Analysis of argumentations and defences employed in short term psychodynamic therapy

By

Harriet Birgitta Calvert

Submitted for the degree of Doctor of Philosophy

Department of Social Psychology

London School of Economics and Political Science

University of London

2002

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Analysis of argumentations and defences employed in short term psychodynamic therapy

Abstract

This thesis maps out the role of and the presentation of mechanisms occurring in an interaction, in this instance in a therapy relationship. The concept of psychoanalytic defences and other related mechanisms served as the bases for identifying these in the therapy **process.** In other words, defences are studied as an **event in a relationship**. This means that the mechanisms are identified by looking at both the therapists' contributions and the patients' responses in this context.

The study is based on audio taped psychotherapy sessions. Seven patients were used as subjects. All seven were undergoing brief psychotherapy. Three subjects were undergoing cognitive analytic therapy (CAT) and four subjects were undergoing brief psychoanalytic therapy. All available sessions were transcribed. The transcripts of selected sessions have been used for an in- depth analysis. The methodology for the in-depth analysis was adapted from methodology developed for decision-making analysis.

The defensive mechanisms and manoeuvres used by the patients have been identified by the analysis, as well as the therapist's various inputs have been described as they occur in the **process**. The nature of the identified mechanisms are described as they take place. The effects of the defensive mechanisms have been discussed in terms of the patients' difficulties and in terms of the impact these mechanisms are having on the ongoing therapy relationship.

Finally the findings are discussed in the light of their correspondence to the existing psychoanalytic literature.

Acknowledgements

I am deeply grateful to my family for their support and encouragement. I am particularly grateful to my husband James Calvert for inspiring me and encouraging me to keep going and helped me to think through my ideas. I would like also to thank both Nina and Stefan for their help with my many 'computer problems'.

I am very grateful to my supervisor Patrick Humphreys who has continued to keep me going through the many years this thesis has taken to emerge.

I am also very grateful to Dr. Anthony Ryle at St. Thomas's Hospital for allowing me to participate in his supervision groups of his CAT therapists and for allowing me to audio tape live therapy sessions. I would also like to thank Josephine Spencer and Ian Simpson for helping me in this task.

Similarly I would like to thank Dr John Denford, Dr Kevin Healey, Dr Jo Bowen and Dr John Gavilan at the Cassell Hospital for allowing me access to live audio taped therapy sessions.

Many thanks also to John Lawrence who provided the independent psycho-analytic assessment of each patient.

I would also like to thank my friends Collin Hyde and Elizabeth Browning for their invaluable help with the endless technical problems I have encountered.

Finally I would like to express my deep gratitude to the patients who were prepared to share with me their intimate and often painful moments as they emerged in their therapies.

Without all the above mentioned this thesis would never had been written.

Table of Contents

1. Introduction and Overview

This thesis addresses itself to the complex issues relating to what actually happens in psychotherapy. What kind of activity is the therapist and the patient engaged in? Are theoretical notions relating, in particular to defence mechanisms useful in explaining what is happening between patient and therapist?

It seems, that to put it at its crudest, there has been a continuing development of the practice and theory of psychoanalysis in parallel rather than interactively. The norm tends to be that the therapist discusses his/her sessions in supervision without necessarily referring to the theoretical concepts but more to any possible meaning emerging or failing to emerge from the material the patient has presented his/her therapist. At the same time, there is no doubt that new theoretical thinking does emerge from clinical observations. Theoretical developments, however rarely spring from observations of the therapist/ patient couple being observed, by a third party.

Practitioners of psychoanalysis have often avoided attempts at systematic observations. It seems the question, 'do psychoanalytic explanations help us make sense of thinking and behaviour as observed by means other than through the therapist's eyes', has not been addressed. In other words can the patient's suffering as expressed in the presence of the therapist, but observed by a third party using non psychoanalytic methods be useful. Can these kinds of observations give validity or not to the psychoanalytic claim that patients' communication in therapy can be understood in terms of psychic pain that has or is becoming unbearable and is avoided by employing defence and other similar mechanisms? Furthermore does this situation change as a result of therapy, or if not, can this be understood, in terms of what goes on in the interaction.

When one asks a psychoanalytic practitioner to define theoretical concepts at the heart of psychoanalytic thinking, such as defence mechanisms, one often gets as many answers as there are practitioners. Sometimes the divergence is due to adherence to a specific school of thought but more often this appears to be a function of lack of clarity in the practitioners' mind.

Psychoanalysts are often accused of theoretical vagueness and lack of rigour in their writing. I believe that this is a direct result of a reluctance to put the various concepts to the test. A frequent objection to putting psychoanalytic theorising to the test has been that the phenomena we are dealing with cannot be observed directly as they are by definition unconscious. This thesis is not an attempt to observe unconscious processes themselves, but the derivatives of these unconscious processes as they emerge in the consulting room, in the interaction between therapist and patient. It steps into the void, left by the lack of systematic observations made in this area. It aims to observe the therapy process as it takes place. It is attempting to capture how new meaning is negotiated or not as the case may be, by observing the interaction between the patient and the therapist. It is an attempt at capturing the kind of thinking which is emerging in this relationship. The type of arguments, used by both parties is examined in terms of their internal consistencies or lack thereof. And finally the question is asked, does what we observe in the consulting room correspond to the mechanisms described in the psychoanalytic literature?

According to Popper (1963), psycho-analysis is a pseudo science. This is, says Popper because psycho-analytic claims are unfalsifiable. Falsifiability is Popper's famous central demarcation between science and pseudo science. Chioffi (1998) claims that it is not the psychoanalytic theory which should be considered pseudo science but psycho-analytic practice. Chioffi claims that although Popper did not make this distinction, Popper would have agreed with Chioffi on this point. Chioffi thus presents a challenge to psycho-analysis to approach its research differently, by using methodology other than free association.

Scientific Realism (Kitcher 1993, Niiniluoto 1999) on the other hand point out that scientific theories when taken literally often seem to refer to and describe *unobservable* entities such as electrons protons etc. Should we believe that such things really exist or are they merely useful fiction? Scientific realists think that we should believe in the existence of unobservable entities postulated by our best scientific theories and that those theories are *approximately true*. When considering Psycho- analytic theories we are also dealing with unobservable entities such as defence mechanisms.

In fact it has been be argued that psycho-analysis like other human sciences, such as sociology and history has been located on the border between science and the humanities. It has sought the conceptual and theoretical clarity and the systematic accumulation of observational data, of the 'scientific'. But it has also followed the humanities in accepting that its understandings depend on an observer's perspective (Rustin 2001)

The private dyadic relationship has until recently been a real obstacle to attempts to explore psychoanalytic claims in ways using methods other than the psycho-analytic ones. It was not until in 1985 that the International Psycho-Analytic Association became formally involved in psycho-analytic research by including two afternoons in the week of scientific programmes at the Biennial IPA Congresses. There after the atmosphere has started to change and professionals within the psycho-analytic arena are increasingly recognising the need to put psychoanalytic claims to the test.

Traditionally the only form of 'psycho-analytic research' was the 'case study', which dates back to Sigmund Freud. Infant observation is perhaps the first serious attempt to make 'non-analytic' observations, which have explored psychoanalytic claims about infancy and early childhood. Infant observation involves an observer spending usually one hour per week at home observing the infant over time. Infant observation is now an accepted part of psycho-analytic training. Briggs (1987) has, in this context, described the role and effect of the observer in a way, which parallels the understanding of the centrality of the transference, and counter-transference in psycho-analytic practice.

Bowlby's work on attachment (1969) has inspired new research in attachment behaviour, both in children and adults. Ainsworth (1991) developed the 'Stranger Situation test' in the 1970-ties in order to study infant's responses to separation and reunification with their mothers. Main (1985) followed in this tradition by developing an additional research instrument, the Adult Attachment Interview. This interview involves inviting subjects to tell their life story, which is then analysed in terms of how the narrative is given. Also Jungian Analytical psychology has given rise to the Myers Briggs (1962) personality test. Based on Jung's Typology.

The debate continues within the psycho-analytic community about what kind of observations and research is acceptable. A. Green (2000) and a few others still argue that free association and free floating attention are the hallmark of the prescribed method of psychoanalytic data gathering and that only facts gathered by these means are admissible to the psycho-analytic knowledge base. P. Fonagy (2000) on the other hand powerfully argues that this approach should be resisted. He states:

> The argument that psycho-analytic observations concerning human behaviour are in some sense incommensurate with any other form of observation is nonsense. The mind remains the mind whether it is on the couch or in the laboratory. To maintain otherwise is logically untenable, and risks denying psycho-analysis fields of observation that have historically proved to be of enormous value. It is inaccurate to state that Freud's own observations were restricted to his consulting room. He was acutely aware of other domains of study- history, literature, anthropology as well as neuroscience- and drew on these at many points of contact.

This Thesis is firmly based in the new tradition advocated by Fonagy above.

This thesis is also based in the approach to qualitative research, developed at the LSE by Bauer and Gaskell (2000). These authors argue that qualitative research always precedes good quantitative research in social sciences. They have developed guidelines for 'good practice' in qualitative research. This thesis has been designed to satisfy the relevant criteria outlined here. Bauer and Gaskell argue that qualitative research must fulfil criteria for *confidence* and *relevance*. This is ensured by the research design incorporating the following five indicators:

a. Triangulation (confidence marker), which means that the problem is approached from two or more perspectives. In this thesis the mechanisms in question are approached form the patient's perspective, the therapist's perspective and from and outside independent perspective. The relevant analysis can be seen in the results chapters 4-10.

b. Transparency and procedural clarity (confidence marker), which means that the data gathering and data analysis is clearly and transparently presented. Every effort has been made for this to be the case in this thesis. The data gathering will be described later in this chapter and in chapter 3 and the data analysis will be described in chapters 4-10

c. Corpus construction (confidence and relevance marker), which means that enough examples of what is being studied is included. Sample size does not matter in it self as long as the gathered material can be seen as showing some examples of each relevant category. In this research while only seven subjects were studied in depth, the material of many sessions of psychotherapy with each of the subjects, provides many of examples of each psycho-analytic mechanism.

d. Thick description (confidence and relevance marker), which refers to the quality of reporting. It is recommended that extensive verbatim reporting of sources should be included. In this thesis the results chapters 4-10 include verbatim reporting of the raw data on which the analysis is based.

e. Surprise as a contribution to theory and/or common sense (relevance marker), which means that there should be space for surprising and revealing insights and/ or evidence of a change of mind that may have occurred during the research process. In this thesis, the nature of how some of the mechanisms emerged such as the many different ways in which 'denial' emerged in the analysis was a surprise. This is described in chapter 11. The behaviour of the therapists was also a surprise and necessitated some initially unplanned thinking about the meaning of this. This thinking can be found in chapter 12.

Data from seven patents/subjects entering psychotherapy was analysed in this study. These patients were followed from the time when they were first referred, all the way to follow-up interviews. The setting, within which the research was carried out, was two National Health outpatient clinics. Both these clinics offered brief psychotherapy lasting between 12 to 16 weeks. The treatment frequency was in all cases once a week. The reasons for choosing short term psychotherapy was twofold; firstly short term psychotherapy provides the opportunity to study the 'whole' therapy process from the beginning to the end in a manageable space of time. Secondly research has shown that brief psychotherapy is comparable with long-term psychotherapy in so far as lasting improvement can be obtained in patients with moderately severe and long lasting illnesses. Furthermore that these results can be obtained with a technique which, apart from being active and focal, closely resembles that of psychoanalysis and deals fearlessly with most of the same issues. (Malan 1963).

Three of the subjects were receiving cognitive analytic therapy (fifteen or sixteen sessions) at St. Thomas's Hospital in London and four were undergoing standard brief psycho-analytic psychotherapy at the Cassell Hospital in Richmond.

Cognitive analytic therapy (CAT) is in practice comparable to standard brief psychoanalytic psychotherapy in so far as the activity in the consulting room is primarily informed by Object Relations theory, which is a type of psycho-analytic theory. It differs from standard brief psychotherapy in so far as it employs additional tools outside the consulting room designed to promote conscious self-observation (Ryle & Beard 1993). These tools include such things as mood diaries, diagrams and written reformulations.

It was felt that the similarities of these two approaches were such that the subjects could meaningfully be studied using the same methodology. Furthermore it was felt that although there were differences in therapist styles these were seen to be more due to differences in personal styles rather than due to the different approaches. Five different therapists treated the seven patients. Two of the therapists were following a CAT model and three were following a standard brief psycho-analytic psychotherapy model. Three of the subjects/patients were women all in their late twenties to middle thirties, and four were men in the age range of early thirties to mid fifties.

All therapy sessions were audio taped with the subjects' consent. Most of these sessions were then transcribed. Some sessions were lost either because the patients did not attend their session or the quality of the recording was too poor to be transcribed. In addition, where possible the subjects were interviewed before and after their therapy and in many cases additional material in the form of notes or referral letters was available. Written reformulations and mood diaries and other similar material were available for the CAT subjects (See appendix 2).

The main emphasis in analysing the material was to observe process rather than content. The main methodology developed for this research, has been based on an adaptation of methodology that was originally developed for decision-making analysis (Hogberg 1984),

(Toulmin et. al. 1979). The adaptation of this methodology for the use in this thesis will be described in detail in chapter 3. In addition the subjects' changing preoccupations have been charted throughout the therapy period to see if the patients are able to explore more widely or whether their preoccupations remain basically the same. Where there is change, the question will be asked whether this can be understood in terms of what has been observed to be happening between patient and therapist, or does this change maybe bear no relation at all to what has been observed in the consulting room?

Detailed analysis was carried out for each patient, of selected sessions, and the results of the analysis is described in chapters 4-10. The analysed sessions were usually chosen from the beginning of the therapy from the middle and from the end. On occasion it was felt that choosing sessions in this way did not adequately capture the flavour of the particular subject, thus the sessions best representing the subjects functioning were selected.

Each vignette, which was analysed in detail, is then discussed in the light of what psycho-analytic mechanism(s) might be at play. The therapists' interventions were similarly analysed in terms of, how did the therapists tackle what they were presented with by the patients. Finally by analysing vignette by vignette the negotiation between each therapist/patient pair was charted. In addition a senior Kleinian psychoanalyst has independently assessed one session per subject. The transcripts of the sessions were given to him for comments, about what he felt was going on for the subject and in the interaction between the patient and therapist. The same sessions were also analysed in detail using the modified argumatics methodology.

Finally, conclusions were drawn as to how well a psycho-analytic explanation describes what is happening in each therapeutic discourse, in chapter 11. Comments are made on the nature of each mechanism observed, each subject's defensive style, any change observed, or if not why not. Differences in therapist styles are discussed and how these impact on the therapy interaction, in chapter 12. In chapter 13 conclusions are drawn with

regard to the nature of the observed mechanisms and their role in the therapeutic discourse for each patient. Finally implications for both the theory and practice of psychotherapy are discussed.

2. Theoretical background

This chapter will describe the relevant theoretical underpinnings of the psycho-analytic mechanisms, which will be examined in this thesis and also the theoretical background to the methodology which has been adapted and used in the analysis of the data.

2.1. Historical developments of the concept of defence mechanisms

This section is an overview of the theoretical background to the mechanisms and defences and to the relevant processes in therapy, which are of interest here.

The argument put forward in this thesis is that the mechanisms described and used in psycho-analytic work are poorly defined both theoretically and clinically. This thesis is an attempt to describe selected defences and related mechanisms **as they occur** in the discourse of psychotherapy, and to discuss their role in, and effect on, the occurring process.

In traditional psycho-analytic thinking the idea of 'defence mechanisms' is inseparably linked to the notion of the existence of the Unconscious. Thus the concepts have been part of the development of psycho-analysis from its outset. It has been argued that Freud's most original contribution to human psychology was his postulation that unconscious defence mechanisms protect the individual from psychic pain. Even today there is broad agreement on this point, indeed it can be stated that no mental state evaluation or clinical formulation can be considered complete without an attempt to identify the patient's dominant defence mechanisms. In the current 'Diagnostic and Statistical Manual of Mental Disorders' popularly known as DSM-IV, the clinician is urged to identify defences and coping styles of the patient. The DSM-IV is one of the current internationally used diagnostic manuals for psychiatrists. It makes no mention of Freud but it describes defence mechanisms as follows: '*Defence* mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from awareness of internal and external dangers and stressors. Individuals are often unaware of these processes as they operate.'

However, as the ideas and concepts have evolved the definitions have changed, sometimes drastically sometimes more subtly. As the concepts have been used and developed piecemeal by many theoreticians and clinicians over many years, the resulting picture has become increasingly confusing. The historical development of the concept of defence mechanism will be sketched in the following section, within the context of the general development of psycho-analysis.

Sigmund Freud did not invent the 'talking cure'. The idea of a talking cure through catharsis of feelings is at least as old as the catholic confessional. Current ideas of 'getting it off your chest' testify to the widespread belief in its value. Aristotle's concept of catharsis was much talked of in Vienna in the 1880s and may have influenced Freud.

There is nothing revolutionary in the idea that we are often in conflict with our feelings, wishes, and memories. Writers through the ages from Shakespeare to Rousseau have described conflicting feelings, which may be defended against. Writing in the 1880s Nietszche anticipated Freud by arguing: ' I did that', says my memory. 'I could not have done that', says my pride, and remains inexorable. Eventually the memory yields (Whyte 1962).

Sigmund Freud's achievement, combining the gift of a great writer and scientist, was to address these ideas in a medical context, in such a way that they have since been given continuing and increasing attention.

2.2. The development of the concept of defence mechanisms

Many major theorists and clinicians have contributed to the development of the concept of the defence mechanisms. Many of these will be outlined in the following section:

Sigmund Freud

A discussion about defence mechanisms can already be found in Breuer's and Freud's 'Preliminary Communication' (1893): 'On the Psychical Mechanism of Hysterical Phenomena'. Of note here is Freud's use of the idea of psychical mechanisms. Freud was at this time engaged in defining the principals of hysterical phenomena, the concept of defence was seen as the defining principle of hysteria.

According to Valiant (1992), Freud had by 1915 described, be it only in passing almost all the mechanisms of defence that Anna Freud was to catalogue more than 20 years later. It is not clear exactly when Freud identified each defence by name, but the following defences were identified by process at this time, denial, distortion, projection, splitting, hypocondriasis, turning against the self, fantasy, dissociation, repression, isolation, undoing, displacement, reaction formation, sublimation, altruism, suppression, humour and also the significance of ego maturity in identifying defensive processes on a continuum.

Freud identified five important properties of the mechanisms of defence, namely:

1. Defences are a major means of managing instinct and affect
2. They are unconscious
3. They are discrete (from one another)
4. Although often the hallmarks of major psychiatric syndromes, defences are dynamic and reversible.
5. They can be adaptive as well as pathological.

Anna Freud

Anna Freud recognised the need to create clear definitions of the distinct mechanisms of defence in relation to ego development. This was a move towards creating what Valiant (1992) terms a 'consensually validated hierarchy'. Anna Freud suggested that

> Defences have their own chronology... they are more apt to have pathological results if they come into use before the appropriate age and are kept up too long after it. Examples are denial and projection, which are 'normal' in early childhood and lead to pathology in later years; and

> repression and reaction formation, which cripple the child's personality if used too early. (A. Freud 1965).

Anna Freud described and charted the different mechanisms of defence in some detail in her classic expose *The Ego and the Mechanisms of Defence (1936).* In chapter 4, of her work, Anna Freud reviews Sigmund Freud's work on defences and reminds the reader that in his view there may be a connection between types of illness and specific defences. She lists ten defences, regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, reversal and sublimation. She then develops a developmental chronology for each of them.

Walder

Walder (1930), (1976) revealed how defences could serve multiple functions, including securing some gratification of the forbidden impulse while at the same time defending against it. According to Walder certain defensive character traits, such as paranoid projection, may include wish-fulfilling fantasies simultaneously with resultant symptoms.

Kernberg

The nature of the relationship between defence and object representation, has been elaborated by Kernberg (1967,1975, 1983). He suggests that defences can be divided into three overall levels of organisation: psychotic, borderline and neurotic, each of which is associated with certain predominant defences. At each level of organisation, defences serve at least in part to protect the individual from anxiety -producing internalised self and object images. Kernberg is perhaps best known for his description of borderline personality organisation, in which splitting mechanisms predominate over repression, the later being characteristic of neurotic personality organisation. According to Kernberg splitting and related defences keep aggressive and libidinal object images apart and thereby they minimise anxiety, but at the price of preventing the individual from synthesising emotional meaning into more realistic representations or schemas of self and others.

Recent views, Brenner and Cooper

More recently published views on defences, particularly those of Brenner and Cooper have emerged primarily from the United States of America.

Brenner's (1975,1979, 1982) theory of defence-mechanisms, explicitly delineates a functional rather than a motivational or a content approach, to the study of defence mechanisms. Brenner argues that defence is an aspect of mental functioning ' definable only in terms of consequence: the reduction of anxiety and/or of depressive affect associated with a drive derivative or with superego functions'. Within this view there are no named, distinct defence mechanisms. Any action on the part of the ego can acquire a defensive function. Brenner does not place the ego's defensive functions within an object-relations context. He perceives these mechanisms as excising strictly within an intrapsychic context, although it would include defensive manoeuvres directed against pain arising in a relational context.

Cooper (1989) argues that as the focus of interest has been on defining the concept of mental mechanisms and specifically defence mechanisms, the value of a content approach to defence has been neglected. He argues that as the scope of psycho-analysis is widening, it would be increasingly beneficial to a conceptualise defences as having at their core instinctual underpinnings. At the same time he is attempting, through detailed clinical observations, to understand and integrate the roles of the external world and experiential aspects of defence. 'Recent notions of the defence mechanism concept, point less to deficiencies in the current body of theory of defence than to the continued need to reconcile and integrate theory with empirical and clinical observations', Cooper argues.

The psychoanalytic community has shown great reluctance to heed Cooper's advice. This issue touches on the painful debate of whether psychoanalytic concepts can be seen to have some scientific basis. Although Sigmund Freud himself was very keen to explore the scientific basis for psychoanalytic thinking, modern practitioners have tended to avoid the issue.

Following Brenner's logic there would be no particular value in describing the specific mental mechanisms in themselves. This thesis however, addresses what I believe is an increasing need for clearer definitions and also the need to identify and describe defences in the context of treatment.

2.3. *Object Relations Theory: Klein*

The thinking about defence mechanisms within psychoanalytic theory and practice took a new turn with the recognition of the importance of Object Relations. Melanie Klein (1946) added to the classic view that defences counter drives, by emphasising the place of defences in relation to object representations. Defences came to be understood in the context of the individual's development through the work of Melanie Klein.

Klein described what she considered to be primitive defences and their development both in their pathological and their healthy forms. Since this thesis will include, and focus, on some of the defences as identified and described by Melanie Klein and her followers, a more detailed expose of her thinking is provided in the following:

Melanie Klein came to view the mind as primarily an 'internal world' consisting of 'internal objects', some of which are more or less stably clustered around the Self, and are identified with and related to who we think we are.

Klein saw the earliest primitive defences as being directed against the 'death instinct'. These defences are universal, in so far as they are employed by every infant in order to cope with early anxieties, while the ego is still too immature to process these. The defences are broadly specific to 'developmental phases', or positions, as Klein prefers to call them. The positions continue throughout life in some form, a position is never fully negotiated; traces of the positions remain, and re-emerge and have to be renegotiated.

For Klein the infant is born with instinct, which demand expression, but unlike Freud the instinct is, from the beginning considered to be attached to an object or to the idea of an object. There is no phase 'prior to the object' for Klein.

In order to make the nature and development of defences clear, it is necessary to examine them as they occur in both normal and pathological development. According to Melanie Klein, the child is born with enough ego to experience anxiety, use defence mechanisms and form primitive object relationships in phantasy and in reality. However, to begin with, the early ego is largely unorganised, but with a tendency towards integration. The immature ego of the infant is exposed from birth to the anxiety stirred up by the inborn polarity of instincts, the life and the 'death instinct'. It is also exposed to the impact of external reality, both in its anxiety producing forms and also to the love and nurturing it receives from its mother. When faced with the anxiety produced by the 'death instinct', the ego deflects it. This deflection of the 'death instinct' consists partly of projection, partly of conversion of the 'death instinct' into aggression. The ego splits itself and projects that part of it self which contains the 'death instinct' outwards into the original external object - the breast. Thus the breast, which is considered to contain a great part of the infant's 'death instinct', is felt to be bad and threatening to the ego, thus giving rise to feelings of persecution. Part of the 'death instinct' remains in the self and is converted into aggression and then directed against the persecutor.

At the same time a relationship is established with the ideal object. As the 'death instinct' is projected outwards, to ward off anxiety aroused by containing it, so the libido is also projected, in order to create an object, which will satisfy the ego's instinctive striving for life. As with the 'death instinct', so with the libido the ego projects part of it outwards, while the remainder is used to establish a libidinal relationship with the ideal object, also the breast. Thus the ego has, quite early a relationship to two objects; the primary object, the breast being at this stage split into two parts, the ideal breast and the persecutory breast.

This state of affairs means that the 'so called' paranoid- schizoid position has been established. In the schizoid position the leading anxiety is paranoid, and the state of the ego and its object is characterised by **splitting.** The ego evolves a series of mechanisms of defence against the overwhelming anxieties inherent in this position. There is a defensive use of introjection and projection. The permanent feature is that, in situations of anxiety, the split is widened and projection and introjection are used in order to keep persecutory and ideal objects as far apart as possible, while keeping both of them under control.

From the original projection of the 'death instinct' another mechanism of defence evolves, namely projective identification. In projective identification parts of the self and internal objects are split off and projected into the external object, which then become possessed by and controlled and identified with the projected parts.

Projective identification has manifold aims: it may be directed towards the ideal object to avoid separation from it, or it may be directed towards the bad object to gain control of the source of danger. Various parts of the self may be projected with various aims: bad parts may be projected in order to get rid of them, good parts may be projected in order to keep them safe from attack from within etc.

It is the splitting which allows the ego to emerge out of the chaos and to order its experiences. This ordering of experience into good and bad organizes the child's universe of sensory and emotional impressions and is the precondition for later integration. Splitting is also the bases for what later becomes repression. If early splitting has been excessive and rigid, later repression is likely to be of an excessive and neurotic rigidity. Splitting itself, provided it is not excessive and does not lead to rigidity, is considered to be an extremely important mechanism of defence during this period, and in fact it continues in modified form to function throughout life.

Within Kleinian Object-Relations theory it is clear that the mechanisms of defence employed in the paranoid-schizoid position protect the immature ego from overwhelming anxiety until such time as the ego is mature enough to confront the

anxieties. Thus the defence mechanisms serve both a function of protecting the ego and as gradual steps in development.

The movement out of the paranoid-schizoid position can begin to take place where good nurturing experience predominates over bad. The ego can acquire a belief in the prevalence of the ideal object over the bad, and also the predominance of the 'life instinct' over the 'death instinct'. The ego repeatedly identifies with the good object and thus acquires greater strength and greater capacity to cope with anxiety. The fear of the persecutory object lessens and the split between the persecutory and ideal object lessens as well. The splitting of the ego also lessens when the ego feels stronger. As the ego feels more closely related to the good object and less afraid of its own aggression, the good and the bad parts of the ego are allowed to come closer together. The ego is preparing to integrate its objects, integrate itself, and through lessening of projective mechanisms, there is growing differentiation between what is self and what is object. Another way of putting it is that, if good experiences predominate in the mother and baby relationship the baby is able to discover that the mother whom he/she hates (the bad breast), during moments of frustration is in fact the same mother whom he/she loves and depends on (the good breast). This development may however not take place if bad experiences predominate over good ones, as this forces the infant to continue to rely on splitting mechanisms.

Under favourable circumstances, the infant's ego becomes much stronger, the ideal object can be felt to be stronger than the bad object. The infant will accordingly feel less frightened of his own bad impulses and will therefore be less driven to project them outside. When the projection of bad impulses decreases, the power attributed to the bad object decreases too, thus the ego will become stronger as it is less impoverished by projection. The infant's tolerance of the 'death instinct' within himself increases and the paranoid fears lessen; splitting and projection decrease and the drive towards integration of the ego and the object take the upper hand. This is the beginning of the depressive position.

The depressive position has been defined by Melanie Klein as the phase of development during which the infant recognises a whole object and relates himself to this object. At first the infant perceives its objects as part-objects, that is the object is seen in terms of its functions, i.e. the feeding good breast or the persecutory bad breast. This changes to a situation, which means that the mother is seen as the source of both bad and good experiences, she can be present or absent, at times good at other times bad etc. The important achievement is that she can be seen as a whole person. Recognising the mother as a whole person means also recognising her as an individual who leads a life of her own and has relationships with other people. The infant discovers his/her helplessness, and utter dependence on the mother, and also his/her jealousy of other people.

Together with this altered perception of the object (usually the mother), there is a fundamental change in the ego because, as the mother becomes a whole object, so the infant's ego becomes a whole ego and is less and less split into its good and bad components. The lessening of projective processes and the greater integration of the ego means that the perception of objects is less distorted so that the bad and ideal objects are brought closer together. When the mother is seen as a whole object, the infant is better able to remember her, that is to remember former gratification at times when she is felt to be depriving, and former deprivation when she is felt to be gratifying. As these processes of integration proceed the infant realises more and more clearly that it is the same person whom he/she both loves and hates that is, his/her mother. He/she is then faced with conflicts arising from his/her ambivalence. This change in the state of the ego and the object integration brings with it a shift in the focus of the infant's anxieties. In the paranoid-schizoid position the main anxiety is that, the ego will be destroyed by the bad object or objects. In the depressive position the anxiety arises from ambivalence, the child's main anxiety is that his or her own destructive impulses have destroyed or will destroy, the object that he/she loves and totally depends on.

The more integrated child who can remember and retain the love for the good object even while hating it, will be exposed to new feelings, unknown in the paranoid-

schizoid position: that is mourning and pining for the good object felt to have been destroyed by the infant, coupled with guilt. These feelings are thus signs of developmental achievements, underpinning healthy relationships in particular and mental health in general. Believing that the child's own attacks have been responsible for the destruction of the object, he/she also believes that his/her own love can undo the effects of the earlier aggression. Failure to repair leads to despair, success to renewed hope. The gradual resolution of depressive anxieties and the gradual regaining of good objects both externally and internally can be achieved by the reparation made by the child, in reality and in omnipotent phantasy, to his/her external and internal objects.

The depressive position marks a crucial step in the infant's development and its working through is accompanied by a radical alteration in the infants view of reality. When the ego is more integrated, and when projective mechanisms are less relied upon, the infant begins to perceive his/her dependence on external objects and with the accompanying ambivalence, he/she discovers his/her psychic reality. The infant becomes aware of his/her objects as separate from him/herself and begins to distinguish between fantasy and external reality. Confrontation with reality also ultimately lessens belief in omnipotence, be it of destructive or reparatory impulses. The new **capacity to feel concern** for his/her objects helps the child to gradually learn to control his/her impulses.

In addition Melanie Klein understood this stage to constitute the beginning of symbol formation. In order to spare the object, the infant partly inhibits his/her instincts and partly displaces them onto substitutes – this is the beginning of symbol formation. In stark contrast to the concrete thinking so typical of the paranoid-schizoid thinking.

Defences are still part of the picture also in the depressive position, however they are less needed, and are of a more transient nature. The primitive defences of projection, projective identification, omnipotent denial and other omnipotent thinking and splitting in general are gradually replaced by more evolved defences, such as repression. The nature of these later defences is laid out in the working through of

both the paranoid-schizoid position and the depressive position. Basically the more these positions have been worked through the less rigid will be the resulting defences, resulting in less distortion of reality.

2.4. What is defended against

It appears that elaboration of what exactly is defended against within the Kleinian theory of Object-Relations, has been very helpful in furthering the development of professional psychoanalytic theory, but has at the same time created confusion and a lack of clarity.

Early in psychoanalytic development, what was felt to give rise to defence was anxiety. This anxiety may be due to superego demands, instinctual pressures, or threats from the external world, (Anna Freud 1936). Kernberg and in particular Melanie Klein added the dimension of internal objects as a major source of anxiety. Klein has described in some detail the psychic defensive mechanisms utilised to minimise the ensuing pain of the battle between the opposing instinctual forces as represented by internal objects and unconscious fantasy. For Klein the internal objects represent an amalgamation of instinctual demands and a reflection of past and present external relationships.

The external relationship as the motivating force of the defensive action can be found in Winnicott's (1965) conceptualisation of the false self. This can also be found in Modell's formulations of denial and self sufficiency, perceived as arising out of a need to defend against unsatisfactory object ties. (Modell 1975, 1984).

2.5. Mechanisms of Defence

The background to the various mechanisms of defence will be discussed in the following section in detail.

Denial

Brenner (1981) argues that to defend against a drive derivative or a super-ego manifestation is to deny or negate it in some way. Denial in the colloquial sense is intrinsic to all defence. However, he allows for a more specific meaning of defence in

a technical sense. In a strictly psychoanalytical sense he agrees with Anna Freud that denial refers to the defensive distortion of one's perception of some aspect of one's environment- of what is referred to as external reality.

Denial is a very early psychoanalytic idea, originally termed 'scotomatization' by Sigmund Freud. This means that a piece of perception is obliterated. Denial in this sense is associated with the idea of negation. Freud discusses this in 1925, in his paper titled 'Negation'. Freud felt that negation often marks the bringing to consciousness of repressed material; 'There is no stronger evidence that we have been successful in our efforts to uncover the unconscious than when the patient reacts to it with the words ; I didn't think that, or I didn't ever think of that'.

In the Kleinian tradition, denial is seen as occurring both in the paranoid-schizoid and in the depressive position. Omnipotent denial, accompanied with splitting is perceived as one of the primitive mechanisms. Denial is also specifically involved in the manic defences, in particular the denial of the reality of some part of the mind, or of psychic reality as a whole. As described in the section on Klein in this chapter, denying the importance of the object on which the subject actually depends is significant. Denial is also involved in idealisation when the bad aspects of the object are disposed of. Rosenfelt (1983) puts it as follows; 'it is omnipotent denial which can completely deny the existence of bad objects and all the painful affects related to them particularly the feelings of persecution'.

Klein (1946) described the mechanism of denial as connected to the fantasy of annihilation, and an actual loss of the ego or object. In this sense it differs from repression, which involves a removal from consciousness only of the reality of some external event, or memory of it. However, there is a tendency for Kleinians to use the term 'denial' in contexts where classical Freudians would refer to 'repression'. In practise there is little clarity on the distinction between these terms. The distinctions, which have been attempted, are generally made on the degree of violence and omnipotence involved in the defensive process. Denial is thus conceptualised as an

omnipotent obliteration without reference to actual reality; whereas with repression external reality is respected although distorted.

Denial is one of the commonest concepts in psychoanalytic thinking, nevertheless there seems to be considerable confusion about what the concept means and in particular what is being denied and why.

Projection

Laplance & Pontalis (1973) describe projection as follows;

> 'In the properly psychoanalytic sense: operation whereby qualities feelings and wishes, which the subject refuses to recognise or rejects in himself, are expelled from the self and are located in another person or thing. Projection so understood is a defence of a very primitive origin which may be seen at work especially in paranoia, but also in 'normal' mode of thought such as superstition'.

Projection has a long history in psychoanalytic thinking. Freud first mentioned the idea of projection in 1895. Klein's important contribution to understanding and expanding the meaning of projection dates back to 1946.

Projection has been viewed as: projection and expulsion, externalising conflicts, projection and identity, projection of parts of the self. In 1895 Sigmund Freud noted the link between projection and paranoia, the latter being an attempt to expel something felt to be threatening. Freud continued to use this concept, but there were important inconsistencies. He often described projection as the distortion of a normal process by means of which we seek the cause of our effects in the outside world: such would appear to be his conception of projection as observable in phobias. By contrast in the analysis of the mechanism of paranoia in the Schreber case (Freud 1911), the appeal to causality appears as an a posteriori rationalisation of projection:...'the proposition ;I hate him, becomes; He hates me, which will justify me in hating him'. In this instance it is the affect or the instinct itself, which is being projected.

Anna Freud (1936) puts it more simply, 'Children employ projection as a means of repudiating their own wishes and activities when these become dangerous and of laying of responsibility for them at the door of some external agent; a strange child, an inanimate object, an animal etc. In the same way prohibited wishes are handled in this manner, these are handed over to other people. If, however, the projection was prompted by a sense of guilt, instead of criticising itself the child accuses others'.

In Sigmund Freud's 'Instincts and their Vicissitudes' (1915) and in 'Negation' (1925), what is considered to be projected is whatever is 'hated' or 'bad'. This is close to Melanie Klein's uses of the concept; for her what is projected is 'the phantasied bad object'.

Melanie Klein's usage of Projection:

Projection of the internal object

The hungry crying infant experiences the absent mother/breast as an active presence of a hostile bad object causing the hunger pains. Through screaming and crying the object comes to be experienced as expelled.

Projection of the 'death instinct'

Klein's view of the 'death instinct', as projected outwards, means that there is a primary inwardly directed aggression, which turns outward against some external agency.

Projective identification

Finally Klein described projective identification, which means getting rid of unwanted parts of the self by attributing them to somebody else, and somehow inducing in the recipient this unwanted quality.

It is important to note that these mechanisms can be pathological or used in normal functioning as well, in spite of their primitive roots. For instance empathy is a

'normal' use of projective identification, with the difference that the subject does not lose touch with the fact that what is being temporarily projected is actually belonging to the subject. Bion (1959) described this difference by pointing out the omnipotent nature of pathological projective identification. 'The subject loses the sense of what is real as the unwanted part is violently projected'. In fact, in present day therapeutic practice it seems that frequently projection is considered as a form of projective identification, involving the recipient in some way.

The above shows some of the rather confusing picture of this concept, which can be found in the literature.

Concrete thinking

Concrete thinking is not usually listed under the heading of defence. However the data of this research suggests that it has a clear defensive role.

Later Kleinian thinkers have drawn attention to the significance of the nature of thinking as a function of the state of the patient's internal world. Concrete thinking refers to a quality of thinking, which has been observed in connection with paranoid-schizoid functioning. It has been described within psychoanalytic theorising recently, notably by Steiner in 1987, although it has a long history within other branches of psychiatric theory (Goldstein and Sheere 1941).

Within psychoanalytic theory concrete thinking constitute both a denial and a destruction of meaning in a characteristic way. Examples of this kind of thinking are evident in the material presented in the case of John and George (see Chapters 4 and 5).

Concrete thinking creates splitting, a large part of 'the equation' is not considered and remain eclipsed behind the concreteness of the interaction. It also introduces a controlling quality to the interaction

In the literature concrete thinking is now considered important in understanding aspects of the paranoid-schizoid position. (Steiner 1987) puts it as follows:

> 'In the paranoid schizoid position anxieties of a primitive nature threaten the immature ego and lead to the mobilisation of primitive defences. Splitting, idealisation, and projective identification operate to create rudimentary structures made up of idealised good objects kept far apart from persecuting bad ones. The individual's own impulses are similarly split and he directs all his love towards the good object and all his hatred against the bad one. As a consequence of the projection, the leading anxiety is paranoid, and the preoccupation is with the survival of the self. *Thinking is concrete* because of confusion between self and object which is one of the consequences of projective identification.'

Destruction of meaning

Bion (1958) describes the tendency to split by highlighting attacks on linking. His main conclusion is that in the paranoid-schizoid position the patient's psyche can contain an internal object, which is hated, and towards which the patient feels destructive. Thus all links whatsoever from the most primitive to the most sophisticated forms of verbal communication are attacked. In this state emotion is hated; it is felt to be too powerful to be contained by the immature psyche, it is felt to link objects and it gives reality to objects which are not self.

McDougal (1982) expands these ideas by introducing the concept of **alexithymia**. This is a state, which can be observed in particular in psychosomatic patients. Psychoanalytic observations of such patients reveal an inability to name recognise, contain or work through one's affective states. This is felt to be a defensive structure of the most primitive kind.

McDougal describes this state as follows:

> 'It is a split between psyche and soma, affective perceptions are largely eliminated and with them goes the destruction of meaning, so that the world and the people in it become devitalised. Feeling is not disavowed, it no longer exist. There is a continuing effort to cut affective links, whether these links are attached to instinctual promptings, emotionally loaded ideas, or relationships with other people'.

Psychosomatic symptoms predominate in these patients, although Mc Dougal argues that the psychosomatic symptoms have neither biological sense nor symbolic significance, thus the body functions in a delusional way.

Another feature of the paranoid-schizoid position is that the patient is anxious about his/her own well- being and is unable to be concerned another person. Psychosomatic manifestations lend themselves well to the focusing on the self.

Omnipotent thinking

Many authors, notably Klein and Winnicott, agree that the early stages of infancy are characterised by omnipotent thoughts, feelings and fantasies. Klein (1946) regarded these omnipotent fantasies as defences against the existence of separateness, dependence and envy. Winnicott (1960) regarded omnipotence as a protected area from the start that must resist impingement, a view that resembled the classical theory of primary narcissism. Without a distinction between him/herself and the mother, the infant exists in a state of 'primary omnipotence'. This stage is felt to be of greatest importance and is not to be disturbed until the infant is 'ready'. It is only after the infant is 'ready' that the mother can begin to bring in reality by introducing gradually some degree of frustration.

To return to Klein, omnipotence is seen as an important defence and a quality of the primitive defence mechanisms, which are involved in breaking down the ego-boundaries so that the experiences of separateness and envy are avoided. Rosenfelt (1987) adds that omnipotent defences can create confusion between self and object in such a way that they persists as 'omnipotent narcissistic object-relations'.

Finally, as has already been mentioned, omnipotent denial plays a part in the Manic Defences, when the value of the object has to be denied in an omnipotent fashion.

Displacement

This concept is today often subsumed under the heading of Projection. Laplance and Pontalis (1967) describe displacement as follows.

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

Displacement is in fact an early original Freudian concept. Sigmund Freud described it primarily in association to dreams, but also in relation to symptom formation.
The DSM IV describes displacement as:

> 'The individual deals with emotional conflict or external or internal stressors by transferring a feeling about, or response to, one object onto another substitute object'.

This concept is used less today in describing a defensive process. It appears that the overlap in the definition with that of projection has meant that the concept is rarely used by modern psychoanalysts. The concept is occasionally referred to, but usually only by neo-Freudians.

Reaction formation

What was said about displacement can also be said about reaction formation. Reaction formation is mostly used in the purely Freudian tradition. Laplance and Pontalis (1967) defines reaction formation as follows:

> 'Psychological attitude or habits diametrically opposed to a repressed wish, and constituted as reaction against it.'

The DSM IV definition of reaction formation is as follows:

> 'The individual deals with emotional conflict or external or internal stressors by substituting behaviour, thoughts and feelings that are diametrically opposed to his or her own unacceptable thoughts or feelings (This usually occurs in conjunction with their repression).'

This defence was described and catalogued in Anna Freud's 'The Ego and the Mechanisms of Defence' (1936). However it is not a defence used or described much in modern psychoanalytic literature outside the Freudian school. Elsewhere the same phenomenon is instead described under the heading of denial.

Identification

Laplance and Pontalis defines identification as follows:

> 'Psychological process whereby the subject assimilates an aspect, property or attribute of the other and is transformed, wholly or partially, after the model the other provides'. It is by means of identifications that the personality is constituted and specified.'

A well-known variant of identification is the *'Identification with the Aggressor'*, one of the defences catalogued by Anna Freud. This means that the individual deals with feeling like a victim, by turning into the aggressor.

In the Kleinian tradition, the concept of identification is described as follows by Hinshelwood (1989):

> 'Identification concerns the relating to an object on the basis of perceived similarities with the ego. However, this is a complex phenomenon, which has several forms. The simple recognition of similarity with some other external object that is recognised as having its own separate existence is a sophisticated achievement. At the primitive level of phantasy, objects that are similar are regarded as the same, and this omnipotent form of phantasy gives rise to confusion between self and object'.

The different definitions of identification are clearly not consistent. It is not even clear if identification is considered a defence. Interestingly the DSM IV does not list identification in its list of defences.

Introjection

Laplance and Pontalis (1967) describe introjection as follows:

> 'Process revealed by analytic investigation: in fantasy, the subject transposes objects and their inherent qualities from the 'outside' to the 'inside' of himself. It is closely akin to identification.'

The DSM IV does not list introjection as a defence. The term introjection, was first coined by Ferenczi in 1909. He felt that neurotic problems were caused by excessive introjection. Sigmund Freud described introjection notably in his paper Mourning and melancholia (1917). In this paper he uses the term identification in the sense of

introjection. He describes a process by which an object is relocated within the ego boundaries that once had been experienced as external.

Introjection is seen as both a defence mechanism and inherent in the developmental process. Sigmund Freud described how the super-ego comes to be 'introjected' following a successful negotiation of the Oedipus complex. For Melanie Klein introjection is one of the cornerstones of the establishment of an internal world. Objects are introjected and thus come to inhabit the psyche as internal representation of external objects.

Intojection as a defence mechanism

For Sigmund Freud, introjection is a defence against the loss of the external object, but for Klein it is a defence against a terrifying internal object. If the internal world is felt in fantasy to contain very bad or persecuting objects that seem to endanger the ego, then the ego defends itself by introjecting the 'good object'

Splitting, Manic Defences constellation, and the nature of Anxiety

These concepts belong mostly to the Kleinian school of thought. The background to these is described in section **2.3** of this chapter. These mechanisms are closely related to defence mechanisms and are therefore mentioned in this context. As outlined above in the section on Melanie Klein the degree of splitting depends on the type of defensive manoeuvres employed by the ego and in addition on the type of anxiety relating to the developmental achievements of the individual. The distinction between the types of anxiety can be clarified by asking the question: Are the anxieties primarily about the individual him/herself or are they concerns about his/her objects. It would be more correct to say that the manic defences is a constellation or a cluster of defences occurring under specific circumstances when the individual is threatened with feeling overwhelmed with anxieties at the threshold of the depressive position.

For the manic defences to happen there has already been some movement towards the depressive position and away from the predominance of splitting in the paranoid schizoid position. However the transition is at this point in time felt to be

overwhelming. Characteristically the patient rules that the loved person/object is not important at all; the loved object's condition whether damaged or sound does not matter. The patient cultivates imaginary states of superiority, triumph and control over the object, a phantasy of omnipotent supremacy is maintained. The manic supremacy is supported by specifically, *a denial of the true qualities of the object, a sense of triumph over the object, which becomes insignificant, and a control over the object, making it dependent instead on the subject.* Klein (1935) (1940) describes the use of the manic defences as a denial of psychic reality. This statement remains somewhat unclear, as in any actual context it will be a specific type of psychic reality (undefined here), which is being denied. Examples of the manic defences can ordinarily be observed in the initial stages of mourning.

Thus the same defences can occur in different contexts depending on what is defended against. In other words depending on in how primitive a manner the defences are used and depending on whether the defences are creating splitting or something perhaps more temporary as might be the case if the defences are occurring on the threshold of the depressive position.

In summary, defence mechanisms are employed by the ego in order to avoid or minimise psychic pain, usually related to anxiety. They arise in a relationship, either in an external relationship or an internal one. They regulate and alter the nature of this relationship and also influence to what extent external and internal reality can be accessed by the individual. In psychotherapy the defence mechanisms employed by the individual largely determine the nature of the therapist-patient relationship. It is also within the therapist - patient relationship that the workings of these mechanisms can be mapped out and potentially altered.

The nature of the psychoanalytic discourse will therefore be examined closer in the following section.

2.6. The Psychoanalytic Discourse

This thesis is concerned with the above named mechanisms *as they occur in a process*, in this instance in the psychoanalytic process. Indeed it is one of the arguments of this thesis that these mechanisms can only meaningfully be described as occurring in a relationship. Thus the key question which needs to be addressed in this context is; 'Under what circumstances does identifying defences make sense?' Sigmund Freud himself described concepts such as defence mechanisms and transference as events in the treatment relationship. Indeed it would not make sense to describe the transference outside a relationship. It is in the discourse, in the living relationship that anxieties arise, and thus it is in this context that defences are employed. And therefore it follows that it is in the relationship that they can best be observed and described.

A lot has been written about the theory and practice of psychoanalysis, but very little about the actual process. What has been written tends to be in many instances embedded in either theoretical or clinical case discussions.

It has been claimed by Malan (1979) that to be a therapist or an analyst cannot be learned from books. The clinician relies heavily on what is called clinical judgement which is something acquired through experience. The experience is likened to a process of programming a computer. At the same time Malan feels that the process of becoming a clinician is essentially intuitive and subconscious. In actual practice the training of therapists and analysts happens in three ways. Firstly every candidate in training is required to undergo his/her own training analysis. Secondly he/she participates in theoretical seminars, where the emphasis is on intellectual understanding. Finally the candidate will during his/her training treat a number of patients under supervision. Thus, in practice, how this clinical judgement comes into being, happens mostly during one-to-one contact between the candidate and his/her analyst and between candidate and his/her supervisor. Similarly the first patients act as teachers as much as they serve as patients for the candidate. It could be argued that the art of psychoanalysis is passed on as a kind of oral tradition.

This explains something of the elusive nature of this relationship. It is very difficult to get a clear answer to the question 'What does the clinician actually do?' and 'what actually happens in therapy?'. Many things can be said in answer to these questions, for example it has been claimed that, the activity of psychoanalysis, be it practised by a therapist or an analyst, is about seeking ***the truth*** about an individual. However it is a particular kind of truth, an intra psychic truth, which furthermore can only be reached, not by the analyst imparting information, but a truth that emerges ***between*** the analyst/therapist and the patient. This is felt to be a very potent 'truth', it is a new understanding, which changes preconceptions held by both. It is a renegotiation of meaning, which takes place as the patient gets in touch with as much of his true feelings as he can bear. The 'truth' is the representation of the unconscious.

A 'gap' has been created in the conceptualisation of the neurotic patient, as Lacan(1977) puts it. This gap is what separates the individual's perception of himself, from a realistic view of who he/she truly is. For instance the depressive tends to experience him/her self as inappropriately worthless, or someone using omnipotent defences, may experience him/her self in inappropriately grandiose terms. Thus one of the primary tasks of therapy will be to expose this gap.

In practice psychoanalytic discourse involves two people, one the helper the other one with a complaint, which is generally badly understood initially by both, certainly anxiety producing and puzzling for the patient. There is also a theoretical idea more or less formulated in the clinicians mind about the problems, which the patient is experiencing. The theoretical formulation acts as a hypothesis, which almost universally needs revising as the treatment progresses. The one theoretical assumption, which is however relied upon, is that there are ***unconscious determinants*** behind the patient's suffering, and the task is to find these and to bring them into consciousness.

Sigmund Freud developed the idea of unconscious determinism, that is, he claimed that the acts, which we attribute to free will, are in fact obeying unconscious directives. Thus in principle everything is subject ultimately to interpretation. However this process is further complicated by the fact that a mere intellectual

understanding will not help the patient. The content of his/her unconscious needs to be brought to his/her attention in such a way that it can be used and assimilated by the patient. It has to ultimately ***feel*** right.

What gets in the way of this understanding are the same processes which led to the initial 'unawareness' in the first place. The truth, which cannot be seen, has at some time been associated with such difficult feelings that it had to be pushed out of conscious awareness. Thus these same feelings have to be negotiated again before the new meaning, or the original meaning can emerge.

The patient will ***defend*** in any way he can against the emergence of the feelings, usually anxiety, associated with the 'truth'. For instance the Lacanian analyst, following the thinking of Jaques Lacan, claims to operate as the sole intermediary of the truth. This means the analyst does not attend to the content of the patient's discourse itself, but to rents or gaps in it, and thereby discovering 'formations of the unconscious'. The analyst is primarily the listener, he/she is the one whom the analysand addresses in order to have the truth of his/her message recognised. The listening process will be discussed in more detail later. Lacan reformulated Sigmund Freud's original work by focusing on language. He formulated the idea that the unconscious is structured like a language.
Thus he claims

> 'Analysis can have for its goal only the advent of a true speech and the realisation by the subject of his history in relation to a future.' Lacan (1977)

Some theorists, for example Wilhelm Reich (1950), felt that the task of the clinician to 'cure' the adult patient is in fact impossible. He felt that:'Once a tree has grown crooked, you can't straighten it out'. He saw the main task of psychoanalysis as preventive. Increasingly some later thinkers such as Michael Balint (1968) have recognised that for the troubled individual there will always remain feelings and aspects of the personality, which he/she just cannot change. Balint calls this the area of the 'Basic Fault'. The Basic Fault needs however to be exposed, and with the help of the analyst this basic fault can gradually take on new meaning, and can in fact become

the source of new creativity. However the discovery of, be it, the Gap or the Basic Fault is highly traumatic, and always involves mourning for the lost illusory state. Donald Meltzer (1967) considers that it is this capacity to ultimately take responsibility for one's psychic reality, which is the goal of psychoanalysis. This involves primarily a reworking through of the depressive position, a realistic perception of one's own destructiveness, followed by reparation. Part of the working through of the depressive position always involves mourning for lost opportunities and a giving up of defensive inaccurate self-perceptions.

The task of the clinician is many fold: to bring to awareness the hidden truth, and at the same time to alleviate the accompanying feelings, so that the truth can be used by the patient. The different schools of thought differ in how they try to alleviate the intense feelings. In the classical tradition the practitioner concentrates on creating a warm and supportive relationship so that this relationship can in itself support the patient, when the clinician interprets what he/she feels the patient is avoiding. Sandor Ferenczi (1932), an early controversial follower of Freud, even suggested that the most important ingredient in the analytic relationship was the establishment of a relationship of trust and sincerity. The analyst may have to even reveal his/her own thought processes, in particular in connection to errors, in order to avoid 'professional hypocrisy', and thus deepen the trust between patient and analyst. Ferenczi felt that, if this aspect was not attended to, the danger was that the analyst would appear as just another, uncaring individual in the patient's life, and thus perpetuating the original pathogenic situation.

