal, but towards the end of the session she began to feel depersonalized, "like I'm sitting opposite me and watching". During the next five sessions she sat in stony silence, she could not look at me and she smoked one cigarette after another. She shut me out.

The silence scared me and I found it difficult to manage. In my reading after Sally's suicide attempt I had come across the phenomenon of the patient's disconnection and withdrawal prior to committing suicide (Gorkin, 1987; Ogden, 1979). This had in fact been my experience with Sally with her suicide attempt. At the time I had noticed that she had withdrawn from me and I in turn experienced some withdrawal from her. Although I was normally meticulous about writing detailed notes after the sessions, I had failed to write up the three sessions prior to her suicide attempt. Consequently, I was afraid to let the process be repeated. I felt I <u>had</u> to remain

emotionally cathected and I had to make her talk. I assumed she was angry about my leaving. (session 95):

Micky: Sometimes silence says more than words. This seems like a very angry silence.

Sally: Silence (5 minutes)

Micky: Seems like you are sitting with very powerful feelings and you can't risk letting them out.

Sally: Silence (10 minutes)

Micky: Feels like there is something happening between us that is making you very angry. You feel uncomfortable with me but its difficult to talk about it.

Sally: Silence (5 minutes)

Micky: Sally if there is something going on I feel we should try and talk about it.

Sally: Silence (2 minutes)

Micky: Feels like we're in a battle, I'm saying "talk" and you are refusing to.

Sally: Silence - stares at me.

Micky: Since I told you I am going away you seem to have shut off completely. I'm sure you have a lot of angry feelings about this but its too scary to talk about them.

Sally: I think I've gone crazy, I think I've lost it.

Micky: Can you tell me a bit how that feels?

Sally: There are no words.

After five sessions like this I felt like I was going crazy. In my therapy notes I wrote: "I'm angry and irritated and frustrated and anxious and scared. It feels like I'm having a head on collision with some mighty angry force and its too much for me". I arrived for supervision immediately after the fifth session on the verge of tears. My

supervisor asked me what I wanted to say to her. "I want to scream at her," I said, "I want to say, 'talk to me, tell me you're furious with me, that you hate me but just talk'". "So do it!", he said. He suggested that if perhaps she had some measure of my feelings and my care possibly it would break this impasse. I never did this but the moment he gave me permission to, I felt the anxiety drain away and laughed with relief. Later that day in my personal therapy I was able to explore why the silence was so intolerable for me, and my feeling of abandonment in being shut out. I could see that it was my selfobject need (Thompson, 1990) that she speak, but it was her need that I tolerate the silence. The next session I arrived, prepared to sit with the silence, and to wait to see what arose from it, willing to sit for weeks if that was what was required. Sally entered the room, sat quietly for a few minutes and then freely and spontaneously began to talk.

Bollas (1983) asks who the patient is in moments like these. He suggests that the therapist, through his 'situational illness', is the patient in greatest need. In order to help the patient, therapists will often have to treat themselves first. Sally's selfobject need was to merge with a calm and soothing presence that would tolerate whatever she was trying to convey with her silence, be it rage, hopelessness or despair. It was only when I could deal with my own anxiety that she could do this.

This chapter has attempted to illustrate the problems involved with empathy and optimal responsiveness, using the notion of the intersubjective field for this purpose. In order for Sally to experience a cohesive sense of self she had to be able to merge, and tolerate being merged with an idealized selfobject which would not abandon her. Her behaviour in therapy and particularly her suicidal ideation was her obscure, indirect and unconscious communication of this need. However her behaviour and feelings impacted on me in such a way that my anxiety became overwhelming. This

was due in part to my own feeling about being used as an idealized selfobject, and in part due to my own fears of abandonment. As a consequence, my ability to empathize with her and to respond appropriately was compromised. My response instead was to try to take the feelings away, either by attempting to gratify her needs, or by trying to control her. These responses then impacted upon the therapy to inform the processes occurring in the intersubjective field.