In the Kleinian tradition it is felt that the alleviation of anxiety is accomplished by interpretation alone: the therapist is felt to provide ego support by being able to speak to the parts of the personality which is most hidden, a kind of breaking the isolation of the deepest layers of the self.

Whichever school of psychoanalytic thought you adhere to, it is felt that the raison d'être for troublesome symptoms disappears once the 'truth' is again known. The

symptom has been a disguised form of the truth in the first place. The situation is however rarely this straight forward in practise.

The central tool available for the therapist is the interpretation, or it may be more correct to call it 'the interpretation process' as it may include many preparatory steps, such as clarifications, timing etc. The process of interpreting is a difficult one as the discussion above shows. It is not easy for the patient to accept even the most accurate of interpretations. Sigmund Freud writes about this problem in the 'Question of Lay analysis':

> 'When you [the analyst] have found the right interpretation, another task lies ahead. You must wait for the right moment at which you can communicate your interpretation to the patient with some prospect of success. How can one always tell the right moment?
> That is a question of tact, which can become more refined with experience. You will be making a bad mistake if, in an effort perhaps to shorten the analysis, you throw your interpretations at the patient's head as soon as you have found them. In that way you will draw expressions of resistance, rejection and indignation from him; but you will not enable his ego to master his repressed material. The formula is: to wait till he has come so near to the repressed material that he has only a few more steps to take under the lead of the interpretation you propose.' (Freud 1926)

Reich (1950), similarly describes this difficulty the therapist has in so to speak selling the interpretation to the patient, as follows:

> 'The rule that the making conscious of unconscious has to take place not directly, but by elimination of resistances. That is, the patient must first find out that he is defending himself, then by what means, and finally against what. It is this work of making things conscious which is called interpretation.'

Elsewhere Reich discusses the conditions, which make an interpretation therapeutically effective. He claims that they are different from case to case, and although they lead to certain valid technical generalisations, these mean little compared with the basic principle that that the technique in every individual case has to be derived from the individual case and from each individual situation.'

Central to the understanding of the psychoanalytic process is the understanding the listening, which the therapist is engaged in. Sigmund Freud already addressed this issue when he stated that the analyst must listen with 'evenly suspended attention' (Freud 1912). This means without preconceptions, or expectations. Theodor Reik (1948) called it 'listening with the third ear'. The aim is to catch the passing glimpses of unconscious elements in the patient's communication. The patients will try at least sometimes, to express things that are at the boundaries of their conscious awareness and of which they have little previous experience articulating. In addition, some patients will systematically lack the concepts necessary to grasp the significance of important aspects of their experience. Psychosomatic patients, for instance, have been said to have poorly developed emotional concepts. Further a patient's motivation to communicate may be variable, some material may for instance feel too embarrassing to communicate. Thus the therapist has to develop a capacity not only to attend to the manifest content of the material, but also sensitivity to these other possible aspects. The therapist will pay attention to such things as voice quality, movement and posture of the patient, slips of the tongue, frequency of topics etc.

Out of this process of listening, then arises the 'interpretation' and, as already mentioned, Sigmund Freud (1926) stressed that, how and when the interpretation is presented is crucial to whether the patient is able to accept and use the interpretation. An interpretation has to have primarily an emotional impact. Sandler and Sandler (1978) have claimed that, an experience only has or retains meaning for the child if it is linked with feeling. The assumption is made that ultimately all meaning is developmentally and functionally related to states of feeling, and that an experience which does not have some relation to feeling states has no psychological significance for the individual at all.

What the psychoanalytic process aims to produce is insight. Frequently what is needed, in addition to the actual interpretation, is preparation for the interpretation, in the form of confrontation and clarification. In order for the interpretation or insight to have the desired effect a period of working through is necessary, which means basically that the

same insight has to be arrived at over and over again. Rycroft (1958) has described the process of interpreting as follows:

> 'The analyst invites the patient to talk to him, listens, and from time to time talks himself. When he talks, he talks neither to himself nor about himself qua himself, but to the patient about himself. His purpose in doing so is to enlarge the patient's self-awareness by drawing his attention to certain ideas and feelings which the patient has not explicitly communicated but which are nonetheless part of and relevant to his present psychological state.
> These ideas which the analyst is able to observe and formulate because they are implicit in what the patient has said or in the way in which the patient has said it, have either been unconscious, or, if they have been conscious, it has been without any awareness of their present and immediate relevance. In other words, the analyst seeks to widen the patient's endopsychic perceptual field by informing him of details and relations within the total configuration of his present mental activity which for defensive reasons he is unable to perceive or communicate himself.'

Susan Isaacs (1939), in discussing the process of interpretation, took the view that the good analyst, by virtue of his training, used interpretations as 'scientific hypothesis concerning the patient's functioning'. She says that:

> 'This becoming aware of the deeper meaning of the patient's material is sometimes described as intuition. I prefer to avoid this term because of its mystical connotation. The process of understanding may be largely unconscious but it is not mystical. It is better described as perception. We perceive the unconscious meaning of the patient's words and conduct, this as an objective process. Our ability to see it depends... on a wealth of processes in ourselves, partly conscious and partly unconscious. But it is an objective perception of what is in the patient, and it is based on actual data.'.

The psychoanalytic interpretation attempts to connect the sphere of basic emotional experience to consciousness and sometimes to the patient's history.

Balint (1968) discusses therapeutic change as follows:

> 'Therapeutic change as a consequence of analysis depends, to a large degree, on the provision of a structured and organised conceptual and affective framework within which the patient can effectively place himself and his subjective experience of himself and others'.

The above quotes demonstrate something of the fact that, how the theory and the practice of psychoanalysis converge tends to elude description. Many attempts have been made, but it appears that to truly appreciate the nature of this process one has to participate in it as either a clinician or as a patient. What exactly causes change is equally elusive, for the same reasons that the actual *process* of psychoanalysis is so difficult to describe. What appears to be clear however is that the therapist/analyst is trying to create new meaning out of old, and this work involves negotiating the defensive style of the patient and thus reaching the unconscious meaning, or the Truth, the Gap and the Basic Fault.

Maybe this elusive nature of what actually happens in the consulting room may go somewhere towards explaining the emergence of significant conflicts and divergences in thinking between the different founding figures of psychoanalysis.

All modern psychoanalysis is based on the work of Sigmund Freud,in so far that the aim of all psychoanalysis is to explore the Unconscious. Over time however important differences have emerged.
Sigmund Freud's theory can be described as a 'drive- theory'. The drive is a concept on the frontier between the psychic and the somatic. It is the drive, which is the activator of the psychic apparatus. Objects are for Freud 'a means to an end', and not primary in them selves. Thus the individual seeks to satisfy his drives by means of object relations. The Libido is central although later Freud also recognized the existence of a death-drive.
From these basic assumptions arose the complex theoretical structures and techniques. The role and presentation of defence mechanisms is closely tied to the basic assumptions held by the practitioner as has been discussed in sections **2.4.** and **2.5.**

According to Couch (1995), Anna Freud followed her fathers thinking closely. She was the first one to catalogue defences in a more systematic fashion as described in section **2.2.** Anna Freud was one of the pioneers of Child analysis and as such she introduced some modification of technique, as Anna Freud felt that the child was still too close to the family of origin to receive verbal interpretation, thus play was used

instead. Theoretically Anna Freud did not introduce anything that conflicted with her father's assumptions.

Jaques Lacan's notion of the Unconscious structured as a language has meant that he developed a unique type of psychoanalysis, with a technique derived from the above assumption. The language it self, which he uses to describe his work, has often felt rather alien and difficult for other European and American practitioners. At the same time Lacan insisted that he was a true Freudian. In fact the Lacanian elaboration of the unconscious is according to Filip Geerardyn (1997) 'not to be understood as a kind of *deus ex machina*, but witnesses, time and again, a rigorous discipline in revisiting Sigmund Freud's writings'. Lacan's basic assumptions led him to elaborate on Sigmund Freud's original understanding of child development and he also introduced the concept of 'The Other', without whom the 'Gap' cannot emerge. The Psychoanalytic community has responded often in a hostile manner to Lacan's contributions.

Melanie Klein's contribution meant finally a significant shift away from some of the basic assumptions introduced by Sigmund Freud. Although Melanie Klein also saw herself as rigorously following Sigmund Freud, her work with children led her away from a 'drive-theory' model. As described, in section **2.3.** the libido is felt to be primarily object-seeking from the start which is different from drives seeking discharge. This shift had also technical implications as well as theoretical ones. These changes meant an inevitable rivalry between Melanie Klein and Anna Freud that gradually spread and created major splits in the psychoanalytical community as a whole.

These conflicts and tensions, which have arisen in the psychoanalytic community, may in them selves have contributed to the lack of clarity of concepts such as are the subject of this thesis.

It is exactly this complex psycho-analytic process that this thesis will examine by the use of methodology adapted from decision-making analysis. This methodology called 'argumatics', will be described in the following section.

2.7. Argumatics as a basis for interaction/process analysis in psychotherapy analysis

This section outlines the theoretical background to the methodology adapted for the purposes of this study.

When a patient presents for psychotherapy, he/she tells a 'story' about his/her difficulties. When we examine people's accounts as stories about what is wrong, we inevitably analyse their explanations of the situation. In giving such explanations, people use a series of claims and counter claims in their attempts to justify why their story must be accepted by the listener as true. In therapy, patients' Claims then give rise to the therapists' 'Challenges'. The therapists, puts forward counter claims or challenges, which the therapists in turn try to justify and expect the patients to consider. Thus, both the patients' and the therapists' communications can be seen as a story-like explanations which consist of series of claims or challenges; if the 'listener' accepts these claims or challenges she/he also gives legitimacy to the claim or challenge.

As Antaki & Leuder (1992) have suggested, explanations can have argumentative functions. The persuasiveness of explanations in people's argumentation can be understood when considering that, when reasoning and arguing, people strive to support their claims/challenges and make them acceptable to their audience. The present study of patients in therapy will show how they discuss their difficulties by using a series of claims and counterclaims, as well as reasons supporting these claims. Such therapeutic discourses can be seen as consisting of various elements which have an argumentative function, in the sense that, when offering these explanations, patients and therapists in turn are concerned to justify their statements and thus have their account accepted. Similarly the therapists advance their interventions in discussions with patients using claims and counterclaims.

The term 'argumentation' alludes to verbal activity consisting of a constellation of statements aiming to justify or refute a certain opinion and persuade an audience. van Eemeren et al., (1987). The manner in which these statements are ordered within the discursive text constitutes the argumentational structure of that text. Even though the field of argumentational research is characterised by the presence of different theories, a recurrent preoccupation of this field has been an attempt to draw a distinction between sound and unsound argumentation, or the need to be making sense; this difficulty is associated with the fact that different theories have divergent conceptions regarding what 'argumentation soundness' is.

The study of argumentation has typically centred either on the interaction between two people having an argument (i.e. discussion debate), or on written texts where a person makes a speech or produces an editorial (van Eemeren et. al. 1997). This alternative focus also reflects the different senses in which the term 'argument' has been used by researchers. On the one hand, argument has been approached as a process; in this case, research has focused on understanding the elements embedded in the process of persuasion between two participant roles (i.e. arguer and opponent, in this case patient and therapist). On the other hand the perspective of argument as a *product* entails looking at the set of elements (i.e. premises and conclusions).

In this study we will assume that therapeutic discourse founded on the notion of 'the talking cure' can be understood as a form of argumentation. In an argument like in therapy the two opponents seek either to have their views confirmed or an alteration takes place as the two opponents influence each other and new meaning is created, a new truth is discovered. Thus therapy can be seen as having its roots in ancient Greece.

In the fifth century BC the citizens were offered the opportunity to express their opinions and to provide arguments for their opinions (Benoit, 1992). Within the context, where people had to defend their opinions by providing arguments for them, or had to compare arguments for opposing viewpoints, questions regarding what constitutes a 'good' and 'effective' argument became very important. These questions were crystallised out in classic logic, dialectic and rhetoric, which was developed as a

means of assisting people to make speeches and develop persuasive arguments. Awareness of rhetoric and persuasion was increased even further through the Sophists, who developed the techniques of persuasion and argumentation for instructional purposes. However, the most significant contribution to argumentation, at the time, was the one made by Aristotele, who developed a theory of reasoning.

Aristotle's primary assumption was that existing knowledge and opinions constitute the material on the basis of which people arrive at new opinions during argumentation and reasoning (van Eemeren et al., 1987). He proposed that two types of reasoning may be used for this: inductive and deductive reasoning. In attempting to draw a distinction between sound and unsound argumentation, he developed a theory of syllogism, which would make possible the testing of the validity of deductive argumentation. According to Aristotele, the syllogism is an argument consisting of a *major* premise, a *minor* premise and a *conclusion*. For instance the combination of the minor premise ' Socrates is a man' and of the major premise 'all men are mortal' gives the conclusion that ' Socrates is mortal'. If the two premises are true then the conclusion is also true. As a complement to his study of sound argumentation, Aristotle also provided a systematic catalogue of *fallacies*, which are forms of unsound argumentation.

Modern studies on argumentation pointed out the limitations of formal logic and challenged its appropriateness for the analysis of everyday argumentation practises, since assessment of ordinary arguments necessitated their 'translation' into logical standard forms (Benoit, 1992). Even though this paradigm on argumentation research did not separate itself completely from the classical tradition, it nevertheless brought to the fore a new approach to logic. This approach has often been referred to as *informal logic* and has focused on everyday argumentation. Its point of departure from formal logic is that, while the standard of validity is clear and relatively unequivocal, it's difficult to apply to real arguments (Antaki, 1994). On the contrary, in everyday life, formally 'invalid' arguments have often been found to be quite reasonable as a basis for practical decisions.

The present state of affairs in argumentation theory is characterised by the presence of a variety of theories and models of argumentation, which often differ in scope and

degree of refinement, as well as in the definition of the norms of rationality according to which the soundness of a given argument is assessed (van Eemeren 1987). The most influential work in this realm of research has been Perelman and Olbrechts-Tyteca's New Rhetoric and Toulmin's The Uses of Argument. What is common in both works is their focus on an interactional view of argument and their challenge of formal logic as a serious attempt to describe human arguing.

Perlman and Olbrechts-Tyteca (1970) developed an argumentation theory, which they termed 'New Rhetoric' which pinpointed the limited applicability of formal logic as a model for value judgements in everyday argumentation. Their theory stresses the role of the audience in argumentation, by attributing the soundness of an argument to the audience for which it is intended. Since, in informal logic, neither absolute truth nor validity exists in rhetorical argumentation, appeals to reason are appeals to the adherence of the audience (Levine, 1991). The aim of argumentation is not considered to prove the truth of the conclusion from the premises, but to relate the premises and the claim of an argument in such a way that 'the acceptance of the data can be transferred to the claim' (Benoit 1992; p.63). New Rhetoric offers a distinction between different sorts of audiences (universal vs. particular), different classes of premises, as well as between different types of argument, which may be successful in practice.

According to Perelman and 0lbrechts-Tyteca, there are two types of premises: (a) premises, related to reality, which consist of facts, truths and presumptions on the basis of which a particular claim is asserted by a 'universal' audience, and (b) premises related to preferences, which comprise abstract values, hierarchies of values and what is preferable to a specific audience (Perelman & 0lbrechts-Tyteca 1958). Even though the New Rhetoric claimed to provide a systematic description of the discourse techniques enabling more effective argumentation, the systemacity and clarity of this description has been questioned (van Eemeren et al., 1987). Moreover, according to Perleman & 0lbrechts-Tyteca (1970) the proposed techniques of argumentation are attuned to the audience to which the person's argument is addressed, and from which approval is sought. However, the authors fail to provide explanations regarding how a particular arguer, in his/her attempt to construct an

effective (i.e. persuasive) argument becomes aware of the premises espoused by the audience (van Eemeren et al., 1987).

Toulmin's layout of Argument Structure

Up to the present time, Toulmin's model for reproducing the structure of an argument, which was proposed in his book Uses of Argument, is the model which has received the most attention in the field of argument research, is cited in all serious handbooks of argumentation and has become the most influential framework for further research in this field as an aid in construing, analysing and evaluating arguments. While New Rhetoric has adopted a descriptive perspective on argumentation, Toulmin's interest when generating a schematic illustration of the argumentational structure was to prepare the argument for a critical evaluation, as well as distinguishing between sound and unsound argumentation (Ball, 1994). As Toulmin himself claims, his focus is to discover.

> 'how [..] to set out and analyse arguments in order that our assessments shall be logically candid [..] that is, to make clear the functions of different propositions invoked in the course of an argument' (Toulmin, 1958).

According to Toulmin, argumentation refers to an activity of making claims, challenging them, backing them by providing reasons, criticising those reasons and rebutting those criticisms (Toulmin et al., 1979). Toulmin based his model on the discipline of jurisprudence as more representative of ordinary arguments than classical syllogistic structures. A central feature of his work is that the criteria upon which the soundness of an argument depends lie on the nature of the problem to which the argumentation relates, and that the criteria of formal validity and analyticity as employed by formal logic are of little value in the assessment of everyday argumentation.

Toulmin questioned the adequacy of the traditional layout of an argument (i.e. major premise, minor premise, conclusion), as proposed by Aristotele, and advocated a more elaborate layout, which would permit a more 'candid' analysis of arguments. In

specific, while argumentation research has traditionally distinguished two functional roles for argumentative statements (i.e., premises-conclusion), Toulmin advocates that an argument is structured in terms of six functional elements; data, claims, warrants, backings qualifiers and rebuttals. Since, according to Toulmin (1958), there are no universal or absolute norms for assessing argumentation, the authority of the warrant is derived from the backing, the content of which depends on the subject of the argumentation. In this sense the criteria for assessing a particular argument are *field-dependent* and need to be established by persons possessing expertise in the particular field. According to van Eemeren et al. (1987), the concept of 'field-dependent' backing in his model is supposed to bridge the chasm, which separates the premises and the conclusion of arguments in the formal logic.

Toulmin centred his attention on the argumentative function, rather than the argumentative form. This means that his model focuses on *the functional relationships among parts of an argument* as an alternative to the traditional approach which, had been concerned primarily with the formal relationships of these parts (van Eemeren et al., 1987). Following this line of reasoning, understanding the structure of arguments in texts necessitates an understanding of the functional roles of the statements included in the argument in the course of the argumentation process (Freeman, 1991). In this respect he has incorporated into his model a number of questions which are asked as a means of distinguishing between the different functions fulfilled by the statements entailing in the argument; in this sense Toulmin's model provides a 'dialectical' analysis of an argument, since it places an argumentative text into the context of the arguer's effort to convince the listener (van Eemeren et al., 1993). In the meantime, the model allows a description of a particular argument as a product (i.e. a specific set of statements used in the employee's utterances), while taking into consideration that this argument evolves through an argumentative (i.e. question response) process.

For Toulmin, argumentation is a movement from accepted **Data** through a **Warrant** (or **Backing**) to a **Claim**. The nature of Data, Warrants, Backings and Claims as adapted for this study will be described in detail in the next chapter.

Inclusion of the above elements means that the individuals in question are constructing a complete argument. However, the structure of an argument may not be fully presented on each occasion. In ordinary language, it is possible that we find some elements of an argument missing, since arguers, not being able to state everything pertinent to the case, necessarily leave much unstated. The missing elements of any particular argument may even be the ones that Toulmin considered to be basic and necessarily present in each argument; that is, the claim of the argument may be missing even though the arguer presents data and warrants for this (missing) claim or, the data, on the basis of which the main claim is stated, may not be reported explicitly; it may also be the case that the rule (i.e. warrant) which provides support to the claim and illustrates the link between the data and the claim is missing. These kinds of omissions are particularly prevalent in 'live interactions', such as the process of psychotherapy. These elements may be missing because the arguer considers them to be well known or assumed by the other party, and thus, s/he does not regard it necessary to refer to them explicitly in his/her attempt to persuade the other. Existing research has indicated that it has mainly been the 'because' part of the argument (either the warrant or the Backing) which is not stated explicitly (Marouda, 1995). As Govier (1987) claims, when presenting an argument, people do not always make references to their beliefs, which thus remain unstated, even though their truth is necessary for the components of the argument to hold together.

Acknowledging the particular and often messy nature ordinary argumentative discourse, we need to approach Toulmin's framework of argument structure as a model for a complete argument, which refers to elements, which may not be present in all cases, rather than attempting to find the various elements of the argument, as proposed by Toulmin, stated explicitly in any given argument. The fact that various elements of the argument may not be stated explicitly in any particular case calls for the researcher who is conducting the argumentational analysis, to infer the missing elements; this will make possible a clearer understanding of what the arguer actually meant when presenting his/her argument and, consequently, an evaluation of the merit of the particular argument. I believe that this task of inferring the missing parts of an argument, in the course of an argumentation analysis, is even more important in the case of warrants and backings, since they both serve as a support of the claim made. In

fact it is often in the warrant and the backing that we can trace the workings of the unconscious in general and its defensive activity in particular. In addition if they are missing and need to be inferred, this means that the conscious mind is not for what ever reason focusing on all elements of the argument and as a result of this 'unconscious interference' the resulting argument may lack significant coherence.

Toulmin's model has been widely used to as a tool for construing, analysing and evaluating arguments. Studies using argumentation analysis have often confined it to the *level of the text*, and so what has been explicitly presented in the context of a particular argument, which resulted in problems of identifying the various elements of the argumentative structure.

Going beyond the level of the text by taking into consideration the situational context within which a particular argument is situated (e.g. both in terms of the wider discourse, as well as the social situation which gives meaning to the discourse, the argumentation analyst will be in a better position to understand and analyse a presented argument). In this study we are looking at arguments and counter-arguments arising in the discourse between therapist and patient in a therapy situation. Thus we are looking at the presented arguments as they arise in a live **process** rather than pre-digested as they might occur in text. The context within which the arguments arise will be evident and will enable the researcher to make more informed choices when identifying the various structural elements of the argument.

2.8. The focus of the thesis

This thesis will not be an investigation of every defence mechanism evident in the process, but will cover a wide range, including many of the classic ones described by Sigmund and Anna Freud.

Of interest will also be the primitive mechanisms described by Melanie Klein. Although mechanisms identified later will also be included. The candidates of categories which will, as far as possible be identified and evaluated will include the following: denial, projection, externalisation, concrete thinking, destruction of

meaning, omnipotent thinking, displacement, introjection used defensively, reaction formation, identification with the aggressor.

The nature of the functioning of an individual using splitting is according to the literature characterised by *part-object functioning*. This means that the individual is in everyday language 'self centred' and relates to other people only in terms of what they can provide for him/her. Therefore suggestions of this type of functioning will be identified where possible. Omnipotent thinking will be examined where it occurs. The nature of the anxiety will be noted indicating whether we are dealing with primarily paranoid-schizoid thinking or if the defences are used in a more mature way on the threshold of the depressive position.

The converse of defence will also be examined. Classically, what is defended against is considered to be anything, which might give rise to unbearable anxiety. Thus the ability to experience anxiety and other feelings and to think about the situations giving rise to feelings is noted. Any expressions of less defended feeling and thinking are examined.

Melanie Klein postulated, as described in section **2.3**., that the maturation of the individual can be understood in terms of his/her defensive style. In other words if the patient is predominantly displaying primitive defences, giving rise to splitting, he/she is felt to display paranoid-schizoid features. On the other hand a more mature individual who has reached or is in the process of reaching the *depressive position*, will be using defences more flexibly and the primitive defences associated with splitting have largely been abandoned. The relationships of an individual who has reached the depressive position are importantly characterised by a *capacity for concern*. Thus any indication of an ability for concern will be noted. As mentioned above Melanie Klein further describes another defence or perhaps it would be more correct to call it a cluster of defences, under the heading of the m*anic defences*. These clusters of defences arise according to Klein as a defence against the pain associated with the depressive position thus located somewhere between the paranoid –schizoid and the depressive positions, any indications that manic defences might be used will

be noted. In conclusion, these theoretical notions will be identified and mapped onto the results of the analysis when or if appropriate.

This research focuses on what happens in the therapeutic relationship. The patterns, suggestive of underlying mechanisms will be synthesized on the basis of how they emerge in the **process** of argumentation in the therapeutic discourse and how they change or not as a result of the therapist's interpretations, challenges, or other interventions within this discourse. In brief how defence mechanisms play a part and are located in the discourse.

The settings, subjects and methodology relating to this research will be examined in detail, in the next chapter.

3. Setting subjects and methodology

This research attempts to map out and examine defences and defensive styles as expressed in brief psychotherapy. The changes or lack of change that may be a feature of the therapies lasting between 12 and 15 weeks will be examined. All patients were assessed as suitable for short-term psychotherapy, by psychiatrists and were suffering from acute distress.

This chapter describes the practical context of the therapies of each of the subjects. It gives the background information about the subjects, and relevant information about the therapists. It introduces the methodology employed in the detailed analysis in the results chapters.

3.1. The setting of the therapies.

The seven subjects/patients participating in this research were all receiving brief psychotherapy on the NHS, at hospitals in the London area. To preserve confidentiality the names of the patients were disguised but the hospitals retained their real names. Three subjects, Carol, Steven and Elisabeth were treated at St. Thomas's hospital in London. These patients were receiving, fifteen sessions of Cognative Analytic Therapy. In practice the patient-therapist interaction resembles that of Brief Psychoanalytic Therapy, however additional methods are used, reflecting the underlying assumptions of this approach. Anthony Ryle (1992) a pioneer of Cognative Analytic Therapy, describes the clinical practice of CAT as follows:

> 'The clinical practice of Cognative Analytic Therapy reflects the assumption that maladaptive procedures and failures of integration are self-perpetuating due to the continuing elicitation of reciprocal roles from others which seem to confirm existing patterns and to the absence of accurate self observation and of an integrative understanding of the self. The reformulation of patients' difficulties, carried out with the patient's active participation, is central to the approach. The aim is to produce a precise verbal and diagrammatic description of recurrent damaging procedures. The patient learns to use these descriptions through active self-observation and through their manifestations in the therapy relationship and as recognition becomes more reliable, control and choice are established'.

The three patients from St. Thomas's were treated by two CAT trained therapists, therapist J. and A., under supervision from a senior colleague. The patients were invited for a follow-up session between three to six months after the ending of their therapy.

The remaining four patients, John, Mary, George and Andrew were treated with Brief Psychoanalytic Psychotherapy at the Cassell hospital in Ham, Richmond. These patients were offered twelve sessions of Brief Psychoanalytic Psychotherapy, employing the 'Focal' technique. This means that although the technique employed by the therapist is firmly based in Psychoanalysis, a 'focus' is identified early in therapy. This 'focus' is a formulation reflecting one or more of the patient's core difficulties. Malan (1975), describes it as follows:

> 'The therapist keeps in mind an aim or 'focus' which should ideally be formulated in terms of an essential interpretation on which therapy is to be based. He/She pursues this focus single-mindedly; he/she guides the patient towards it by partial interpretations, selective attention, and selective neglect. If the material admits of more than one interpretation he always chooses that which is consonant with the focus, and he/she refuses to be diverted by material apparently irrelevant to the focus'. The early sessions are felt to be particularly important. It is in the initial interview and in the early sessions that the early interaction between patient and therapist crystallises into a 'focus' on which most of the rest of the therapy is based.'

In practice however the focus tends to be more of a 'background guiding principle', rather than a hard and fast rule. This is particularly the case in the therapies included in this work. The four subjects/patients, who received Brief Psychoanalytic Psychotherapy, were treated at the Cassell hospital by three therapists, therapists K., I., and G., all medically qualified practitioners. Two of the therapists were psychotherapy registrars doing their nine months rotation as part of their psychiatric training. One of the therapists was a senior registrar also in training at the Institute of Psychoanalysis. All the cases were treated under supervision.

3.2. The subjects/patients and the therapies

The subjects were adults between the ages of 25 and 53. There were three women and four men. Their names have been changed for reasons of confidentiality. All of them had been referred by their GP, and had been assessed to be suitable for brief psychotherapy. Notes relating to their initial assessment were available for Carol, Elisabeth, Steven, John,

Mary, George and incomplete notes were available for Andrew. These can be found in appendix 1.
In addition the reformulations and diagrammatic representations of the three CAT patients were available. For Elisabeth and Steven therapist's 'good-bye' letters are also available. These can be found in appendix 2.

All the subjects were initially assessed by psychiatrists. At St. Thomas's hospital they were then transferred and the therapy was carried out by lay therapists, thus the initial assessment and subsequent therapy was not carried out by the same clinician. At the Cassell hospital the initial assessment and the therapy was carried out by the same therapist, in all cases except one. Due to a delay of some months between the initial assessment and the availability of a therapist, Andrew was assessed by someone other than his therapist.

Research interviews with all the subjects, were conducted by myself before therapy started but after the patient had been assessed to be suitable for brief psychotherapy. These interviews focused on how the subjects saw themselves and their difficulties. Similar interviews were conducted after the ending of therapy with Mary, Steven, John and George. The other subjects were either refusing to participate in an after-therapy interview or did not respond to requests to be interviewed for reasons unknown. Transcripts of these interviews can be found in appendix 3.

An independent assessment of transcribed sessions for each patient by a senior Kleinian psychoanalyst is also included. These can be found at the end of the results chapter for each patient. The independent assessments for each patient, were carried out by a senior psychoanalyst with no prior information about the subjects/patients. He was asked to comment on, what he felt was going on in the therapy process and also on how the patient was functioning in general.

3.3. Methodologies used in the analysis of the Psychoanalytic Discourse

Defences and defensive mechanisms have traditionally been described in Psychoanalysis descriptively, without reference to the **process** within which they occur. In other words the centrality of the discourse which gives rise to the defences has been neglected. Therefore it is the aim of this work to locate and describe the defensive mechanisms within the **process** that takes place between patient and therapist, to describe the psychotherapeutic discourse as it happens.

In this thesis the process is examined from a number of different angles. In each of the results chapters (chapter 4-10) there will first be a general introduction to each patient. Thereafter the transcripts of the psychotherapy sessions are analysed in a number of ways. Initially a subjective/intuitive analysis is offered as an introduction with reference to defences and defensive style employed by the patients in the interaction. A detailed argumatics analysis is carried out on 1-4 session per subject. The number of sessions analysed in detail was determined by how the typical mechanisms were presented in the different sessions and in order to demonstrate change in the pattern of defences when changes were felt to occur. If the defences did not significantly change over the therapy sessions it was felt that to analyse more than one session in depth, would not to provide new information.

The argumatics analysis shows the patients' and therapists' arguments and counter arguments as they unfold during the therapy process. A rotated histogram per subject showing changes in frequencies of important themes, or specific preoccupations is included in the results section for each subject. Finally the independent assessment by a senior Kleinian psychoanalyst of one session per subject is included in full in the results chapters for each subject.

Subjective/ intuitive analysis

This section serves as an introduction to the nature of the interaction between patient and therapist. The subjective/intuitive analysis involves identifying such issues as a patient using defences, or distinctly one-sided arguments, or demonstrating a tendency to destroy meaning by responding to a therapist intervention on a different level of abstraction etc. It was felt that the subjective/intuitive analysis closely mirrors the activity of a therapist in a session.

In addition the nature of the anxiety, or indeed any apparent lack of it, will be noted. In other words, does the anxiety displayed by the patient seem persecutory or depressive (as defined by Klein). Persecutory anxiety is closely linked to paranoid thinking, which in

turn is linked to an excessive and inappropriate fear for one's own safety in the absence of identifiable threats. In addition, any evidence of a capacity for concern, as expressed by the patient in terms of significant others is noted.

Argumatics methodology, as applied in the present study

Argumatics has been adapted for this research in order to identify defensive mechanisms and conversely also moments when the patients/subjects are able to think in a relatively undefended fashion. In addition the therapists' inputs have been examined in the same way. The argumatics analysis consists of examining the statements (Claims) that the patient makes and how these are supported, in other words what 'evidence' is used. In addition it may be significant to note what alternatives are discussed or not discussed and perhaps avoided? The argumatics analysis makes possible to expose the underlying logic of the arguments, or the underlying 'irrationality' of the arguments of both patient and therapist. This in turn enables conclusions to be drawn about the effects of defensive mechanisms employed by the patient or the therapist, in each patient/therapist pair.

In the detailed analysis for each patient an analysis is also carried out of the therapist's input, i.e. his/her challenges (Challenges) to the patient and how these are supported. Key sessions are looked at in greater detail. The conclusions are, when appropriate, cross-referenced with the independent psychoanalyst's evaluation. Additional information is used from other material, such as from initial assessment interviews and final interviews. In some cases additional material was available such as assessment notes, follow-up interview notes or written material used in the CAT therapies. When relevant these were referred to. Selected section of the transcripts were be analysed in detail using argumatics.

As described in the previous chapter, the techniques adapted for this research are based on argumatics as developed by Toulmin, and applications developed by Högberg (1984), for his study about the Swedish Energy Debate. Hogberg presented this as as a 'case study' using Toulmin's argumatics. In Toulmin's original schema, argumatics involves identifying how an argument (Claim) is constructed at any given time. By applying these techniques it is possible to examine the 'building blocks' of any argument both explicit and implicit. It is these 'building blocks' or components of argumentation, which Hogberg using Toulmin's original schema, worked out in detail. It is Hogberg's version of Toulmin's original set of categories, which form the basis for the argumatics framework in this study and will be described in detail in this chapter. All the included categories are Toulmin's/Hogberg's except for the category of 'Challenge'. This

additional category was introduced for this study as it was felt that this would more accurately reflect the nature of the interaction to be studied.

It is also possible using this method to identify what other factors in an argument may be ignored either consciously or unconsciously, in order to make the argument coherent.

The methodology which has been adapted for the purposes of this research was tested out by three researches acting as assessors in the trial of the methodology. One assessor had much experience but was unfamiliar with its use for the purpose of analysing clinical data, another assessor had some experience of the use of the methodology and with psychotherapeutic experience. The third assessor had psychotherapeutic experience but had no experience of using the methodology. The inexperienced assessor received detailed instructions in the use of the methodology. Two sessions were chosen at random from the data. These two sessions were then coded by each of the assessors independently. The results of this exercise showed a high degree of correlation. Differences occurred in the exact wordings used by the assessors of for instance implied communications by the patients and therapists, but the content of all the coded communication implicit and explicit, showed a high degree of correspondence.

In this way it was possible to achieve confirmation of reliability of coding from the consistency of the results of these assessors.

The analysis of the data in the transcripts, involves identifying the following components:

- *Claim(C)*

This is the output of an argument. It can be either explicit or implicit. It is the conclusive statement produced by the argumentation. A Claim may have a controversial nature and answers the question: WHAT ARE YOU TRYING TO SAY? That is, it is what the patient wants to put forward as his 'rational' conclusion. For instance a patient may say: My problems are of a physical origin.

- *Challenge (Ch)*

This is a statement or a suggestion made by one of the participants of an interaction, which challenges a held belief or a previously made Claim, the belief may be explicitly held or implicitly held. It follows an explicitly or implicitly stated: I HAVE REASON TO QUESTION..... For instance the therapist may in response to a Claim made by the patient say: 'It is not clear how you face your own doubts in life.

- *Data or Grounds (D)*

This may comprise experimental observations, matters of common knowledge, statistical data, personal statements, or other comparable 'factual Data'. It gives the answer to the question: WHAT DO YOU HAVE TO GO ON?

For instance a patient may offer as grounds for his statement that his problems are of a physical origin something like: My symptoms started after an infection.

That is (C) or a (Ch) is followed by (D), because of (D) therefore(C) or (Ch).

- *Warrant (W)*

The argument might appear a bit thin without additionally making the mental jump from (D) to (C) clear. That is the Warrant answers the question HOW DO YOU GET THERE? This authorising function of the Warrant can generally take the form of assumptions, regarding, for example: possibilities of generalisation, general laws of nature, statutes, models or rules. For instance the patient in the above examples may present as a Warrant for his statement that his problems are of a physical nature. Because my problems started when I had an infection it means that the problems are physical in nature. The Warrant can be either explicit or implicit.

(D) therefore (C) or (Ch) because of (W)

- *Backing (B)*

The Backing serves the purpose of increasing the credibility of the Warrant or directly the Claim. That is, it consists of statements that further build up and support the basic argument. It may draw on for the arguer unquestionable authority, such as God, generally accepted beliefs, or deeply held personal beliefs, which the arguer feels that the opponent will respect if not share. Backing has to do with the facts supporting the way of arguing, often expressed in the Warrant. The Warrants normally 'draw their strength and solidity from the further', substantial supporting consideration. The Backing can be either explicit or implicit. In the example used above statement such as: The doctor diagnosed me as having an infection, might serve as a Backing together with more implicit ones such as ' if I have been troubled ever since my infection *this indicates that my problems are physical in nature*. It can also represent a dialogue or the resulting values of previous dialogues with authorities, such as: we have all been taught the virtues of honesty, therefore one can assume that values relating to honesty are commonly held by the opponent. The Backing

may also consist of values not necessarily shared with the opponent but instead with an authority or a collective authority such as The Bible with an individual who is religious or past learning or experience with for instance a therapist, a dialogue with an 'internal supervisor'.

- *Rebuttal (R)*

The Rebuttal is made manifest by identifying extraordinary or exceptional circumstances that might undermine or weaken the force of the supporting arguments. It may also include alternative interpretations of the Data. This can be either explicit or implicit, but tends to remain implicit. The patient may make the Rebuttal explicit either in order to protect his original argument by as it were anticipating the weak points, or he may voice it as a result of the original argument weakening in his mind. The difference will become clear from the context. The Rebuttal could follow the phrases, 'UNLESS OR IF NOT'. The opponent when stating a Rebuttal, probably starts by saying something like 'yes but'. A Rebuttal for the patient may be something like: my problems are of a physical if the infection is still there in some form, but if the infection is cured my symptoms may indicate a psychological conflict.

- *Qualifier (Q)*

Qualifiers consist of phrases used to indicate strengths and limitations in the argument. HOW VALID IS THE REASONING? Expressions like 'certainly, presumably, maybe, plausibly' etc. often coupled by stating the conditions of validity of the proposed argument show that Qualifiers get into the argument. For instance, surely the fact that my problems started at the time of the infection means that....

- *Alternatives (A)*

Under this section alternative interpretations of the Data are listed, if you like alternative Claims. This category remains almost always unstated, because by its' nature it may undermine the argumentation. It can however be a category of great interest for the present research. For instance the patient may claim his symptoms are of a physical nature, because his problems started at the same time as he suffered an infection. The Alternative Claim may in fact be something like, 'although my symptoms started when I was ill they may still be of a psychological nature.' There may be many Alternatives. The Alternative is the exploration which may or may not be referred to but which does not take place.

Using this methodology it is possible to explore the degree of rigidity in the argumentation, that is are Rebuttals voiced. The nature of the Warrants and the Backings

used explicitly as opposed to implicitly, shows us something about how the patient is attempting to protect (defend) himself and his arguments. It is assumed that by using argumatics it is possible to pick up something about the nature of the defences, even if indirectly. This will be illustrated in detail with the first subject in chapter 4.

Defences and related mechanisms which will be identified in the process of psychotherapy

As described in chapter 2 the following categories have been proposed as candidates for identification as process patterns evident in psychotherapeutic discourse.

- *Concrete thinking*

Within psychoanalytic theory concrete thinking constitute both a form of denial and a form of destruction of meaning in a characteristically concrete fashion. It usually indicates that the individual functions on the paranoid-schizoid level. This will be identified from the context and from the argumatics analysis of the patient's main argument. That is the context, of what the patient is expected to think about, and from the nature of the patient's Claim and possibly also from the nature of the supporting Warrant and Data.

- *Projection*

Operation whereby qualities feelings, wishes etc, which the subject refuses to recognise or rejects in himself, are expelled from the self and located in another person or thing. Projection is a defence of primitive origin which may be seen at work in paranoia, but also in 'normal' modes of thought such as superstition. Projection is a form of displacement but more specific. Projection is often used to justify one's own feeling state, such as I don't need to worry about anything, because you have the problem. A form of Projection is called **projective identification,** where the subject projects a feeling state into somebody, and at the same time through subtle forms of behaviour forces the recipient to behave in accordance with the projected feelings.

In the analysis projection will be identified from the context and from the constituents of the argumatics analysis of the patient's main argument. In the preliminary trials of the methodology evidence of the fact that the communication was a projection was found in the Warrant or sometimes in the Backing.

- *Denial*

Denial can involve both denial of painful external issues and a denial of aspects of the self. In order to identify whether something like denial is taking place, the context needs to be identified. The context will be identified from either the therapist's input the Challenge, or from the patient's earlier input the Claim, that is what issue is the patient trying to address. The argument that, the patient puts forward in response to the therapist's Challenge, is analysed. The constituents of this argument show if denial is employed and how it is employed. Sometimes it is possible to use the patient's later arguments as additional evidence for the fact that denial has been used.

- *Destruction of Meaning*

Destruction of meaning might seem like a curious 'defence'. What could possibly be gained by destroying meaning? What is attempted here is the cutting of links of affect. The way this will be identified will be by finding a mismatch between the therapist's and the patient's communication. This will be done in the same way as in identifying denial, by the context and the content of the therapist's and the patient's communication dissected by argumatics.

A destruction of meaning can be seen when the patient insists on communicating or responding to the therapist by changing the level of abstraction. This changing of levels of abstraction can be seen as a mismatch between the patient's Claim and the therapist's Challenge. For example, the therapist may put forward a suggestion that the patient might have feelings about the late starting of the session. If the patient responds by discussing something unrelated or even discussing lateness in an unconnected way, then the meaning of the therapist's communication has been destroyed.

- *Omnipotent thinking*

Omnipotent thinking is characterised by a form of uncritical belief in ones own ability to perceive anything that can be perceived or think what can be thought about. There is a quality about this type of thinking which excludes the abilities of others to perceive or think. These instances will be identified from the context as described above and from the detailed dissection of the argument, which the patient is presenting. In the evaluation of the methodology it was found that the nature of this kind of argument could be identified in particular from the nature of the Backing.

- *Displacement*

This represents the notion that an idea's emphasis, interest or intensity is liable to be detached from it and passed onto other ideas, which were originally of little intensity but which are related to the first idea by a chain of associations. This occurs primarily in dreams, but also in for instance phobias. Laplanche and Pontalis argue that displacement has a clearly defensive function.

As in the above this will be identified from the context, and from the constituents of the patient's' argument as dissected by the argumatics analysis. Later communication by the patient, verifying the use of this mechanism will be used if available.

- *Reaction formation*

This means that the anxiety provoking thought or idea is turned into its opposite. This will be identified from the context and from the patient's Claim. Later communication by the patient verifying the use of this mechanism will be used if available.

- *Introjection /Internalisation*

This means that the subject transposes objects and their inherent qualities from the outside to the inside of himself. In its defensive capacity, introjection involves internalising, for instance a lost object, or defending against anxiety about one's internal states by introjecting the ' good object'. As above this will be identified from the context, the argumatics analysis and later confirmation from the patient if available.

- *Identification*

In a defensive sense this means that the object and the self are regarded as the same. The classical example of this is the identification with the aggressor. This will be identified from the context as above and from the dissection of the patient's main argument.

- *The Manic defences*

These are a clusters of defences employed specifically against the recognition of the qualities of the object. Klein locates theses as coming into play as a defence at the threshold of the depressive position. The important issue is to deny any feelings of dependence on the object. Thus a number of defensive strategies may come into play. However what distinguishes these as manic defences is what they are defending against. The context and the detailed dissection of the patient's arguments will make it possible to identify the important elements. Patient's later communication may give further confirmation to the conclusions drawn from the analysis.

Other aspects, which will be identified

In this context it is also important to describe what 'non pathological' functioning may look like. It is believed that this can also be described using argumatics. The following will be of interest:

- *Nature of anxiety*

As described by Melanie Klein the predominant anxiety in the paranoid-schizoid position is persecutory in nature, and in the depressive position of a depressive kind. Depressive anxiety has as a central feature that it encompasses concern for the object. The nature of anxiety will be judged from the argumatics analysis as and when appropriate. The nature of anxiety is apparent from the context as defined above and from the detailed dissection of the patient's communication.

- *Capacity to think/feel*

This final category includes moments when the patient explores in a relatively uninhibited way. These are moments when the patient can tolerate anxiety. Sandler & Sandler 1978 claim that a capacity to think is linked to a capacity to feel. Thus it is important to identify and describe moments in the patient's therapy when thinking and feeling are evident without an excessive need to defend against these. These may be just fleeting moments but will nevertheless possibly constitute movement in the therapy process. As above these can be identified from the context and from the argumatics dissection of the patient's contribution.

Histograms demonstrating major preoccupations of the patient's and degree of awareness of another person

In each of the chapters 4-10 a number of sessions for each patient will be further analysed in terms of how many statements the patient makes in relation to a number of relevant categories. Rotated histograms showing the changing concerns for each patient is included for each of the subjects in the results chapter for each patient. The following six categories are used for each patient:

- The patient demonstrates a capacity to reflect on his/her own feeling states. This tends to suggest that the patient can tolerate the confusion and ambiguity of such states rather than take refuge in, such things as, intellectualisations or projection etc.

- The therapist's suggestions are not considered, indicating possible persecutory anxiety, resistance, or a need to deny the relevance of what is being said.

- The therapist's suggestions are considered, indicating some willingness to co-operate. This suggests that the persecutory processes appear to be in some sense limited.

- Awareness of another person's situation is expressed, indicating a possible capacity for concern.

- Somebody is perceived as unhelpful/hostile, indicating possible persecutory anxiety, or paranoia.

- Somebody is perceived as helpful/kind, indicating the possible existence of some good internal objects, i.e. that the internal persecutory processes are in some sense limited.

In addition, further categories, specific to each individual patient, are added in order to reflect that patient's individual difficulties. These are categories similar to the above six in so far as they appear to reflect the nature of the anxiety and defensive styles of the patient. The specific categories relate to repeated references (or indeed sometimes the surprising absence of such references) to significant issues in the patient's life. These categories have been identified by reference to what has followed such introductory words as: I feel..., I think..., I am worried that..., It concerns me that.... These statements may or may not have been prompted by something the therapist has contributed.

The histograms are compiled by using frequency counts of how often the patients mentioned their major preoccupation and how often the patient mentioned significant others, ignores or acknowledges the therapist comments.

The independent Psychoanalytic Assessments for each patient

A senior psychoanalyst was given transcripts of one session per patient on which to comment, with regard to what he felt was going on and what defensive mechanisms were employed. This was done in order to bring in an additional dimension, similar to what happens in psychoanalytic supervision.

The next chapters 4-10 will present the results of the analysis for each patient, which will then be followed by a discussion of the finings in the later chapters.

4. Results: John

This chapter introduces the first one of the subjects. Included in this chapter are a short background to the patient, a subjective/intuitive analysis of selected sections of this patient's therapy sessions, a detailed argumatics analysis of sessions one, two six and eleven. The text in bold is the verbatum interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to maintain the authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in five selected session from the beginning, the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the the presented material is included with reference to before and after therapy interviews conducted with the patient for the purpose of this research. Transcripts of the before and after therapy interviews can be found in appendix 3. Notes on John's initial psychotherapy assessment can be found in appendix 1. The interview shedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of John's sessions of psychoanalytic psychotherapy are available on a CD-rom, appendix 5, available on request from the author.

4.1. John

John is a 44-year-old priest who was referred for psychotherapy because of panic attacks associated with tachycardia. He was referred to the Cassell hospital and underwent twelve session of brief psychoanalytic psychotherapy.

John presented as a pleasant, slightly chubby man. He was very concerned about a number of physical symptoms he had been experiencing. Medical investigations had not showed up anything significant. There had however been many important changes in his life lately. His mother had died, he had left his childhood home for the first time and he had joined the clergy. His relationship with a colleague was very difficult.

John was invited to talk about his life in the assessment meetings. He remembered his childhood as happy and uneventful. He and his brother and sister were adopted, John at the age of 2 months and his siblings also in infancy. He mentioned a desire to trace his

real parents but had so far done nothing about that as he felt his adopted parents would disapprove.

John admitted to being homosexual. He had in the past had a few short-term relationships, with men who later married. He maintained that his homosexuality did not cause him any problems, and added that sex was not something he was much concerned about. He entered theological college in his teens but failed important exams. Therefore John left to work for the railways, but returned to theology later and had only recently been ordained as a priest. The relationship with a senior college was frequently referred to during the initial interview. John felt great anger towards this colleague but felt unable to express it, 'in case it would kill' this man (give him a heart attack). John was offered 12 sessions of brief psychoanalytic psychotherapy.

Therapy

As John is the first subject his sessions are analysed in significant detail and the use of the methodology will be discussed as the analysis progresses. The events unfolding during John's therapy will become clear from the analysis and from the summary at the end of this chapter.

4.2.1. Session 1

Subjective/Intuitive analysis

The patient has been seen a few months earlier by the therapist for preliminary assessment interviews.

John starts the session by complaining about his symptoms; in fact within the first couple of minutes there is some suggestion of persecutory anxiety, expressed as inappropriate fear for his own safety.

Patient:'...and having unfortunately a very vivid memory of those things that particularly brought the tachycardia and the other nervous symptoms, whenever I'm in a similar situation they automatically come back. And so there's always now an anxiety about the next situation that's going to occur when those symptoms are going to appear.'

This may at first sight seem like an innocent remark but within the context of the patient having had repeated reassurance that his symptoms were not medically significant it appears that these remarks are more likely to be an expression, reflecting his emotional state.

The therapist is frequently in this session left with the task of bringing in the possibility that emotional factors are at play too. The therapist's comments however are greeted by more talk about symptoms. For instance the therapist points out that the patient seems to keep ideas of what may be physically based and what may have psychological bases as completely separate.

Therapist:'...you also distinguish something which you talk about this unbalanced sensation in your head which in a way you're presenting it as something that you feel is quite separate and I don't know whether your seeing it as something which we can discuss here or make sense of here or whether you're separating it out as something else completely.

Patient: Well, I see it as something, as quite separate, its interrelated because the tachycardia and umm the shaking and all that sort of thing and the hyperventilation, that was caused by stress. That seemed to go to my weakest point which was that sense of unbalance....'

The patient is doing two things, firstly, although paying some lip service to the therapist's suggestion, he is basically unable to entertain any possibility that deeper psychological reasons may be at play, and secondly destroys the line of enquiry that the therapist is attempting to introduce. Therefore it seems that denial and destruction of meaning are at play here.

Another example of destruction of meaning in the sense of not communicating on the same level of abstraction with his therapist can be found about 15 minutes into the session.

Therapist: 'I'm thinking this unbalanced sensation might have a psychological meaning to it. But I'm wondering about your, you feel a need or a wish to have something to hold on to, to deal with this unbalanced situation and I was wondering what you said when you came in first, it does not seem such a long time since we last met. I wonder what you might have had to hold on to deal with the unbalanced psychological situation.'

The therapist is in this instance trying to translate the patient's communication into something concerning the patient's internal world, not his concrete 'symptom filled world'. The patient responds by, as if, not understanding, and does in fact change the level of abstraction once again into something practical, and concrete. In the following manner:

Patient:'...since I last met you I've been on holiday and my own parish priest as you know resigned, and so when it came to conducting services I've been able to fashion the priest who has gone from the parish where I was had a thing about not using any

church furniture. He always wanted to be out in front, talking very directly as the man in charge. Whereas using church furniture in the natural way I'm never in a situation where if the room just suddenly gives a lurch there's just not something for me to hold on to while it passes and get on with it.'

Another example of the same occurs when the therapist about halfway through the session attempts to talk to the patient about his difficulties of considering emotional factors at all. The patient destroys this in the following manner:

Therapist: 'I'm aware how when I asked or commented in an open sort of way about perhaps there's something that might be psychological to hold on to, to deal with some sort of inner sensation of imbalance in your mind there's, it was very difficult for you to follow that possible psychological train of thought, that the symptoms, the physical explanations and ways of trying to think about dominate very much...'

Patient:' (Laughing) I suppose that was always being a great lover of chemistry at school. Whenever Dr. Francis has given me a drug he has always told me the physical processes by which they worked so I suppose it's because I can't understand the psychological road in the same sense that I can understand the physics road but it puts my mind to thinking of physical, one's mind would always go to the known rather than the unknown I think.'

The interaction continues in this fashion between the patient and the therapist. The therapist tries to talk about psychological aspects and the patient repudiates every attempt to create psychological meaning. Towards the end the therapist confronts the patient as follows:

Therapist:' I wonder how it was that you were able to deal with that sensible, rational way of looking at things and still come along here looking for some sort of psychological meaning to your life, what's been happening?'

Patient:' I suppose because my GP had, at the time of seeing my GP in Dover and then the GP here, the tachycardium and all the psychological reasons had taken such a grip they weren't too ready to grasp what the thing that triggered it all in the first place. But it's dragged on for so long now that even if Dr Frances could cure the physical imbalance overnight I'm sure that my reflex action, psychological action all the physical symptoms would still come back because they got so used to making their appearance. And my life
isn't such that I can do graduated things to get rid of it.'

The above statements by the patient are clearly very confused, and appear to be an attempt to answer the therapist's questions without actually addressing them. Which is in itself another way of destroying meaning.

In this session a battle has been set up in which the therapist is discussing one thing and the patient something else, but in order for this distortion to be maintained defences are employed over and over again. The exploration remains superficial on the part of the patient. In addition it is worth noting that no reference was made to any 'significant other', past or present in this session. The only other person mentioned in passing was the troublesome college.

4.2.2. *Argumatics analysis of session 1*

This analysis is an attempt to demonstrate the way in which meaning is negotiated in the session and how the defences come into play. This will be done taking selected vignette and analysing them one by one.

Patient: The first thing in the morning is the one time when I'm likely, when I wake up that there are none of these generalised nervous symptoms at all. And then when I get up they come on suddenly and they're then with me for the morning and the afternoon. And roundabout now, at this time of the day they often disappear altogether. And I don't know, but would it affect the fact that if I took medication in the form of Larazepam, which I do the first thing in the morning at about 8 o'clock, would that be through the system by say
the afternoon?

Therapist: I'm not sure that that sort of real question , you know, whether it makes sense for us here to get into talking about medication getting through the system and information I'm sure that perhaps your GP might give you, you've clearly distinguished something which you feel is psychological or has psychological roots.

Patient: Yes the effect of the last parish priest.

Therapist: and you also distinguish something which you talk about this unbalanced sensation in your head which in a way you are presenting it as something that you feel is quite separate and perhaps I don't know whether you are seeing it as something which we can discuss here or make sense of or whether you're separating it out as something else completely.

Patient: Well I see it as something as quite separate but it was that that brought all the other things on. So although it's separate it's inter-related because the tachycardia and the um shaking and all that sort of thing and the hyperventilation that was cause by stress last year, that, that seemed to go to my weakest point which was the sense of unbalance. But the sense of unbalance had been there at different times before any of this business occurred....

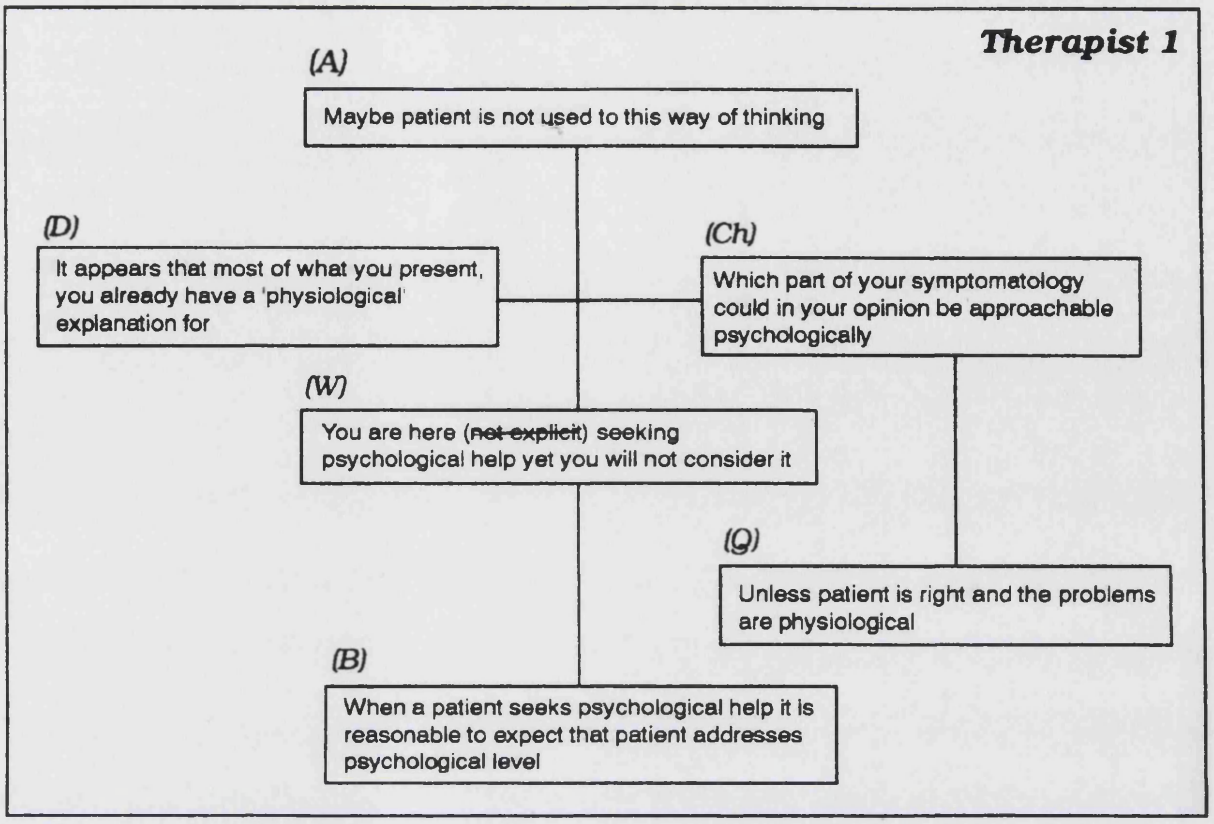


Diagram 1 - Therapist The Challenge that the therapist introduces is via a question: 'Which part is the patient prepared to entertain might have a psychological bases. The Data to this Challenge is the fact that from the material it appears that the patient already has got an explanation for his symptoms and that does appear to be physiological. The Warrant, although not verbalised here is that this patient has come for psychological help and yet does not appear to want to entertain anything psychological. The Backing similarly is not verbalised but could be that if a patient seeks psychotherapy it is reasonable to expect him to address himself to the psychological level. The Alternative could be: maybe that the patient cannot or is not used to thinking along these lines. The Qualifier: The patient may be right, in spite of contradictory evidence.

The therapist is challenging the patient to think again about what he is saying. The therapist is doing this by amplifying the concrete reasoning which the patient is introducing.

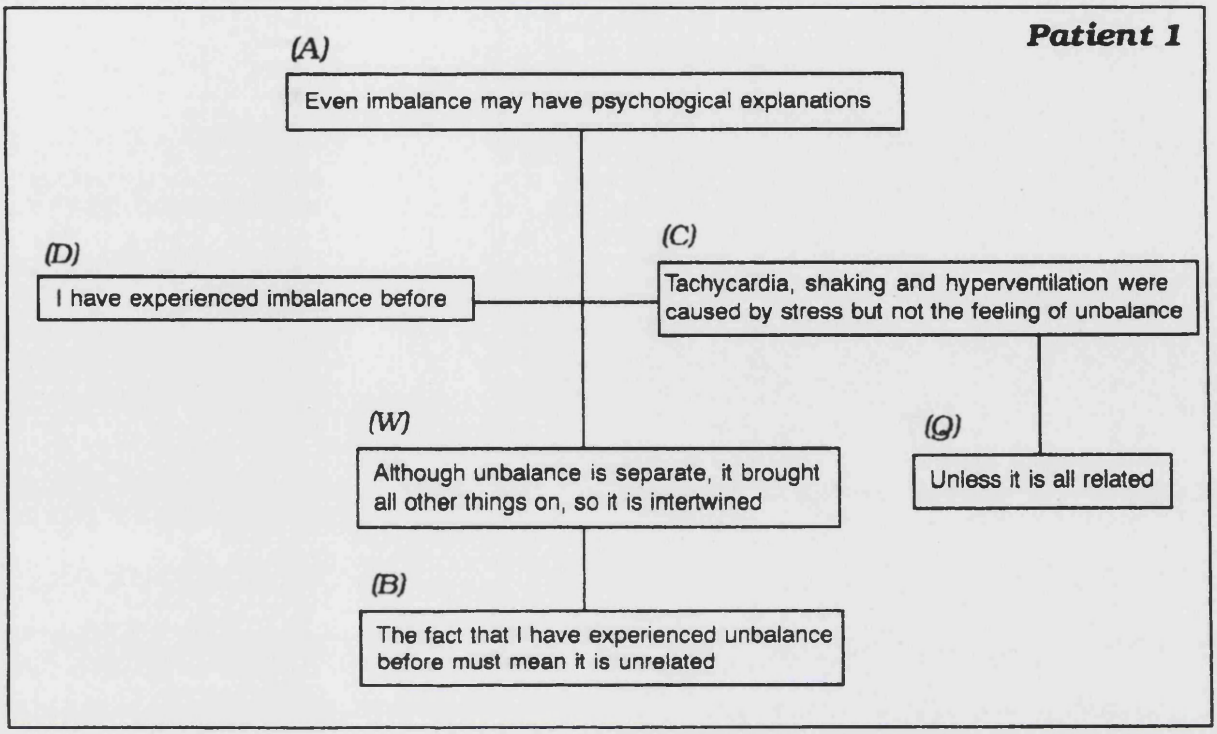


Diagram 1 - Patient The Claim is that the hyperventilation and shaking had been caused by stress (psychological) but the feeling of unbalance was not.

The evidence offered or the Data this Claim is based on, is that the patient had experienced feelings of unbalance before. The Warrant is that, 'although the feeling of unbalance are separate, it brought on the other things, so it is intertwined'. The Backing (not verbalised) is that as the patient had experienced unbalance before it must mean therefore that it has a different origin. The Alternative (not verbalised) is that there is a possibility that all the symptoms have a psychological origin. The Qualifier is that the symptoms listed are separate unless they are all related.

The patient is struggling to rise to the Challenge, which, the therapist has offered. That is, he tries to give an impression that they are 'speaking the same language'. He is answering the question put to him, but he is at the same time denying the existence of a psychological reality. His argument rests on very shaky ground, he argues, that because one symptom has existed previously this must necessarily mean that it is of a different origin now. Thus there is a denial of the possibility that it all could be of psychological origin, that is a Claim, which is made in the face of contradictory evidence. The Claim is poorly argued, that is without a solid Backing (which is either agreed between therapist and patient or generally accepted). Splitting is created between a concrete reality and a psychological reality. The analysis suggests that there is a mismatch in the communication as basic assumptions are not shared such as if one comes for

psychotherapy it is reasonable to think in terms of a psychological reality. Thus the thinking is concrete in nature.

Patient:....My main difficulty at the moment is because these physical unpleasantnesses occur I want in my heart of hearts to... to avoid the situations that occur that bring them on and that can be arranged but at the same time when the crunch comes and you really do have to do something that brings them on it's far worse than if you sort of dabble gently into the phobic area all the time and not let it totally take over. I don't know if when I last came to you I said that um one of the things I've become very uneasy about doing things that I haven't done for a long time. And so one would have been going into crowds, you know without a car, by public transport and that because of the feeling of unpleasantness, this unbalanced situation, so in the course....

Therapist: I am wondering about your phrase 'this unbalanced situation'. And I'm not thinking of it just in the physical sense. I mean that's what you were meaning this physical sense.

Patient: Yes.

Therapist: I'm thinking this unbalanced sensation that might have a psychological meaning to it. But I'm wondering about your, you feel a need or a wish to have something to hold onto, to deal with this unbalanced situation and I was wondering what you said when you came in at first, it doesn't such a long time since we last met in the summer. I wonder what you felt you might have had to hold on to to deal with the unbalanced psychological situation?

Patient think it's the fact that I've never in..., since I last met you I've been on holiday and my own parish priest as you know resigned, and so when it came to conducting services I've been able to fashion the priest who was gone from the parish where I was had a thing about not using any church furniture. He always wanted to be out in front, talking very directly as the man in charge, whereas using church furniture in the natural way I'm never in a situation where if the room just suddenly gives a lurch there's just not something for me to hold on to.... Where this feeling of unbalance first occurred it did happen to three other people at the same time because of the origin of it was in a germ that was going around....

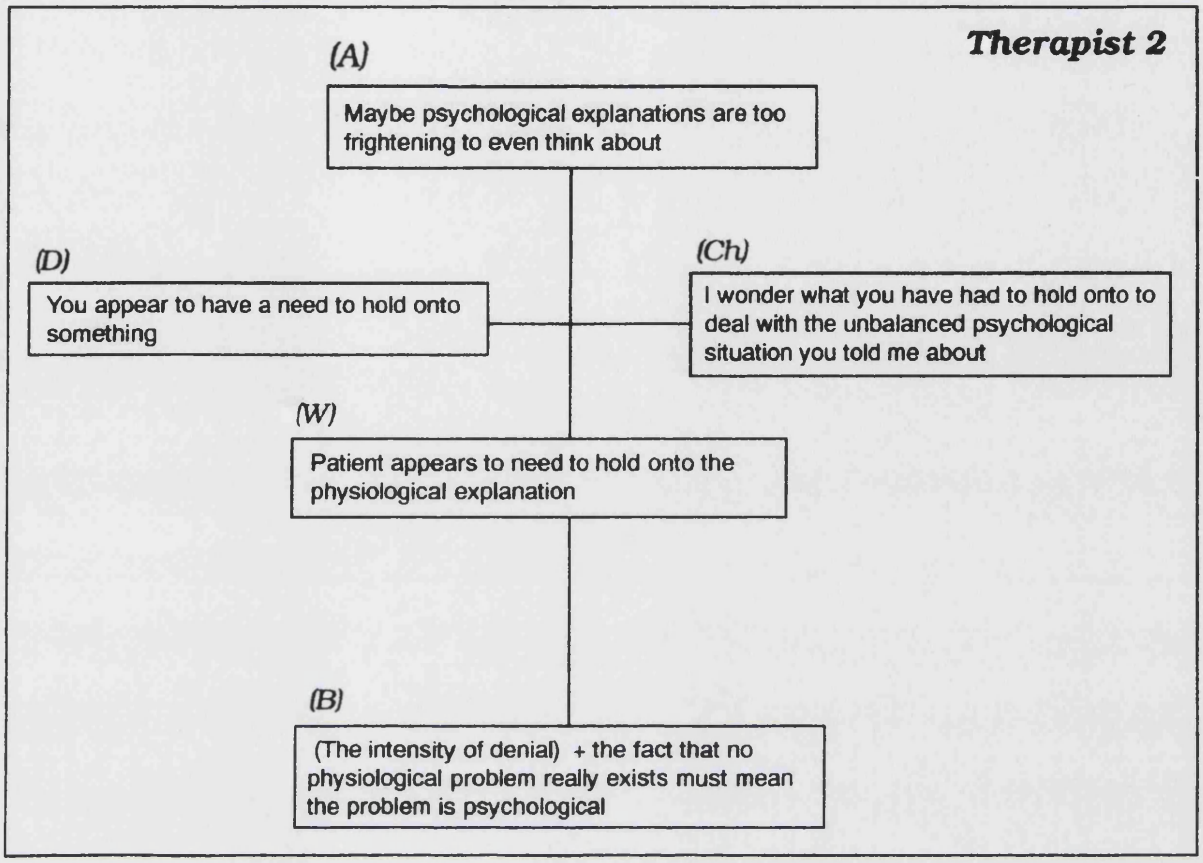


Diagram 2 - Therapist The Challenge posed by the therapist is that he wonders what actually the patient has had to hold onto lately, to get him through a difficult time.
The Warrant is not verbalised explicitly but is that the patient appears to need to hold onto his physiological explanations. The Backing although not verbalised could be the intensity of the denial of needing to think and the fact that there appears not to be any real physiological problems. The Data is a statement that the patient appears to need to hold onto something.

This is attempting to communicate with the patient on a metaphorical 'non –concrete' level. The empathy that the therapist is not expressing might be that it may be difficult for the patient to understand or to use Challenges on this level at this stage.

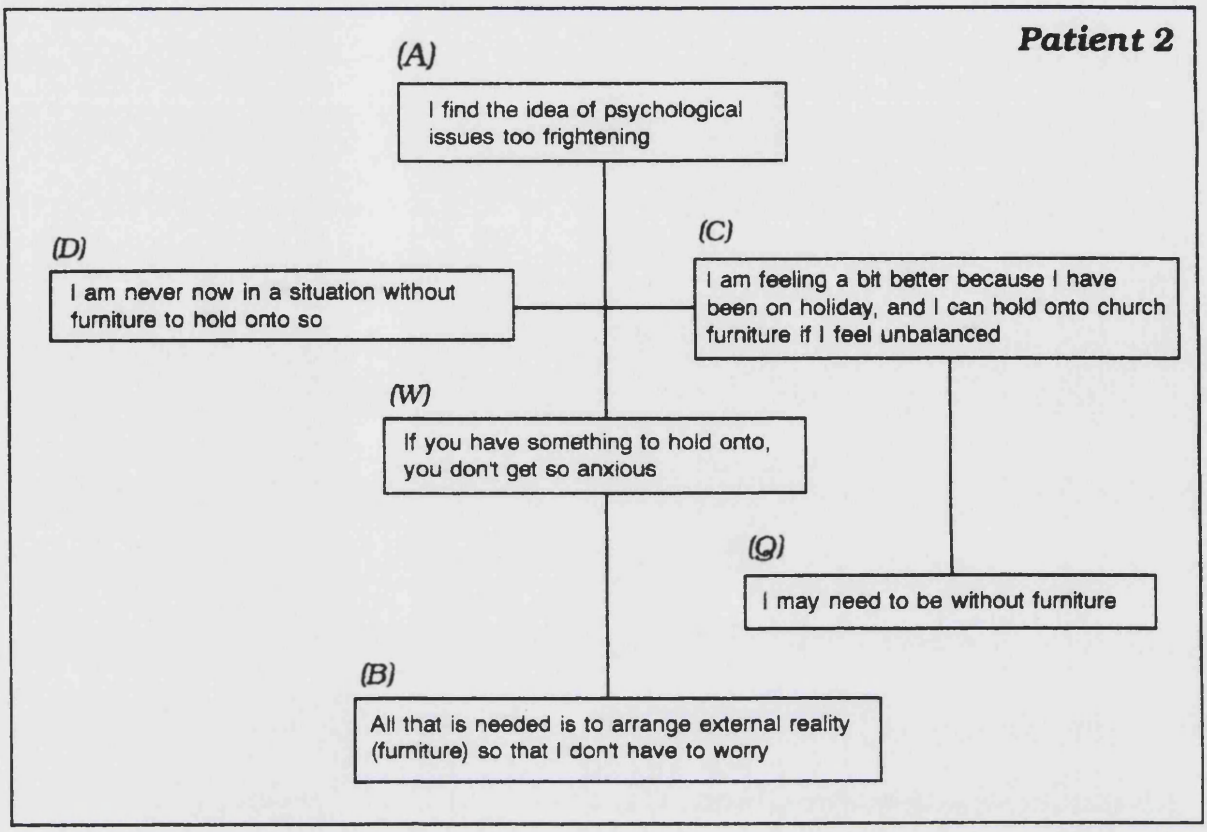


Diagram 2- Patient In response the patient's Claim is that he feels better (why is he saying this at this point?) and then a statement that he can now hold onto church furniture. The Data on which he appears to base his statement of feeling better, is that he is never now in a situation without furniture to hold onto. The Warrant although not verbalised is that if you have something to hold onto you don't have to be so anxious .The Backing also not verbalised is that this can all be reduced to a practical problem and if only the right external situation can be arranged there is no problem. The Alternatives that psychological explanations are either too frightening or too incomprehensible are no acknowledged. The Qualifier that the furniture solution cannot be a permanent solution is also not verbalised.

A *mismatch in communication has emerged. The therapist attempts to communicate on a psychological level and the patient is ignoring the Challenge and instead is insisting on continuing his communication on his concrete level, see Claim. It is difficult at this point to know exactly why the patient insists on not hearing the therapist's communication. It may be because of anxiety or because of incomprehension. From the Warrants and Backing it is also clear that the patient is coming from a different direction from the therapist. There is an insistence on operating on a concrete level and thus denying internal psychic reality.*

Patient:...You can see the symptoms underneath but they are enough to let you get on with things without having a wavy voice or breathlessness or anything like that. Is this adding up to any sort of picture at all? Well all I can say is that I can see the pattern of what's happening but now I don't know how to break it.

Therapist: Mm... It does, it does seem as I say a pattern of feeling very difficult to break here because you are stuck in this pattern of these physical symptoms, the physical explanation and trying to make sense of it that way. And it does seem to add up completely for you. And I, I'm aware of how when I asked or commented in an open sort of way about perhaps there is something that might be psychological to hold onto, to deal with some sort of inner sensation of imbalance in your mind there's, it was very difficult for you to follow that possible psychological train of thought, that the symptoms, the physical explanations and ways of trying to think dominate very much...

Patient: (Laughing) I suppose that was always being a great lover of chemistry at school. Whenever Dr. F. has given me drugs he's always told me the physical processes by which they worked so I suppose I've got a mind that tends to work like that. I suppose it's because I can't understand the psychological road in the same sense that I can understand the physics road but it puts my mind to thinking of physical, one's mind would always go to the known rather than the unknown I think.

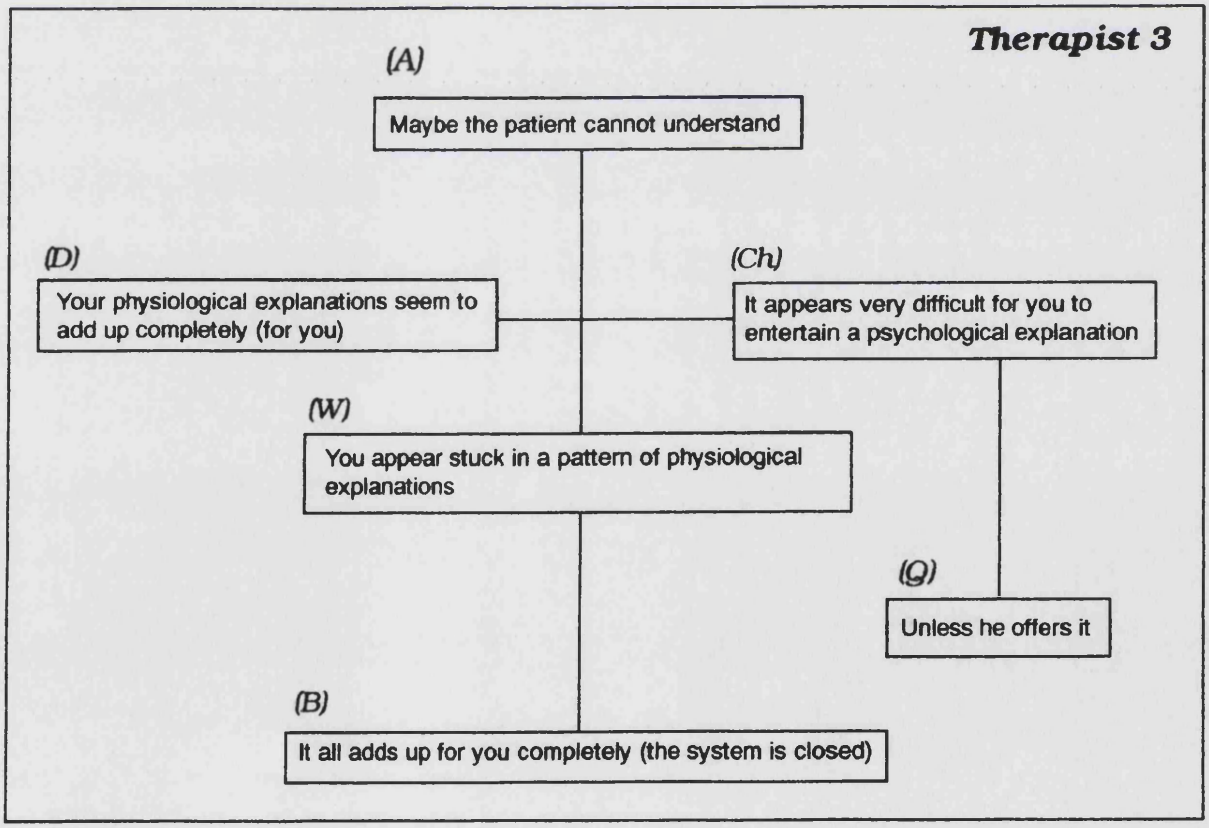


Diagram 3. - Therapist The therapist is offering the Challenge that it might be difficult for the patient to entertain psychological explanations, the Data behind this observation is that the physiological explanations seem to add up completely. The Warrant is that he appears stuck in a pattern of physiological explanations. The Backing is the same as the Data, that it all adds up completely, (that is, it is a closed system). The Alternative that the patient for some reason cannot understand a psychological explanation, is not verbalised, the Qualifier that the patient may be able to consider a psychological explanation if he himself offers it, is also not verbalised although there is some evidence of this later in the text.

The Claim and Data constitute a clarification and an amplification of the patient's difficulties. They are comments on the nature of the patient's communication rather than comments on the content. The therapist is beginning to highlight the defensive style of the patient.

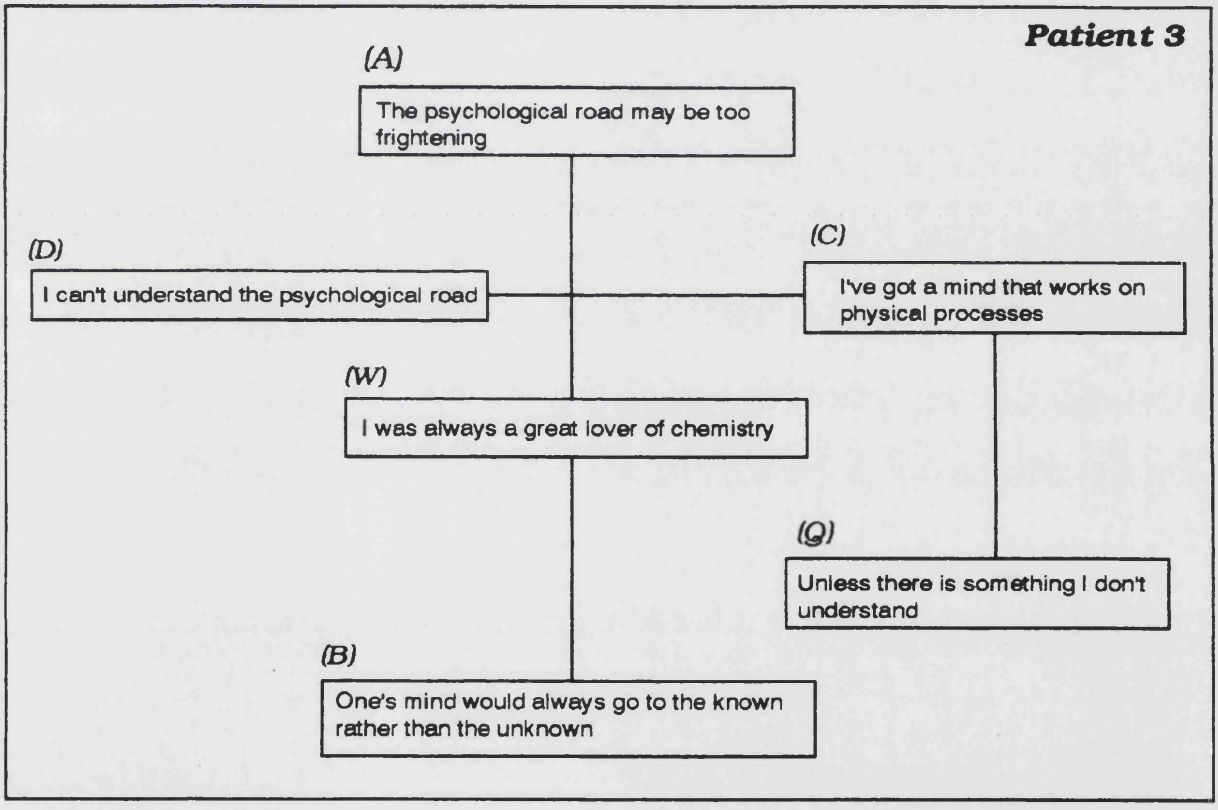


Diagram 3- Patient The Claim that the patient offers is that he has got a mind that works on physical processes. The Data he bases this Claim on is that he cannot understand the psychological road. As a Warrant he offers that he is a great lover of chemistry. Furthermore he offers a Backing that is, 'one's mind would always go to the known rather than the unknown'. The Alternative is not surprisingly, not verbalised. It could be

summarised as something like the psychological road is too frightening to look at (this is a reasonable assumption considering material from later sessions when the patient tells how he had earlier attempted to think of psychological options and this had led him to think of frightening possibilities such as having schizophrenia).

The therapist has attempted to draw the patient's attention to the fact that his thinking appears completely closed. The patient has already got his explanations for his problems ready, there is, as it were nothing for the therapist to contribute. In response the patient does not address himself to that issue at all, but provides 'an excuse' why he thinks the way he does. He goes onto justify his position by verbalising both his Warrant and his Backing, so as to ascertain agreement between him and his therapist about his Backing. If he were to receive agreement for his Backing, that would for him provide a justification to interrupt this line of exploration. The Alternative that it all feels for him at this time too frightening is not verbalised. In fact, because the Claim is in this instance accompanied by Data, Warrant and Backing, none of them very convincing, it gives an impression that the patient is trying to hide something. The patient has by not addressing the issue which, the therapist attempted to bring up, managed to destroy the communication. He has demonstrated an inability or unwillingness to think about what has been presented to him, i.e. the Challenge.
The concrete nature of the thinking is evident. It provides a way out of thinking about anything, which might provoke anxiety such as the Alternative.

Patient: I suppose the greatest sadness in it all was that when the unbalance business hit me that it came as such a shock because that was so related to my career, just as if I'd stayed with the railways and suddenly become colour blind, that would have meant that I couldn't go on but I suppose that as that is now a year on I've resigned myself to the fact that if things didn't improve well I'd just have to do something else.

Therapist: Well I'm aware of your struggling to try and find the meaning for all that's been happening. And I was puzzled by one of your statements about if you went colour blind with the railways you have to give up that job. If you remained unbalanced or whatever and it really affects your job as a priest then you have to give that up. And I was struck by in that way you said it, you didn't seemed to get across at all the meaning of doing priestly work as opposed to working with The railways. You know as if it was much the same sort of thing for you. And yet I doubt it.

Patient: Well er... in a sense yes it is because I'm coming from a high church tradition of Christianity one would see just as a priest has a priestly vocation, one believes that that's his work in life ... As I look back on my own railway career I can see people that were just literally made for that work just as people are literally made to be priests. It's a rather modern idea to regard priestly - for Christians in general I would say it's a very modern idea to regard, well one from the last century

- to regard a priest that; a priestly vocation and um a vocation to something else is quite different. In classical Christianity one would see God as giving a vocation that might be that of a priest, a teacher, a doctor, a railway man or anything. Anything that they are absolutely at one with in the world, that seems to be right for them.

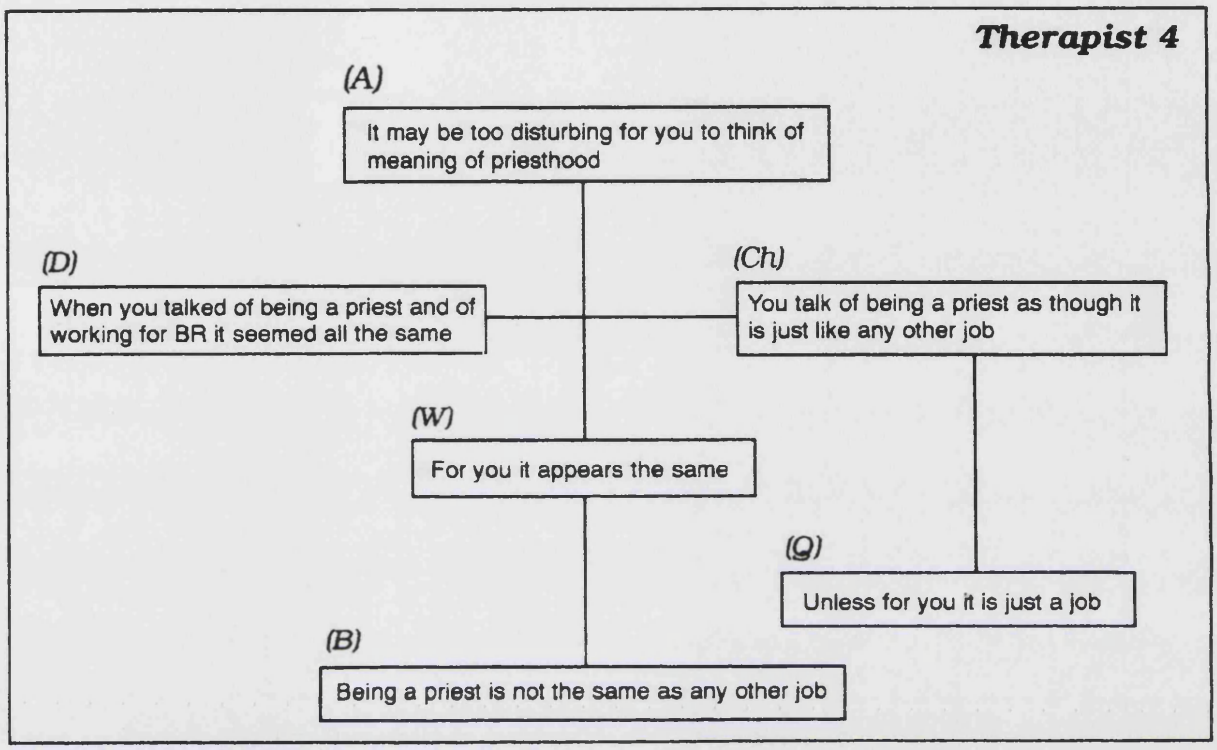


Diagram 4 - Therapist The therapist offers a Challenge to his patient in response to the patient having talked of being a priest, as though it is comparable to working for the railways. The Challenge is that the patient talks (thinks?) of being a priest as though it was just like any other job. The Data is, how the patient had talked of his work. The Warrant he offers, is that in the patient's thinking, presented earlier, both jobs appears the same. The Backing, which is verbalised here, is that to be a priest is not the same as any other job. The Alternative that is not verbalised is that maybe the priesthood is too difficult for the patient and presents him with too much potential disturbance. The Qualifier is, although not verbalised that maybe for the patient being a priest is just a job.

The therapist is trying to confront the patient with the peculiar quality of his thinking. The therapist is doing this by trying to confront and amplify the nature of the patient's communication.

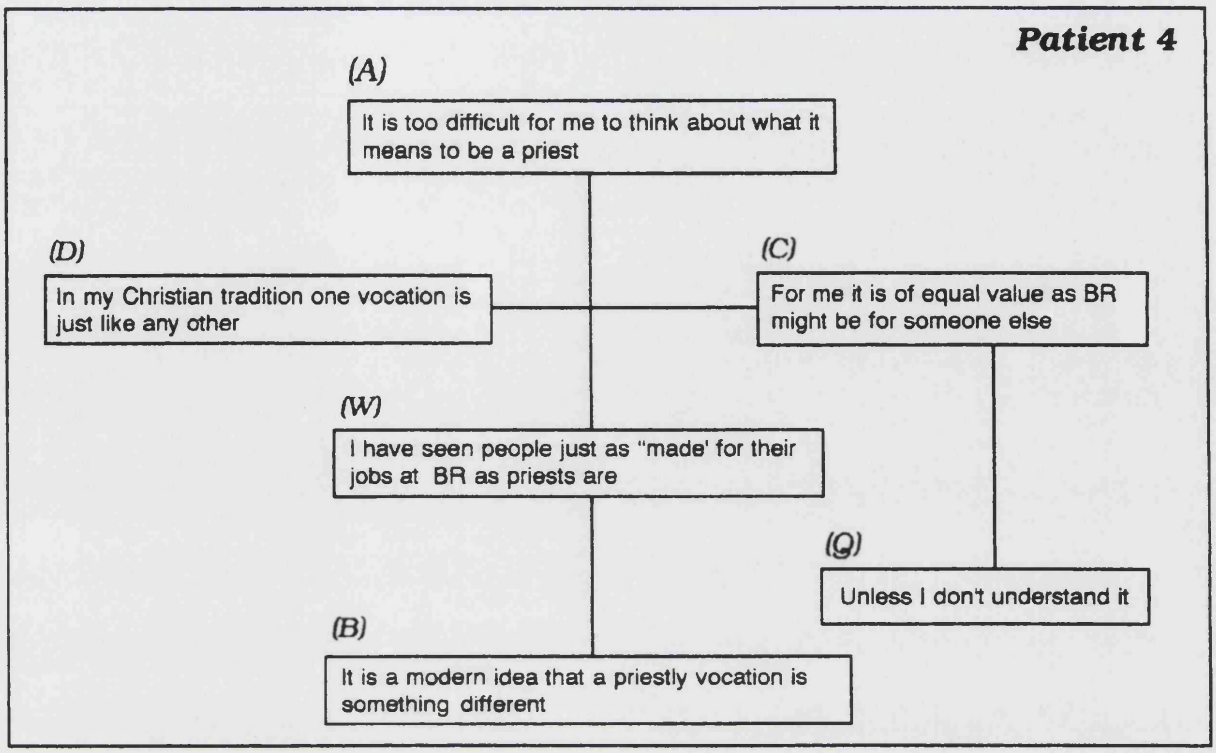


Diagram 4- Patient The Claim offered by the patient is that he feels that to be a priest is of equal value as working for the railways. The Data offered is that in his Christian tradition vocations are equal. The Warrant is that he has seen people just as suitable for the railways as someone else might be for the priesthood. The Backing, which is verbalised, is that the idea that priesthood is something different is a modern idea. The Alternative, which is not verbalised, is that it may be too difficult for him to think about what it really means to be a priest.

In this interchange the patient has dealt with the Challenge by challenging the therapist's assumptions in the Claim and Data. He is offering another entirely different type of Backing. By doing this he has altogether avoided the issue, which was brought by the therapist. He has in this way destroyed the meaning of the communication from the therapist and has instead reverted to a concrete level of offering 'teachings' and justifying them by a form of dogma. This is another example of denial of psychic reality.

Therapist: But how would you know what was right for you. Because this in a way is what I am puzzled about, puzzled as to whether you had a sense of what is right for you or whether you could work for The railways or as a priest or something else equally easily.

Patient: No I couldn't equally easily no. It seems to me that in the light of my Christian life my right place is to be a priest. But I also see with equal reverence that the right place for another Christian could be something else. Within sort of Protestant Christianity from the.....I can regard other vocations with equal

veneration but it's not mine. I chose the railway example because that was my previous career and I'd seen many people had to give up because a promotional prospect was there and their colour vision wasn't up to it.

Therapist: And yet is does puzzle me. I mean I see what you're saying different vocations for different people and one is not better than another or whatever. I see that but for you, you were actually saying you were The railways or whatever you were working with in Dover, and now you are a priest. You could be something else if your sense of balance didn't allow you to be a priest.

Patient: I was trying to give the example of how someone else would feel if they'd got a definite sense of vocation, were ready to do something and there was something to hinder them. And I swung to that example because that was from my own working environment experience. Like a surgeon suddenly developing arthritis perhaps.

Therapist: But I'm sticking to your experience.

Patient: Yes, yes.

Therapist: And your experience of coming from an environment, a pleasant environment but with a, an experience without too much distress apparently from what you said, moving on to something else if your sense of balance didn't allow you to fulfil yours..

Patient: Well what I was trying to say was that that it came as a big shock to the system and its only now after a year that I could begin to resign myself to the fact that if I can't be a priest I can't be a priest. In the ordinary sense of a parish priest with its processions and thing where one's walking in that manner. If there is a, if it is just on a physical bases that can't be cured but if the psychological factors, if it is psychological factors that are causing it all well then maybe it can be brought around. I suppose the one thing I'm always doing is looking for steps to find a way of dissipating it.... I mean I know what I'd like to be doing now as a parish priest and the way I would like to feel as a parish priest and these physical symptoms are saying no, your not going to do that.

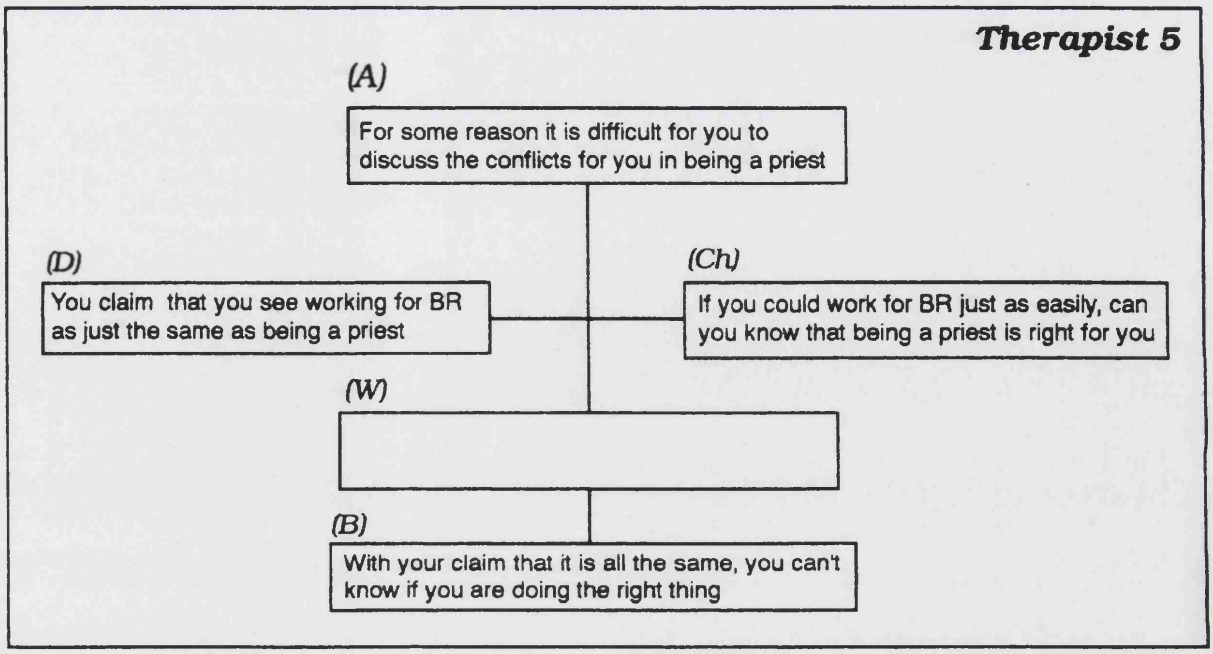


Diagram 5- Therapist Continuing in the same fashion the therapist is attempting to demonstrate the difficulty with the patient's position, as stated above. He provides the Challenge that, if it is true, as the patient claims, that in some sense it is just the same to be a priest as it is to work for the railways, it follows that there might be some difficulty in knowing if being a priest is right for the patient. The Data is the patients earlier Claim and the Backing, which is verbalised is the logic of the situation that one cannot know if something is right for you if it is all the same. The Alternative, which is not verbalised, is that there is something very difficult about being a priest for the patient.

The therapist is trying to confront the patient with the consequences of his thinking, by amplifying it.

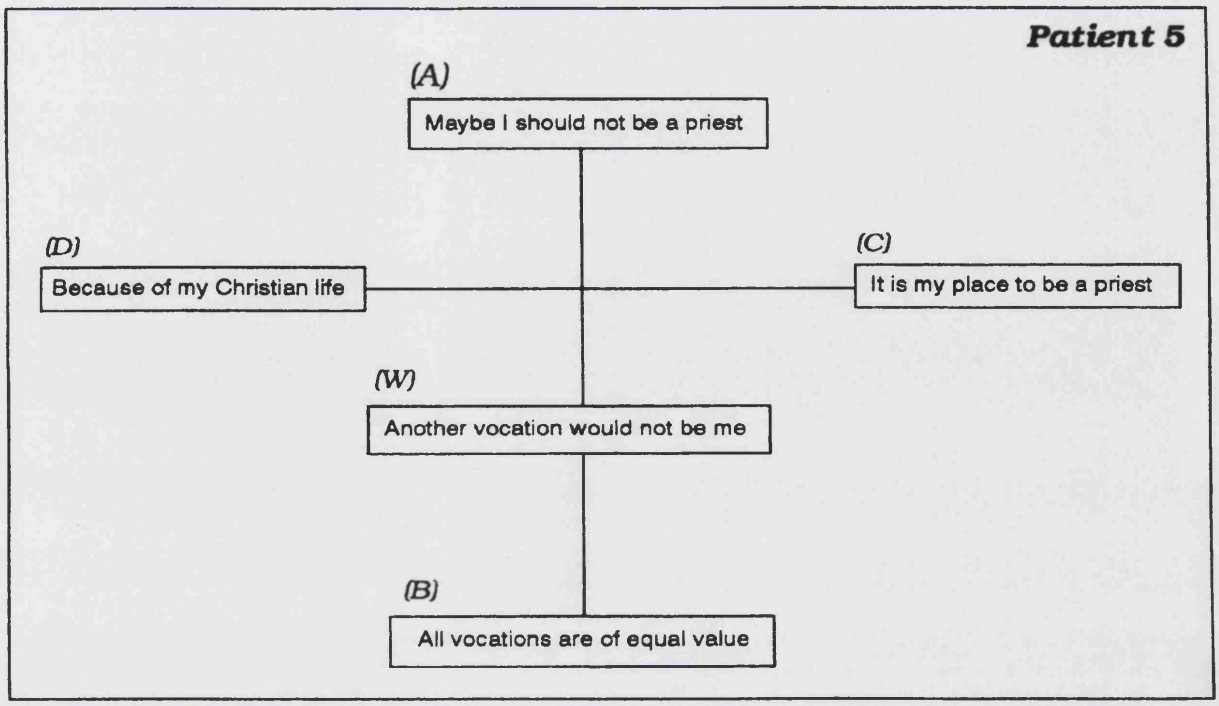
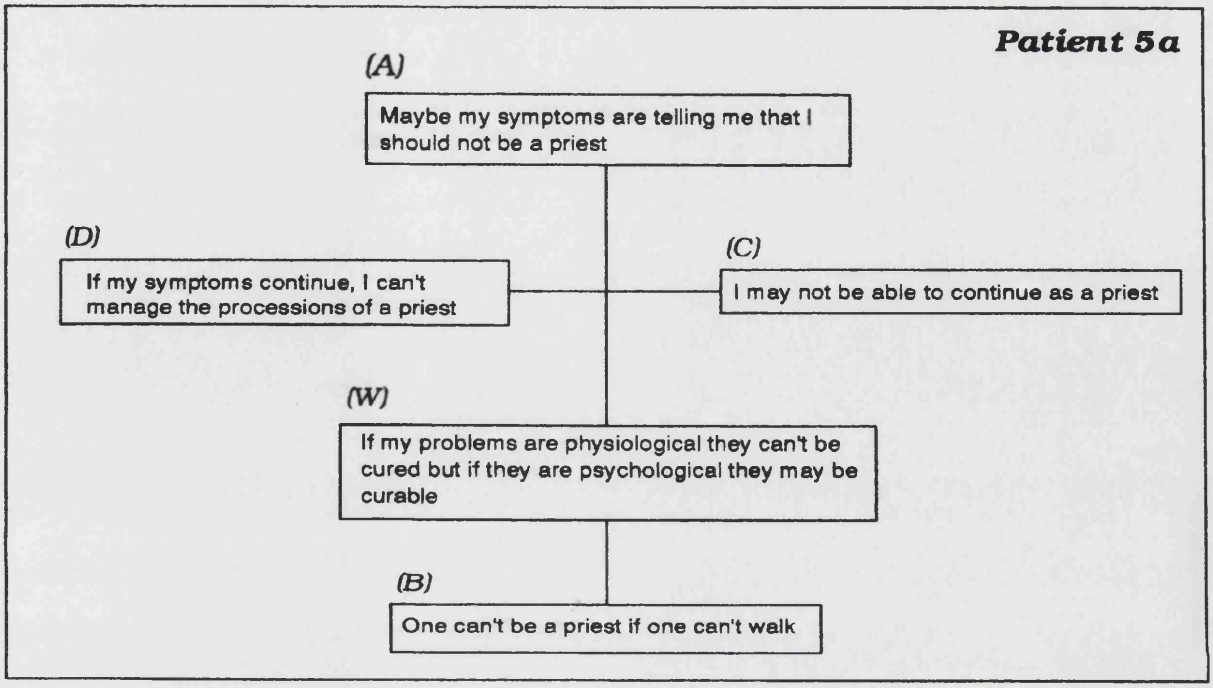


Diagram 5- Patient The Claim produced in response to the Challenge is a denial of the Challenge and a denial of the patient's own earlier communication. The Claim is that it is the right thing for the patient to be a priest (that means it is not the same as being something else for him). The Data he bases this Claim on, is that it is right because of his Christian life. The Warrant is that another vocation would not be right for him (why is not explained). The Backing offered and verbalised is that all vocations are of equal value. The Alternative is not verbalised and could be that maybe it is not right for the patient to be a priest and maybe this is what his symptoms are telling him.

The patient is trying to reinforce his position by using a process of elimination of any other possibility, see Warrant. This constitutes a denial of having to think. The thinking is concrete in quality.



In diagram 5a - Patient The Claim is made by the patient, that he may not be able to continue as a priest. The Data is that if his symptoms continue they might become too much of an obstacle. The Warrant is that if the symptoms are physiological they can't be cured but if they are psychological they may be curable. (why a statement like this is made is not clear). The Backing to the Claim is that one cannot be a priest if one cannot walk. The Alternative that, maybe the patient should not be a priest, is not verbalised.

The conclusion is reached, by the patient, together with the previous Claim that the patient knows that to be a priest is right for him. This way of arguing protects him from considering the Alternative. The Challenge of the therapist is denied initially and then the possibility that the patient may have to give up priesthood is considered in a 'harmless' way, see Claim and Warrant (5a). The defences employed here are, denial of the possibility that the therapist might have a point and refuge is then sought in concrete thinking. In other words, the symptoms may make it impossible for the patient to continue as a priest for ***physiological or concrete*** *reasons rather than for psychological reasons.*

Therapist: How do you face your doubts about meaning in your life, meaning in your life as a priest?

Patient: I think with any, any aspect of life in general that there are certain things beyond our understanding and you have to take it. I mean life for a priest shouldn't be different from the life of any other Christian and their environment of life that they are living in.

Therapist: Mm. You know I'm quite sure that that is the case and I'm quite sure you are very in touch with other people's doubts about the environment and lives they are living. But I wonder how you face your doubts about your life? But as you say you are no different from other people no.

Patient: I'.. I don't think I can answer that because it's too general, I'd have to think of indivi- because doubts tend to be of individual things and there are aspects of Christianity or any religion that to me don't make sense, but then to take the opposite argument it makes just as much lack of sense for example all sorts of things surrounding the problem of suffering and the purpose of creation and things like that but these are matters that are not peculiar to the priest. They are matters peculiar to anybody. As I suppose my own view is that there will always be things that are beyond man's understanding and that I've got no alternative but to live with them.

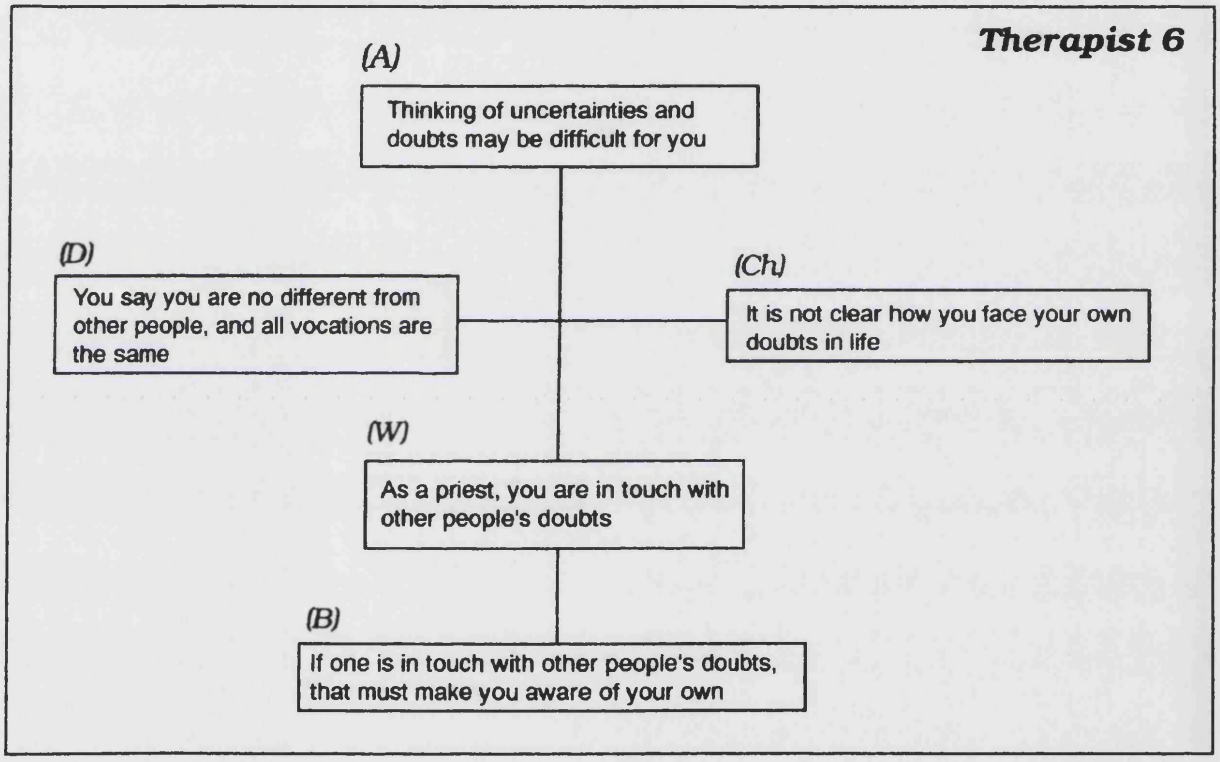


Diagram 6 - Therapist The therapist is offering as a Challenge, the fact that given these sets of circumstances it is not clear how the patient can face up to his doubts in life. The Data is that the patient says that he is no different from other people, and all vocations are the same. The Warrant offered here is that as a priest he is in touch with other people's doubts. The Backing, which is not verbalised, is that, if one is in touch with other people's doubts it must make you think of your own doubts. The Alternative is not directly verbalised but implied, that is, that the patient has difficulties thinking of his doubts.

The therapist is trying to amplify the patient's inconsistent argument. He is confronting the patient by asking a strategic question.