CHAPTER SIX

CONCLUSION

In attempting to describe the struggles involved with empathy and optimal responsiveness, retrospective learning has taken place which has served an important function in enabling the author to begin to grow into the role of psychotherapist. While it is hoped that this dissertation may be of use to future trainee therapists, there is a recognition that learning to function in the empathic mode comes through the struggle involved in the therapeutic experience.

The thesis has aimed to illustrate that empathic responsiveness, fundamental for the restoration of the cohesive self, arises from an understanding of the intersubjective field, and any exploration of the empathic mode may only be achieved through placing oneself inside the observational field. However, in writing the dissertation, it has been necessary to attempt to examine the process from a distance, to explore the therapist's subjective experience, objectively. In this particular therapy a struggle existed for the therapist, as for many trainee therapists, to master the delicate balance between subjectivity and objectivity, between being immersed and being clinically objective. The very process of writing the thesis whilst continuing the therapy, amplified the tension within the author of being both inside and outside. Prior to writing the thesis these positions were viewed as antithetical, with the belief that objectivity would bring the clarity that was sought after. Writing this thesis has brought into focus the understanding that both these positions are crucial and that the therapist is challenged to walk the tightrope between them. While this has been a difficult process, acquiring the capacity to exist in this state of tension has been the

crucial learning experience. It is this very tension that is essential to the role of the therapist working in the empathic mode.

Kohut's emphasis on the importance and centrality of introspection and empathy in the therapeutic process defocuses from the use of theory in psychoanalytic practice. He insisted that "theory, regardless of its content, can and must be formulated only through an empathic immersion in the patient's subjective experience in the clinical situation and cannot be a priori imposed on the clinical material" (Chernus, 1988, p. 337). While this has become a fundamental tenet of Self Psychology it is problematic for trainees. When a therapist, particularly a trainee therapist, is immersed in the "situational illness", theory or an 'objective truth', serves a containing and necessary function (Kottler, 1990). To find the balance between using theory to contain rather than constrain is a difficult task. It seems that only with an abundance of clinical experience (Steiner, 1984) does theory become so integrated that the therapist is allowed the freedom to wait and trust that clarity will emerge.

Proponents of the concept of intersubjectivity (Stolorow, Atwood, and Lackmann, 1981) maintain that no clinical phenomena, including psychopathology in general, can be divorced from the intersubjective contexts in which they take form. As such they claim that there is no such thing as 'a difficult patient'. "There are only difficulties that arise in the unique intersection of two subjectivities which constitute the psychoanalytic situation" (p. 127). It falls outside the scope of this thesis to enter the debate as to whether or not there are patients who are 'difficult to treat'. Rather, what has been demonstrated in the thesis is that events are not isolated in the mental apparatus of the patient alone. Whilst acknowledging this, this viewpoint possibly lends itself to a tendency on the part of trainees to overemphasize the role of the therapist. They may begin to blame themselves, their use of technique and their

personal dynamics, for the difficulties that arise, or feel that the onus is upon them to change in order to remove these difficulties. Thus the focus shifts from 'the difficult patient' to 'the difficult therapist' which is equally problematic for the unfolding of the therapeutic process. It requires of the therapist to find a balance between understanding the limitations imposed by having their own selfobject needs and their own fears and defenses whilst accepting and tolerating the powerful emotions that are inevitably stirred by this process.

The issues that Sally presented were confronting, and would probably have unsettled even an experienced therapist. For a therapist in training, however, being challenged in this way was uncontaining and anxiety provoking. The search for a comprehensive theory to explain away the difficulties and provide ways to respond was everpresent, and was possibly the motivation for writing this thesis. Steiner (1984) maintains that in learning psychotherapy the three essential requirements are the study of theory, personal therapy and clinical experience with supervision. Indeed all three of these factors were used in this process to provide assistance, containment and a place for reflection. Self Psychologists suggest that the ability to understand and respond to a patient will arise from the empathic immersion in the patient's subjective experience. The patient will teach the therapist how to proceed, only if the therapist has the humility to listen, and the courage to wait without knowing.

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