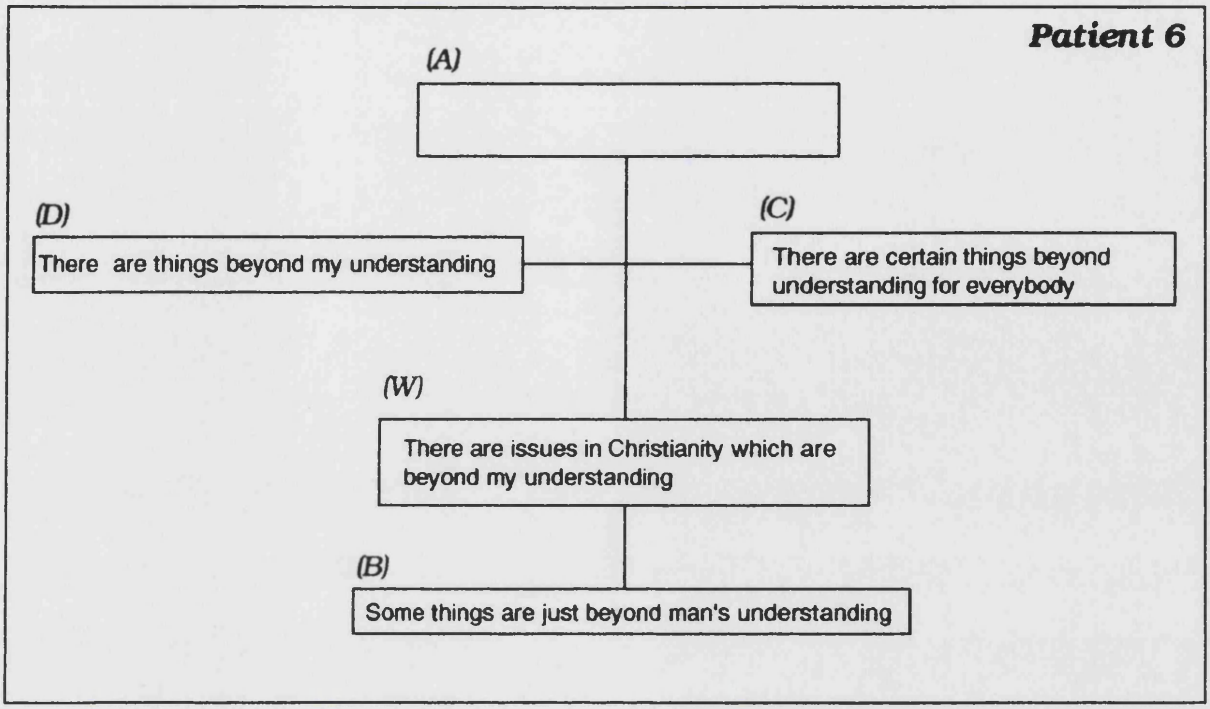


Diagram 6 - Patient The Claim offered in response to this is that, there are certain things beyond understanding for everybody. The Data on which this is based is that the patient feels that there are things beyond his understanding. The Warrant is that there are issues in Christianity beyond his understanding, such as the purpose of creation. The Backing although not verbalised seems to be the same that some things just are beyond man's understanding.

The patient is using defensive mechanisms in order not to directly respond to or think about the Challenge. The patient avoids directly responding, by introducing 'teachings' in a concrete fashion. The result is that the communication and meaning is destroyed or does not take place in the first place. This also constitutes a denial of having to think.

Therapist: Well let's really take the specific, which I think is very relevant to coming here. Your doubts about coming here, your doubts about 12 weeks of therapy with me.

Patient: Probably because I'm too physically minded (laughing). Probably because I see the human body too much in it's chemical sense. You see if Dr. F says to me 'Well when you chew this tablet it's going to cut off that stuff that's going to chuck the adrenaline round your body and it's your adrenaline that's making you shake' that I can make sense of. My doubts of the course were quite simply that I didn't, don't know how psychology trains the body back to equilibrium. I think often when you know how a thing works it works better for you. And I suppose the greatest doubt was not that it could be helpful but with all the ways it could be helpful the one thing right at the front of it all was that imbalance that led to the nervousness etc. etc. and that seemed to be the one thing that had a purely physical bases because it happened

outside my priesthood and it happened to other people at the same time and when that origin started call-, when the symptoms of that original complaint started causing distress that's when it all took on it's psychological basis and I wondered if somehow that physical element of it, if it's separate, entirely separate from the psychological problems that followed afterwards, whether the psychology can work with that physical bit in front of it all, if that makes any sense.

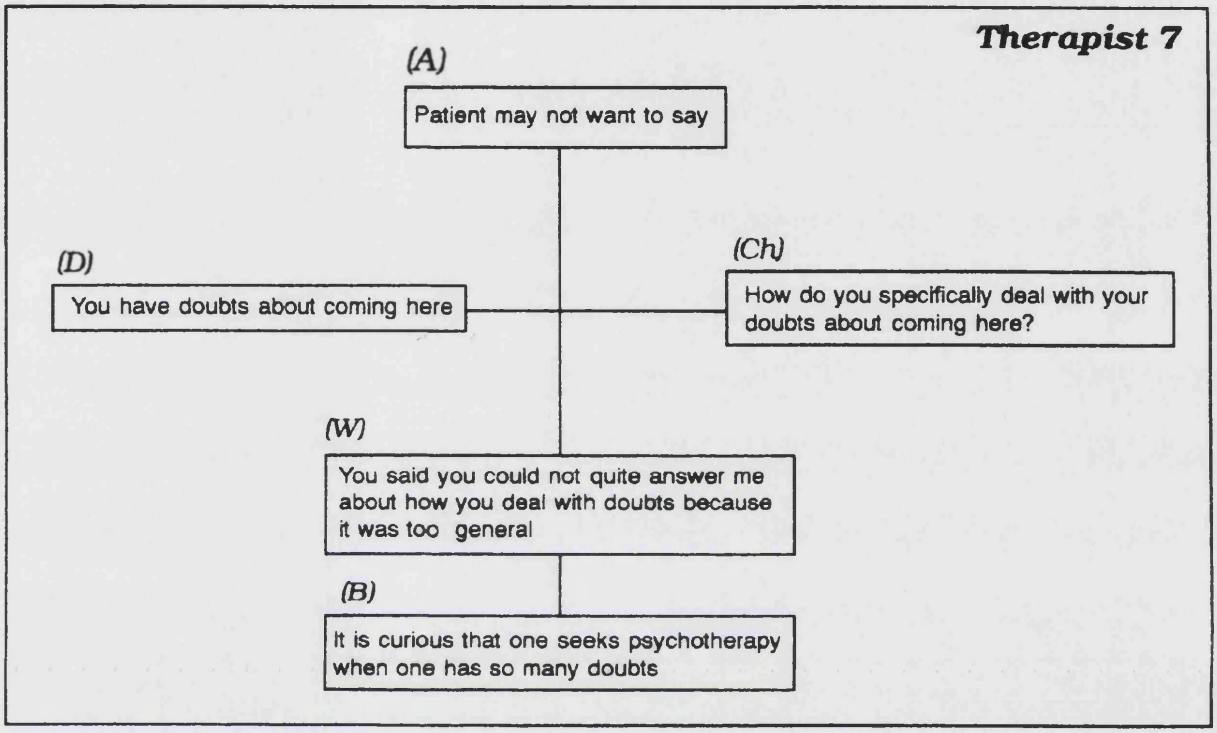


Diagram 7 –Therapist The therapist is still continuing to explore how the patient is dealing with his doubts. The therapist offers the Challenge of how is the patient dealing with his doubts about coming to therapy. The Data is that he appears, from the material, to have considerable doubts as to the usefulness of psychotherapy. The background to this Challenge is that the patient was saying that he could not respond to the therapist's earlier question about how he deals with doubt, because the question was too general. This serves as a Warrant here. The Alternative that the patient may not want to or be able to discuss doubt is not verbalised. The Backing is that, it is curious that one seeks psychotherapy when one has so many doubts about it.

The therapist is confronting the patient's avoidance, by following the theme of the patient's difficulties with thinking about doubts. This time it is done in the here and now.

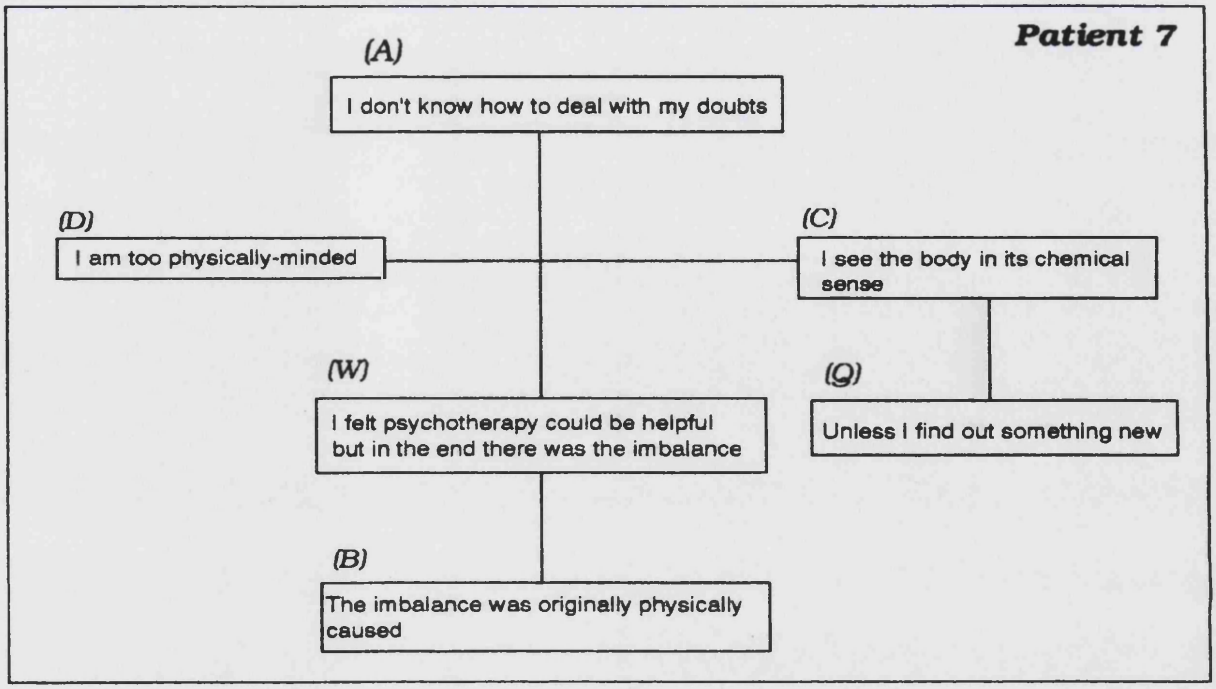


Diagram 7 - Patient The patient responds to this Challenge by making a Claim that he sees the body in its chemical sense. The Data for this Claim is that he is too physically minded. The Alternative would be to express the confusion that the patient is feeling and say for instance that he does not know how to deal with his doubts. The Warrant is that he feels psychotherapy could be helpful but in the end there would still be the imbalance. The Backing is that the symptom of imbalance was physical, as he had once had an infection which had at the time caused imbalance and this sensation has continued.

In this instance the therapist's Challenge is avoided by taking to desperate measures in order to avoid uncertainty. The logic of the argument, even disregarding that it is not addressing the original Challenge, does not hold together. There occurs a destruction of communication and of any possibility of thinking. This constitutes a complete disregard for what the therapist is trying to bring in to the situation. The concrete nature of the thinking is evident in the Warrant and Backing.

Therapist: Mm very much so. I mean so much so in fact that I wonder how it was that you were able to deal with that sensible, rational way of looking at things and still come here looking for some sort of psychological meaning to your life, what's been happening.

Patient: I suppose because my GP had, at the time of seeing my GP in Dover and then the GP here the tachicardium and all the psychological reasons had taken such a grip they weren't too ready to grasp with the thing that triggered it in the first place. But it's dragged on for so long now that even if dr. could cure the physical imbalance over night, I'm sure that my reflex action, psychological action all the physical symptoms would still come back because they've got so used to remaking

their appearance. And my life isn't such that I can do graduated things to get rid of it. I'm always in at the deep end.

Therapist: Well in a way I'm remembering what between us we arranged in relation to these sessions. We wouldn't be starting it straight away because you were going on holiday and you wanted while on holiday I think still to have access to your medication. And you thought that perhaps when you're back in this country for a while it may be possible for you to consider stopping it or discussing that with Dr F. But I think you have lots and lots of doubt about that too.

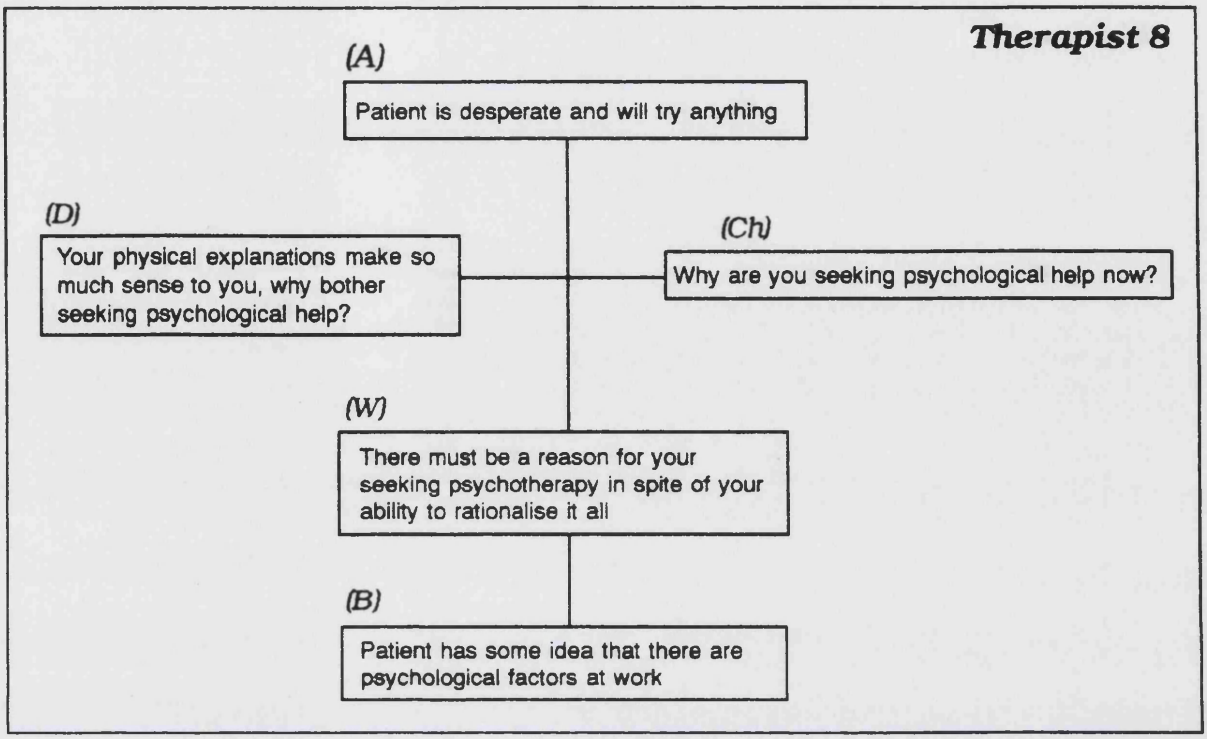
Patient: Yes terrific doubts now, especially as I often, um-

Therapist: Especially as we've come up to the point when...it might be possible..

Patient: I've um the dose that seems to be, but the way I need doses seems odd. I definitely need that dose in the morning to stop the shaking and sweating and ataxia that I get when I get up because depending on how I feel I will take one Larazapan tablet an if there's nothing that I have to do in the course of the day that I, from memory has brought it on badly before, that would be quite sufficient. But if it's a day say um when I've got to do a lot of things closely related to when all this blew up and I can see myself at that moment relating to the previous situation I might and it's not very often, once a week I think at the most, have to take the full dose of 2 milligrams three times a day. That would always hold the worst things at bay and allow me to proceed but, but normally that, one on getting up and one at night holds things.

Therapist: I think it is a very difficult situation for you to be in because you obviously have so many doubts, so many real doubts about whether a psychological understanding, a trying to find meaning this way is going to be....and yet you've come along thinking that too..

Patient: I see in my own mind I see the ultimate solution has got, is going to be a mixture of treatment, physical and psychological because as I say right back at the very beginning that physical bases of the unbalance. If that could be cured there's no, there's no raison d' etre for the other symptoms to reappear and by psychological methods they might be able to be coaxed away. Presumably that's... that's what psychotherapy does, doesn't it.



Diagrams 8 - Therapist: The Challenge is, why are you seeking psychological help now. The Data is the contradiction of coming to therapy although the physiological explanations make sense. The Warrant is that there must be a reason, in the patient's mind, why he seeks psychological help in spite of his ability to rationalise his symptoms. The Backing, although not verbalised is that the patient must have some idea that there are psychological factors at work in the creation and maintenance of his symptoms. The Alternative, which is not verbalised, could be that the patient is desperate and will try anything.

The therapist is confronting the patient with the logic of the situation, which the patient is creating. That is, as the patient is apparently convinced that the physiological explanations are what matters why is he then seeking psychological help.

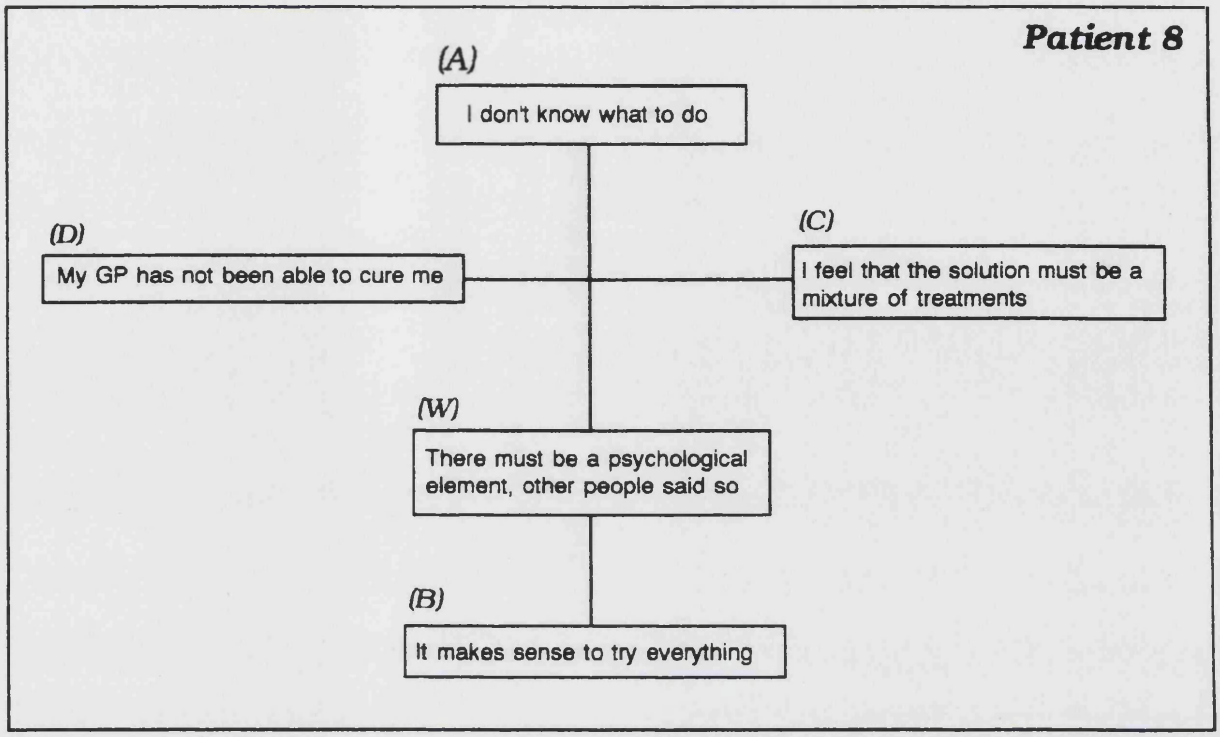


Diagram 8 - Patient: The Claim is that he feels the solution must be a mixture of treatments, because (Data) his GP has not been able to cure him. The Warrant is that other people have suggested psychological treatments. The Backing, although not verbalised, is that it makes sense to try anything. The Alternative that he is desperate and does not know what to try is not verbalised.

The patient is not responding to the specific Challenge that his behaviour in seeking psychological treatment is in contradiction to insisting on thinking physiologically. He is evading the Challenge by providing empty statements such as, it makes sense to etc. The patient is employing concrete thinking. The logic implicit in the Backing seems to be that if you try everything available you should find the solution ***without thinking****. This constitutes a denial of the need to think.*

Therapist: I was remembering what I was holding on to, to use your analogy for... the summer, was the possibility that it might be very hard for you to live without these physical sensations because the physical sensations may present, the only or one of the only ways you can be in touch with your sexual sensations and your aggressive and angry sensations. Now that is something that I held onto.

Patient: Um I can understand the aggressive one at the time (laughing) particularly because I, I felt so bad about working with that other priest but with that factor completely out of the way, I mean if I am in an argument with somebody, I'm not the sort of person that necessarily holds back. I mean I would have an argument with somebody, I won't say happily because I don't like to get into an argument, I am a person who fights shy of them. So there is always that release then when if it ever

comes to the crunch though I was being, I particularly made a point of not being aggressive towards that priest an shutting him up at any stage because..

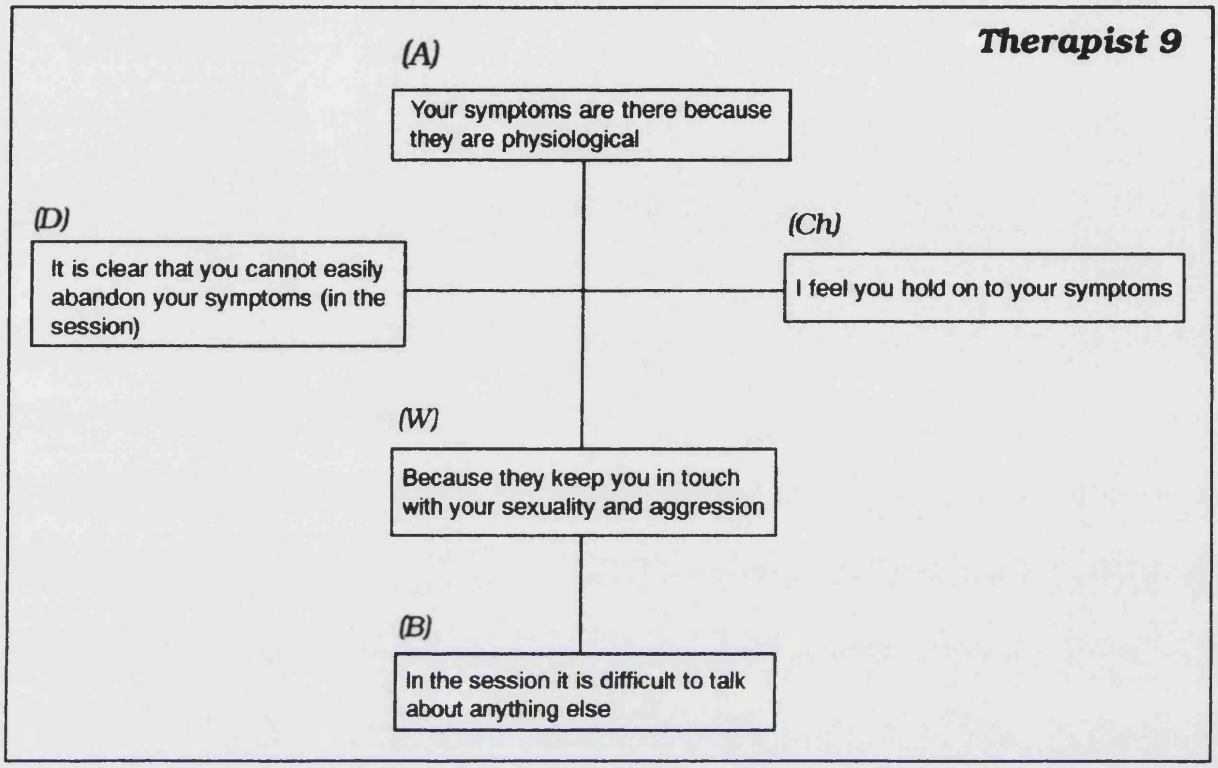


Diagram 9 - Therapist: The therapist is making a Challenge that he believes that the patient is holding on to his symptom. The Data for this Challenge is that it seems clear that the patient cannot easily abandon his symptoms. The Warrant is that the symptoms keep him in touch with his sexuality and his aggression. The Backing, which is not verbalised, is that in the session it is impossible to talk of anything else except the symptoms. The Alternative is not mentioned and could be something like although unlikely, the symptoms are physiological in nature.

The therapist is making an interpretation of unconscious content.

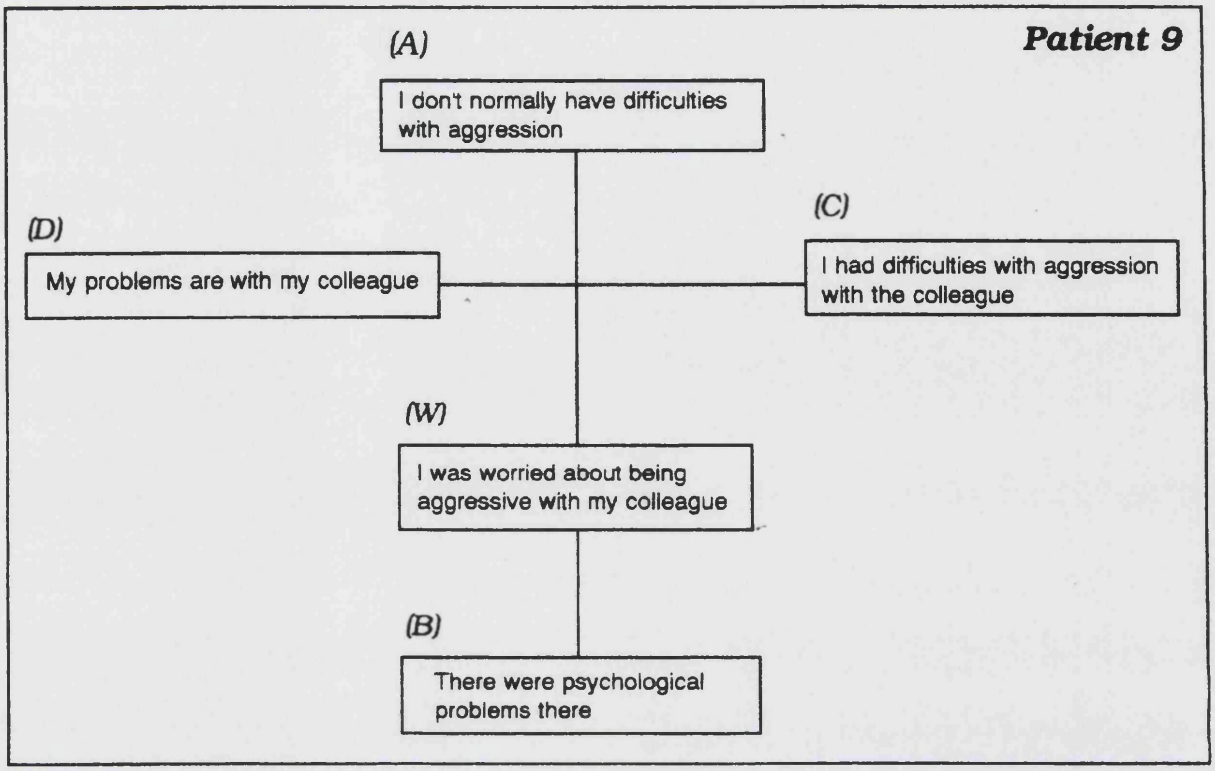


Diagram 9 - Patient: The patient's Claim is for the first time in tune with therapist's comment. That is the patient admits that he has had some difficulties with aggression in relation to his former colleague. The Data is the story of the difficulties with this colleague. The Warrant is that the feelings this former colleague had engendered in him had been truly troublesome. The Backing although not verbalised must be something like, there has had been real psychological difficulties there. However interestingly an Alternative is actually verbalised here by the patient. The Alternative, which could also be a Qualifier, is that the problems were only in existence, with regard to this troublesome priest but not under other circumstances.

There is some communication between the therapist and the patient; the two of them have found something to think about together. However the fact that the patient unusually verbalises an Alternative interpretation is an indication that he is preparing an exit for himself from this difficult exploration.

Therapist: You were frightened of killing him, you could hurt him-

Patient: Because of- but in general with more robust people (laughing) I mean at work on previous occasions I've had rows with people and there's been no problem. I've not felt a need to hold aggression back where it seemed called. As I said I did make an exception with that priest and I would have thought that April now October with him gone for that long that it ought to be shaking out the system if that's it. And sex has never been a particularly high key one for me.

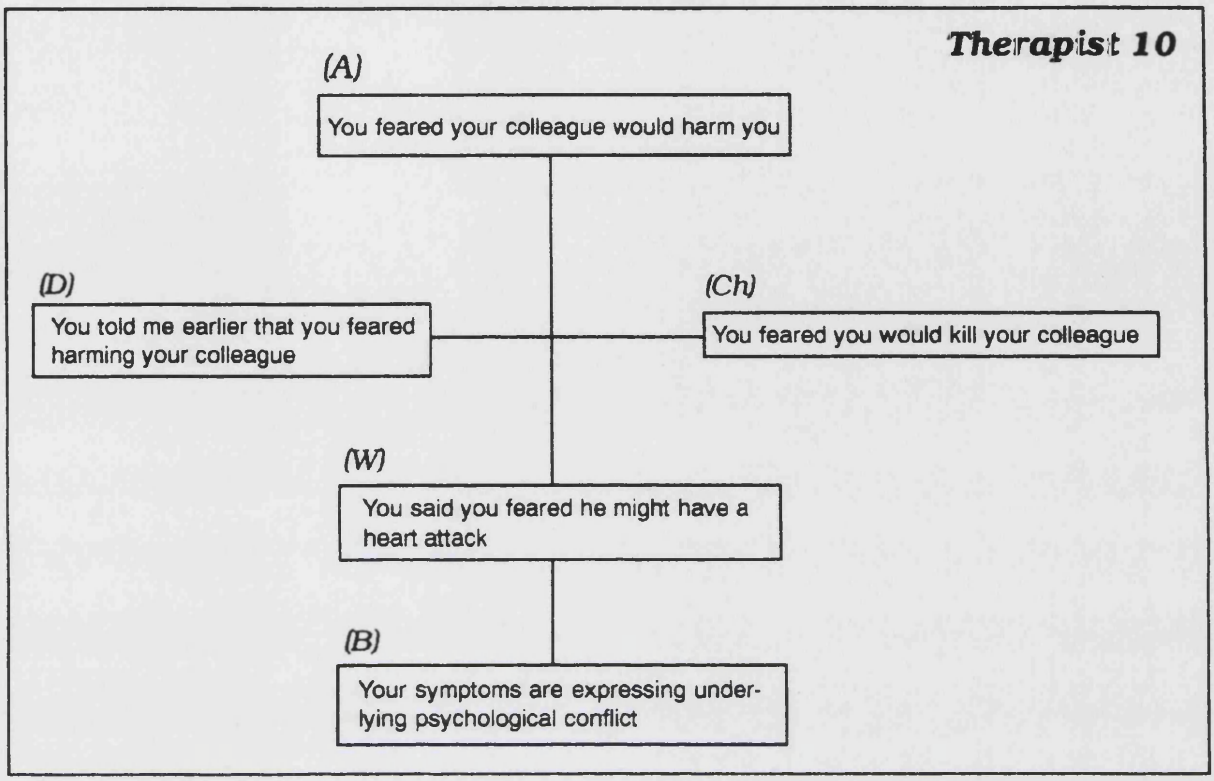


Diagram 10 - Therapist: In the same context the therapist makes another Challenge, that is, that the patient actually feared that he would kill his colleague with his anger. The Data for this Challenge has been presented earlier when the patient said he feared that the colleague would have a heart attack if the patient showed his anger. The Data also serves as the Warrant. The Backing, which is not verbalised, is that there is a psychological conflict underlying all this symptomatology. The Alternative, which is not explored explicitly, is that the patient may have feared that his colleague might harm him if anger was shown.

The therapist is amplifying what the patient has previously said, in order to help the patient hold onto his momentary recognition of the validity of at least part of the interpretation described in diagram – Therapist 9

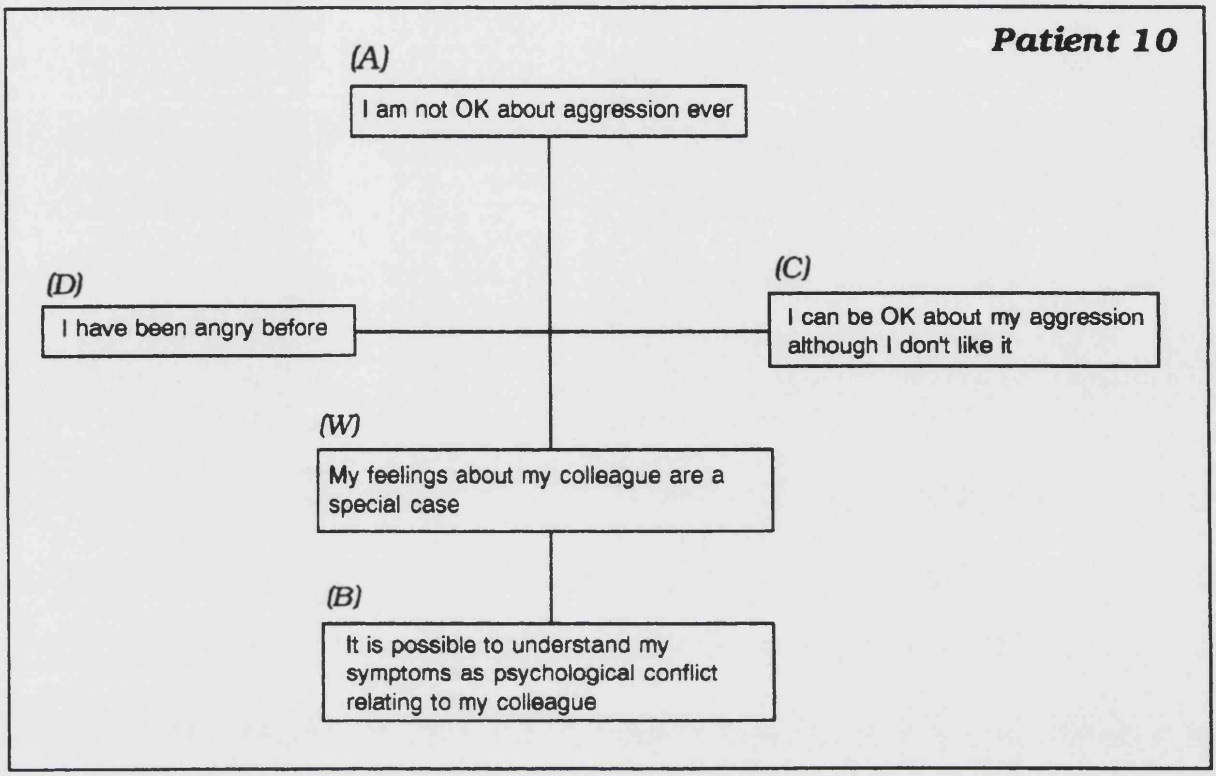


Diagram 10 - Patient: The patient Claims that he can be OK about his anger although he does not like it. The Data presented is that he has been able to show anger before. The Warrant is that the feelings he had towards his fellow priest were a special case. The Backing although not verbalised can be perceived as an admission that something psychological underlies at least some of his symptomatology. The Alternative, which is not verbalised, is that the patient genuinely has difficulties with anger.

When you look at the above text you notice that the therapist's Challenge, 'you feared you would kill him', is in fact ignored. The structure of the whole argumentation is in fact a moving a way from the communication that was beginning to happen between the therapist and the patient. The notion that there is something psychological going on has not been completely dismissed. This is a form of 'isolating' the case of the difficult colleague, from anything else.

4.3.1. Session 2

Subjective/Intuitive analysis

The flavour of the session is evident in the first remark the patient makes. The therapist enquires: **What is going through the patients mind.** The patient responds with: **'There's not very much going through my mind'.**

This may in it self seem like an innocent remark but when you consider the situation in which the patient finds himself in it seems less so. This is a second session of his psychotherapy, it is very unlikely that nothing is going on in his mind. So it is reasonable to assume that some denial is going on. The next statement is equally a denial.

Patient:' I didn't want you to feel distressed at me not being able to sort of help you to...help me further.'

The patient has reversed roles with the therapist and is denying who is there to be helped. It is the beginning of an attempt on the part of the patient to assume control of the session. A few sentences further the patient is destroying the meaning of what the therapist is suggesting in the following manner:

Therapist: 'Apparently you didn't have any idea that we might discover avenues that you hadn't been able to think of on your own.' The patient responds:' No because in talking together we, I thought we'd more or less agreed that we'd got through all the ground that it was possible to move along...'

The patient is not addressing what the therapist is saying but instead he takes refuge in some supposed agreement with the therapist that did not take place in the previous session. A little way further into the session we get an explanation of this behaviour by the patient, in a rare insightful statement. The following statement follows the therapist suggestion that the situation is quite difficult for the patient.

Patient:'...Anything I've found difficult is not, it's not been one of embarrassment or puzzlement but having never talked along certain lines before ....., ' and later on: 'parishioners open conversations with me along lines that I'm not familiar with and it's tough going for me.'

This statement indicates that some feeling is being experienced although the patient is not able to quite articulate what it is. Another indication that some feelings are emerging can be found a few sentences along.

Therapist: 'Do you know what specific things you felt you were having difficulties with...?

Patient:'...you mentioned the sexual aspect of life and well I that was the only one really. (Long silence) And that was um difficult to talk about.'

However the patient has barely uttered this before he backs out again, he says:

'I've not seen that aspect of my life as anything that really caused me a great deal of concern that would have really led to this symptomatology. The symptomatology seems to me to have arisen if not through entirely physiological causes....'

The patient is both destroying the meaning and denying any possible significance of what he himself has just said. Later in the session the therapist was attempting to explore the relationship between the patient and the patient's colleague, which had caused the patient considerable anxiety because the fellow priest had made him frighteningly angry.

Therapist:'(Attempting to tie in anger with college with anger with therapist) I wonder if that's a feeling that really is difficult. How you might feel here, frustrated, angry or whatever and the impact that might have on me....

Patient: 'Yes it's difficult the anger with this man was literally because he was such a horrible person and living with that for two years...,'and also: 'There's been momentary anger, it, there's been moments of anger in my life that have, that have been typical to many other people but this is the only occasion in my life where I've had to work alongside someone for about...

Therapist:'...it might be that something like that may stir memories in you of some other time when you were concerned of your angry feelings and their effects on whoever you were living with...

Patient: 'Yes we thought of this before didn't we but I really can't think of anything. I've had a.. a very pleasant existence really...'

The patient is getting some way towards recognising that this anger may be of some significance for him. However as soon as the suspicion emerges that the therapist may be breaking through to some new recognition, the patient reverts back to his old pattern of defence, trivialising and denying. The denial is in this instance accomplished by a generalisation (I only do what most people do), which is a denial of any special relevance this may have for the patient. Later in the session the anxiety that the patient is experiencing is discussed.

Patient 'It was particularly frightening the first time I came to see you I didn't know that I was going to be left with the parish on my own....There have been times lately

when expecting the symptoms and it just hasn't happened and the suddenly quite unexpectedly the symptoms will overtake me....

The patient is telling the therapist about his anxiety, but is then unable to think about what this might mean in terms of his life and in terms of his psychology and instead he reverts back to his familiar mode of defence in which the meaning of symptoms has no place. Such as in the following:

Patient: 'It seems as though the adrenaline is held back and then floods itself out...

Towards the end of this session we have a typical example of destruction of meaning by way of concrete thinking:

Therapist: 'You know I was thinking of something very similar about what it was like for you in the children's swimming pool or as a child, whether what you're saying now makes any sense in this you know very happy childhood, the previous life you talked about. If what your saying now has any meaning at all in your childhood like the experiences in the children's pool.'

Patient: 'I don't think so, one it was only momentarily and it was abandoned anyway in the evenings it was not used by children so there was no atmosphere of children present.'

Therapist:' You've taken what I said literally as a swimming pool.'
Patient: 'Yes whit all its atmosphere of a children's pool. In fact in Dover there is no children's pool but you can do the same trick by going into the shower.....'

The therapist has made several attempts at trying to bring to the patient's attention the fact that the patient had used the children's swimming pool as a metaphor and not literally but the patient refuses to recognise this, he responds by saying:

Patient: 'You're not saying that going into a children's pool was somehow reminding me of all the comfort and pleasure of childhood and that was making it possible for me...

The communication is breaking down in the above vignette. The patient and therapist are talking on different levels. The therapist attempts to point this out to the patient. The session ends however on a hopeful note, that is, the patient recognises that he needs help in order to make sense of things:

Patient:'....I've gone as far as I could with the ground that I kept treading over in my own mind and now to widen the field I need help. I need help in being drawn forward.'(Long silence)

The nature of the anxiety in this session is persecutory. There is no evidence of depressive anxiety; in fact no 'significant other' is mentioned in the whole session. The only other characters that appear are the colleague of the patient and the therapist in his capacity of providing something for the patient. Thus no capacity for concern is evident.

4.3.2. Argumatics analysis of session 2

(Long silence at the beginning of the session)
Therapist: Do you think that you feel able to say whatever might be going through your mind?

Patient: There's not very much going through it actually except to say as I'd said in that letter, that I'd gone, that last time we met I'd gone through the ground to it's very limits to anything that I could see that was of any relevance sort of right on to the, right on to the boundaries of anything else.

Therapist: I wonder if that feels very frustrating to you because as you said in your letter you weren't sure that you would be able to say anything.

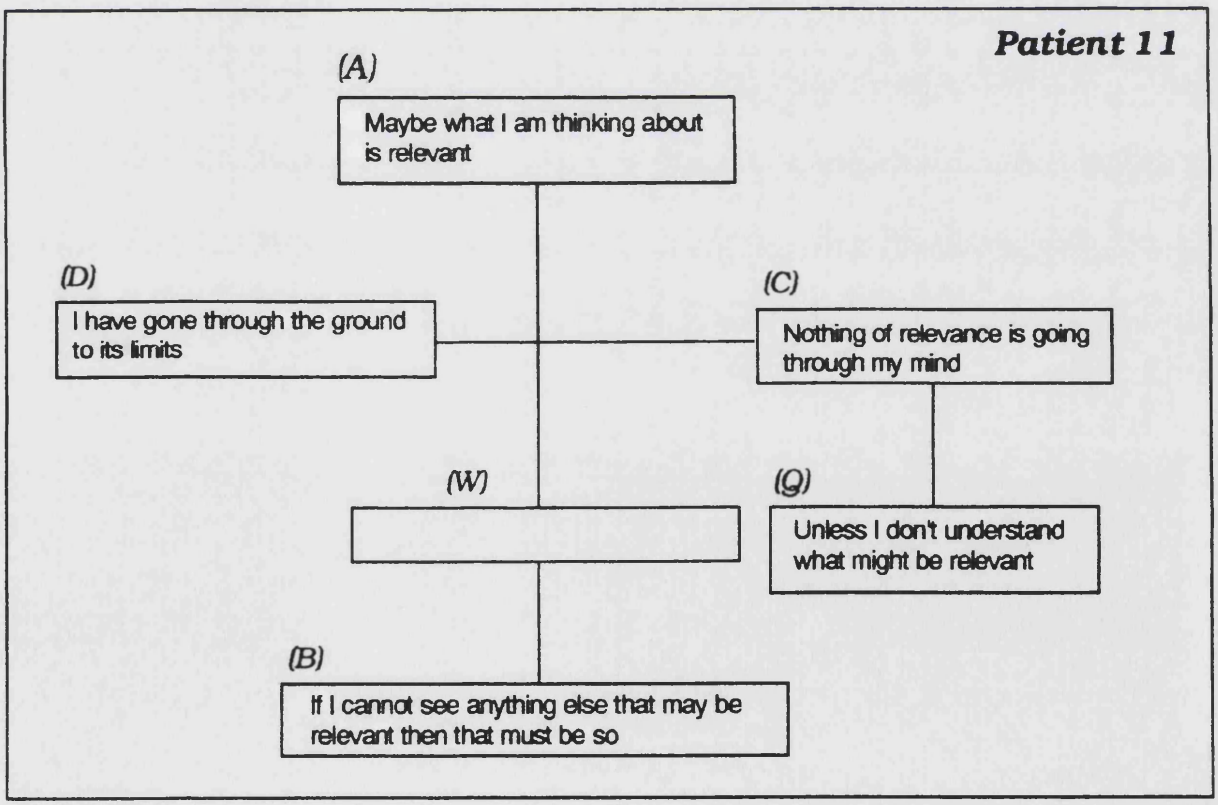


Diagram 11 - Patient: The patient makes a Claim that nothing of relevance is going through his mind. He makes this Claim after a lengthy silence and some prompting from the therapist. The Data offered is that as he said in his letter he feels he has covered the

ground 'to its limits'. No Warrant is offered. The inferred Backing must be something like: 'If I cannot see anything else that may be relevant then that must be so'. The Alternative, which is not verbalised, could be: 'maybe what I am thinking about may be relevant although I don't know it or understand it'. Similarly the Rebuttal could be: 'unless I don't understand what might be relevant'.

The flavour of the Claim and the relevant paragraph is one of avoidance; the patient does not want to engage in an exploration of his situation. The Claim appears to be a denial that is, nothing of relevance is going through his mind. The significant word here is relevant. It indicates that a censoring process has taken place that has not been shared. The Data on which the Claim is based is a reference to a letter the patient had written to the therapist, in which, he had said much the same thing. No Warrant is offered, and although the Backing can only be inferred, it must be something like: 'if I think so it must be so'. If we can assume that the patient is serious and not playing games, this communication indicates omnipotent thinking. It is a curious set of affairs when a patient comes for help but at the same time censors what he is prepared to offer.

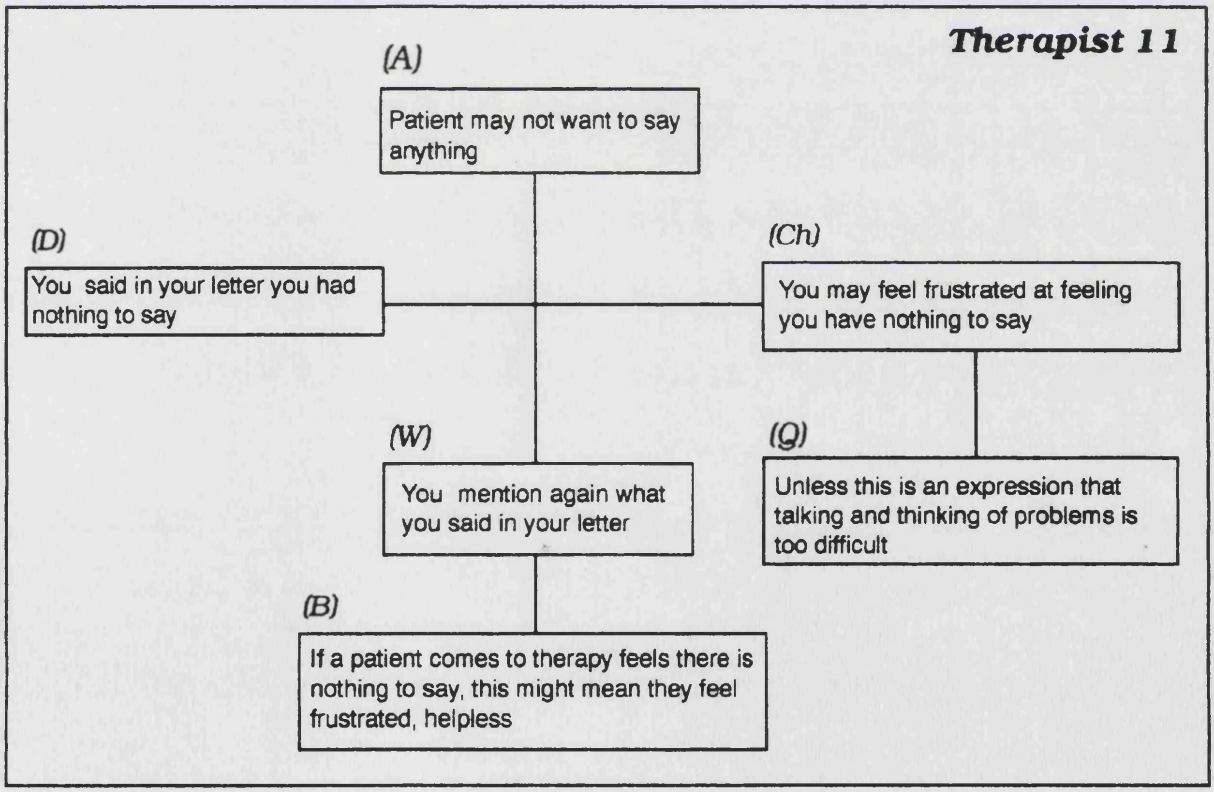


Diagram 11-Therapist. The therapist produces a Challenge, which introduces a new angel on the situation. The Challenge is that there might be some frustration on the part of the patient at not having anything to say at this point. The Data is that the patient had

written to him and said he had nothing to say. The Warrant appears to be the same thing as repeated in the session. In fact the Data and the Warrant rest on rather shaky ground, there seems to be no real stated bases for assuming the Data, only circumstantial evidence that the patient might be frustrated. The Backing incorporates the thinking behind the Challenge or suggestion that the patient is frustrated. The Backing, which is not verbalised might be something like a dialogue with an internal supervisor, or a hunch born out of previous experience. The Alternative that the patient may not in fact want to talk, or indeed may not even want therapy is not mentioned. The Qualifier is that the issues involved may at this point in time be too difficult to think about, and therefore needs defending against.

The therapist makes a suggestion in the Challenge, which he hopes will open up new exploration.

Patient: It does and I didn't want you to feel distressed at my not being able to sort of help you to.... You see with this business once it started all the stresses that seemed to be related to it have all been removed more or less one by one and aren't there any more.

Therapist: But apparently from what you've just said a new one has been added that you didn't want to feel that I would be distressed about you, as if that in itself became stressful for you.

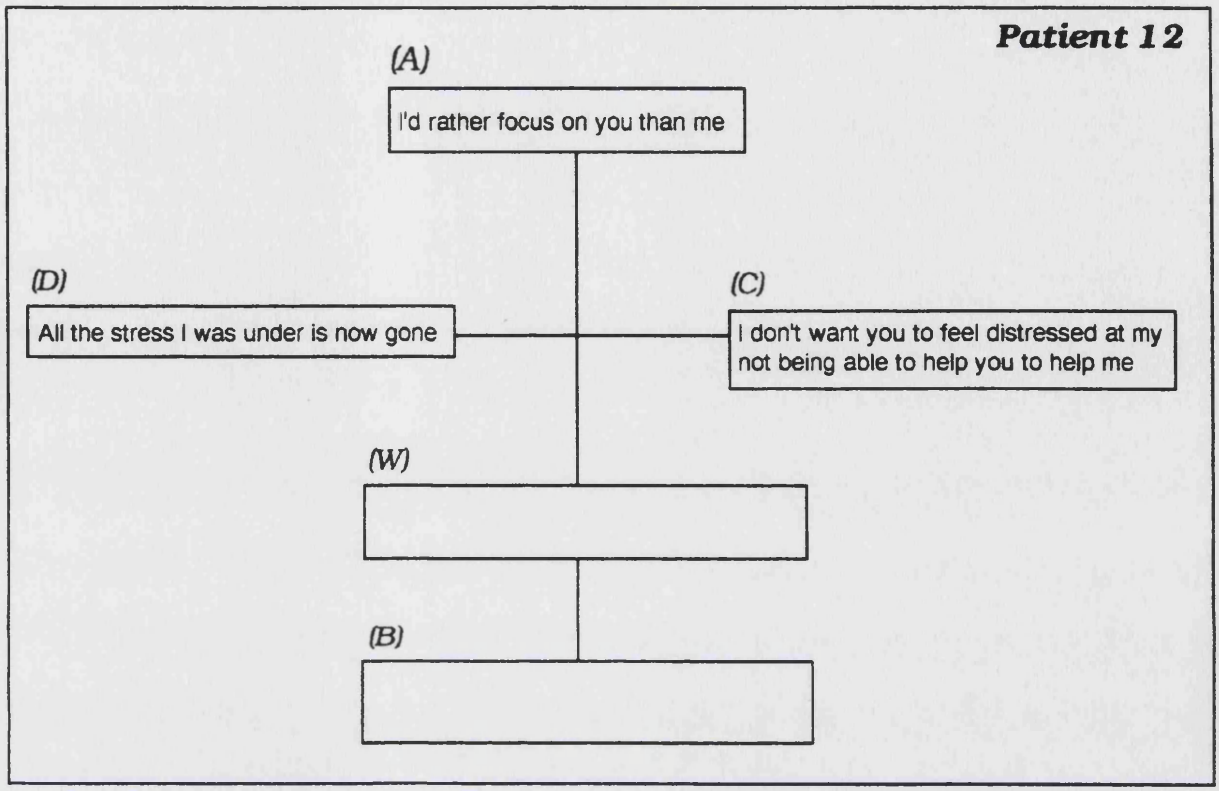


Diagram 12- Patient. The exchange continues with a surprising Claim by the patient in response to the therapist's previous suggestion, namely: 'I don't want you to feel distressed at my not being able to help you to help me'. All that is offered, as Data is that, now the stress has gone that was previously mentioned (I assume the situation with the difficult colleague). No Warrant is mentioned nor any implied, and the Backing is not clear. Alternatives are not explored. The Alternative could be that the patient might rather focus on the therapist's difficulties rather than his own.

The patient has attempted to turn the tables on the therapist. The problems are now not his but his therapist's. The statement that it is the patient, who can enable the therapist to do his job and not the therapist enabling the patient, is a further suggestion of omnipotent thinking and projection, especially as this assertion is made without evidence. As a sequence is that the therapist is now the one with the distress and the patient's distress is gone.

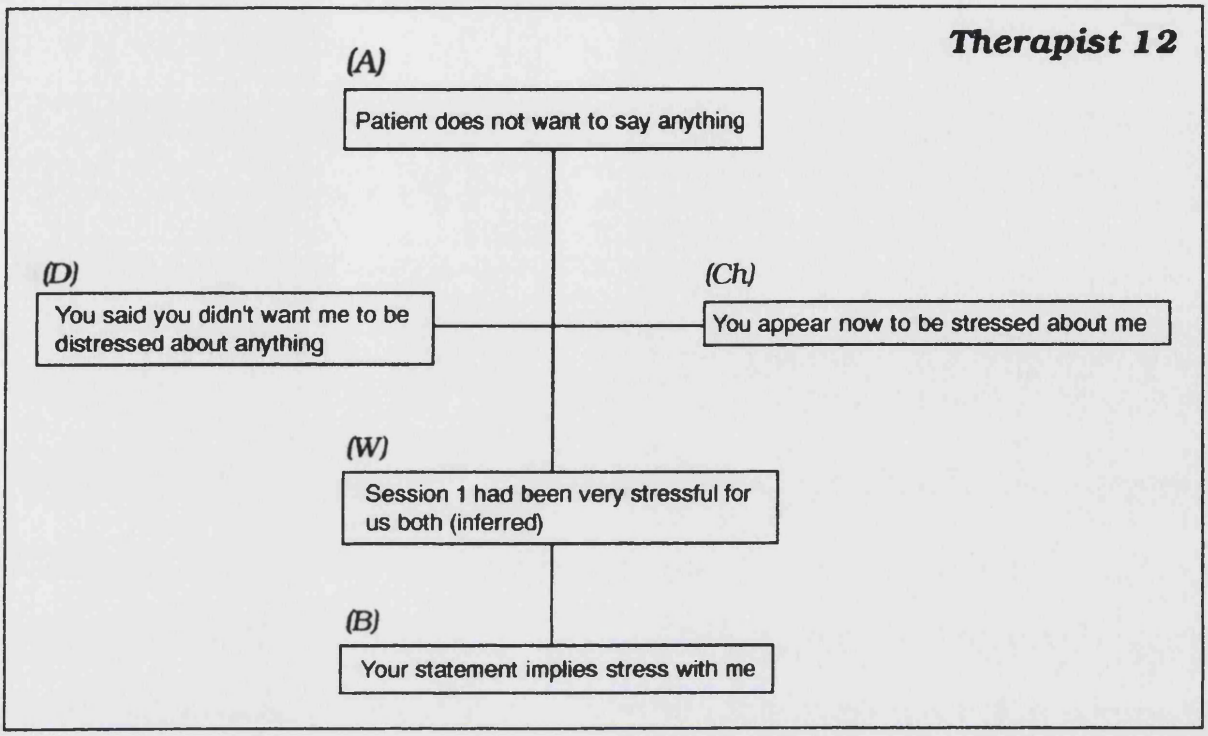


Diagram 12 - Therapist: The Challenge, which the therapist introduces, is that the patient now appears to be stressed by the fact that, having taken responsibility for the therapist's possible distress, this in itself appears to have caused more stress for the patient. The Data is that the patient had just mentioned that, possible distress of the therapist worried him. No Warrant is offered but the stress present in the previous session might be at the back of the therapists mind. The Backing is not articulated but seems to originate with 'the internal supervisor', and might be something like this statement seems to be about the stress in the transference. The Alternative that this is the patient's way of communicating that he does not want to talk on this level with the therapist is not acknowledged.

In the few opening remarks analysed above, it appears that the patient returns to his second session rather alarmed. The patient has in fact written to the therapist in between the sessions suggesting discontinuing the therapy. The attempts by the therapist to address the psychological level in the first session have created considerable anxiety and defences were mobilised. Omnipotent thinking which relies on splitting, that is large parts of reality had to be denied and projected, such as the fact that it was the patient who was distressed and not the therapist. The therapist makes an attempt to clarify where the patient stands at the beginning of this second session.

Patient: No because in talking together we, I thought we'd more or less agreed that we'd got through all the ground that it was possibility to move along ....

Therapist: Because I'm not so sure because you assumed something about me. You assumed that between us we had agreed that you had gone as far as you could go. But that wasn't true as far as I was concerned.

Patient: No I'd agreed that I'd gone as far as I could go. And if psychotherapy could only be a one direction thing, me talking, which is much truer to the definition of counselling, I would have thought, if the response could, was to only come from me then I'd gone as far as I could.

Therapist: Mm. But you made... assumptions about me. You didn't leave any room for me to have a view on that..

Patient: Which particular assumptions? Mm? Which particular assumptions?

Therapist: Pardon?

Patient: Which particular assumptions, what assumptions, what assumptions do you think I made or I did make?

Therapist: Well you concluded that I believed something was wrong and that we had between us decided. That's what you said earlier in the session.

Patient: If I said between us we had decided then that was not meant. I had dec- I had decided that I had gone along the road as far as I could and without any help from you I couldn't do anything more of my own volition. That's the truth of the matter.

Therapist: I see. So what you're saying, and this is important, with out any help from me so that coming along here and again this might be an assumption, felt as if you wouldn't be getting any help from me.

Patient: I didn't know. It depends how, it depends how psychotherapy works. If it is to be just a one-way thing of a person talking then I've done all I could but if there's avenues you can take to help me in the flow of conversation then I could see there is possibility.

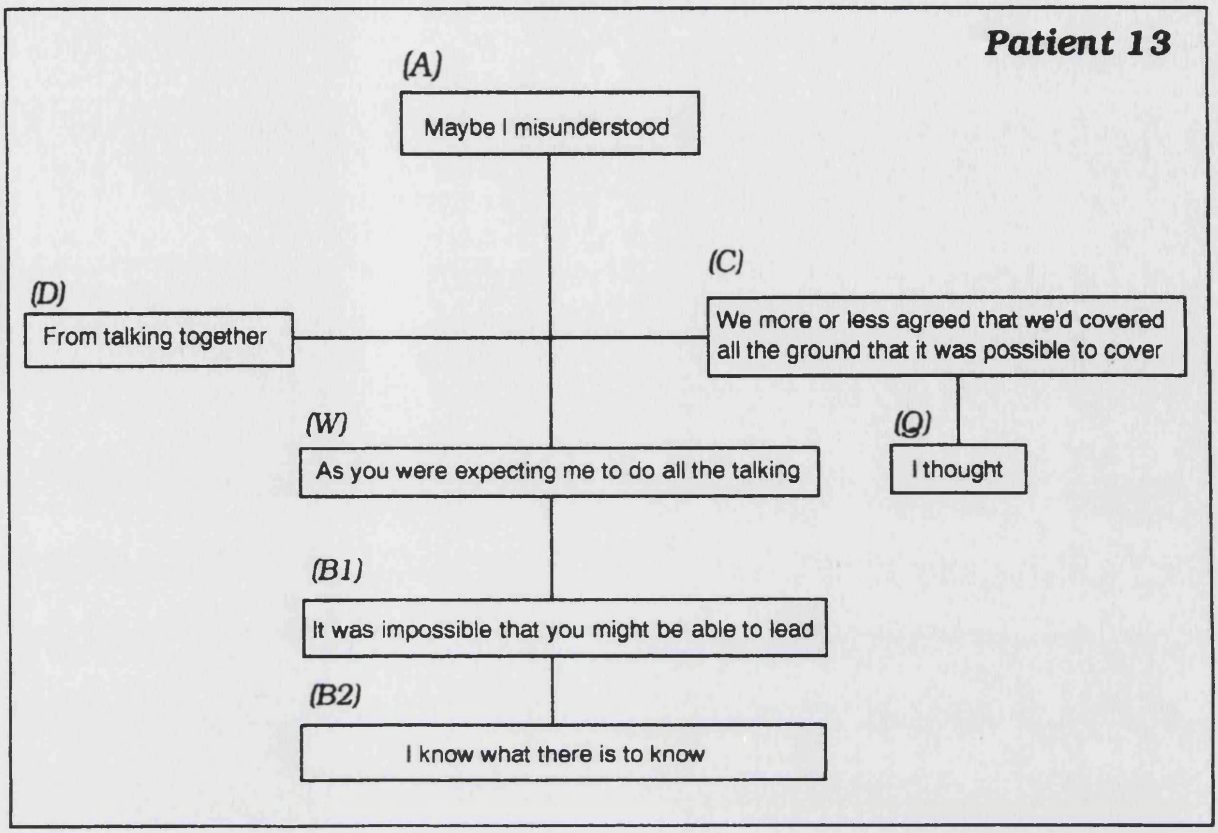


Diagram 13 - Patient The patient makes a Claim that he thought that there had been a kind of agreement between therapist and patient that all the 'ground' possible to cover had in fact been covered in the previous session. The Data offered in this context is that this was the conclusion that the patient had reached from talking with the therapist. An Alternative which is not verbalised is that maybe the patient misunderstood. A curious Warrant is offered which is that this must be the case as the patient 'was expected to do all the talking'. As Backing the patient actually concludes that it was impossible for the therapist to lead. A second Backing appears to be that the patient knows what there is to know. The Claim does include a Qualifier 'I thought'.

This diagram contains a great deal of conflicting material. There had factual been no agreement that all possible ground had been covered. The Warrant does also not make sense in this context, why would the fact that the therapist wasn't more active in the session mean that everything that could be covered had been covered. In order for the situation described here to have any coherence, there must either have been a misunderstanding, which is an Alternative, but which is not considered by the patient or omnipotent thinking is in operation.

It can be assumed that it is omnipotent thinking that lies behind this reasoning therefore it does not matter that the facts don't quite add up, as the feeling of knowing what is possible to know is enough to convince the patient that it must be the case.

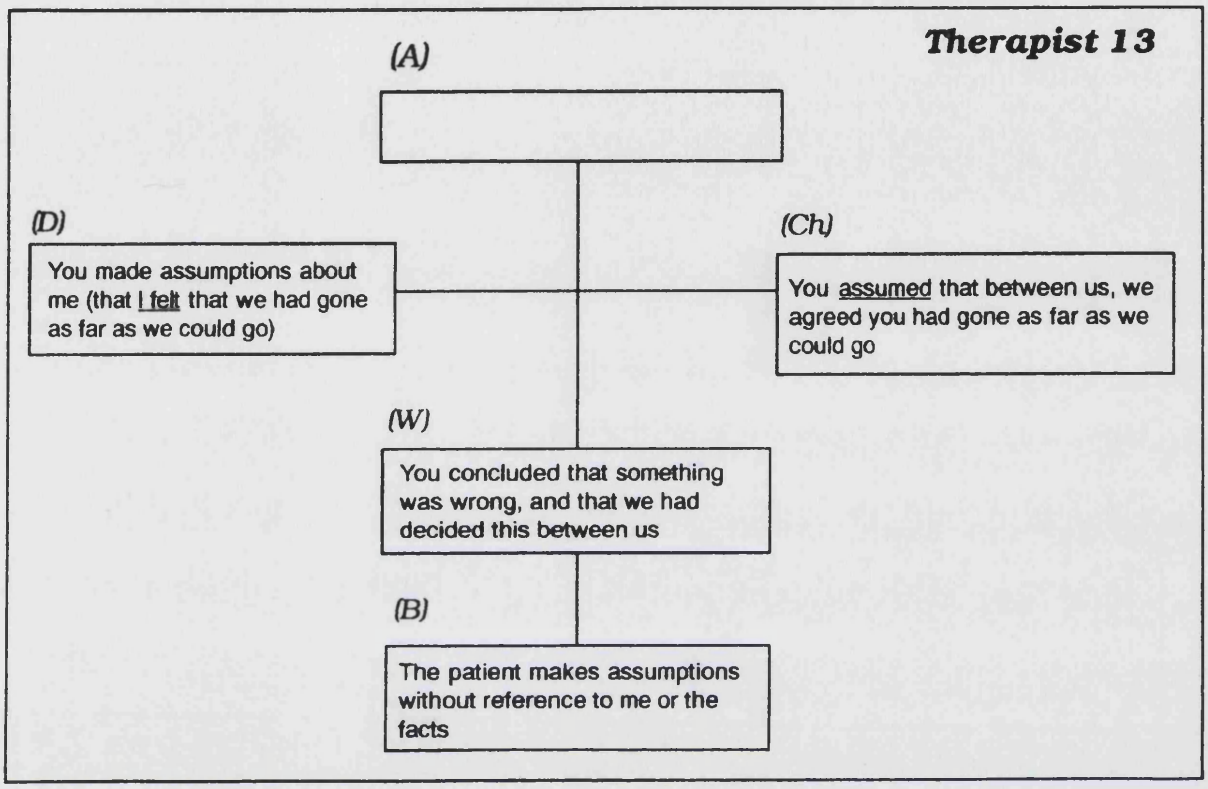


Diagram 13 - Therapist The Challenge is that, you assumed that between us we agreed you had gone as far as you could go. The Data is that, you made assumptions about me (that I felt that we had gone as far as we could go) without allowing me to have a view. The Warrant is that, you concluded that something was wrong and that we had decided this between us. The Backing which, appears to underlie this reasoning, is: The patient appears to make assumptions without reference to the therapist or the facts. No alternative is offered.

The therapist is attempting to draw the patient's attention to the fact that, he makes statements and assumptions without reference to reality, by amplification. In so doing he challenges the patient to reflect on the distortion of reality which the patient has created in the therapy relationship.

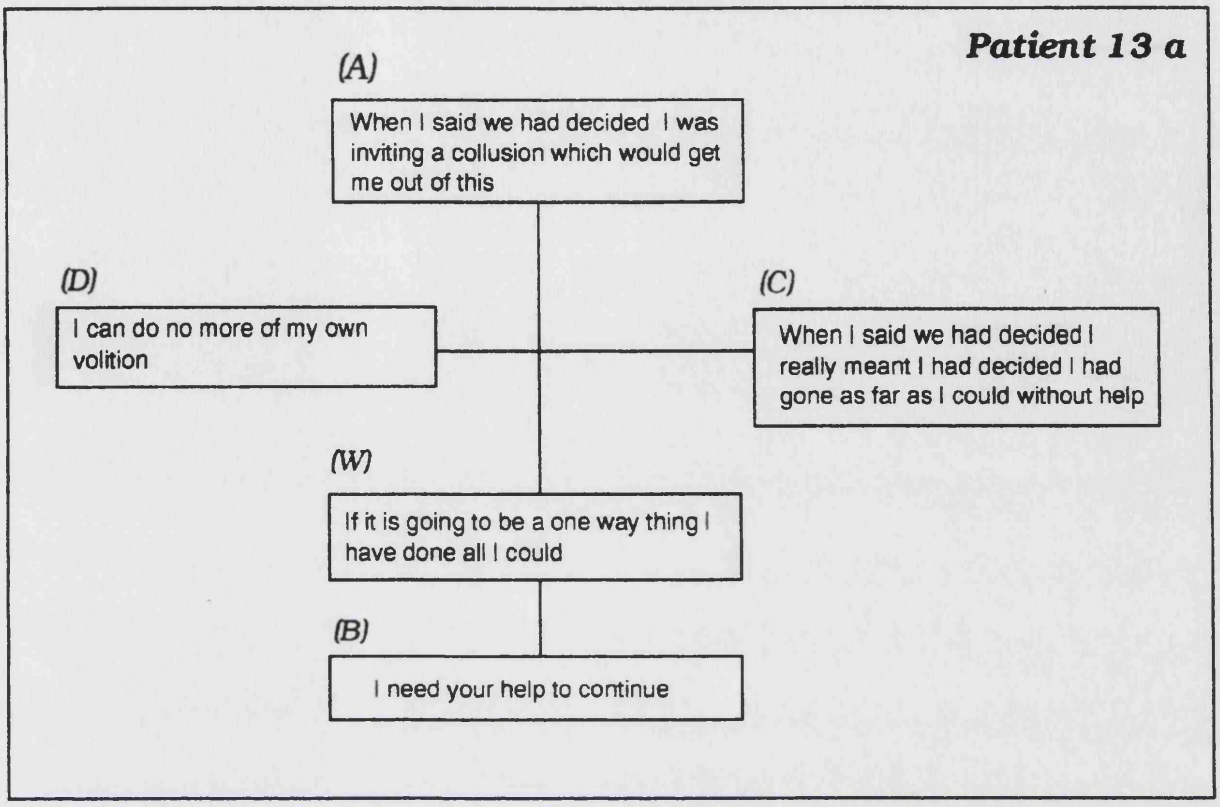


Diagram 13a - Patient. The Claim here is that when the patient had said, there had been an agreement he had really meant he had decided that he had gone as far as he could go without help. The Data is that he feels he can do no more of his own volition. The Warrant is that if therapy is going to be a 'one way thing' he has done all he can. The Backing which is verbalised is that he needs help to continue. The Alternative which is not explored is that maybe the patient was inviting a collusion which would enable him to get away from this uncomfortable situation called therapy.

The Claim in Diagram 13a - Patient, is based on an omnipotent belief in the patients own capacity to see anything of importance. The Challenge by the therapist does however strike at the heart of this belief and the verbalisation of the Warrant (Therapist) helped to demonstrate how this assumption by the patient was in fact based on very shaky ground. And in fact as a result of the communication described in Diagram 13a - Patient, the patient completely changes his story. He contradicts himself, by making the new Claim that when he had said there had been an agreement he had in fact meant that he himself had decided that, he had gone as far as he could without help....

In this vignette there has been a transformation from omnipotent belief which was challenged to a recognition that the patient needs help.

Patient: It seems somehow that the adrenaline is held back and sort of physical terms it's as though all the adrenaline has been held back and then floods itself out, whereas if you allow yourself some anxiety enough trickle flows to not suddenly be overwhelmed if anxiety does appear. I don't know if that makes any sort of sense. A bit like going into the children's swimming pool instead of getting a really cold dose straight off. I was thinking by analogy you see. In Folkestone there are two, I come from from there are two swimming pools, there's the adult pool and the children's pool. And the water is pretty cold in the adult's pool so what people do is go in the children's one for a few minutes that's coolish and then into the other one to sort of break it down.

Therapist: You know I was thinking of something very similar about what it was like for you in the children's pool or as a child... whether what you are saying now makes any sense in this you know very happy childhood, previous life that you talked about. But whether what you're saying now has any meaning at all in relation to your childhood.

Patient: I don't think so because one it was abandoned anyway in the evenings, it was not used by children so there was no atmosphere of children present.

Therapist: You've taken what I've said literally as a swimming pool.

Patient: Yes with all it's atmosphere of a children's pool. In fact in Dover there is no children's pool but you can do the same trick by going into the shower that's fairly cool and then going into the water so I don't think that children's pool in itself was of any significance. It's just that breakdown of two levels of water. And everybody else did it as well.

Therapist: It's difficult for you when I, I suppose I imagine you might have been using some sort of metaphor or you know talking about children's pool or getting in touch with things that surround children before you can move onto the colder adult pool. And I'm wondering if you are actually talking about your own childhood, getting in touch with things from your own childhood before you can go on and face the colder adult sort of stuff that you have to face now. And it's difficult for you to I suppose think in these terms.

Patient: I can understand what you're saying but I can't think that because it was other people who taught me the trick of going in....

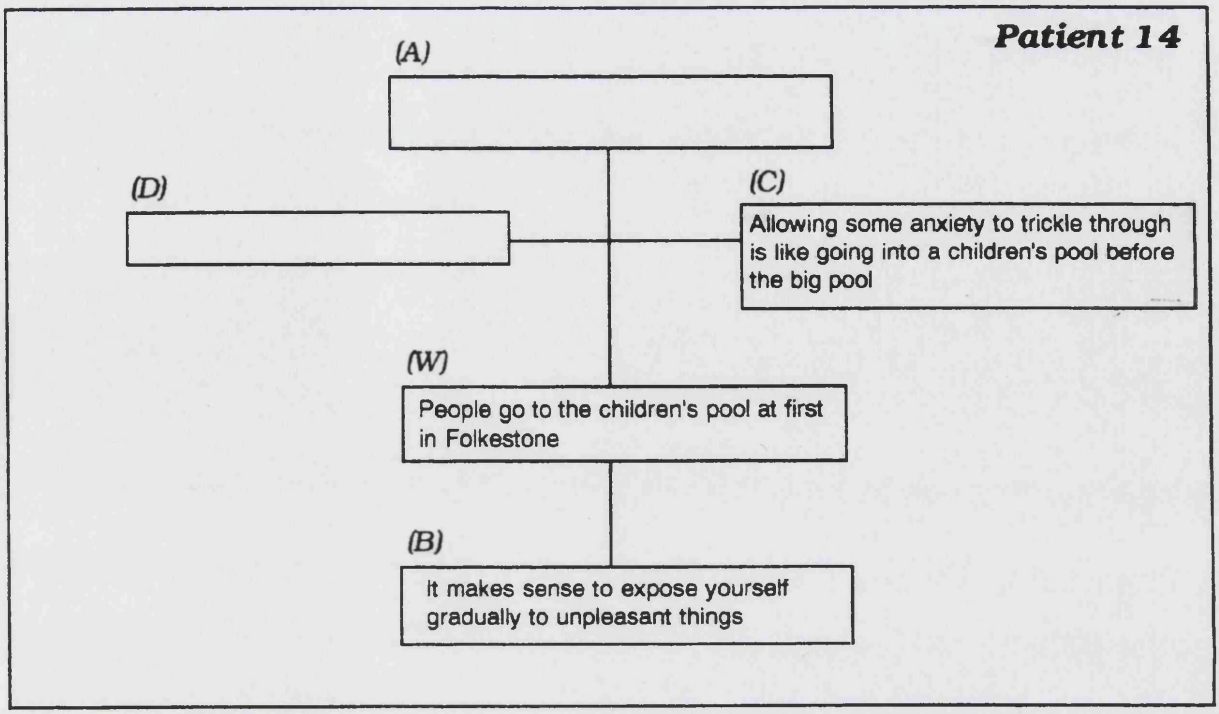


Diagram 14 - Patient The patient is making a Claim that 'allowing some anxiety to trickle through is like going into a children's pool before entering the adult's pool. There is no Data for this Claim. The Warrant is that 'people go into the children's pool at first in Folkestone'. The Backing is not verbalised but appears to be something like a principle that it makes sense to gradually expose yourself to difficult or potentially unpleasant things.

In the Claim the patient offers an analogy or what appears to be a metaphore about his way of trying to deal with his difficulties. He does however also reveal something about the nature of his anxiety, that is his need to carefully explain and eliminate uncertainties as far as possible.

Although using a metaphore in this vignette, the patient's communication has a distinctly concrete flavour. The patient starts off by using a metaphore, but it loses its 'as if' quality, and the concrete meaning of the analogy/metaphor takes over at the same time as the anxiety diminishes, see Warrant. It appears that the patient starts thinking in metaphorical terms, but as he tells his story the concrete elements of it take over. At the same time it is a less defended communication to the therapist, a possible opening for new meanings.

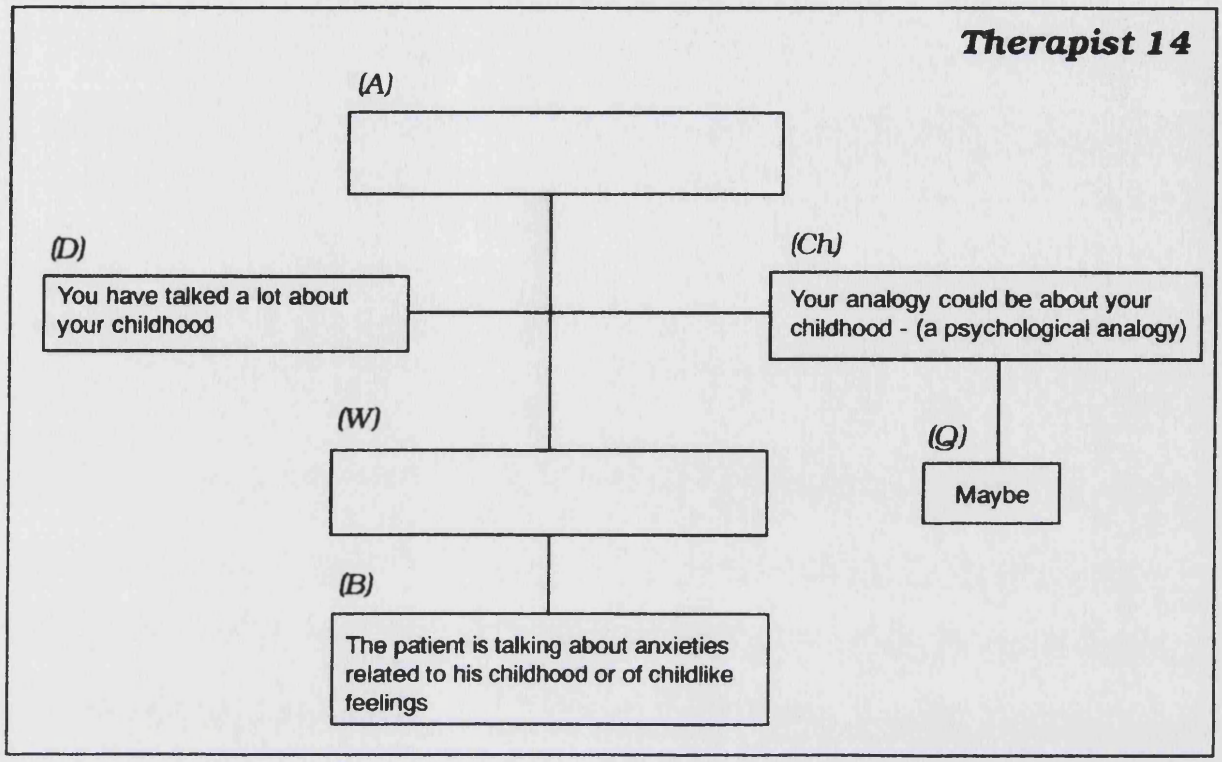


Diagram 14 - Therapist The Challenge offered by the therapist is that the analogy/metaphore could be interpreted more widely, that is it could also relate to the patient's childhood in some way. The Data is that the patient has talked at some length about his childhood. A Qualifier is verbalised, that is, this could 'maybe' be the case. No Warrant or Alternative is verbalised. The Backing which is not verbalised appears to be that what the patient is talking about is something wider, to do with his childhood or childlike feelings.

Here the therapist is addressing the closed system that the patient is attempting to create. The suggestion is that the metaphore which has been offered could be understood and explored in a wider context. The Backing on which the Challenge is resting appears to be based in the therapist's own theoretical framework, perhaps a dialogue with the internal supervisor. The therapist challenges the patient to think.

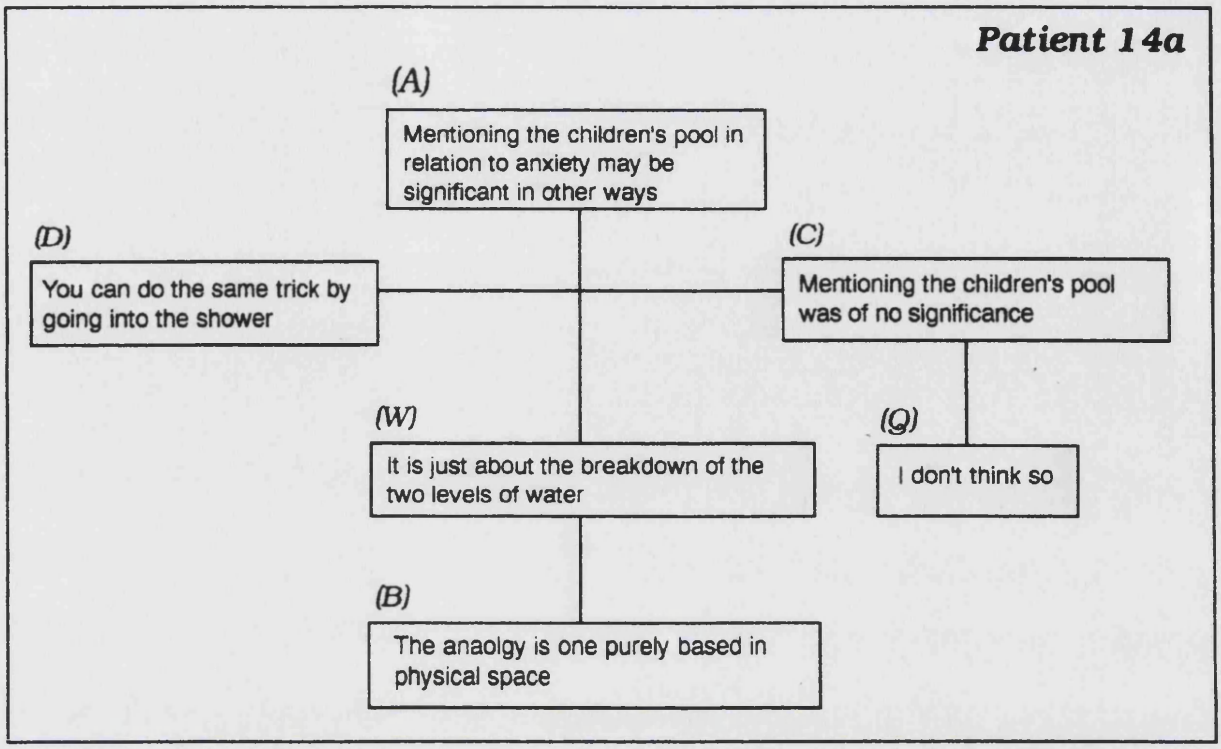


Diagram 14a - Patient. The Counter Claim now presented by the patient is 'that mentioning the children's pool was of no significance. The Data for this Claim is that 'One can do the same trick by going into the shower'. A Warrant is offered to back up this Counter Claim, 'it's just about breakdown of two levels of water. The Backing in this scenario, although not verbalised is that 'the analogy is one purely based in physical space' An Alternative to the Counter Claim is possible here but is not verbalised by the patient, that is' mentioning the children's pool maybe significant in other ways not considered by the patient. Some uncertainty is expressed, as a Qualifier is verbalised, that is the patient says he **thinks** mentioning the children's pool is of no significance.

In this scenario it becomes clear that the therapist's Challenge has created anxiety in the patient. The patient immediately falls back on his customary defence mechanisms, denial of psychic reality and concrete thinking see Claim Data and Warrant. The suggestion by the therapist needs to be rebuffed and not considered, and to solidify the denial the patient reverts to concrete thinking. This means that he becomes insistent that the 'analogy' shall only be interpreted in a certain concrete way, that is children's swimming pools are used to get used to adult swimming pools because they are warmer. The verbalising of a Warrant in this context further demonstrates the anxiety present, ***it is only about the breakdown of two levels of water.*** *The concrete quality of what was an analogy/metaphore is now very apparent.*

4.4.1. Session 6

Subjective/Intuitive analysis

This session starts with a lengthy monologue by the patient about his symptoms, and how these had developed during the past week. There is no exploration or thinking about what anything might mean, only a long moan about his 'sympathetic and parasympathetic systems'. The situation is clearly anxiety driven. This man worries considerably about what is wrong with him. This anxiety is finally expressed directly, when a little way into the session he tells the therapist that it had been suggested to him by a friend that he might be depressed. In fact there seems to be some real feeling in the following:

Patient:'...and the racing from the heart area in case there was something wrong with the heart itself and the anxiety feeling in case this was leading into some sort of nervous breakdown or the beginning of some other bad mental disease such as schizophrenia or something like that.'

In response, the therapist tries to expand on this anxiety, and is inviting the patient to keep thinking about it. However at this point the patient turns instead to one of his characteristic defences, that is he destroys the meaning of what the therapist is suggesting.

Therapist: 'Sound as if you have been very frightened at time at what's going on inside you, inside the vital organs like the heart or your mind, the brain'

Patient: 'That's right certainly, certainly until .....It was the bad period that spanned from coming back from Canada last September until about February this year. I suppose some of the fright has gone with the symptoms recurring when I am doing things sort of in a way just become habitual and acceptable in the end but there are days when that feels more acceptable and habitual than another.'

The patient takes the focus away from the anxiety by turning to 'theorising'. Some anxiety has at this point emerged but it has to be neutralised and destroyed, instead of thought about. This can be seen in the following as the patient is responding to the therapist mention of the patient's fear of mental illness such as schizophrenia.

Patient: 'That's because, I think I said the word schizophrenic because that's the only mental illness I've ever heard of had I known an array of them I'd probably have considered them all.

The patient is trying to play down his earlier mention of schizophrenia. Midway through the session there is further anxiety expressed about the continuing symptoms. There is further denial about fear of schizophrenia in the following:

Patient: Well as the Schizophrenia society now meet in my own Parish Church Hall I know that I haven't got schizophrenia because I've learned what it is. It was just a word in my head.'

4.4.2. Argumatics Analysis of session 6

Patient: Er well the heart, the palpitations and the racing from the heart area in case there was something wrong with my heart itself and the anxiety feeling in case this was leading into some sort of nervous breakdown or the beginning of some other bad mental disease such as schizophrenia or something like that because I didn't know much about it.

Therapist: Mm ...but sounds as if you have been at times very frightened at times at what's going on inside you, inside the vital organs like the heart or your mind, the brain.

Patient: That's right, certainly, certainly until- It was the bad period that spanned from coming back from Canada last September until about February this year. I suppose some of the fright has gone with the, the symptoms recurring when I'm doing things sort of in a way just become habitual and acceptable in the end but there are days when that feels more acceptable and habitual than another.

Therapist: Mm... more frightening about what is going on.

Patient: Yes. There are some days when I feel, when it's almost turned off completely. But it's pretty well turned off today but that er that spinning round three time has still left my head heavy now and I wouldn't particularly want to take command of a large gathering again today, just as someone who had a heavy cold coming on, feels rather like that.

Therapist: You see ... you told last time about similar things, when these symptoms or similar symptoms came on when you were sixteen and-

Patient: The ladder climbing.

Therapist: Yes. Obviously there have been sensations something like this for a long time in your life and I suppose it is the terror of something, it's got to be something odd for not... but you had this feeling of being a bit odd.....
Well I think you had the feeling. You were describing yourself as perhaps feeling a bit odd if, we didn't agree... that was a word that I used but I wonder if it does make this odd feeling what your saying now about the terror that something awful is going wrong with your vital internal organs....and schizophrenia.

Patient: That's because, I think I said the word schizophrenic because that's the only mental illness I've ever heard of.... had I known an array of them I'd probably have considered them all.

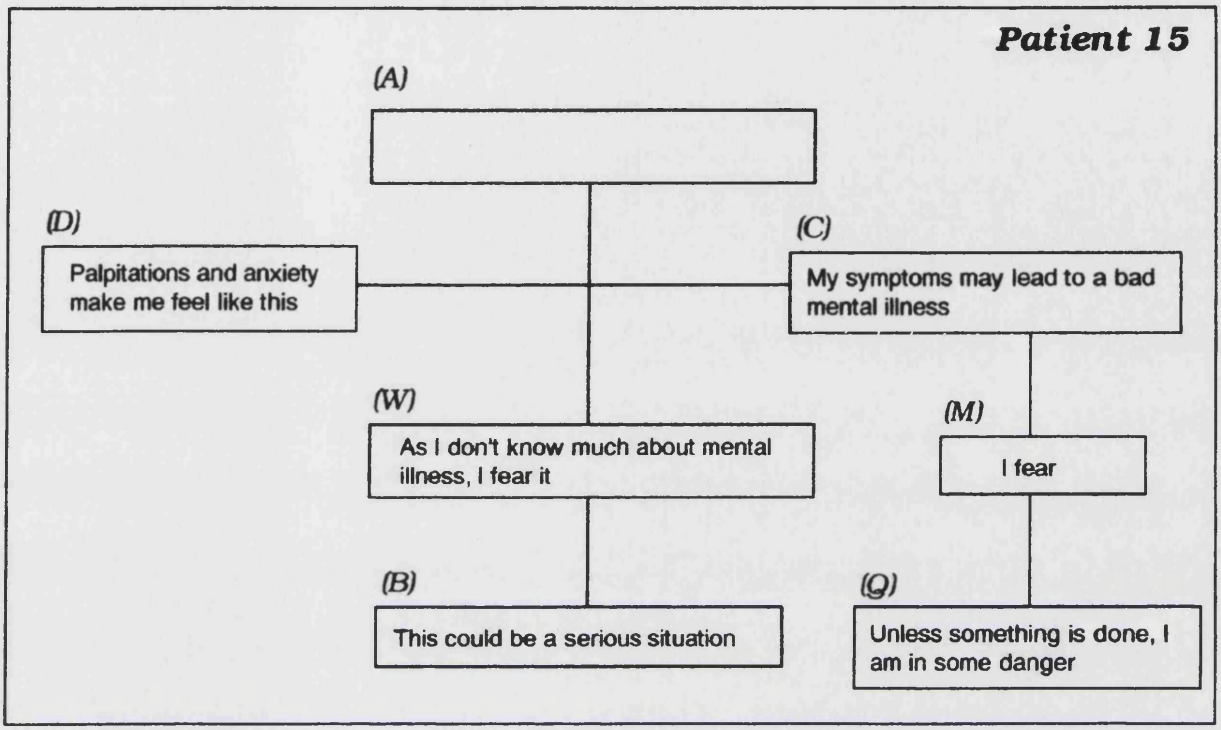


Diagram 15 – Patient As a Claim the patient voices a fear that his symptoms could be leading to some kind of 'bad mental illness'. The Data offered is that the symptoms and the accompanying anxiety makes him feel like this. No Warrant is given, nor is any Backing verbalised but it appears that he is implying something like 'as I don't know much about mental illness I am bound to fear it, as a Warrant. The Claim also has both a Modifier , 'I fear' and an implicit Qualifier, 'Unless something is done, I am in danger,' attatchet to it. The Backing implicit in this argument is that, 'This could be a serious situation.

The Claim which is really more of an expression of fear is that the symptoms may in fact have some psychological meaning. This is an important consideration on part of the patient. From the context it is however clear that he cannot stay with this anxiety and does in fact immediately need to explain it away as just a function of his ignorance and not something to think about, see Warrant. He attempts to desrtroy the meaning of what he has expressed himself, by introducing an
'It is only because... '

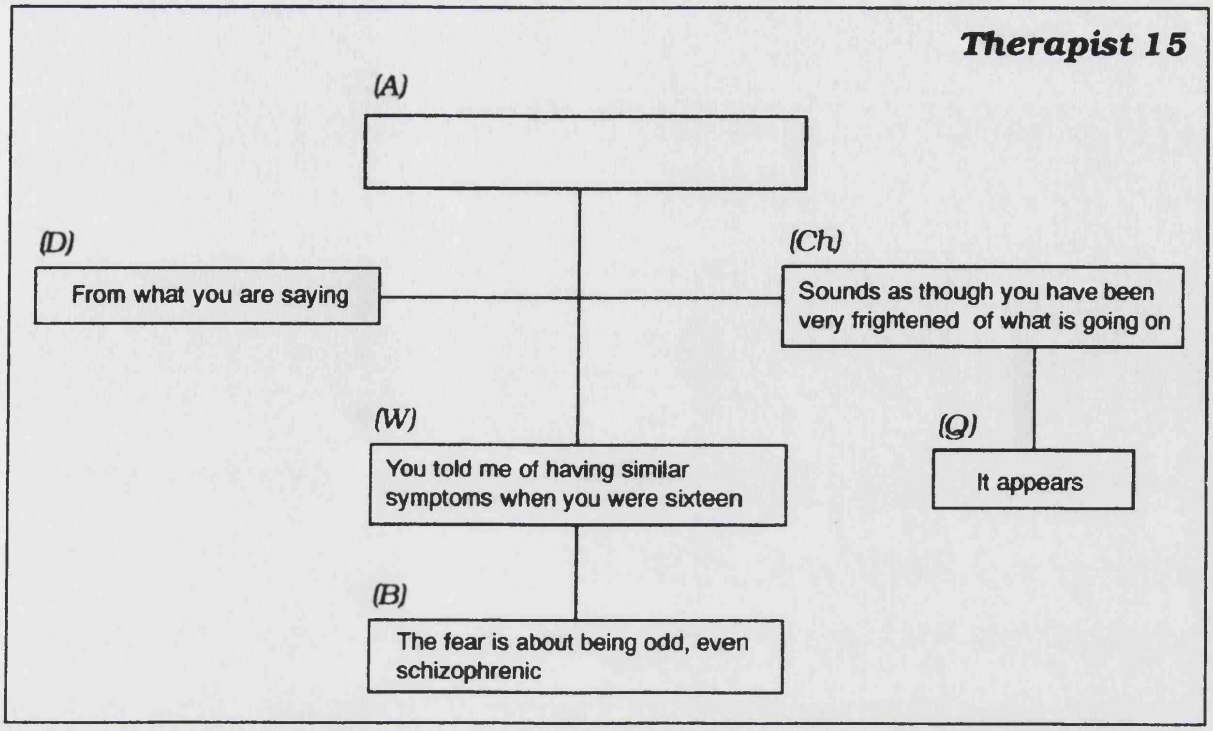


Diagram 15 - Therapist The Challenge offered by the therapist is that it sounds as though the patient has (and for a longer time- Warrant) been rather worried about what is going on for him. The Data referred to is the patient's own statement. The Challenge comes with a Qualifier, 'it appears'. The Backing which is verbalised is that the patient fears being odd even schizophrenic.

The therapist tries here to strengthen and amplify the patient's own thoughts in order to encourage further thinking abouth the patient's anxiety.

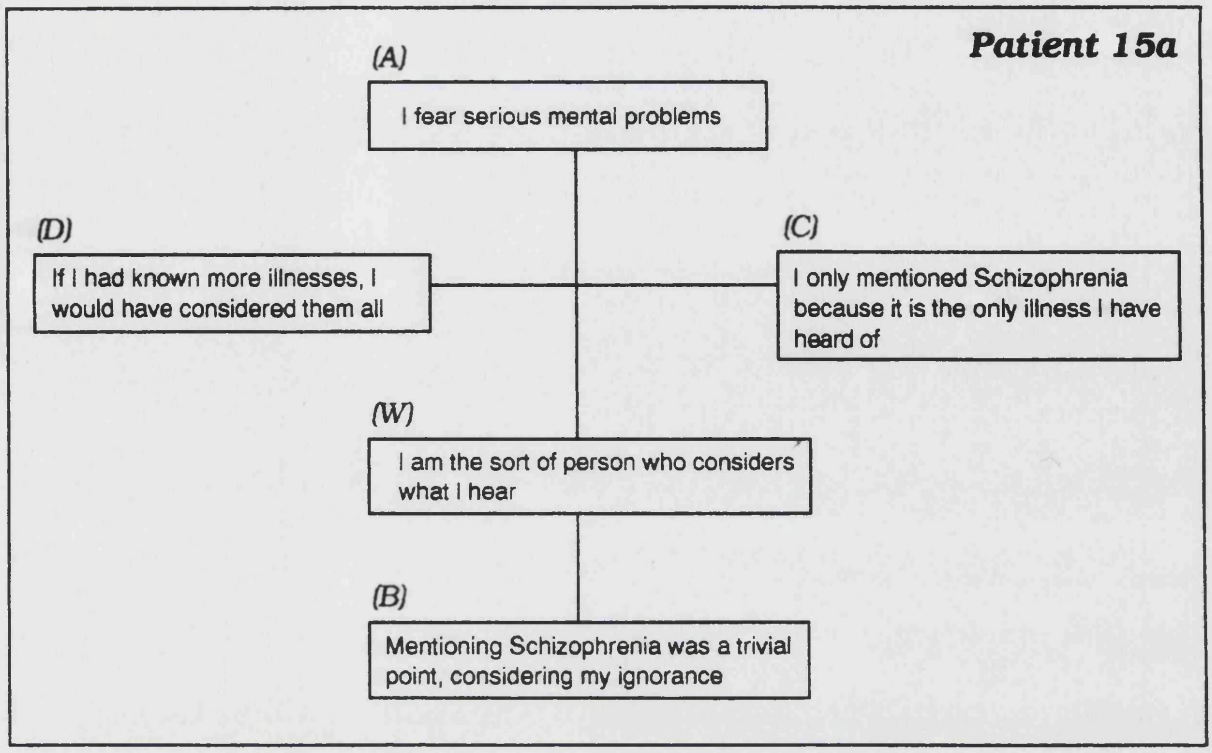


Diagram 15a - Patient The Claim which is produced in response to the therapist's input above and also in response to his own ideas expressed earlier, is that he had only mentioned schizophrenia as it is the only mental illness he had heard of. The Data is that had he known more mental illnesses he would have considered them all. The Warrant is not verbalised but implied, that he is the kind of person who considers anything he hears indiscriminately. The Backing is not verbalised but appears to be that mentioning schizophrenia was a trivial thing considering his ignorance. The Alternative which is not verbalised here but was verbalised above (diagram 15 Patient, Claim) is that there is still considerable fear of something like schizophrenia.

It appears that the patient is attempting to cover his tracks, using denial of anxiety in response to threatening material emerging, see Claim and Data. Here too the concrete nature of the argument is evident. Anxiety started to emerge, but this was felt to be too overwhelming, so the patient reverts to concrete thinking and denial of anxiety.

Therapist: But I wonder if coming here to see me at times feels like grounds for discomfort and maybe fear. Because last week you talked a lot about your earlier life and in a way that you hadn't spoken freely like here before but by the end of our session, coming near to the end, you were feeling frustrated and you really hadn't been talking about your symptoms, they're what is important to you. And you were saying to me well....let's get back to things, get back on the right track next week.

Patient: That's why I started this one.

Therapist: Mmm

Patient: But I wasn't really, I wasn't really frustrated too much about what we did last week because I'm always aware of the twofold nature of these sessions that one is here to get rid of whatever is wrong with me and two, whatever I say will help your research people in some way so from what I've said about my early years might well have, might well be of value to them.

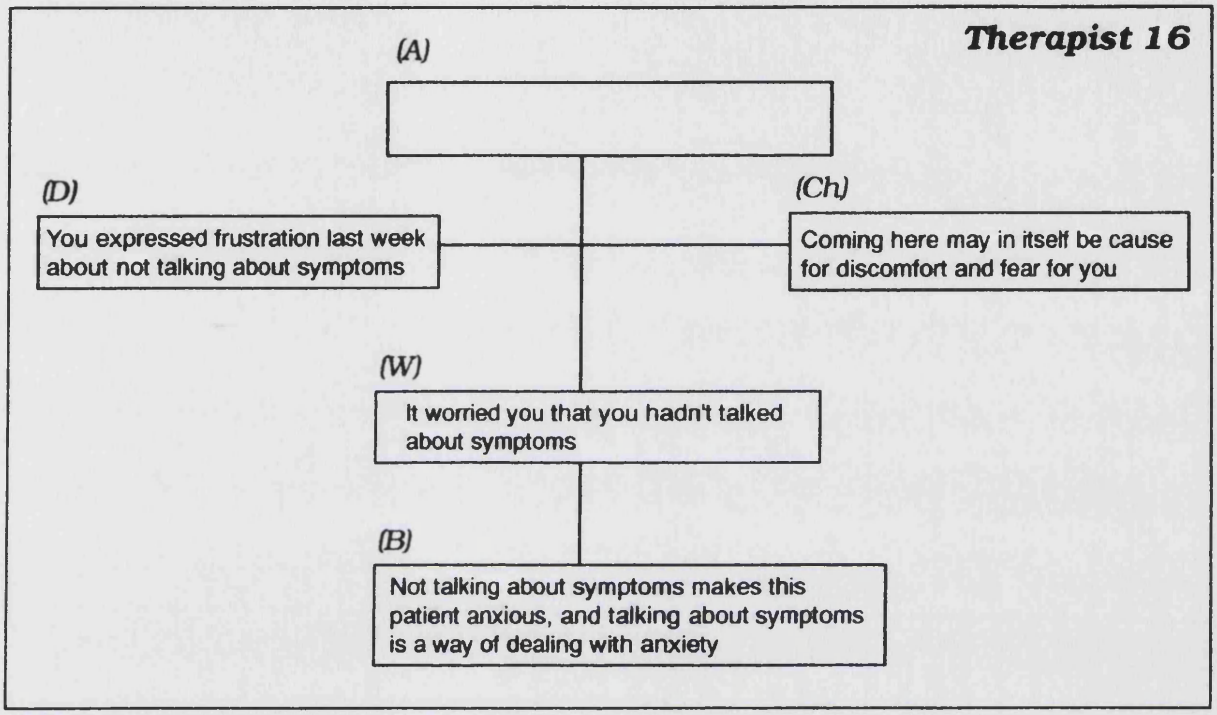


Diagram 16 - Therapist The Challenge presented is that coming to the sessions may in itself cause discomfort or fear for the patient. The Data refers back to the previous week when the patient had expressed frustration at not talking about symptoms. The Warrant which is implied, is that it had worried the patient that he had not talked about his symptoms the previous week. The Backing although not verbalised is that it causes anxiety for this patient when he is not talking of symptoms, and conversely that talking of symptoms is a way of dealing with his anxiety.

This is both a challenge and an interpretation.

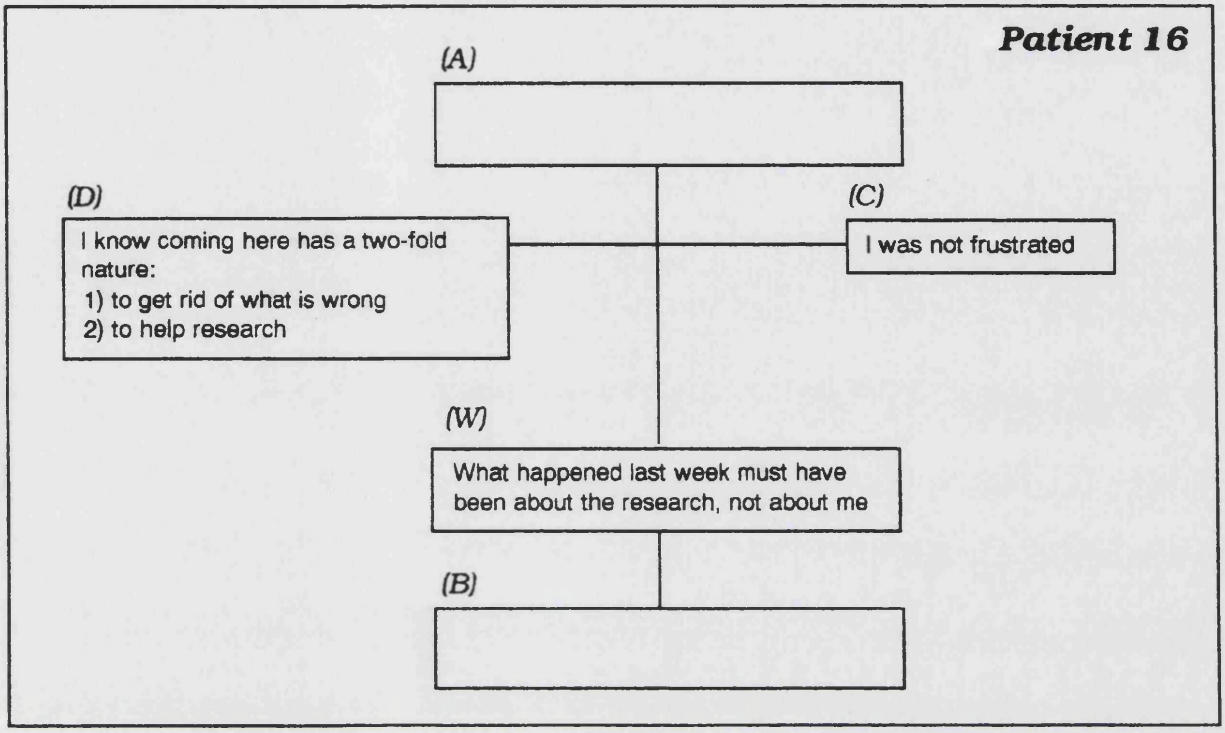


Diagram 16 - Patient The Challenge is met by a Claim denying that he the patient had felt frustrated the previous week. The Data offered is that he knew that the therapy has a twofold purpose, to get rid of what is wrong and to help with research. The Warrant is not verbalised but implied and seems to be that what happened the previous week had less to do with his treatment and more to do with the research aspect. The Backing is not clear.

The patient is again using denial of an omnipotent kind. He uses the research as a way to disassociate himself from whatever difficult feeling had emerged the previous week. The Backing is not clear in this instance.

The need to resist the therapist's Challenge seems here to be overwhelming. The patient's Claim seems to be hanging in the air and is more an attempt to deny the therapist's Challenge.

Patient: ....There is good reason for the sympathetic nervous system to react like that when climbing a ladder because one it was wobbling, I had good reason to think I could fall off I could have injured myself and there's that awful bit near the top where you've got to leave the ladder and join the roof of the building or even worse getting your footing right coming down so that was a very good reason for the sympathetic system to react strongly.

Therapist: But you've given me what sounds like to me equally frightening reasons today about images of something being dreadfully wrong with your heart or something being dreadfully wrong with your brain, that you end up with depression and have violent electrical treatment for schizophrenia, whatever that means, but it's serious.

Patient: But now that's all been checked out and isn't a worry any more I still can't get rid of the sympathetic nervous system behaving in a heavy handed manner.

Therapist: You know it strikes me that you would very much like it not to be a worry but I suspect that it's still around in the back of your mind.

Patient: Oh it's still there I agree I agree, yes. It's a worry, a frightening worry. But the symptoms as it were I see as being proportional to the degree of worry when it all started but now the symptoms are not proportional to the worry.

Therapist: To your conscious worry.

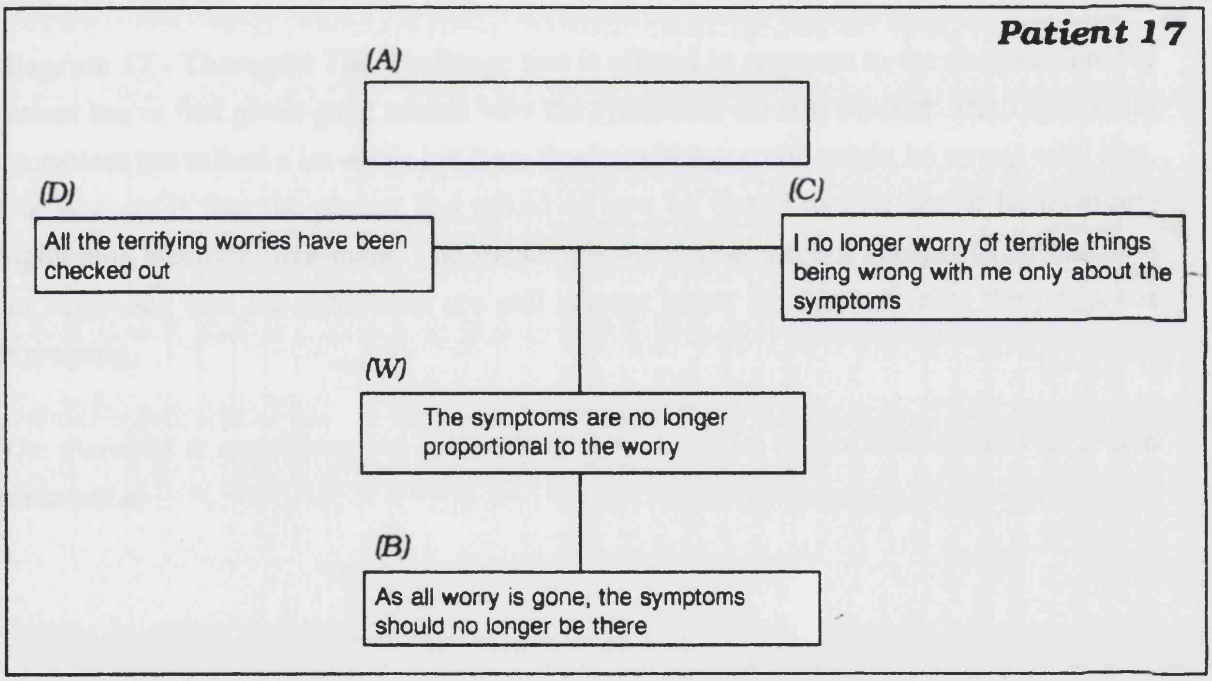


Diagram 17 - Patient The Claim put forward is that there are no particular worries any more about terrible things being wrong. The Data is that 'all the terrifying worries have been checked out'. The Warrant is that the symptoms are no longer proportional to the worry. The Backing although not verbalised is that the symptoms should no longer be present.

This suggests continuing omnipotent denial of anxiety.

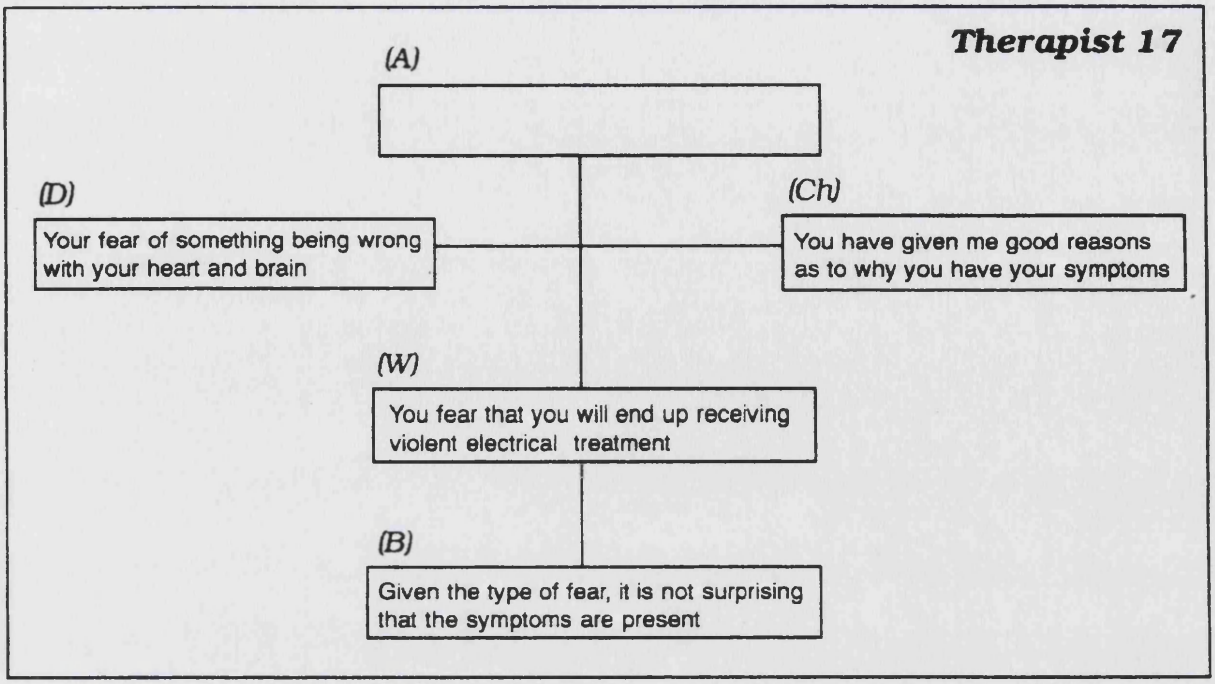


Diagram 17 - Therapist The Challenge that is offered in response to the above is that the patient has in fact given good reason why the symptoms are still present. The Data is that the patient has talked a lot about his fears that something awful might be wrong with him. The Warrant is that the patient had talked of how he feared that he would be receiving frightening electrical treatment. The Backing is not verbalised but appears to be that 'it is not surprising that the symptoms are still present given the type of fears the patient is expressing.

The therapist is amplifying the patient's anxiety, in order to get him to focus on it and not avoid it.

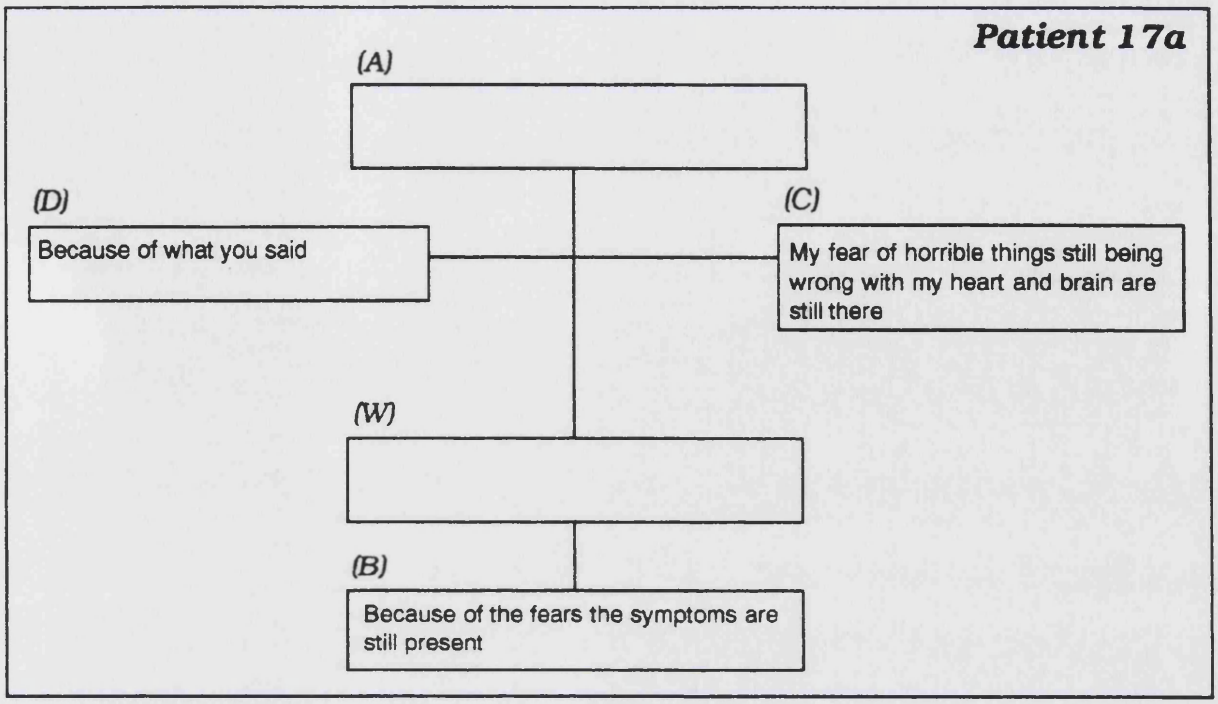


Diagram 17a - Patient. The second Claim in the above vignette in response to the Challenge by the therapist, is that the fears that something awful is wrong are still present. The Data for this Claim is the intervention by the therapist. No Warrant is offered or implied but the Backing is the same as the therapist's, it is not verbalised but implied, that is, the symptoms are still present because of the fear.

In this section it is apparent how the patient at first tries to use one of his characteristic defences: denial (Diagram 17 Patient). The fact that we are talking about denial in the first section of the vignette is clear from the fact that the Claim is later contradicted. The therapist's intervention , his Challenge destroys the use of the defence in this instance and the patient recognises that things are still not right.

Patient: Well as the Schizophrenic Society now meet in my own Parish Church Hall I know that I haven't got schizophrenia because I've learned what it is. It was just a word in my head.

Therapist: Something you needed to check out?

Patient: Yes but I've eliminated it. Depression I've been able to eliminate totally , and it was all a reaction to loneliness, yes, it was a reaction to a bad priest to work with, which was related to anger but they've now been removed. So the situation should be one of sort of, there's no good reason for the symptoms to continue.

Therapist: Yet they do?

Patient: Yet they do. And this morning's one seemed, this morning's form of giddiness was the form that it took when I had the virus. I really could not relate it to internal feelings. It's only that second form that comes on afterwards and that sort of thing.

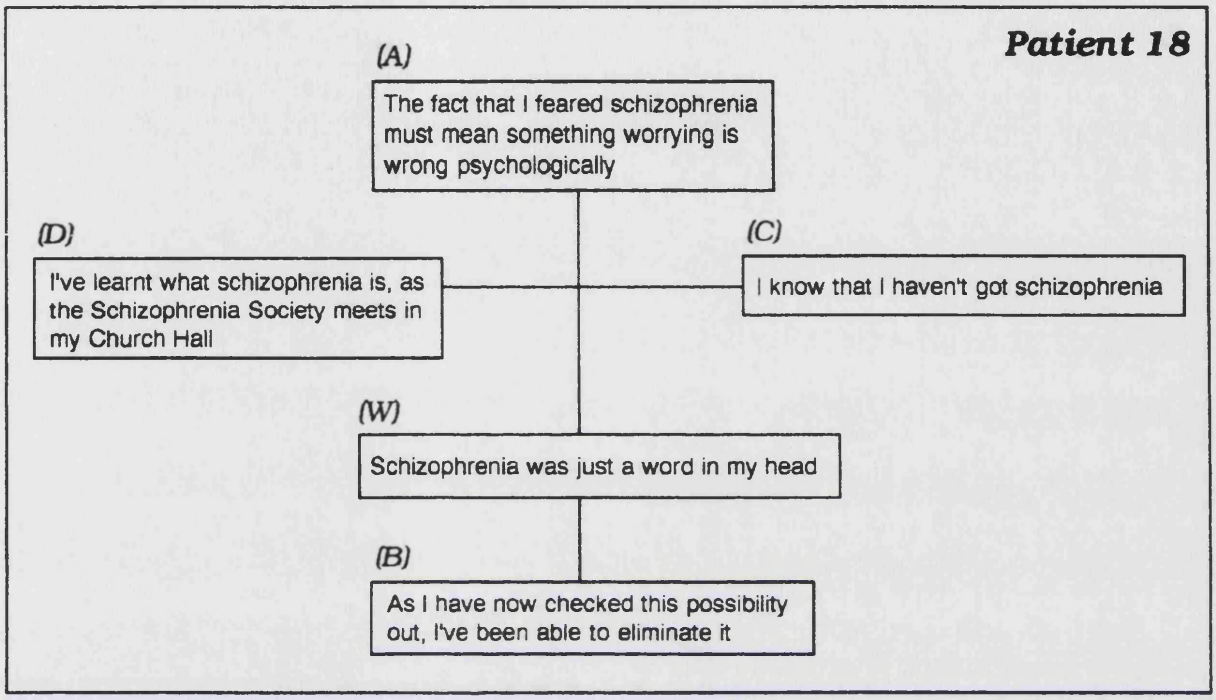


Diagram 18 – Patient The first Claim in this vignette is that the patient knows he has not got schizophrenia. The Data for this Claim is that as the Schizophrenia Society now meets in the patient's Church Hall he has learned what schizophrenia is. A Warrant is added, which is that schizophrenia was just a word that had popped up in his mind. The Backing is, in this instance verbalised, that as he has had the opportunity to learn about schizophrenia and therefor to check it out, he has been able to eliminate it. A possible Alternative, which is not verbalised is that the fact that these kinds of worries had been in the patient's mind, might in it self mean that something worrying is wrong **psychologically**.

The patient is trying to present a superficially, logical argument, why he is now convinced that he has not got schizophrenia, see Claim, Data and Warrant. If however we look at the Data it is apparent that it is very anecdotal. The Warrant appears to be part of a denial of anxiety. It rests on an assumption that words just pop up in the patients head at random. The Backing shows omnipotent thinking, the patient feels that he, by acquiring what he considers valid information, can by himself eliminate the possibility that he has got schizophrenia. No Alternative is verbalised, because to consider an alternative, would weaken this kind of argumentation, in other words the defences.

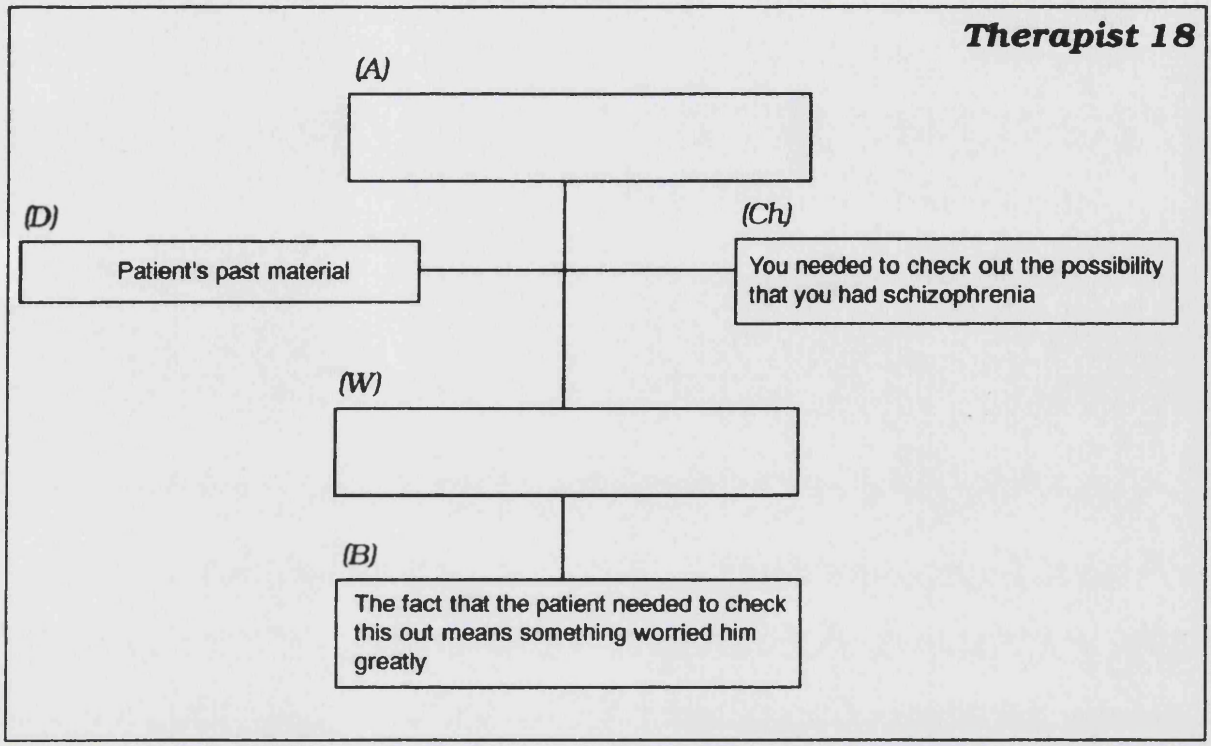


Diagram 18 - Therapist The Challenge offered in response to the above Claim is that the fact still stands that the patient needed to actually check out the possibility that he might have been suffering from schizophrenia. The Data for the Challenge is the patient's material. No Warrant is offered. The Backing is not verbalised, but appears to be an assumption that, the fact that the patient needed to check this out meant that something is worrying him greatly.

*The therapist amplifies what the patient has just said. He confronts the patient with the fact that the patient has **needed** to check this out in a somewhat irrational manner.*

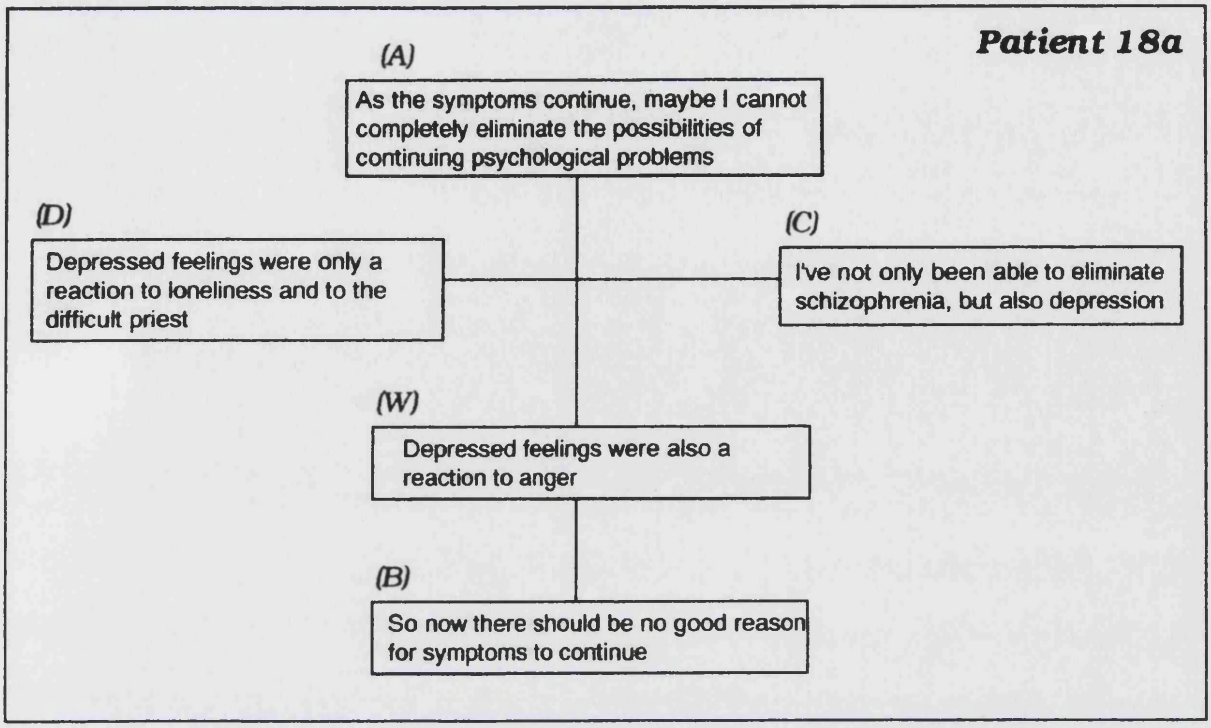


Diagram 18a - Patient The second Claim in the above vignette is that not only has he been able to eliminate schizophrenia, but also depression. The Data for this Claim is that he feels that whatever, depressed feelings he was experiencing were in fact related to loneliness and to the effects of the difficult former colleque. There is also a Warrant offered in this context, that is, that the patient feels that the depressed feelings were also related to the anger he had felt in relation to his colleque. The Backing is verbalised, and is that, it follows that now, as he has eliminated all good reasons for his symptoms, they should not continue. No Alternative is verbalised, but could be that the fact that the symptoms are continuing may be an indication that it is not possible to completely eliminate the possibility that there may be continuing psychological problems.

From this section it is apparent that for some reason the patient needs to deny the existence of psychological problems, he uses defences against the possibility, such as omnipotent denia. However he is actually aware that in spite of his efforts the symptoms still persist, so there is doubt in his mind.

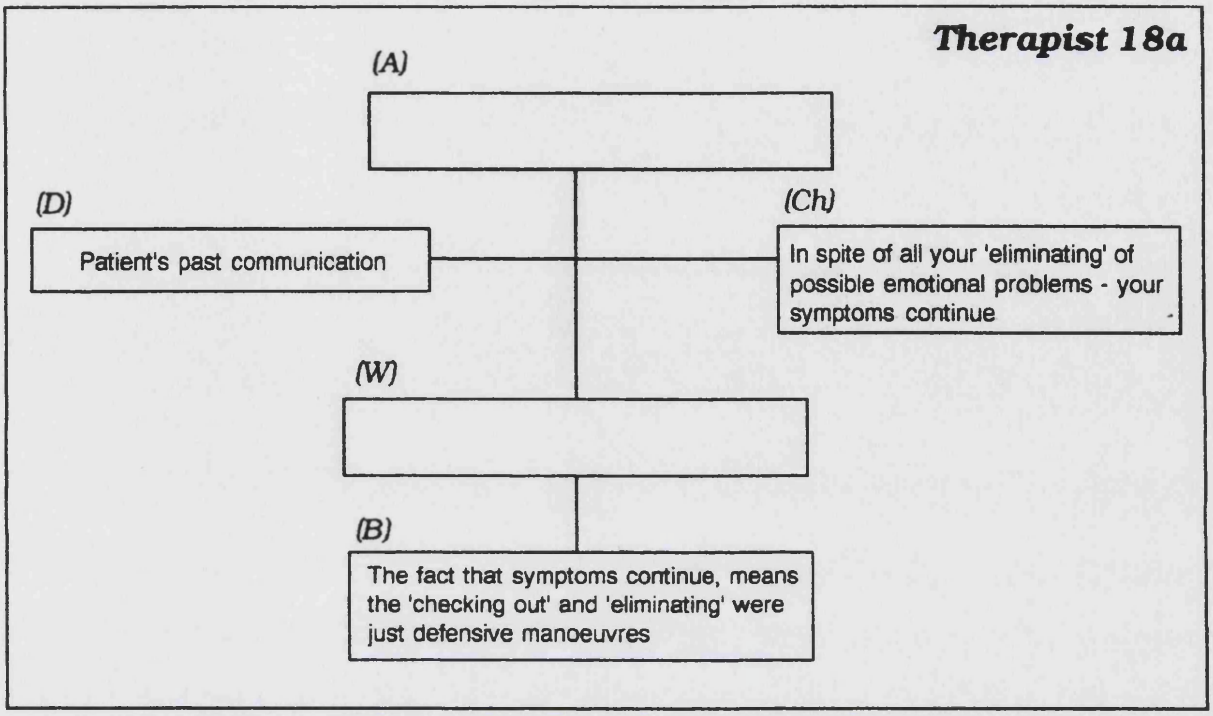


Diagram 18a - Therapist The Challenge is an amplification of the patient's realisation that the symptoms persist in spite of the removal of the patient's stress factors. The Data is referring back to the patient's material. No Warrant is offered, the Backing is not verbalised, but implied, that is, the fact that the patient's symptoms continue means the patient's attempts to 'check out', and 'eliminate' various possible psychological possibilities, were just defensive manoeuvres.

An amplification of the irrationality of the patient's communicationl.

4.5.1. Sessiojn 11

Subjective/Intuitive analysis

Session 11 is the penultimate session in this course of therapy. This session follows a session during which feelings of loneliness and isolation were explored by the patient and therapist. Some thoughts and feelings surrounding the impending ending of therapy were also mentioned. The atmophere of this session is considerably less combative than the feelings evident in the early sessions. This can be seen in the following selected vignettes.

The session begins with the patient talking of a general sense of improvement in his state of mind. The earlier preoccupations with symptoms are still present but are felt to be less bothersome. It appears that the patient is allowing more feelings of anxiety through, and this anxiety is therefore not immediately expressed as physical symptoms.

Patient: The other, the other way that I looked at this dizziness was you know when I said there was the real physical complaint of labyrintheesis just before I became a priest.- because I know of those symptoms is it possible that this other stress, the stresses that I was encountering last year has has generated a psychosomatic representation of them?

Considering the possibility that his problems may have a psychological base is now a possibility but in turn creates more anxiety.

Patient: I didn't know if you ever encountered it at all, you see say: 'Oh yes, about a dozen people have come to me like that'.

Here the patient appears to ask for reassurance.

Therapist: Or coming to see me once a week because I think not having me to cling onto is quite upsetting for you...

Patient: I don't know because coming to you has never relieved that particular set of symptoms. So in a sense I am exploring, trying to explore how one goes from the end of this to try to dissipate those.

The patient is still employing denial, but behind the denial the worries about what to do after the ending of therapy are emerging. The idea that the relationship with the therapist may have been helpful in itself remains a frightening possibility for the patient. The therapist's comments above are treated as though the therapy had been a course of medication and not a relationship. That is, the patient operates on the 'part object' level, when objects are considered only for what they can offer, the therapist in this instance. The patient talks of his father in the same fashion. Later in this session he says that the quality of his life has improved because his father is now living with him and the patient does therefore not feel as lonely. It appears that it is very frightening for the patient to allow himself to recognise the value of the therapist's contribution.

Patient:....if there's any specific guidelines that you could give me as to how I go on from here about that aspect?

Therapist: I suppose if there is a guideline it would be to trust your own feelings about things, make your own mind up.

Patient: Yes but -

Therapist: Understand what you've been experiencing here over these last 10, 11 weeks you know in relation to , you are saying some things might have been helpful, some things definitely weren't helpful. Or some things definitely weren't helped.

Patient: I'm not sure what you mean I make my mind up. I mean I can't, I've found no way of determining how, whether I am going to overcome this giddiness or not....

Further on in this session the patient reports a dream, the first one in this treatment. He says that it was an erotic dream. The patient is, very reluctant to discuss the dream in depth. It is only after some considerable prompting by the therapist that the content of the dream is revealed. The dream centres on the patient being involved in a homosexual encounter in an expensive hotel. The therapist tries to use the dream to discuss the impending ending of the treatment.

Therapist: Mm . I was wondering about this dream. Because it seemed that it was a bit more mutual.

Patient: Yes it was.

Therapist: And I wonder if it might reflect what you feel at times has gone on here and at times you have been open, intimate with me in a way that that perhaps you've felt very great difficulty being in other relationships. Something that feels mutual and sharing and I wonder if it's also like an alarm going off, if it is frightening, alarming, that it is coming to an end.

Patient: But the alarm is not there because the most alarming symptom has not been touched at all the way through.

It becomes clear that the idea of mutuality has to be defended against from the characteristic and curious way in which this patient responds. The essence of what the therapist says is, as though, misunderstood and the issue is addressed on an entirely different level of abstraction. In other words the meaning of what the therapist is saying is destroyed. In spite of these defences presented by the patient, the therapist persists in attempting to draw the patient's attention to the meaning of the ending of the therapy.

Therapist: But that sound very much how you might experience not being supported here by these sessions, by me... and you have this alarm that what ever it is, the sensation, the symptoms will come back and back. Nothing to support you.

Patient: Alarm is the right word to use that I have at the moment towards not getting anywhere with resolving the symptoms of dizziness. Alarm is the correct word for that. The correct word to describe these sessions coming to an end is apprehension.

In the above the patient is relenting a little and is considering the possibility that he does have feelings about the ending of therapy. However these feelings have to be redefined as something much less intense than the therapist had suggested.

Towards the end it appears that the patient is allowing himself to reflect on what may have been helpful, even about things he does not fully understand.

Therapist: And I wonder if the erotic, the angry are feelings that really you prefer consciously not to really know about, but touching on them here has had some impact.

Patient: I can' t picture the mechanism but sort of an instinct tells me it has.(silence) At least I presume it has if something has happened in the 12 weeks for the better. ... Perhaps if I gave it some thought it would come to light but off the cuff I couldn't immediately. When you identified the abject nature of the loneliness last year that certainly engaged very strongly. And in the earlier sessions when you said that this misbehaviour is of the nervous system must produce such a sense of misery.....it was something that had not been picked up by anybody else.... it was clear that you were aware of the depths to which that discomfort went.

4.5.2. Argumatics analysis of session 11

Patient: Whenever I cough quite heavily exactly the same form of dizziness for a measured amount of time came on.(silence) The other,(silence) the other way I looked at this dizziness was you know when I said there was the real physical complaint of labyrintheesis just before I become a priest - because I know of those symptoms is it possible that this other stress, the stresses that I was encountering last year has generated a psychosomatic representation of them. Is that the sort of thing that's known to happen?

Therapist: I, you know I'm not sure and I don't think that- (interrupted)

Patient: I didn't know if you ever encountered it at all you see, say 'Oh yes, about a dozen have come to me like that'. So you couldn't immediately say that there's a dozen people come to me like that.

Therapist: I'm not sure that I would say that, because that may be you wanting me to reassure you and that's important. That you want from me to be able to say,' Oh don't worry about it.' (interrupted)

Patient: No it wouldn't be- if you said yes or you said no it wouldn't be reassurance would it? It would just be ruling out.

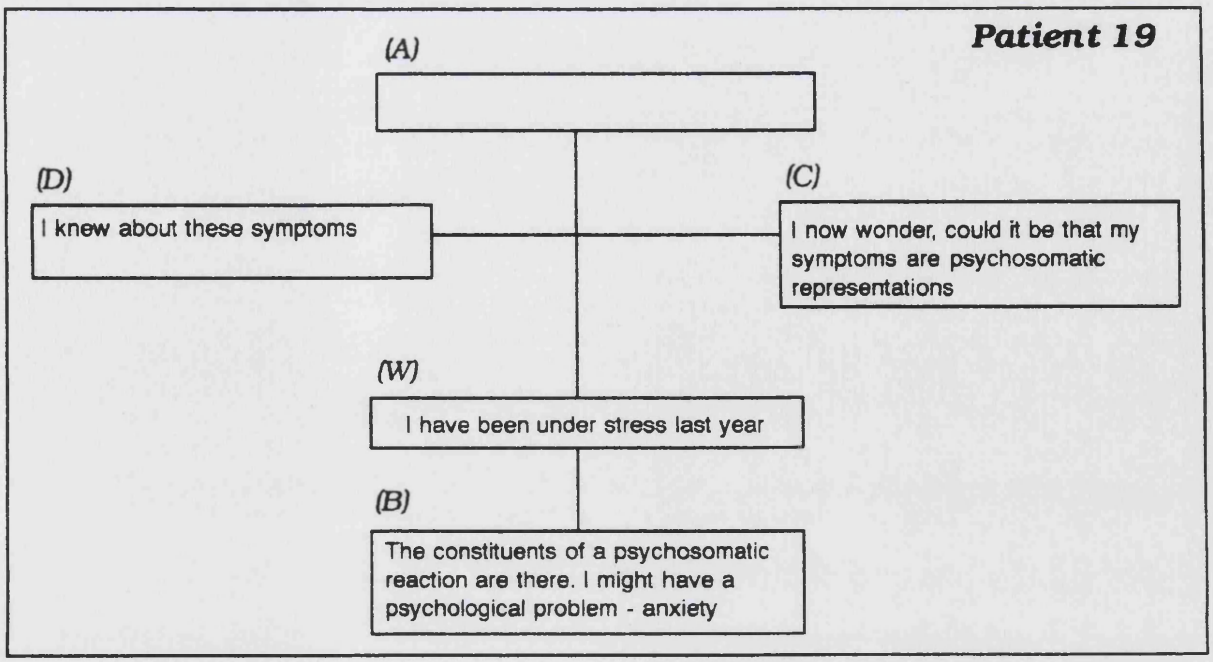


Diagram 19 – Patient The Claim is a hesitant wondering, could it be that the symptoms are psychosomatic representations of something. The Data relevant to this thought is that the patient realises that he has an intimate knowledge of these symptoms. The Warrant is that he also realises that he has been under stress during the past year. The Backing is not directly verbalised, but could be something like, 'the constituents of a psychosomatic reaction are there'.The patient realises that he may have a psychological problem.

For this patient in particular the idea of his symptoms being psychological in nature is very alarming because earlier he has spent some considerable effort in defending against this idea. Some thinking is happening as defences have lessened. Although the Backing is in itself not verbalised, the effect of this kind of realisation is there, that is anxiety is emerging, but tolerated for a while.

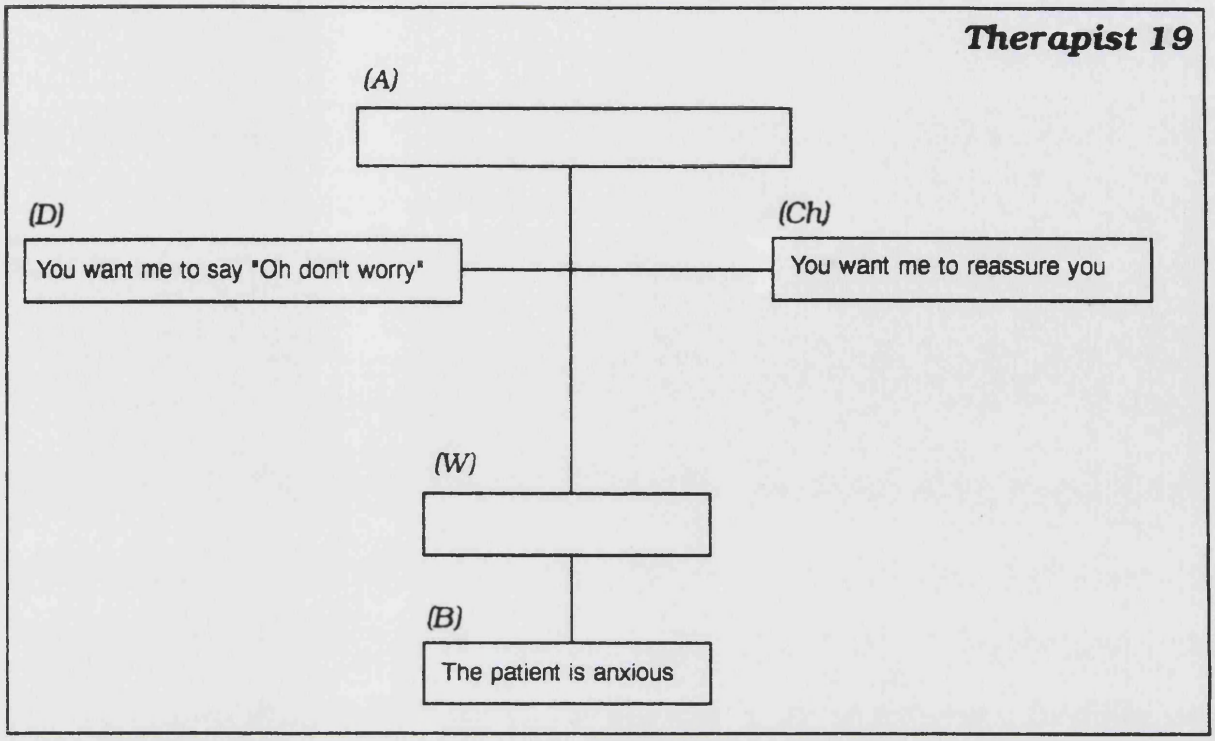


Diagram 19 - Therapist: The therapist's Challenge is : 'You want me to reassure you', it addresses itself to the anxiety generated in the patient, and not to the presented Claim. The Data is that the patient appears to want the therapist to say something like 'Oh don't worry', the Backing is not verbalised but appears to be that the patient is now anxious.

This is a comment on what is going on between the patient and the therapist, a transference interpretation.

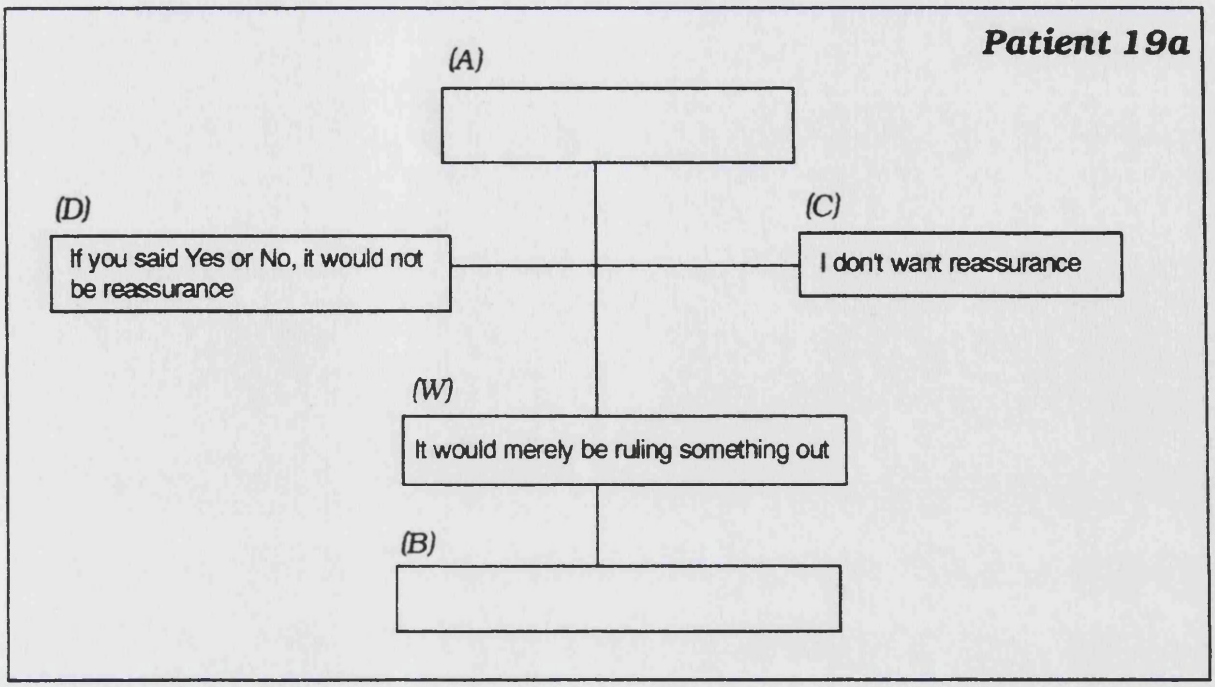


Diagram 19a - Patient: The patient's Counter Claim is that he does not want reassurance. The Data that if the therapist would only say yes or no that would not constitute reassurance. The Warrant offered is that to say yes or no would merely be ruling out something. There does not appear to be any Backing to this Claim neither explicit nor implicit.

Here it appears that the patient wanted to explore the psychological meaning of his symptoms. The possibility did however generate so much anxiety that he wanted something from his therapist to make it feel safe enough. The indirect request did not however succeed, and the patient is thrown back on using his defence of denial of an inner feeling state and on concrete thinking , to cope with the anxiety. The silences and interruptions are also interesting in the relevant vignette, and further suggest the presence of conflict and anxiety.

Therapist: But I was wondering about this dream. Because it seems as if it was a bit more mutual.

Patient: Yes it was.

Therapist: And I wonder if it might reflect what you feel at times has gone on here and at times you have been open, intimate with me in a way that perhaps you've felt very great difficulty being in other relationships. Something that feels mutual or sharing and I wonder if it's also like an alarm going off, if it's frightening, alarming, that it is coming to an end.

Patient: But the alarm is not there because the most alarming symptom has not been touched all the way through. No, I'll rephrase that. Two alarming symptoms have been going on, one of which has been removed, the other of which still goes on.

Therapist: That's alarming, mm

Patient: But in my heart of hearts I never could see how that was going to go. I could see how psychotherapy might gradually help the other to peter out but I could never see how this real dizziness was going to be wiped out in anything we do.

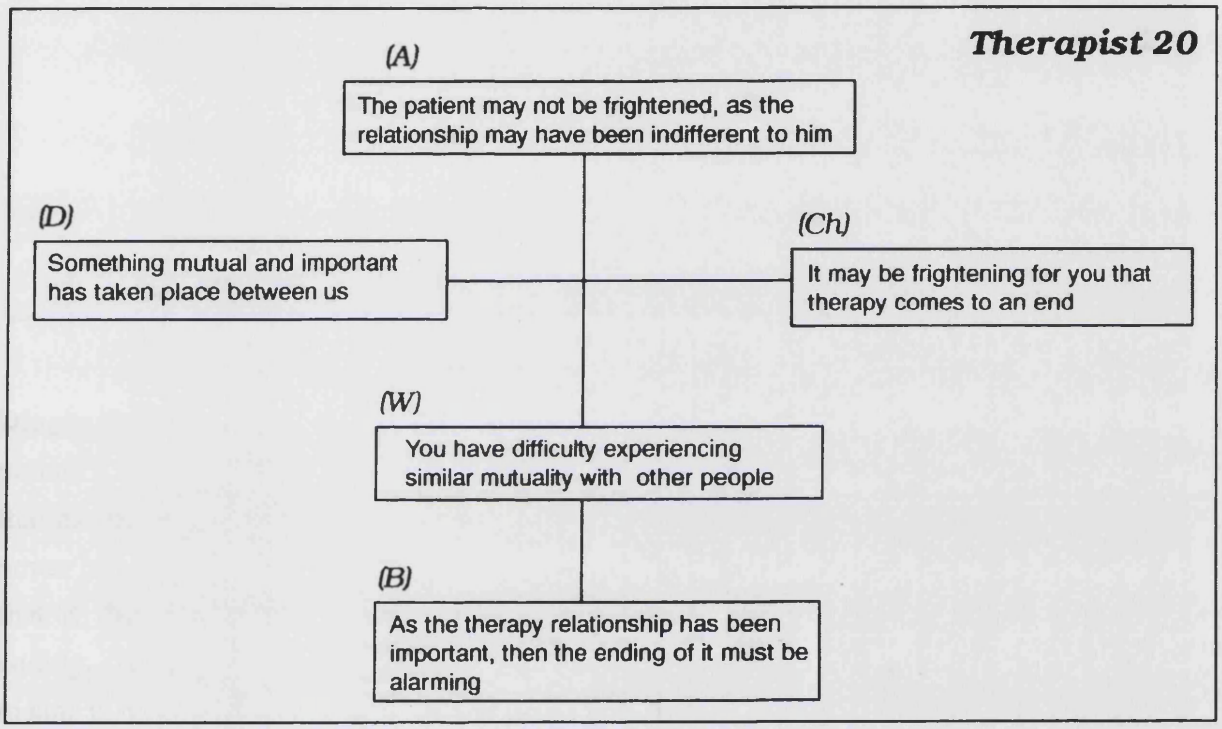


Diagram 20 - Therapist The Challenge presented by the therapist is that it may be alarming for the patient that the therapy is coming to an end. The Data is that the therapist feels that something mutual and important has taken place between them. The Warrant is that mutuality is something the patient finds great difficulty in experiencing in his other relationships. The Backing which is not verbalised is that it makes sense if a relationship has been important that it's ending will cause alarm. The Qualifier 'maybe' is verbalised. However the Alternative interpretation might be that the patient does not experience the ending of therapy as frightening as the relationship has felt to him to be indifferent.

This is another transference interpretation based on the context.

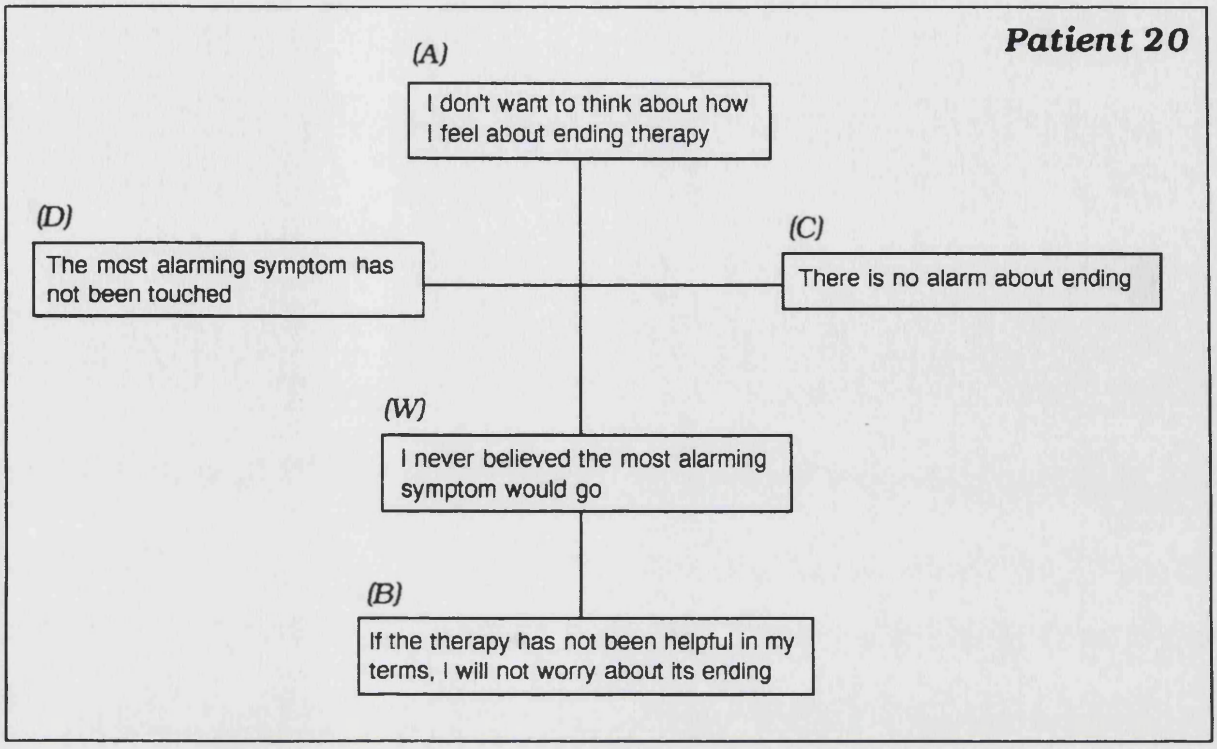


Diagram 20 - Patient The Claim in response to the therapist's Challenge is that in the patient's mind there is no alarm about the ending of therapy. The Data for this Claim is that as the most alarming symptom has not disappeared. The Warrant is that the patient never believed that this symptom would go. The Backing is not verbalised, but could be that if the therapy has not been helpful (in his terms) then he won't worry about it's ending. The Alternative that maybe he does not want to think about what the ending means is not verbalised.

The therapist has offered his patient something to think about. The Challenge is substantiated by his subjective opinion that something mutual has taken place between them, see Data in Diagram 20-Therapist. There is no agreement to this fact from the patient. The patient appears determined not to consider the Therapist' Backing. He may not want to consider the possibility because it simply has no validity or he may want to avoid the issue because it causes him some distress. If we look at the the Claim and how it is developed by the patient, it is noticeable that the patient does approach the issue at a different level of abstraction. He is not talking about a relationship of mutuality, he is discussing a treatment that has in an important sense failed, to relieve his symptoms. By remaining on this level, he can construct an argument of why there is no alarm about ending. It is not possible to establish the truth about whether he does or doesn't find the ending of the treatment alarming, but it is clear that in order to construct his argument he has had to destroy the meaning of what the therapist was talking about, that is the feelings about the ending of a relationship. In this instance the defences used can be

understood as manic defences as they are directed against recognising the value of a relationship.

Therapist: ...And I wonder if the erotic, the angry are feelings that really you prefer consciously not really to know about, and touching on them here has had some impact.

Patient: I can't picture the mechanism but sort of an instinct tells me it has. (silence) At least I presume it has if something has happened in the 12 weeks for the better in the course of our inter dialogue, but for me to identify the points at which that happened is not possible. Perhaps if I gave it some thought it would come to light but off the cuff I couldn't immediately. When you identified the abject nature of the loneliness last year that certainly engaged very strongly, perhaps it was the strongest engagement of all , the realisation of that. And in the earlier sessions when you, in practise it was only about the second session you said that this misbehaviour of the sympathetic nervous system, it chucking out feelings of nervousness all the time must produce such a sense of misery, that rang home very true. The awareness that you had that whatever was going on was producing sheer misery or hell, in it self, was something that had not been picked up by anybody else and I've not pressed anybody about picking it up, you know it was clear you were aware of depths to which that discomfort went.

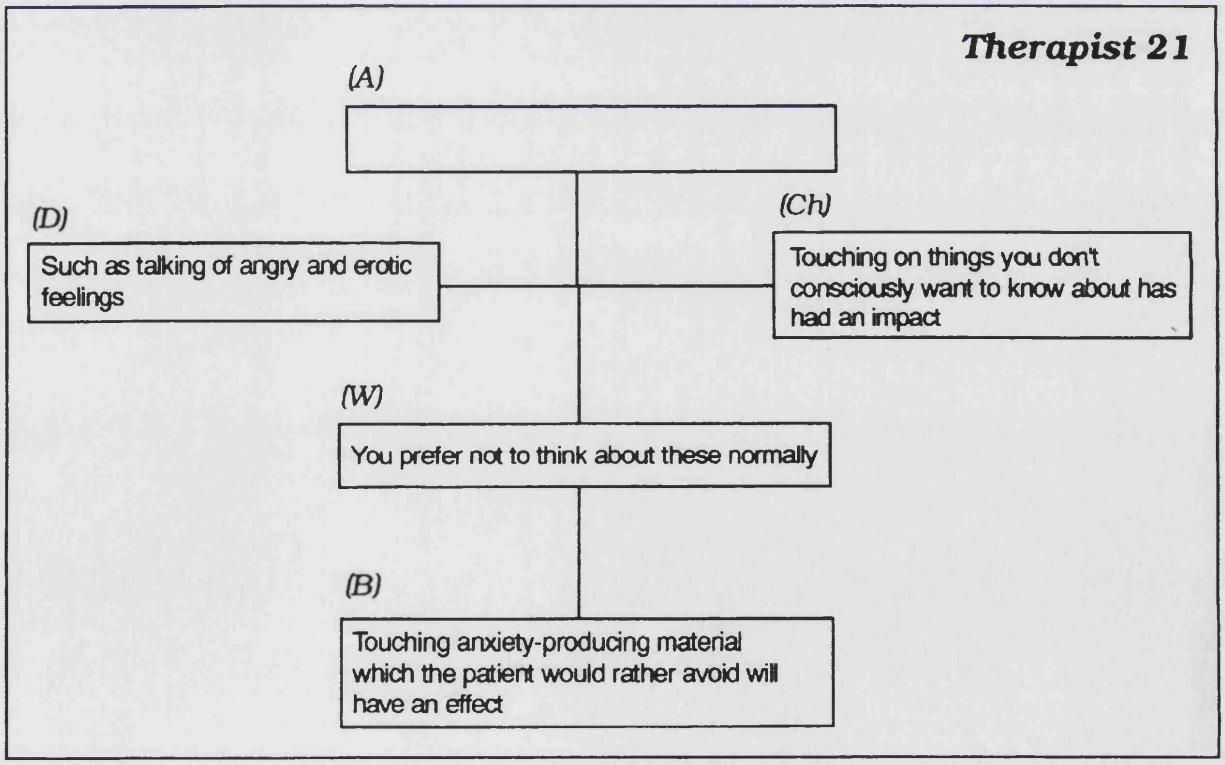


Diagram 21 - Therapist The Challenge is that touching on things the patient did not consciously want to know about has had an impact. The Data is that talking about angry

and erotic feelings seem to have been important. The Warrant is that the patient appears not to normally want to think about these. The Backing is not verbalised but appears to be an idea that talking about difficult subjects the patient wants to avoid will have an effect.

The therapist makes an interpretation that in spite of everything touching on unconscious material has had an impact.

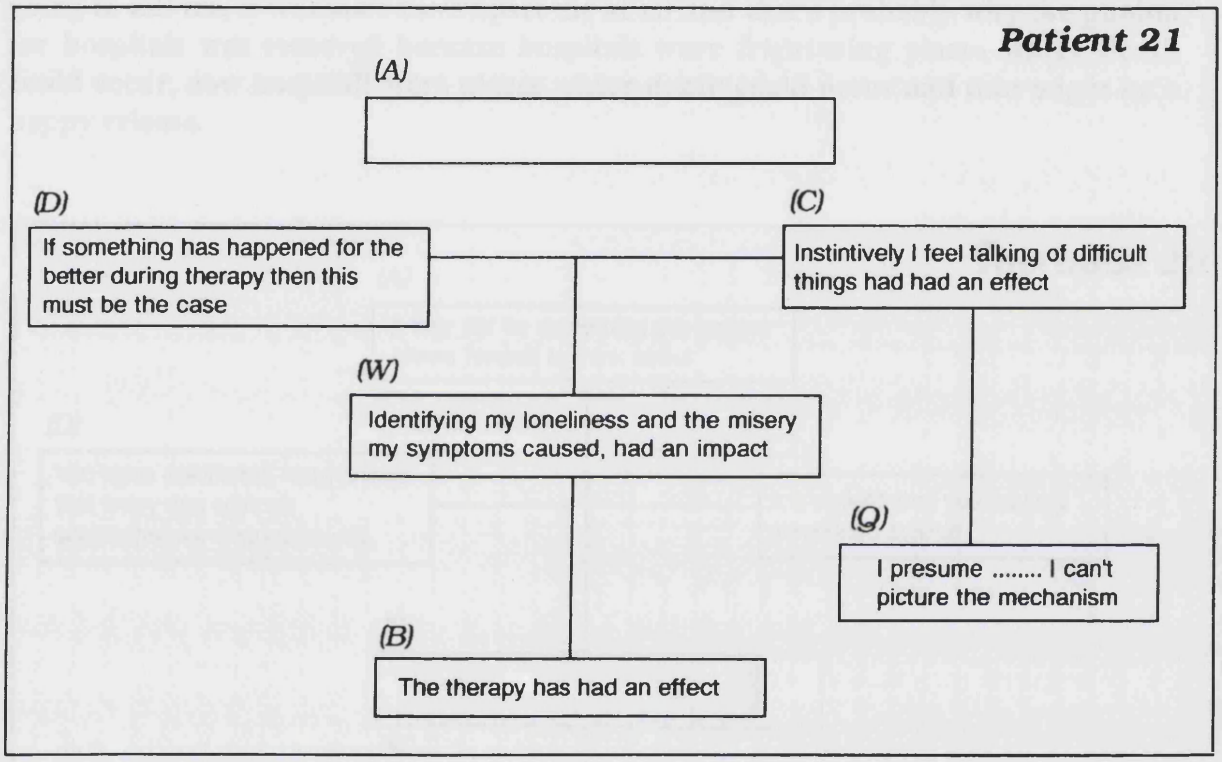


Diagram 21 - Patient The patient's Claim in response to the Challenge by the therapist is to agree that instinctively he feels that talking about these difficult things has had an effect. The Qualifiers of 'I presume' and 'I can't picture the mechanism' are added. The Data is a reluctant 'If something has happened for the better during the therapy then this must be the case. The Warrant offered is that identifying his loneliness and the misery the symptoms had caused, had an impact (perhaps a connection with his therapist). The Backing is not verbalised but implied and seems to be that the therapy has had an effect in some way.

The patient has insight that things have had an effect. The Warrant adds more weight to the insight.

Therapist: I was thinking today and you reminded me again about the depths because you've just come from three funerals today and some of the comments you

made - rest in peace, whatever one says, one of the depths you didn't mention in the long list of things that you did mention about what it might be, from very serious schizophrenia and major depression, violent ECT, one thing you didn't mention was suicide, the despair of being homeless.

Patient: Yes there are two er... firstly when I woke up this time I think I said to Harriet on her tape recorder that er... she had asked me if I ever felt suicidal and I had to say the truthful answer was no, not that but I've woken up some mornings in a state that could have led almost to that accidentally.....But when this illness came upon me it was so miserable at times that if I had found I'd got an illness that was going to kill me, it wouldn't have upset me at all and that's probably why the phobia for hospitals was removed because hospitals were frightening places where death could occur, now hospitals were places where death could occur and that might be a happy release.

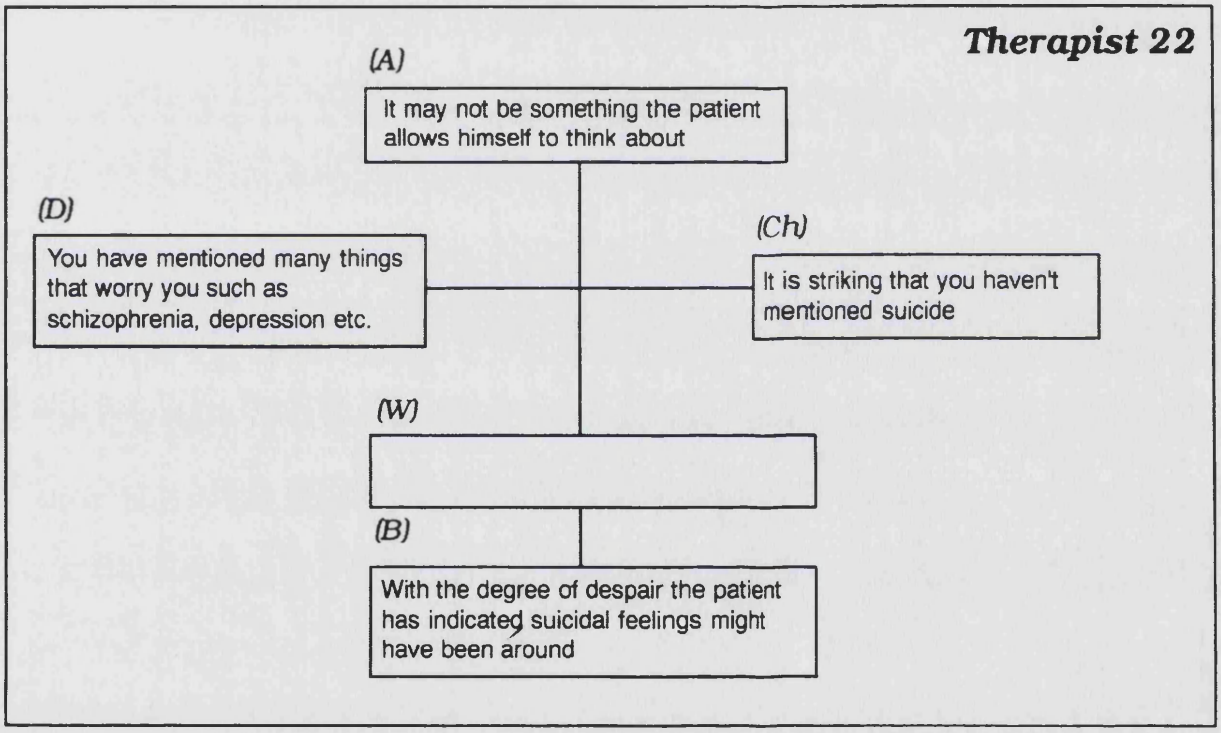


Diagram 22 - Therapist Immediately following the above the therapist produces another Challenge, that is, that it appears to be striking and perhaps a bit surprising that the patient has not mentioned suicide during his therapy. The Data is that many other worrying possibilities of what might be wrong with the patient have been mentioned. No Warrant is offered, and the Backing is not verbalise but implied, in that given the degree of despair expressed by the patient it is possible that suicidal feelings have been around. The Alternative that suicide may for some reason be something the patient has difficulties admitting to or thinking about is not verbalised.

The Challenge arises out of the Backing as an 'educated guess'.

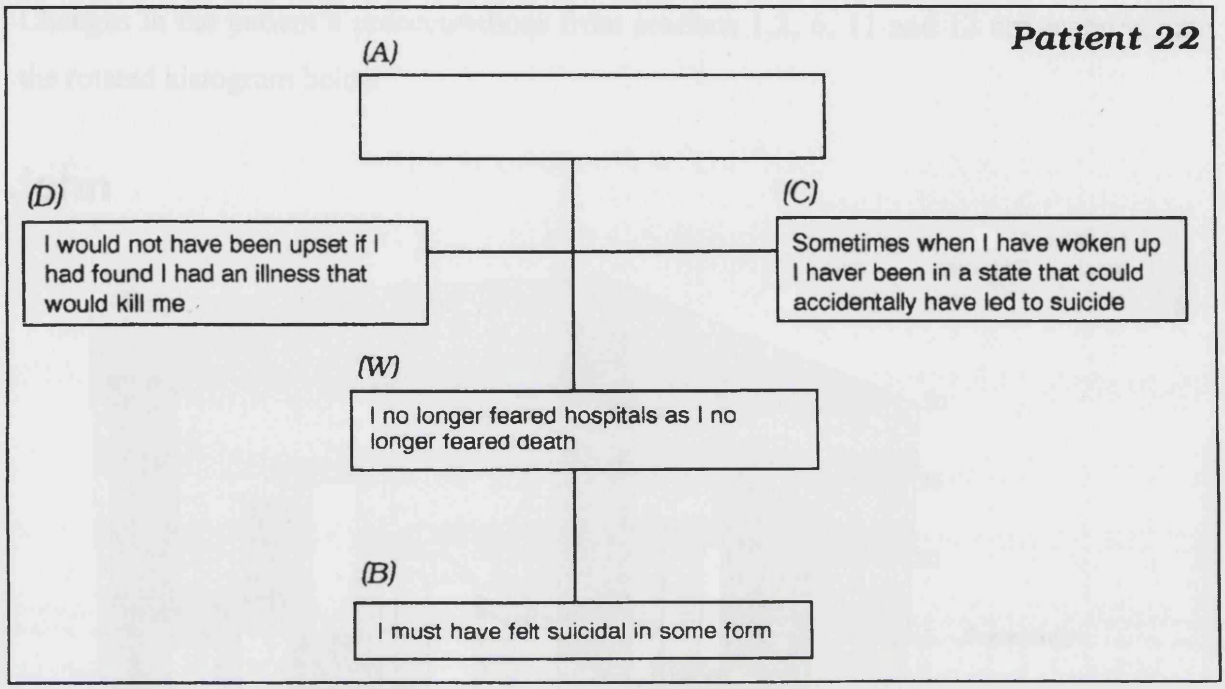


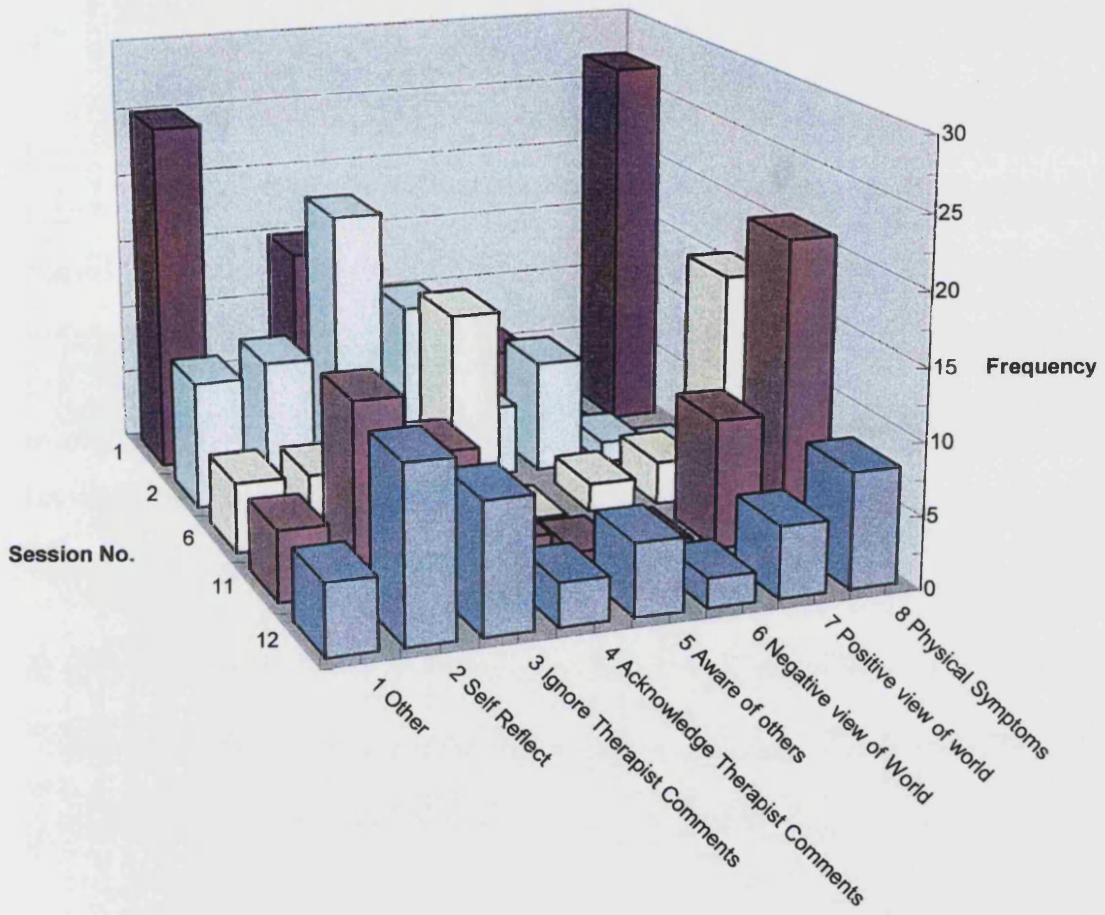
Diagram 22 - Patient The Claim in response to this Challenge is that he admits that although he feels he has not consciously been suicidal he has sometime woken up in a state of mind which 'accidentally ' could have led to suicide. The Data offered is the fact that the patient feels that when he has felt really bad he would not have minded if he had been diagnosed as suffering from an illness that would kill him. The Warrant is that he no longer feared hospitals as before as he no longer feared death. The Backing which is not verbalised is that this must mean that the patient is or has been suicidal.

In the above the flavour of the interaction is different. The suggestions by the therapist are thought about and not immediately dismissed. This indicates a greater tolerance of anxiety, that is, it does not feel so dangerous to think about and even to talk about difficult feelings. In other word there has toward the end of this session been a lessening of persecutory anxiety. The value of the therapist's contribution can be acknowledged, the existence of the relationship can be thought about. The symptoms do not in the above vignette play centre stage, but instead the recognition of their impact is considered. It appears that for a brief moment the therapist is allowed worth and you get a feeling that the patient is actually grateful for the therapist's contribution.

4.6. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1,2, 6, 11 and 12 are mapped onto the rotated histogram below

John



The variables in this histogram are as follows: The first column (1) is a catch all category. The second column (2) shows the number of statements indicating self reflexion. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of stements indicating that the patient is acknowledging the therapist's statements The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative world view or negative statements.

The seventh column (7) shows the number of statements indicating a positive world view or positive statements. The eighth column (8) shows the number of statements relating to physical symptoms.

The niumber of statements relating to physical symptoms decreased noticably, and negative statements decreased somewhat while positive statements increased slightly.

4.7. Independent Psychoanalytic Assessment of John (Session 1)

I thought the client conveys his anxiety at finding himself in the interview and at the same time use his familiar methods to control it. Early on he gives an indication of the level and intensity of his anxieties by speaking of phobic anxiety and his various methods of controlling his panic. He unconsciously sets about controlling the therapist by preaching, persuading and restricting areas of thought and awareness. Some of his feelings about the interview can be seen in derivatives such as in his talking about cancelling the holiday and his feelings linked to the parish priest. Firstly a parish priest has resigned but then a parish priest was someone who 'might have different ideas as to conduct in services'.

In an attempt to control his anxiety the client struggles hard to 'conduct the service (the interview)' along familiar lines. He repeatedly emphasises his need for something to hold onto and so he clings to his ideas about his symptoms. His symptoms are familiar and always present; his therapist is unfamiliar and, up until now, absent.

I thought that he feared that the therapist threatened change in his material he conveys that change is threatening. Change appears in his mind to lead to catastrophic change. Hence promotion is prevented by colour blindness and progress as a priest by falling down on the job. The whole notion of being a priest is so threatening to him that he does not think about it. Instead his feelings of threat and awareness of his anxieties are kept out of his mind and held in the form of symptoms. As Bion says these symptoms cannot be thought - they are felt to be things - in - themselves - fit only to be gotten rid of. However he does realise that his methods, aided by Dr F., have not been a success.

In the interaction I felt that the therapist found himself struggling to achieve some meaning in the room. Perhaps he did not quite realise how powerfully the client was controlling his thinking to prevent meaning. The client believes, as he says, in being 'absolutely at one' - and he fears in the interacting that the therapist will remove the oneness and bring about change. Change threatens feelings and as he makes clear, and he is fearful of his abnormal feelings taking over and bringing loss of control. As long as he can keep his abnormal feelings in his symptoms he can control them. In the interview he uses preaching to convert the therapist to his gospel - the gospel that he describes as 'all factors removed that were making life difficult'. The only person in the room who might make life difficult by bringing feelings and awareness alive is the therapist - hence he is controlled and preached to.

I thought that the therapist rallies towards the end and tries to name missing feelings and address the missing relationship - but a bit too late. Perhaps one way it might have been described something of the clients system and his partial awareness that it was not working. Anxieties linked to his fear of a close relationship and his fear of being seen as inadequate and disturbed fuel and his need to control himself and his objects. His dilemma is partly that he fears that the therapist will want to remove his defences and at the same time he knows that he need help to dismantle them. A further problem however is that he does not believe such help is possible or that he deserves it.

I noticed that the client says nothing of any personal life and only speaks of work. However, he seemed to have little idea of what being a priest actually means and at one point tries to argue that it is no different to any other job!

Comments:

The independent assessor comments on how the patient is struggling with handling his anxiety. The anxiety is felt to arise both from within and from the therapy situation itself. The therapy situation which introduces the possibility of change is felt to be dangerous. The independent assessor comments on the patient's need to hold onto his defences in order not to address all the anxiety provoking issues. He also comments on the absence of any reference to personal relationships.

4.8. Summary of John

This chapter has presented the analysis of the collected material for patient John. All the material has demonstrated John's heavy reliance on defences in order to cope with his anxiety. The detailed argumatics analysis has described in detail how and when in the therapy interaction this defencive process has expressed itself. The Rotated histogram showed that over time there was some lessening of the patient's preoccupation with physical symptoms, and a slight increse in positive statements. The frequency of therapist's statements being considered did not increase. However in looking at the material from session 11, there are moments when it appears that the patient and therapist can think together in a trusting atmosphere about the patient's fears.

The pre-therapy interview (see appendix 3) is yet another example of this patient's need to concentrate on physical symptoms. In the post therapy interview (see appendix 3) the patient claims that he did not find the therapy helpful, and that it had made very little difference. He does however have a more positive outlook, and feels that there had been some improvement in his symptoms. This may be how things are for John or his responses during the interview may in them selves be a response to the ending of the therapy. The independent psychoanalyst commented that one sorce of anxiety for John was relationships. Maybe therefore John felt a need to continue to deny that his therapy relationship might have had meaning and value.

5. Results: George

This chapter introduces the second of the subjects, George. Included in this chapter is a short background to the patient, a subjective analysis of selected sections of this patient's therapy sessions and a detailed argumatics analysis of session one. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain the authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in four selected session from the beginning, the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the presented material is included with reference to before and after interviews conducted with the patient for the purpose of this research. Transcripts of the before and after therapy interviews can be found in appendix 3. (In George's case the transcripts have been edited and sections left out in order to preserve confidentiality). Notes on George's initial psychotherapy assessment can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of George's sessions of psychoanalytic psychotherapy are available on the CD-rom, appendix 5, available from the author on request.

5.1. George

George was undergoing brief analytical psychotherapy. He was offered twelve sessions at the Cassell hospital. Session one was analysed in detail. Transcripts of George's psychotherapy assessment and also of a follow-up consultation conducted at the Cassell hospital can be found in appendix 1.

George is a man in his early fifties. He is a reporter, who has recently experienced difficulties at work. He has been demoted rather than promoted. A detailed argumatics analysis was carried out of material from session one as it was felt that this patient's typical functioning was evident in this session and did not change much during the therapy. The independent assessment by a senior Kleinian analyst is included for this session.

George is a reporter for a well-known media company. George's difficulties at work had sparked off a series of symptoms, directly caused by hyperventilation, which in turn was caused by anxiety. The patient saw himself as a high achiever whose self-esteem was closely linked to academic and other achievement. He had excelled at school and had attended the best universities. His job had been one where he had constantly had a high profile, and one, which had given him a lot of narcissistic gratification. However, for reasons not entirely clear he had recently been moved into another department, and been given less high profile assignments. In addition the possibility of redundancy was there. The patient felt these events had taken place as a result of internal power struggles at his place of work. He also felt that due to his age he was no longer valued.

George is married with two adopted children. He claimed there were no significant problems with these relationships. He resisted more in depth exploration of these relationships. George maintained that he had a happy childhood. He came from an achievement oriented family. He had two brothers who had not been as successful as he had. In fact, George, had been considered by his family of origin, as something of an academic showpiece. There was some anger with his father about this.

Therapy

The therapy started off in an unfortunate manner. The relatively inexperienced therapist was in the initial consultation also offering to refer George for behavioural therapy. Although this other therapy did not start during the 12 sessions of analytical therapy, it seemed to colour the interaction in a way, which promoted splitting. That is, this man did not want to entertain the possibility that his symptoms may have a deeper meaning. This created a contradictory state of affairs, as at the same time it was clear to George that his symptoms were of a psychological nature. George's rationalisation for attending therapy was that he did not want to miss the opportunity that it might do some good. Maybe as a result of the confusion he approached the therapy in a rather passive way.

The therapy sessions were characterised by George bitterly complaining of how unjustly he had been treated, and discussing at length his previous achievements. In his first session he was very keen to talk about his many celebrity contacts, as if this gave him a

greater sense of self worth. The sessions frequently contained lengthy ruminations about the nature of the symptoms, and how troublesome they were. However in the second session there was a realisation by the patient that his self-esteem, which he had always considered high, was in fact rather precarious. Feelings of not being in control and feeling powerless were discussed. George showed a marked reluctance of taking responsibility for his feelings and his predicament. George expressed this by saying: '**that is the way I was made**'. The therapist's interventions were frequently either dismissed or not understood. It appears that a negative therapeutic reaction was developing, not helped by the prospect of having behavioural therapy later.

It seemed as though a situation arose which meant that if George were to allow the therapist to help him, his already low self-esteem would get even worse. This situation could arise as a result of recognising that some one else had something to offer him that he could not provide for himself. Some anger was emerging during the therapy but any connection between these feelings and the therapist was denied. Very little concern was expressed for anyone else, such as his wife, who seemed to have had a hard time with the patient's symptoms. However it is worth noting that in the post therapy interview George expressed some concern for his wife. During the same interview it appeared that in spite of the seemingly unproductive time spent in therapy, George felt a lot better, although he was adamant that it had nothing to do with his therapy. In his opinion the therapy had been entirely useless.

The subjective/intuitive analysis of this therapy suggests that George relied heavily on denial and on destruction of meaning, in dealing with the therapist's interventions. This happened often by a switching of levels of abstraction in the service of denying and avoiding uncomfortable feelings. For example, in session 2 when the therapist was drawing George's attention to the fact that he seemed very uncomfortable about not getting any direct feedback from her, his response was:

'I'm in completely new territory and I don't know what is the norm, I don't know how your other patient's operate, I don't know what the technique is etc.'

That is not addressing himself in any way to the issue of how he felt, but addressed himself to how the therapist might be working, an issue not appropriate in this context.

Projection also featured strongly in this therapy. This conclusion was drawn from the fact that, all George's misfortunes were consistently blamed on somebody else, usually his employers.

...Well I feel I'm one of an old school an um a bit like a walrus really (believing in good values), you know surrounded by sort of er rather nasty, younger, go-getting clever people. I think the nature of the place has changed...

There was no thought given to whether George may in some way have contributed to his career problems, a possibility that one might expect worthy of consideration.

The material George was bringing had a one-sided flavour. George was complaining bitterly about how hard done by, he felt in relation to his employers. Attempts by the therapist to bring in other areas of his life as possible sources of conflict were rejected. The discussion was kept within familiar safe areas, that is, problems were explained, and discussed only with reference to familiar external issues. When the therapist suggested on several occasions alternative explanations for the patient's anxiety, they were denied or destroyed by semi deliberate misunderstandings or by changing the level of abstraction of the communication.

For example, the therapist said:

'this is the ninth session and we are nearing the ending of the therapy, and you maybe experiencing some sort of dependency and are wondering now about what it will be like without the sessions.'

The patient responded by,

'No not at all. I mean I think...er, I was quite surprised at the kind of re-emergence of anxiety although it's because at work I am sort of self-pacing etc.. So I mean I think the er.. what I felt is simply a straight reaction to the circumstances and the context in which I was working....'.

Disagreeing with one's therapist is of course a common thing in treatment, but in this case almost every suggestion the therapist made was rebuked in this manner. The nature of this interaction alone suggests that we are dealing with a need to deny and destroy the meaning that the therapist attempts to bring to the situation. It furthermore serves the patient's need to triumph over the therapist. In fact the patient discussed on many occasion how he would be conducting the sessions if he were a therapist.

5.2.1. Session 1
Subjective/Intuitive analysis

The session is initiated by a discussion about what the focus of the therapy should be. The therapist suggests that it might be helpful to focus on the relationship with the patient's father, and on the patient's need to be in control. The suggestion is however immediately dismissed by the patient. He feels that the relationship with his father is irrelevant to his present problems.

The issue of needing to be in control, is dismissed by:**'I don't sort of use that phrase. I think it's more the fact that I've been used to succeed.'** There after George launches into a lengthy rumination about work. He appears very keen to convince the therapist of his abilities. The therapist introduces the idea that as there has been difficulties in the patient's life these could have also caused tensions in his marriage. This suggestion is dismissed. The patient feels for instance that his infertility, and the subsequent adoption of two children were areas, which caused remarkably little tension. Only the dog appears according to the patient to be a bone of contention in his marriage.

...There is just a small thing, rather a bone of contention between us which is that er...we had a dog which I didn't like, which I never wanted and which uh... possibly I was very angry about....

One gets the impression that the feelings about the dog are really projections of feelings belonging elsewhere. His wife or his children are not discussed without prompting. No concern of their 'well-being' is expressed. From time to time in the session the therapist attempts to bring in, what it means for the patient to have started therapy, and what it feels like to now be in a situation where he is not in control, and may need to trust his therapist. These explorations are met with statements that this is not relevant and in any case the therapy situation does not cause him any anxiety.

.... you keep using the expression 'out of control'. I feel completely in control...

Whenever possible the patient likes to talk about his work and explicitly or implicitly tells the therapist how capable he is and how humiliated and rejected he feels about the changes in his position. He further talks at some length about how worried he has been about alarming physical symptoms he has experienced during recent times. The only

domains, which the patient introduces in this session, are his work situation and his health.

5.2.2. Argumatics analysis of session 1

Therapist: I think how you view this is probably much more like a question and answer session, the way you're speaking it's much more like a sort of interviewing type situation and not finding ways in which one, we can both together explore how you're feeling.

Patient: Well, um I'm used to an interview format because I'm doing it myself um, but if I stop on the whole I feel I've said everything, I can think of.
Therapist: I think you are finding it very difficult...

Patient: Well, yes but you have to give me guidance, I don't quite know where I am going.

Therapist: You don't know where you are going...(Unclear material)...

Patient: Uh, I suppose it is in a way. I previously had got rather stale doing the same thing for a long time. I mean, I think er, you know I like new challenges, maybe. You know I have applied for new jobs previously without success but I think I've got that kind of mind that needs fresh stimulation otherwise it would atrophy...I don't feel frustrated at home. You know I'm OK at home. But I've just got a sense of dissatisfaction and um... unfulfilment really.

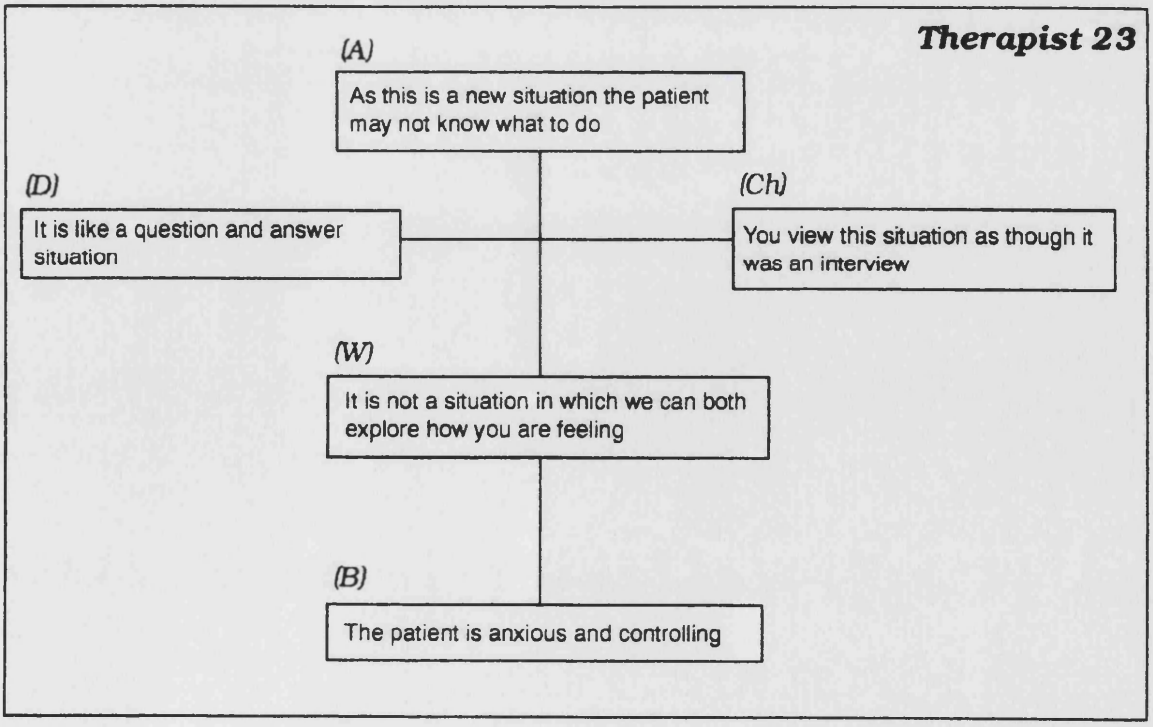


Diagram 23 - Therapist: The therapist offers the Challenge that the patient appears to view the present situation similarly to an interview. The Data is that the situation appears like a question and answer situation. The Warrant is that the situation does not appear to be one, which is conducive to both of them exploring what the patient is feeling. The Alternative, which the therapist is not verbalising, is that as this is a new situation for the patient and he may not know what to do and therefore 'uses an interview format'. The Backing, which is not verbalised, is that the patient is anxious and controlling.

Here the therapist is gently trying to draw the patient's attention to what he is doing, that is to the Backing, although she is not spelling it out.

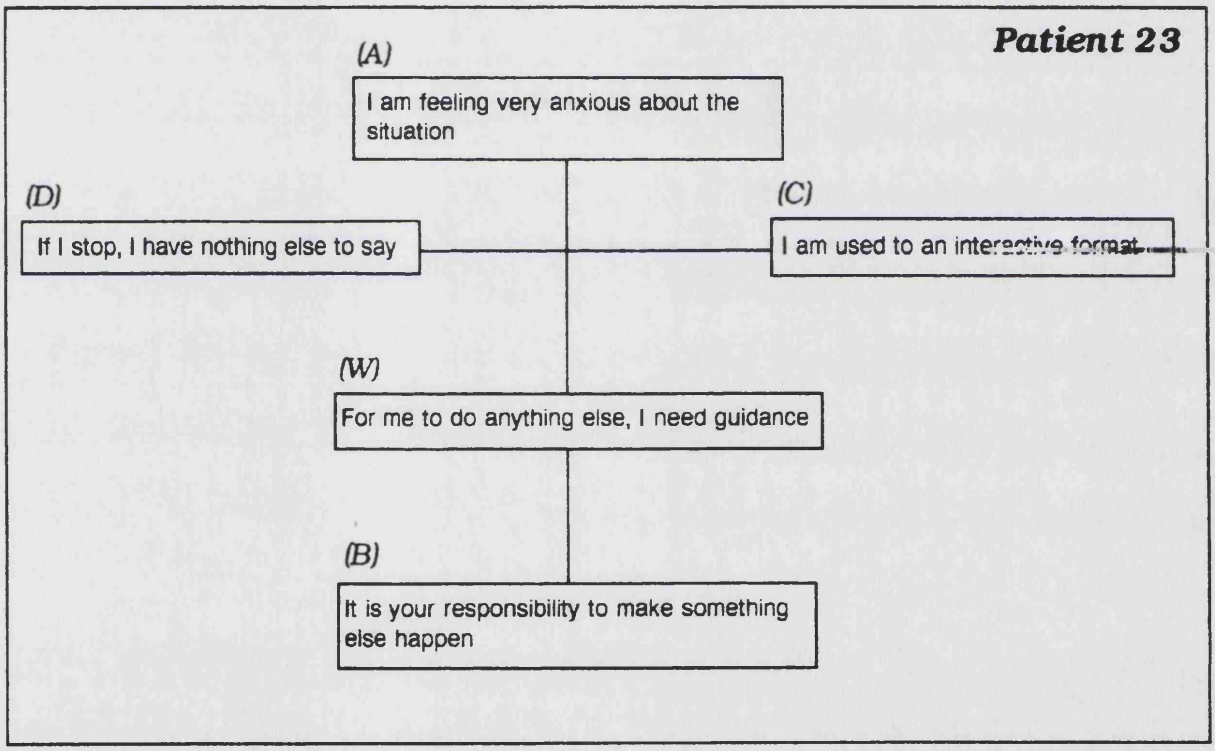


Diagram 23 – Patient: The patient's Claim is that he is 'used' to an interview format. The Data is that if he stops (does not say anything) that means that he has got nothing else to say. Slightly later on he offers a Warrant, that he needs guidance. The Backing, which is not verbalised, does appear to be about responsibility. There seems to be in the patient's mind the idea that it is the therapist's responsibility to make something happen. The

Alternative that the patient is finding the situation very anxiety provoking is not considered.

The patient makes a Claim, which on the surface seems reasonable enough, given that he is a reporter by profession. However he offers curious Data to substantiate his Claim. He says that if he stops talking it means that he has got nothing else to say. The Claim does not follow the Data although it is presented as though it did. The Warrant does on the surface appear reasonable enough, however in this context it seems to serve a function of not taking responsibility. The suggestion seems to be that the responsibility for making things happen rests in the patient's mind with the therapist. Which amounts to a denial of having to think, and a projection of responsibility onto the therapist. It is also an example of concrete thinking in the sense that the patient does not take up the Challenge to think why he reacts in this way. He uses the idea of an interview format concretely.

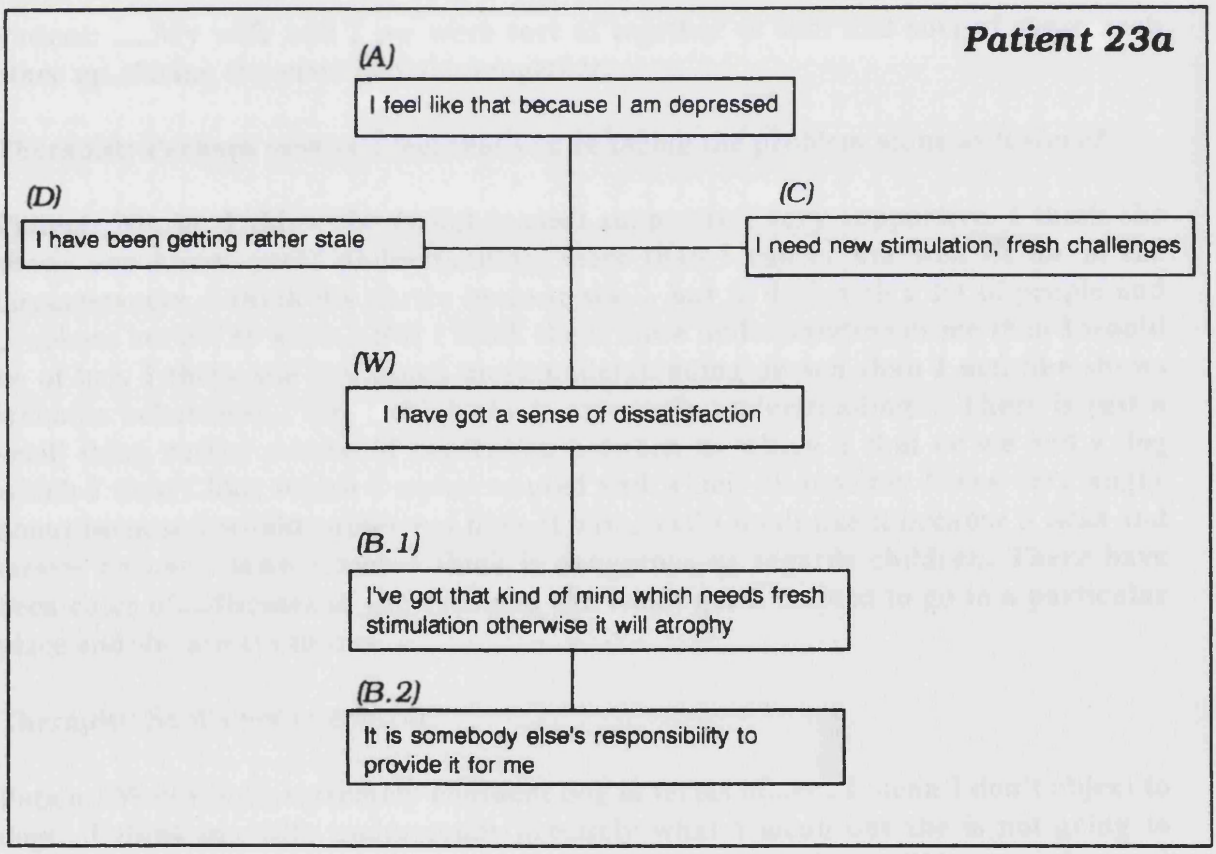


Diagram 23a – Patient: (This interchange is preceded by a Challenge by the therapist which is unfortunately very unclear on the audio tape).

The Claim here is that the patient feels he needs new stimulation and a fresh challenge. The Data is that he feels he has been getting rather stale. The Warrant is that he is feeling a sense of dissatisfaction. There appear to be two Backings. The first one is verbalised, and is that the patient has got the kind of mind which needs fresh stimulation otherwise it will atrophy. The second one, which is not verbalised, is that the responsibility for providing this stimulation is somebody else's not his own. The Alternative, which is not verbalised, could be that his present state of mind may have more to do with the way he feels, that is depressed, rather than with needing stimulation.

This suggests narcissistic personality traits (he is a special kind of person). At the same time it constitutes a suggestion that the responsibility for providing the stimulation is not his but somebody else's. Thus George uses projection of responsibility and a denial of having to think about his situation.

Patient: .....My wife and I we were sort of together in that and sort of shore each other up...facing the same problems together.

Therapist: Perhaps now you feel that you're facing the problem alone as it were?

Patient: No, no I think she (wife) is most supportive, very supportive. I think she shows you know, great understanding, more than I can er um well fit for in the circumstances. I think it's partly because she.... has to deal with a lot of people and problems herself at work... But I think she is more understanding of me than I would be of her. I think she is a much more understanding person than I am. She shows irritable behaviour.... but I think she is extremely understanding. ...There is just a small thing rather a bone of contention between us which is that er we had a dog which I didn't like, which I never wanted and which uh possibly I was very angry about because I would rather not have it but...Well I don't like it because it licks and messes on one's lawn which I think is dangerous as regards children. There have been cases of,...diseases of the eye...and she won't get it trained to go in a particular place and she always thinks....

Therapist: So it's not in control?

Patient: Well it's an extremely ebullient dog in terms of...er , I mean I don't object to dogs....I think my wife understands precisely what I mean but she is not going to change things...and the whole things gone too far...the children will be terribly upset if you get rid of it. I think that's the only persisting sore...
(long silence)

But I don't think what goes on at home er bears any relevance to what has happened to me over the last year...and nor am I trying to put off exploring that side but um I

really don't know if I'm looking for causal....I don't think that that is of any relevance. I think there have been spin offs, I think um the sort of emotions, the strength of emotions I've felt since last year have er... perhaps made relationships at home rather more difficult but that's because I'm being more uptight and um you know, my wife has told me so as well.

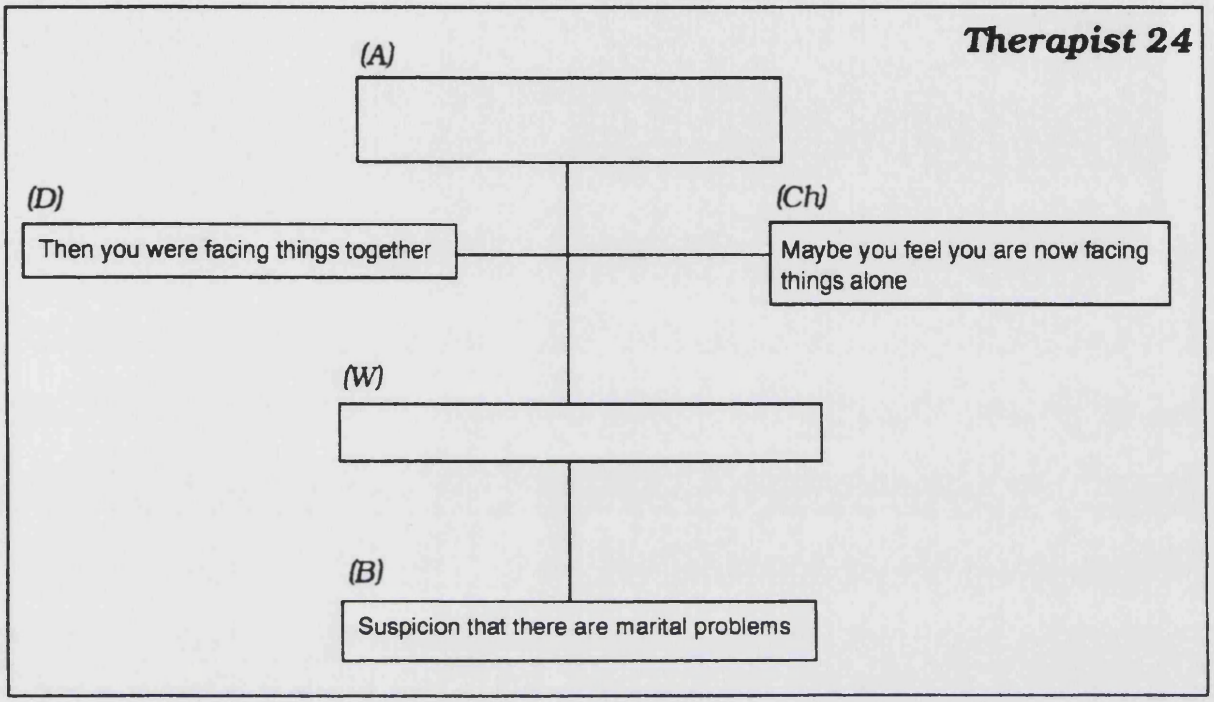


Diagram 24 - Therapist: The Challenge offered here is that maybe the patient feels that he now is facing things alone. There is no real Data for this Challenge, only that in the previous sentence the patient had referred to the past when he said he and his wife had faced things together. There is also no Warrant. The Backing is not verbalised but is something like, one might expect a patient who is presenting like this to also have marital problems.

It appears that the therapist is merely guessing here.

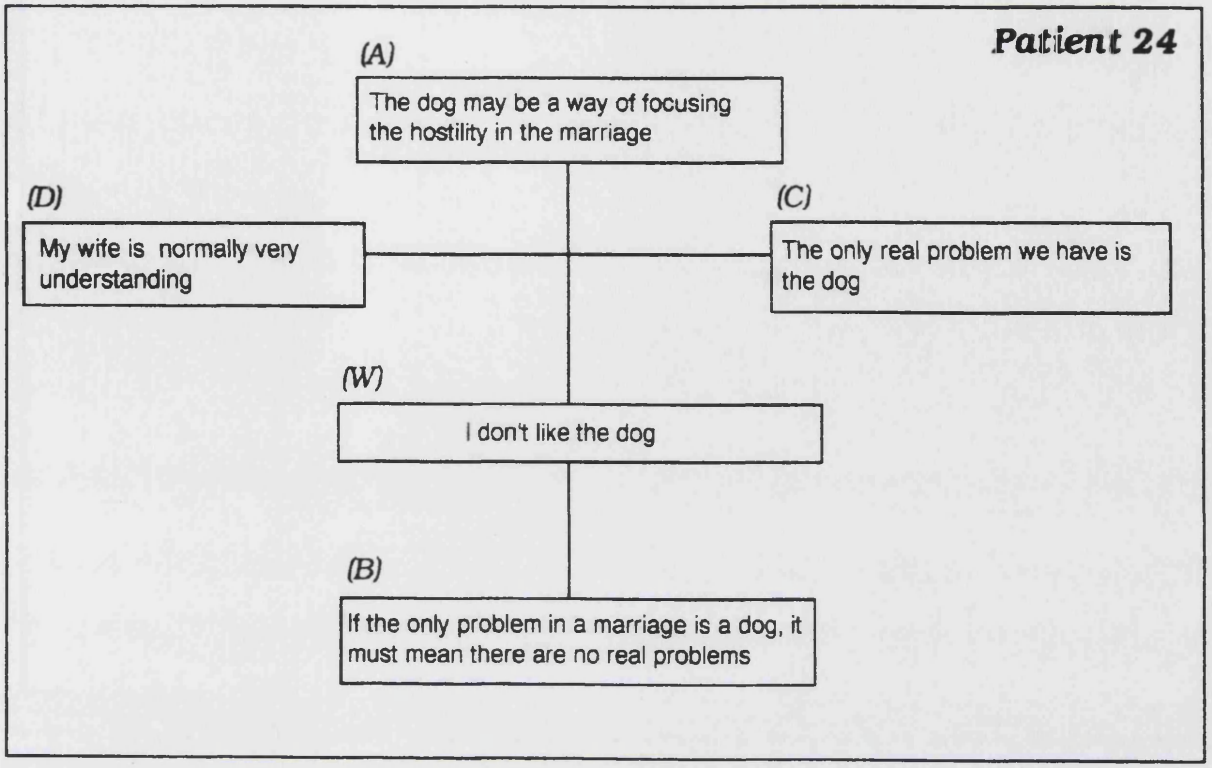


Diagram 24 – Patient: The patient's Claim is that the only problem he is having at present with his wife is about the dog. The Data is a lengthy monologue about how supportive and understanding his wife is. The Warrant is that **it is the dog he doesn't like.** The Backing, which is not verbalised but strongly implied is that, if the only problem a couple are facing is about a dog then that must mean that there are no real problems. The Alternative is not verbalised and not apparently thought of either. The Alternative could be that the dog is the focus of the hostility that exists between husband and wife.

This scenario is about minimising and dismissing the possibility that there might be issues worth thinking about in relation to his marriage. The defence used is denial of a need to think, plus displacement and projection of anger, and irritation onto the dog. 'I don't need to think because the dog is the problem, if the dog were different or not there, there would be no concerns'.

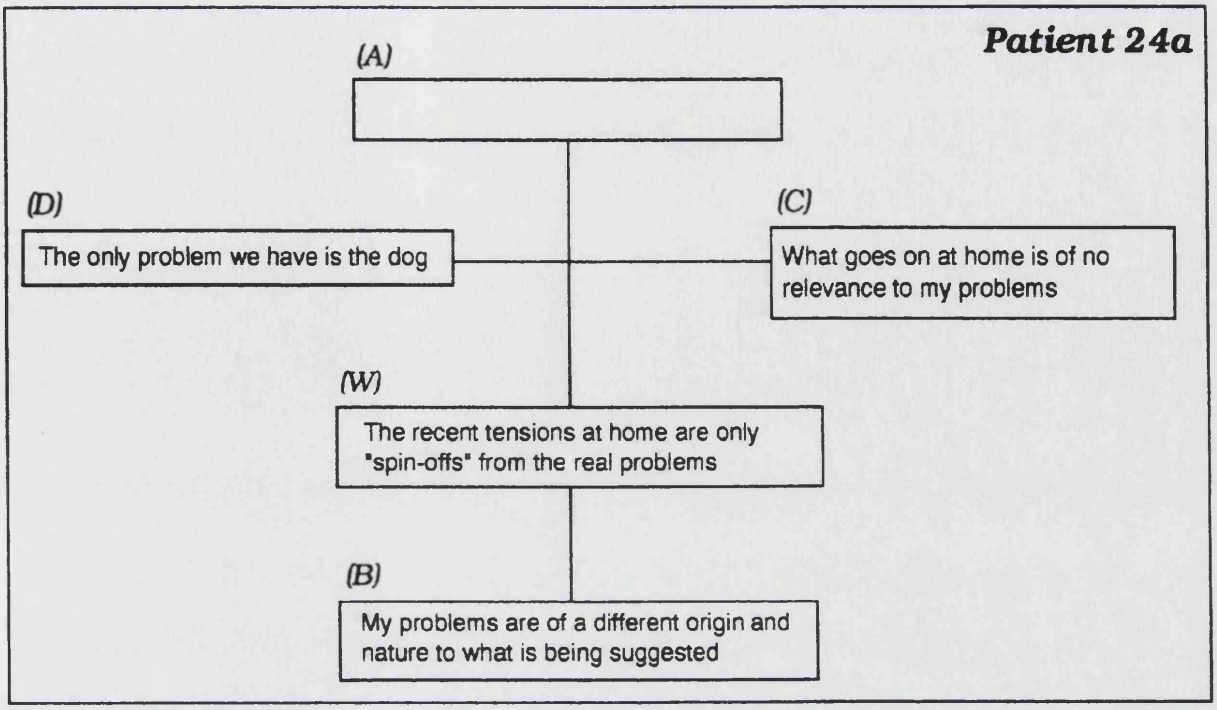


Diagram 24a - Patient: The Claim is that what goes on at home for the patient is of no relevance to his problems. The Data to this Claim appears to be the discussion above, leading in his mind to the conclusion that the only problem around at home is about the dog. The Warrant is that although there has been increased tension lately at home these are just 'spin offs'. The Backing isn't verbalised but seem to be an idea that his problems are of a different origin to what the therapist is suggesting.

Here it appears that the patient is trying to direct the attention away from his marriage and home life. He uses denial of responsibility, and displacement.

Patient: Er you know I can handle these sort of things but yet just as an illustration er of what we're talking about I do feel a strong knot of nervous tension the whole, the whole day which .... I don't want to run the risk of snapping as has happened in the past. Undoubtedly something does snap inside I don't know what it is.

Therapist: Perhaps you worry that if you were to snap like that that you'd actually break down in other sort of ways?

Patient: I don't know (silence). I mean I'm um, I have broken down and cried over a situation but I can't say I've ever broken down in the sense of breakdown...I don't know what that would involve. You hear people saying, someone had a breakdown, which usually involves sort of I don't know, complete collapse of some sort, and they, you know seem to take a long time off. Well, I don't really understand what that really means. I've certainly never suffered it myself.

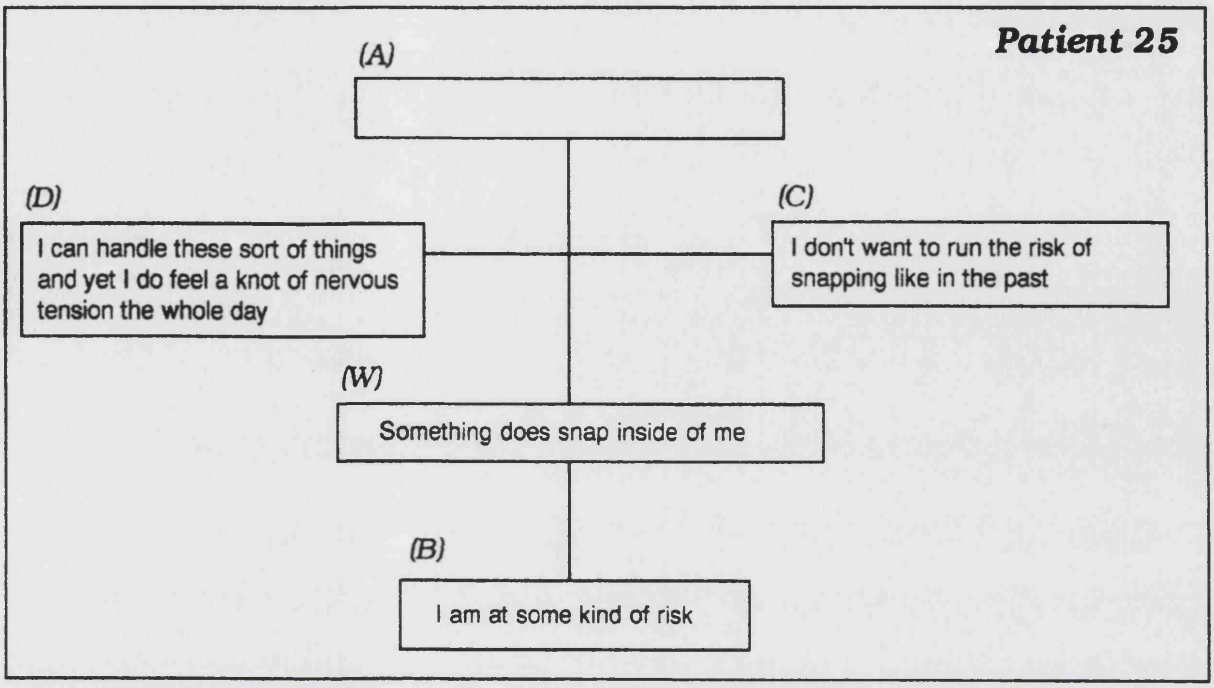


Diagram 25 – Patient: The Claim is that the patient does not want to run the risk of 'snapping' like in the past. The Data is that although he feels he can handle these 'sort of things', he does feel a knot of nervous tension the whole day. The Warrant is that the patient does feel that something does 'snap' inside him. The Backing is not verbalised but implied, in that the patient feels he is at some kind of risk.

The patient is expressing anxiety in a perfectly coherent way, however it is not clear what he imagines the risk might be.

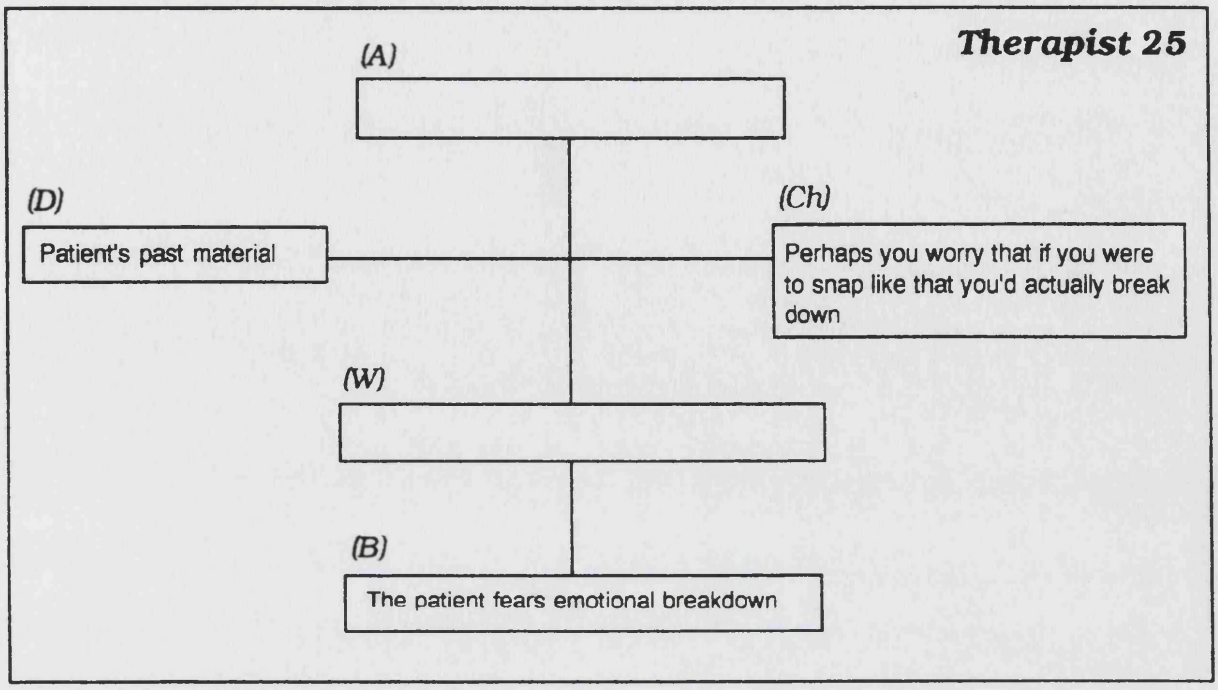


Diagram 25 - Therapist: The Challenge is that maybe the patient feels that if he were to 'snap' again this would actually be a 'break-down'. The Data is not spelt out, but the Challenge rests on the patient's previous communication. No Warrant is offered. The Backing is partly incorporated in the Challenge, that is, the patient fears an emotional breakdown.

The therapist is in this communication trying to make explicit and explore the patient's Backing, an amplification of the patient's anxiety..

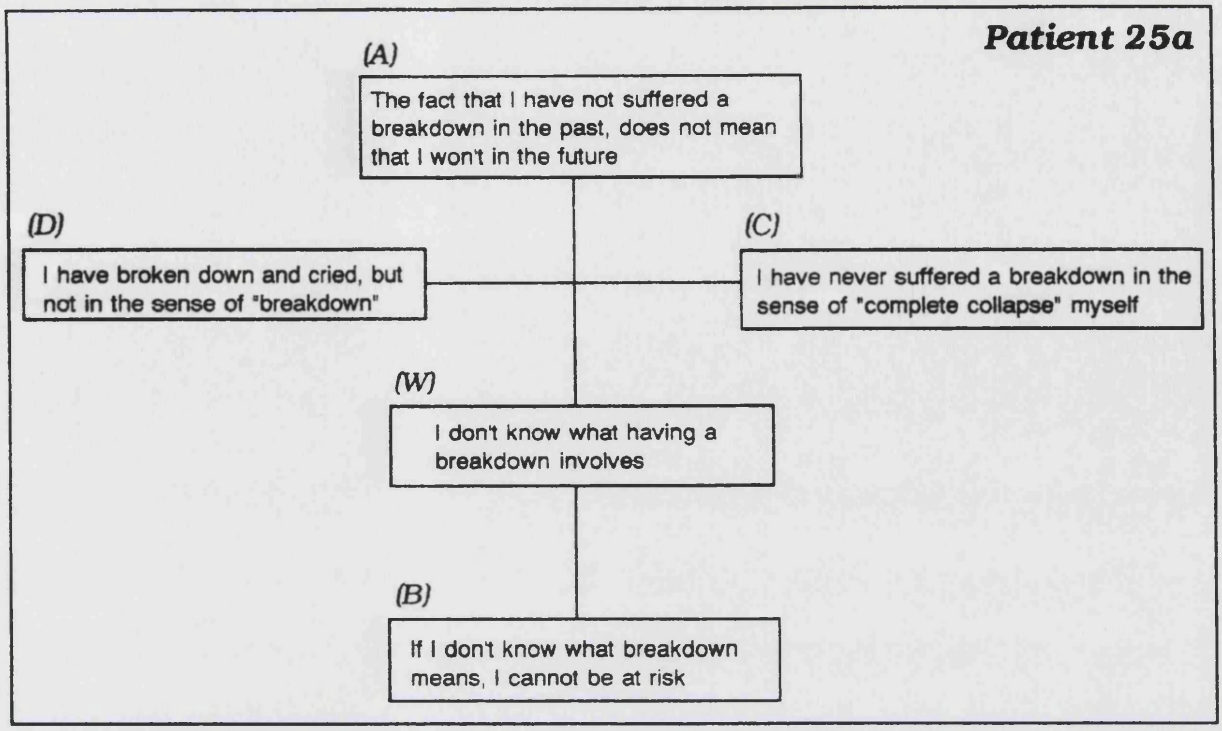


Diagram 25a – Patient: The Counter-Claim in response to the therapist's Challenge is that he, the patient has never suffered a breakdown in the sense of 'complete collapse'. The Data is that although he has broken down in the sense of crying, he has not broken-down in the sense of 'breakdown'. The Warrant is that he does not know what having a breakdown involves. The Backing is not verbalised, but implied, that is if he does not know what a breakdown means he cannot be at risk. The Alternative, which is not explored, is that the fact that he has not suffered a breakdown in the past and that he does not know what it involves, does not mean he could not be at risk or fear it in the future.

In this vignette the patient completely contradicts himself, from quite coherently discussing that he feels he is at risk of some kind of 'breakdown' to denying it. As the therapist was amplifying George's anxiety George found it intolerable and his defences, needed to be mobilised, in order to ward off more anxiety. It is clear in the second part of the above section,(Patient 25a) that the argumentation has become 'concrete' in nature, it has become a play on words. The Backing reveals omnipotent thinking, and the section illustrates a denial of the anxiety which was being expressed by the patient himself only a few moments earlier.

Patient: But you must have done this with other people and had a, I don't know, a degree of success that achieves but its your business.
Therapist: Are you saying that your actually feeling quite out of control at the moment of the situation.

Patient: I don't, I mean you keep using the expression out of control. I feel completely in control....It doesn't mean to say that I'm out of control because one can't for see consequences. I feel that would be a very controlled position to be in.

Therapist: I think that's quite an intellectual approach to how you're actually feeling.

Patient: Uh, well I've not thought of, I mean you must have deduced that's the kind of person I am. I'm very I try to be as rational and I work out things in my head...but I think it's a sensible approach, because as I say I've got no experience of ever doing this kind of thing before and I haven't read much about it either. As I said almost my only knowledge or experience is through my particular friend who is a psychiatrist.

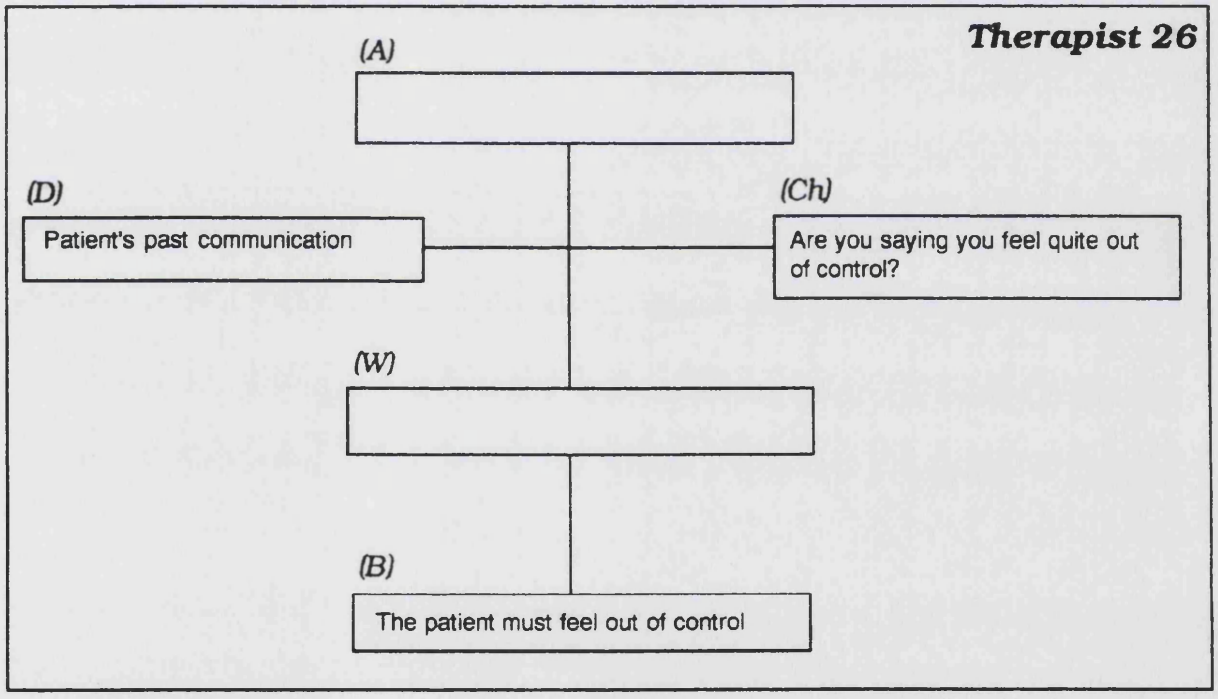


Diagram 26 – Therapist: The Challenge is that the therapist is wondering if the patient feels quite out of control in this situation. The Data is the patient's previous communication. No Warrant is offered. The Backing is not verbalised, but is an assumption, given the situation the patient finds himself in that he must feel out of control.

This constitutes an educated guess or a suggestion. The therapist is not linking this suggestion directly to the material, but she is making assumptions. She expresses the situation in strong terms by saying, 'quite' out of control.

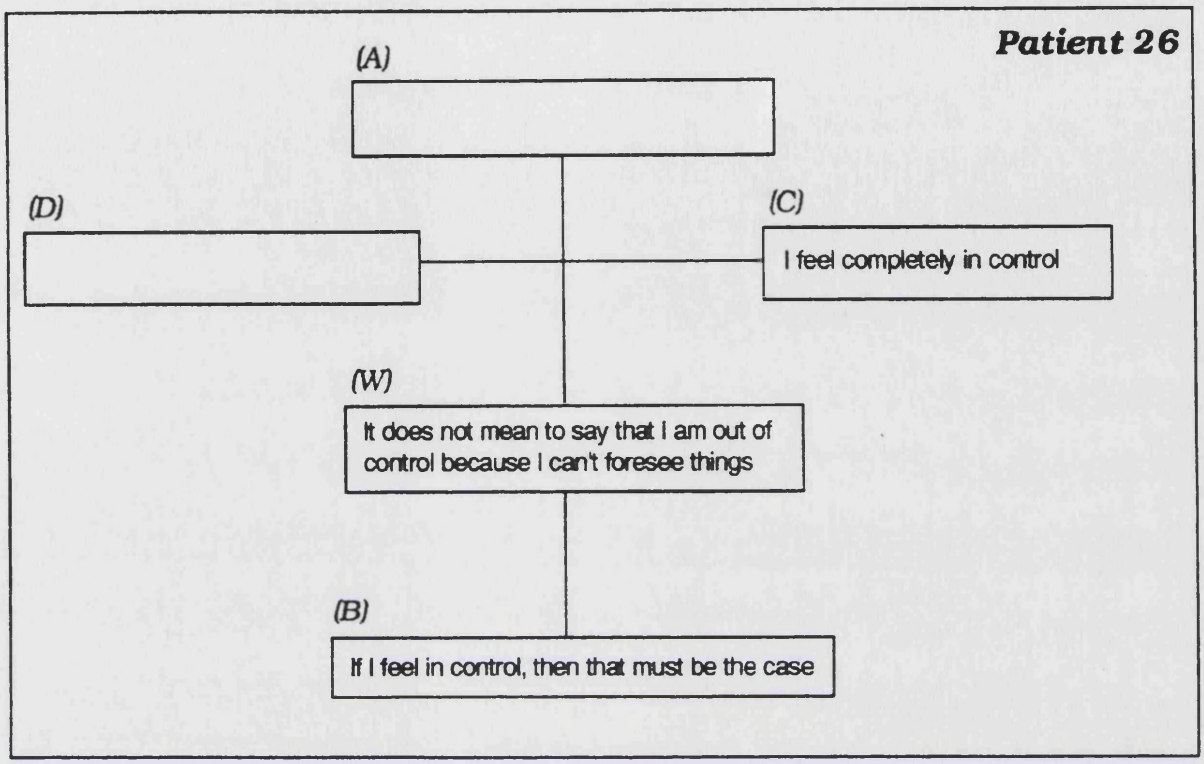


Diagram 26 – Patient: The Claim in response to the Challenge is that the patient says he feels completely in control. There is no Data for this Claim. There is a Warrant, namely that the fact that he cannot foresee things, does not mean that he is out of control. The Backing is not verbalised, but seems to be that if he feels he is in control then that must be so.

In response to the therapist's suggestion the patient responds by a denial. This is a denial of a need to think about the ***possibility*** *of feeling out of control. The way the denial is constructed suggests the use of omnipotent thinking. It is possible that the intensity of the denial arose in response to the way the therapist worded the original Challenge to the patient.*

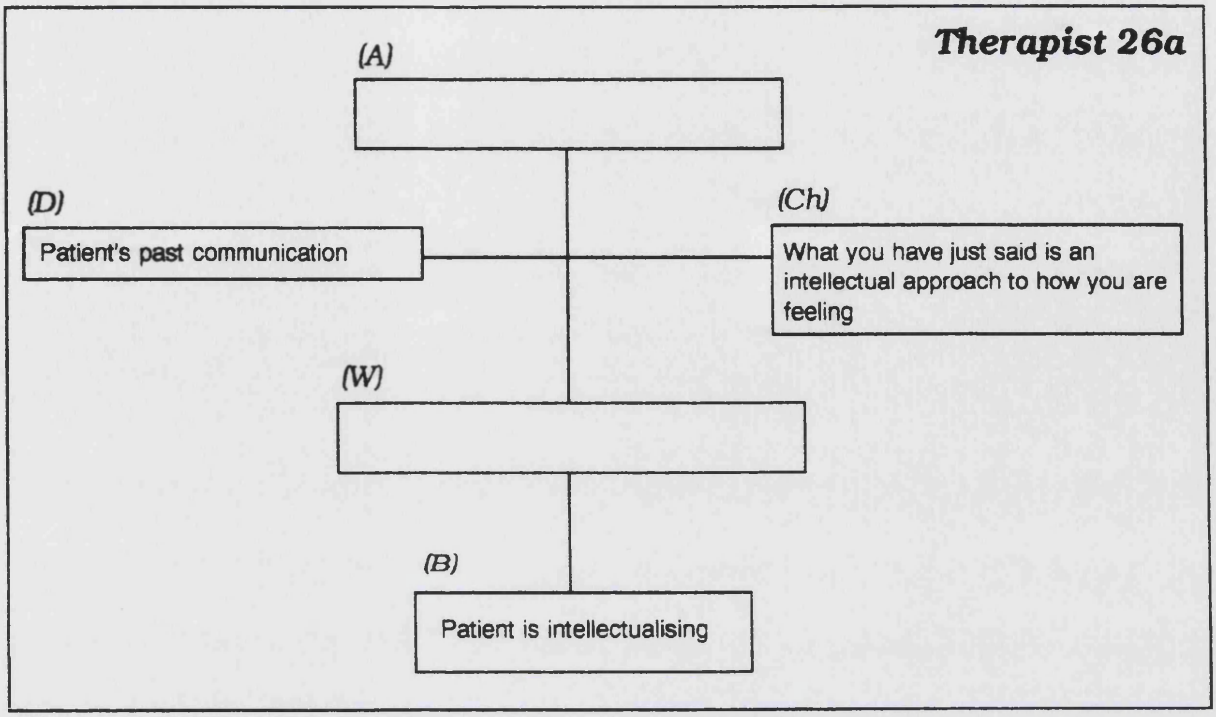


Diagram 26a – Therapist: The Counter-Challenge in response to the patient's Claim above is that what the patient has just said represents a very intellectual approach to his feelings. The Data is the patient's previous communication. No Warrant is offered. The Backing is incorporated in the Challenge and is a belief on the therapist's part that the patient is intellectualising.

The therapist is trying to challenge the patient to think about the defensive quality of his argumentation.

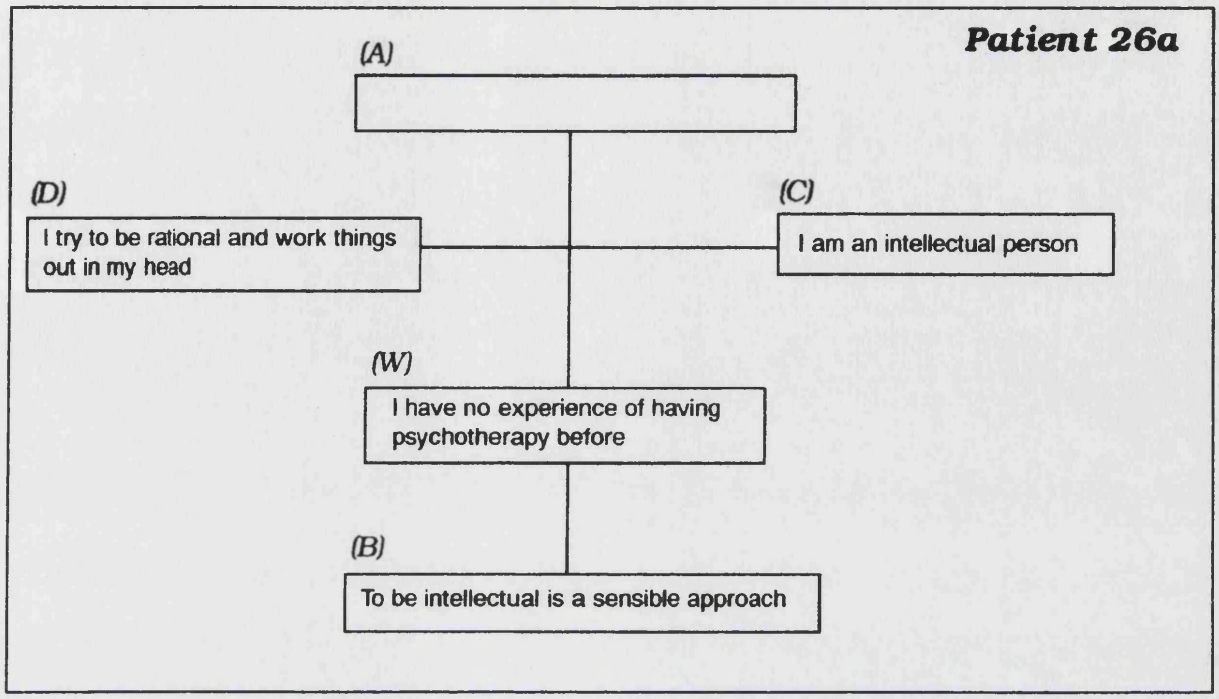


Diagram 26a – Patient: The Counter-Claim in response to the previous Counter-Challenge is that the patient agrees, he feels he is a very intellectual person. The Data is that he tries to be rational, and work things out in his head. The Warrant is that he has no experience of psychotherapy. The Backing is verbalised and is that he believes that to be intellectual is sensible.

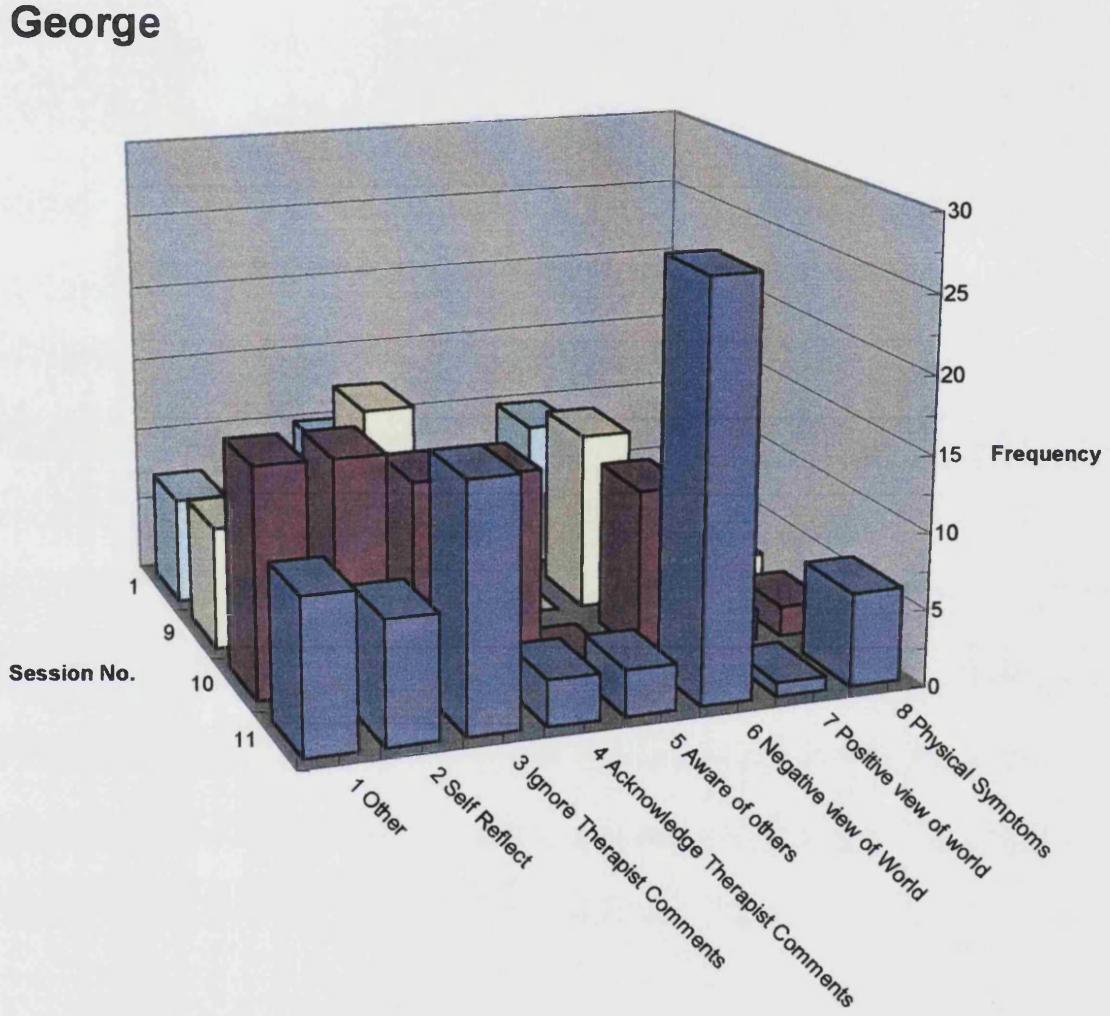
At the beginning of this vignette, it seems the patient is getting in touch with some anxiety, which the therapist is then amplifying. The patient cannot cope with the amplification therefore he needs to deny again what he has already considered. Typically there is no Data for his statement that he feels ***completely in control.*** *The fact that he needs to underline his belief by using a strong word like* ***completely****, further suggests that defensive thinking is at work. As mentioned above the patient's* ***'completely'*** *may be in response to the therapist's* ***'quite'.*** *The therapist responds to the patient's Claim by commenting on the 'intellectual' style of the patient's response. This was meant to draw the patient's attention to the concreteness and superficiality of the patient's argument. However the patient responds on a different level of abstraction, he responds on a 'concrete' level, by agreeing that this is the kind of person he is, as if he had not understood the Challenge at all. He gives Data and Backing for his position. Interestingly the Warrant gives an indication of uncertainty, he points out that he has*

never been in psychotherapy before, as though on some level he is aware that he is distorting the levels.

It seems that to call the patient's style of communication 'intellectual' was an unfortunate choice of word in this instance. Anything called intellectual is highly valued for this patient and it provided him with a way out of 'understanding' that the therapist was talking of defensive functioning.

5.3. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1,9, 10, and 11 are mapped onto the rotated histogram below



The variables in this histogram are as follows: The first column (1) is a catchall category. The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative

statements. The seventh column (7) shows the number of statements indicating a positive worldview or positive statements. The eighth column (8) shows the number of statements relating to physical symptoms.

The patient's preoccupations did not alter noticeably. His frequency count of statements indicating a negative worldview almost doubled by session 11.

5.4. Independent Psychoanalytic Assessment of George (Session 1)

The client came across as difficult and defended, appearing reluctant and uncomfortable in the position of interviewee, rather than interviewer. His feeling of having some self-awareness provided for him to appear threatening. In the exchanges about control and losing control etc., I feel he did not like the counsellor noticing things about him and saying them.

I think the interview is characterised by a feeling of coldness and accompanied by an intellectual quality and rivalrous undercurrents. A further feature is hostility and cold hostility at that. It is first expressed towards the dog, then his wife then his employers. In the last part of the interview hostile and critical feeling is directed towards the counsellor when he feels he has been left to experience silence. He comes near to saying that if he had been conducting the interview he would have protected the client against it. I think that it adds up to narcissistic defences. Further corroboration of narcissistic structure is seen in his internal conviction that psychic well being is inextricably linked with achievement and success. Prospect of failure is shot through with feelings of paranoid anxiety. His attitude towards those from whom he feels he is (or has) receiving hurt is moral hostility.

I think the interviewer finds herself struggling to think - not surprisingly since she is in receipt of feelings of failure and inferiority actively projected into her. I also find the typescript interesting firstly because the client drifts off - presumably because he becomes inaudible, and secondly because it is hard to tell who is who. Whilst both characteristic of narcissistic interaction. The interviewer must strain to listen; and increasingly there is an unconscious attempted take-over by the client of the interviewer's mind.

Comment: The independent assessment summarises the hostile atmosphere between patient and therapist. It highlights the patient's need to push away (project) onto the therapist feelings of failure. The patient's need to rely on defences is highlighted. The difficult situation thus created for the therapist is also commented on.

5.5. Summary of George

George presented as a rather reluctant and uncooperative patient. It is not clear why he stayed the course of therapy. He had a great need to see his difficulties as due to external factors and not essentially his responsibility. How he maintained this view is illustrated in the detailed analysis. The hostile attitude of the patient towards being helped is also evident in the rotated histogram, which shows a high frequency of incidents of ignoring the therapist's comments and a low frequency of incidents of acknowledging the therapist's comments. The independent assessment highlights the hostile self-centred or narcissistic quality of this man's interactions.

The pre-therapy interview (see appendix 3) similarly illustrates this man's need to see his difficulties as being entirely due to external factors and his need for being the focus of events. The post therapy interview (see appendix 3) also highlights the hostility of George. He is not allowing for the possibility that the therapy might have been helpful in anyway although at the same time he reports that he feels a lot better. In fact he remained very critical of how his therapist had conducted the sessions.

George's defensive style did not change significantly during the treatment. The areas explored remained the same safe ones over the therapy, as would be expected since the defences did not get significantly modified. More work on this patient's defensive style might have moved the therapy forward and allowed for the exploration of deeper levels. These findings are in agreement with the independent psychoanalytic assessment of session 1.

In this session the defences at play were denial of feelings related to beginning therapy. George used intellectualisation, that is, everything was approached in an intellectual

fashion. There was destruction of meaning of the therapist's suggestions furthermore there was evidence of concrete thinking with excessive anxiety for his own safety and projection. The prominent use of these defences amount to considerable splitting. The anxiety present in the session was of a persecutory nature. There was no evidence of concern for anybody else. In fact a kind of combat situation was set up between the therapist and the patient, where the patient avoided any suggestion coming from the therapist and instead redefined the issues as he saw them. He was thereby exercising considerable control over the session. Notably he felt **hard done by** because the therapist did not provide the patient with any guidelines and further he seemed annoyed by the therapist leaving him in silence.

6. Results: Elizabeth

This chapter introduces the third of the subjects. Elizabeth was undergoing cognitive analytic therapy.

Included in this chapter are a short background to the patient, a subjective/intuitive analysis of selected sections of this patient's therapy sessions and a detailed argumatics analysis of sessions seven and eight. These were analysed in detail as these were felt to reflect the typical interaction between this patient and her therapist. The recordings of the early sessions were of such poor quality that transcripts could not be produced. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain the authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in four selected session from the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed.

Finally a summary of all the presented material is included with reference to before and after interviews conducted with the patient for the purpose of this research. Transcripts of the before and after therapy interviews can be found in appendix 3. Notes on Elizabeth's initial psychotherapy assessment in the form of a GP letter can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of Elizabeth's sessions of psychoanalytic psychotherapy are available on a CD-rom, appendix 5, available on request from the author.

Included in the appendices is also additional material used in cognitive analytic therapy, such as a letter from the patient to the therapist, the therapist's reformulation of the patient's situation, a diagrammatic representation of the patient's dilemma and the therapist's good-buy letter to the patient. These can all be found in appendix 2.

6.1. Elizabeth

Elizabeth was 29 years old at the time of her therapy. She is a single woman, a filmmaker by profession, but unemployed at the time of the therapy. Elizabeth was seeking psychotherapy as a result of stress caused by the 'on and off' relationship with her boyfriend of a few years standing. Elizabeth came from a religious, puritanical home. She is the third of five siblings. Elizabeth describes her family in an unemotional detached fashion. In fact, she appears contemptuous and clinical. Her father is described as **'superficially quiet but a massive egotist underneath'**. Her mother is described as **'also very inhibited'**. One of her brothers is described as **'probably educationally subnormal'.** When describing her own early experiences, it was difficult to ascertain the facts, such as where she grew up etc. What she volunteered were feelings of being emotionally abandoned by her mother because mother was working, and also needed to attend to her other children. She felt that her father was a strict disciplinarian, who occasionally caned her, especially if she had wet herself. During therapy Elizabeth described how she and her sisters had to undergo humiliating examinations of their underwear by their father. Elisabeth talked of how she feared being punished in her childhood. At the same time she lived in fear mixed with pleasure of seeing one of her siblings punished rather than her.

Elizabeth felt the need to achieve from an early age. She suffered sleepless nights from the time before sitting her 11 plus examination. She also remembers having been very competitive. However, Elizabeth left school at the age of 16. After many false starts in working life and doing courses of clothing design, Elizabeth started studying photography and filming. She had subsequently some success working as a filmmaker and a scriptwriter, although at the time of seeking therapy she was unemployed.

Elizabeth's first long-term relationship lasted for three years from the time Elizabeth was 17. She said she was dependent in that relationship but eventually they drifted apart. In the interviews conducted with Elizabeth it became clear how frightening and distasteful she found feelings of dependency. Her next long-term relationship was with Martin who is also working in the film industry. This is the relationship, which was causing Elizabeth

concern at the time of her seeking therapy. This relationship had been characterised by Elizabeth feeling, competitive, dependent, and rejected.

Elizabeth talked a lot in her therapy about having a very blurred image of herself **'like a four year old child, who can't face the world'** as she put it, or she put on an act of being in control. She felt she had difficulties identifying with her gender. When Elizabeth was faced with situations where she was expected to be an adult woman she felt like a 'humiliated child'. The 'woman' in her felt as weak as she felt her mother had been. In fact Elizabeth experienced her mother as being not only week but also what she called **'grey and un-feminine'**.

Therapy

Elizabeth, entered therapy with feelings of isolation. These feelings seemed to enter into the therapy situation, and she spent long stretches of time in what sounded like lonely monologues. This state of affairs was already evident in the pre-therapy interview (see appendix 3). In the diagram drawn up by the therapist, the patient's core state of mind was identified as *'deprived empty isolation'*. In therapy Elizabeth attempted to explore her childhood and the relationships in her family. What was striking about this exploration was how she had seen herself as a victim of cold unfeeling parents, and in competition with her siblings. The fact that her father was in the habit of inspecting his daughter's underwear was in therapy felt to constitute a form of sexual abuse that the patient was compelled to repeat in a disguised form. During the therapy the patient started doing 'live modelling' (nude modelling) for a group of painters. This was seen as a repetition of the earlier abuse, especially as Elizabeth wanted to be painted naked with a blindfold.

In the therapist's supervision group it was felt that in session 7 something had moved when Elizabeth talks of feeling shocked by seeing the painting of herself naked and blindfolded. It appeared that Elizabeth gained some understanding of the way she was compelled to set up destructive situations for herself. She described how she often has found herself in exploitative relationships with men. However the connection with the earlier abuse was not made by the therapist in this context, and was also not perceived by the patient. Related issues of fear of neediness and passivity were being expressed and

these were connected in Elizabeth's mind with her feeling like 'her ineffectual mother', and more indirectly with being a woman. It appears significant that in session 8 Elizabeth expressed some of her feelings about sex, and her sexuality. Her body image was not surprising poor and she appeared to have found sex a very difficult issue. Urinating played a significant part in her masturbation fantasies. It was connected in her mind with her father's strange practices of inspecting Elizabeth's underwear.

The therapist worked mostly with extra transference material, neglecting almost totally the patient's fantasies about her as a female therapist whom the patient described as **'very feminine'**, in the post therapy interview. It appeared that envy of the therapist was an underlying feature of this therapy, and the fact that it was ignored in the therapy work meant that much that was worked on in this therapy might have become undermined. In fact in the post therapy interview there were some indications that a negative therapeutic reaction set in, as the patient felt the need to deny some of the useful work that had been done.

6.2.1. Session 7

Subjective/Intuitive analysis

This session starts with the patient reporting back on the events of the previous week. Elizabeth does this in the form of reading the diary she has kept about her moods during the week. Elizabeth reports that the feelings she has experienced in response to seeing a painting of herself in the nude blindfolded, were shock and distress, contrary to what she had expected. The patient has been doing 'life modelling' for some painters, and had requested to be painted with a blindfold. She had expected to see something powerful, but instead she sees in the picture something frightening, and perverse (her expression).

'It looked (silence) bizarre. I mean it looked, I felt ashamed somehow because it looked like somebody going to die or something'.

There appears to be some confusion in the patient's mind about whether or not she has allowed herself to be abused by doing the modelling. She discusses at length her feelings about the painter who painted the picture. She clearly tries to see him as somebody who treats her well, but cannot easily sustain this line of thinking. The associations take the patient further into thoughts about situations when she has felt used. Elizabeth remembers

a boyfriend who was only interested in her sexually. Finally her associations take her to the conclusion that she cannot trust herself and her feelings, as they are so volatile.

'Yes, and they really swing to extremes and I feel almost humiliated when I am at one extreme that I could ever have thought of other things'.

The therapist is drawing parallels to the patient's childhood and how she felt confused as a result of the harsh treatment by her parents.

6.2.2. Argumatics analysis of session 7

Patient: That was, I wrote that when I got back home last week. I was sort of, because I felt really kind of strange and I told you that I'd been doing life drawing and you were talking about how my idea about women was that they were actually passive and I sort of thought my God, what am I doing, doing this? I sort of in a way I wanted to tell you that I'd written this letter and somehow it just seemed to compound my stupidity, you know I just felt well, keep quiet about that. You know, that,... Therapist: Maybe you were trying to be more active, to suggesting the idea of creating, writing. Patient: Oh I don't know, it's a combination of things. I am sort of genuinely interested in pursuing being a life model for a while because for some reason it interests me. Also I really like the paintings that this man has been doing and well, I like him (laughter). And I am sure it just has something to do with our relationship. You know, him the painter and the model and that's why I felt particularly stupid about - I mean I didn't write anything particularly awful in this letter at all and I did, I have an idea for something which I wanted to do which we did, this image of somebody blindfolded. But in fact it came out really strange, it looked perverse. It hadn't occurred to me what the combination of nakedness and a blindfold would imply at all and....

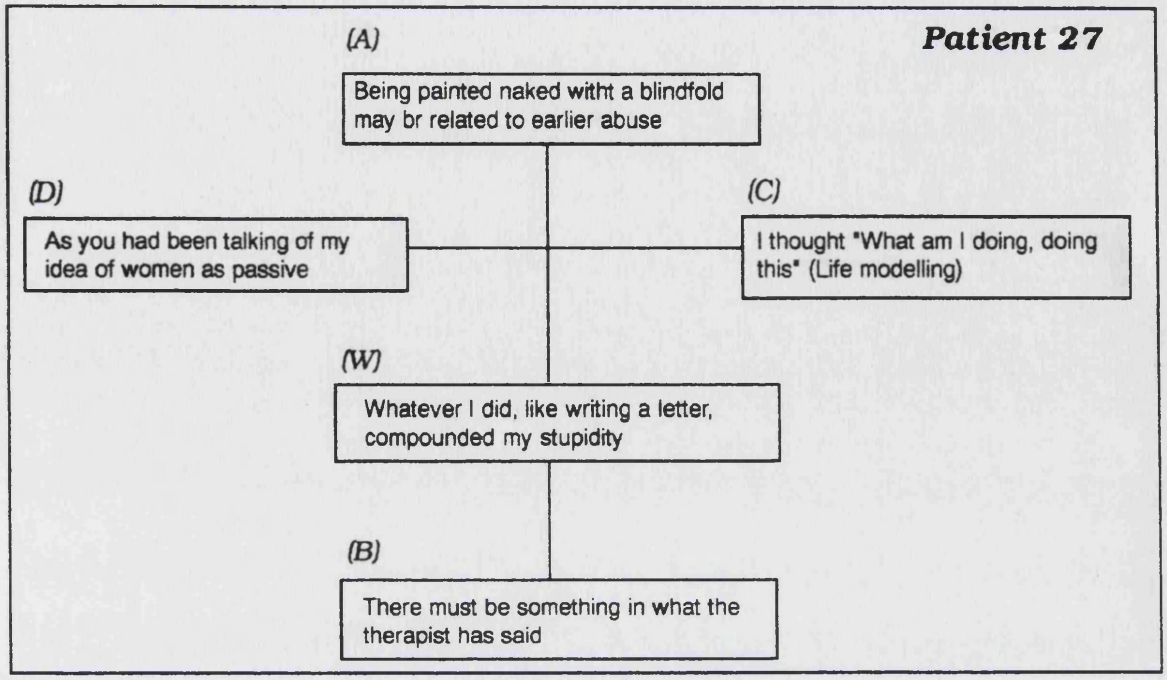


Diagram 27 – Patient: The Claim is that the patient wonders, what is she doing, doing this! The Data appears to be related to the previous session, she says 'as you had been talking of my idea of women as passive'. In the Warrant she says 'whatever I did, like writing a letter compounded my stupidity'. The Backing appears to be some reference to the fact that there must be something in what the therapist was saying or implying, that is, the patient puts herself in a passive situation. The Alternative, which is not explored, is that wanting to be painted naked with a blindfold may be related to some earlier abuse.

Some anxiety and confusion appears to have emerged here, as the different elements do not hang together.

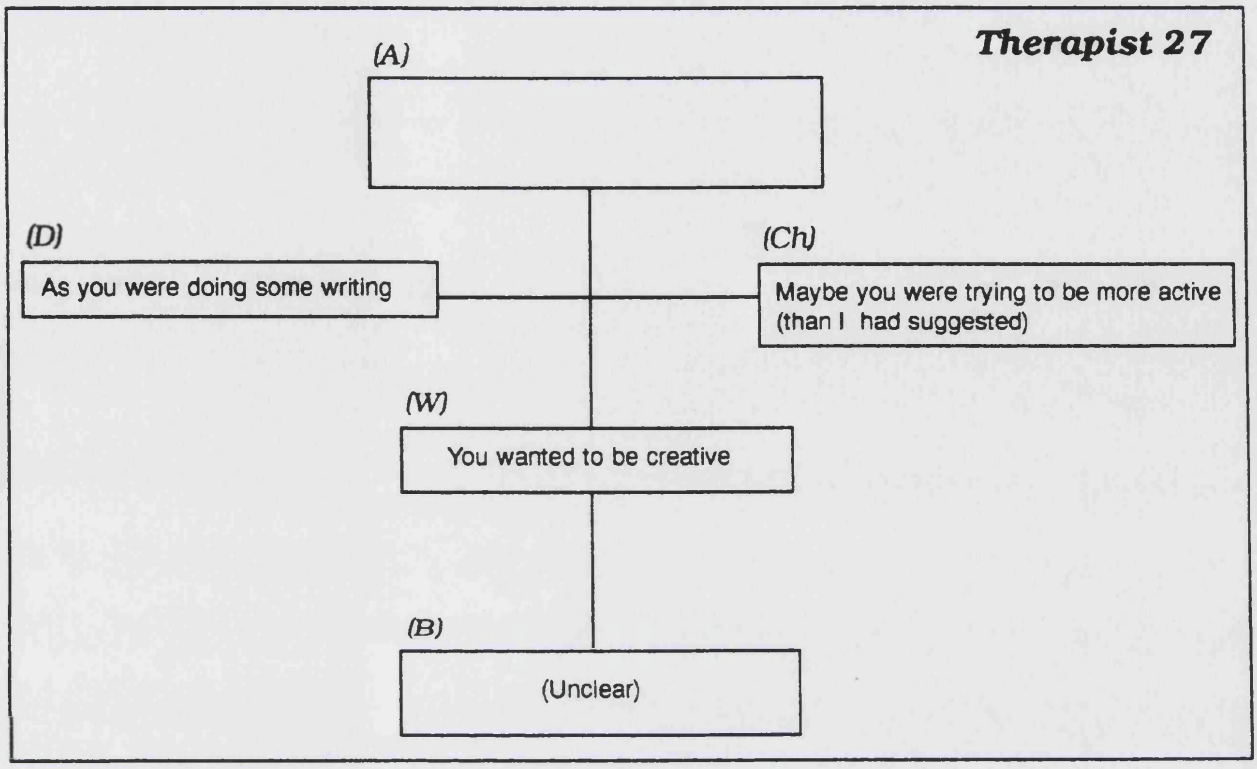


Diagram 27- Therapist: The Challenge, which comes in response to the patient's Claim above, is that ' maybe you were trying to be more active (than I had suggested)', The Data offered is the fact that the patient was doing some writing. The Warrant is that the patient wanted to be more creative. The Backing seems unclear.

The suggestion from the patient is that some anxiety was stirred in the patient by the previous session and that she was thinking about this. However it seems that the therapist is for some reason trying to find some 'safer ground', and gives an alternative explanation to the patient's thoughts, expressed by her writing. In effect the therapist is showing the way into new defensive thinking.

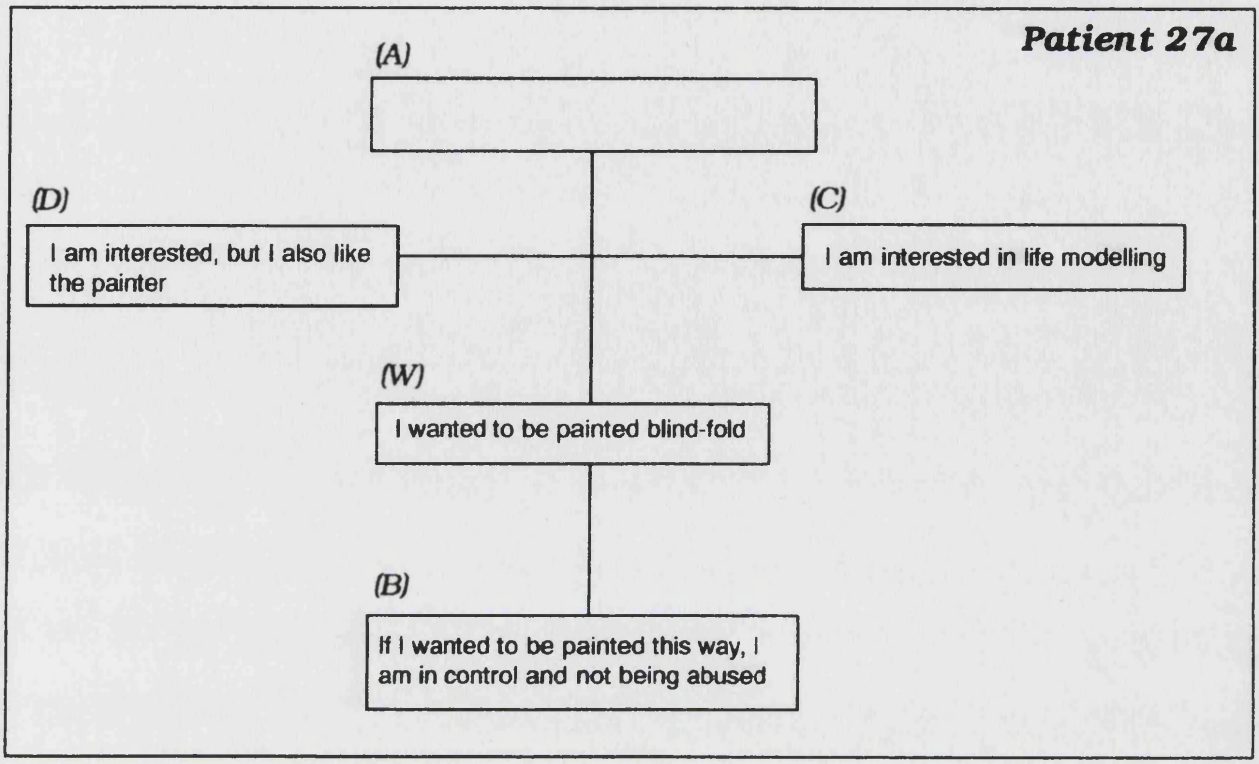


Diagram 27a- Patient: In response the patient produces the Claim is that she feels that she is truly interested in nude modelling. The Data is that she also likes the painter. The Warrant is an assertion that she **wanted** to be painted blindfolded. The Baking is not terribly clear, but seems to be something like, if I wanted to be painted this way, I am in control and consequently not used or abused.

This argument arises in response to the therapist's intervention. Elizabeth had been offered a return to defended thinking, with the therapist's help and 'blessing'. There is a denial of conflicting feelings expressed earlier and a form of reaction formation can be seen. These are expressed in the Claim and the Warrant.

Patient: It looked - Bizarre. I mean it looked, I felt ashamed somehow because it looked like somebody going to die or something. A combination of nakedness plus blindfolded-ness. And there's also, I mean when I am naked I think there's something very kind of bovine about my body, um, I find it particularly strange you know, the combination of my body and the blindfold.

Therapist: A bit like an animal, which is blindfolded, which is going to the slaughterhouse. Patient: Yes. It reminded me of - somehow it's more distressing because it's a woman's body and unmistakably a woman's body because you know my body is quite sort of fleshy and flabby and I did it, it sort of....

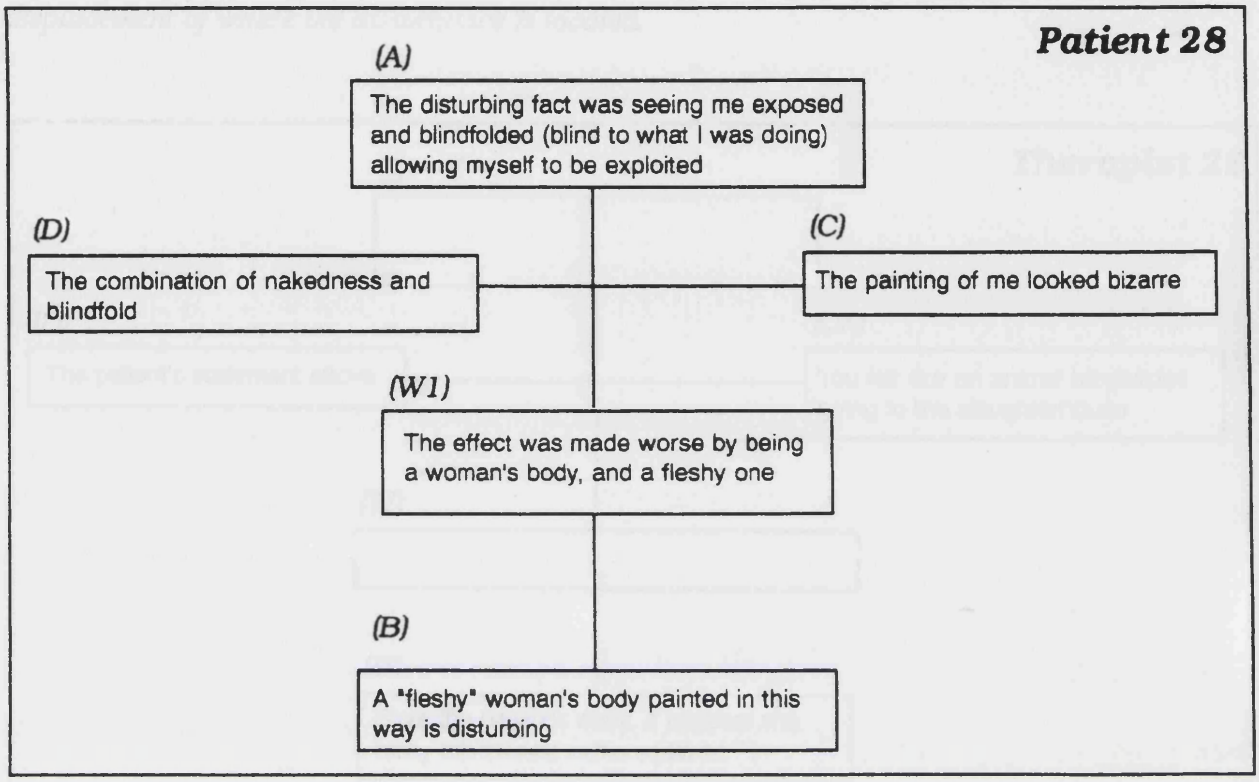


Diagram 28 – Patient: The Claim offered by the patient is that the painting of her, naked and blindfolded, looked bizarre. The Data for this statement is that this effect was a result of the combination of the blindfold and the nakedness. The Warrant offered is that the effect was made worse by the fact that it was unmistakably a woman's body and a 'fleshy' one. The Backing, which is only implied, is that a 'fleshy ' woman's body painted in this way is disturbing. The Alternative, which is not verbalised, is that the disturbing fact in this scenario is the fact of being confronted with an image of her self in this way, blind to how she was allowing herself to be exploited.

In this scenario one gets the impression that the patient is shocked by the image of herself, and is struggling to find defences in order not to confront the Alternative that she is exposing herself to an exploitative situation. The rationale is found in the Warrant, that is, the fact that she feels that her body is unmistakably feminine and 'bovine' and fleshy. This patient quite clearly has a low self-image but here she is beginning to be confronted by something even more disturbing about her self, that is, that she has set up a situation where she invites exploitation. It is therefore safer to fall back on her bad feelings about

her body rather that to look at the more disturbing possibility. This constitutes a displacement of where the disturbance is located.

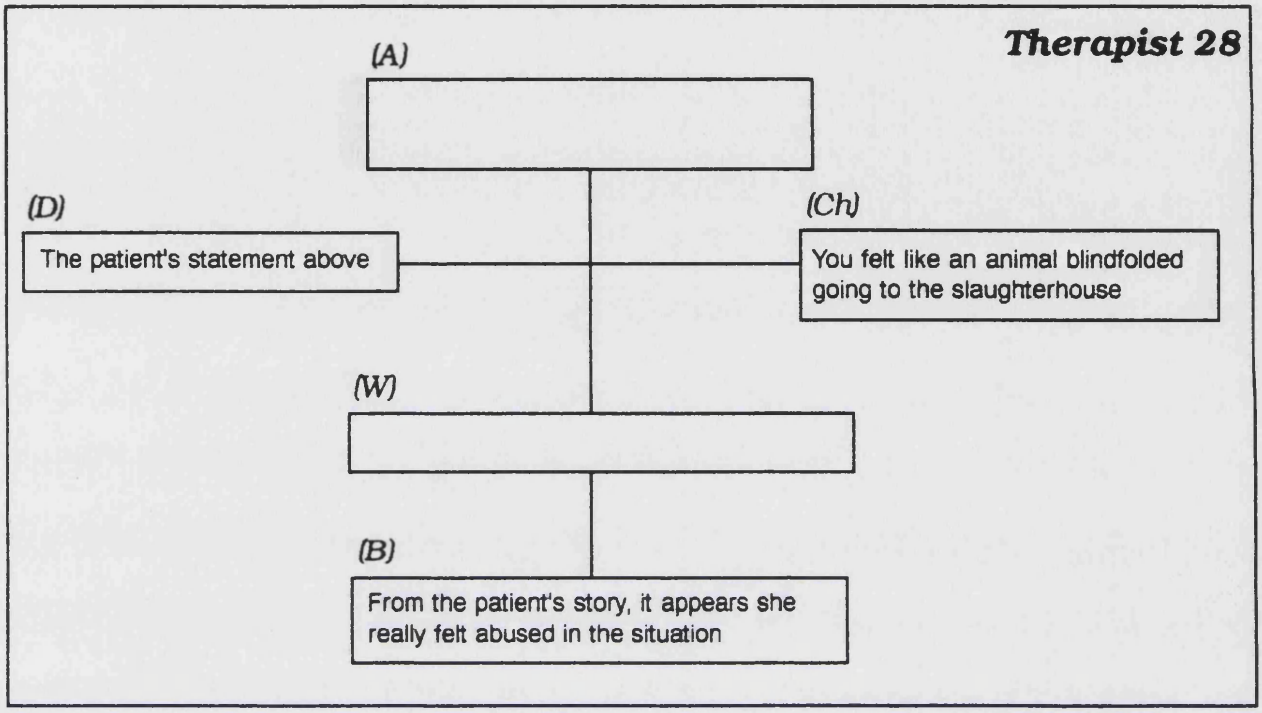


Diagram 28 – Therapist: The Challenge is that the patient felt like an animal blindfolded and going to the slaughterhouse. The Data appears to be the previous statements by the patient. No Warrant is offered. The Backing, which remains implicit is that, the patient must have felt ultimately abused by the situation.

Here it appears that the therapist amplifies the patient's feelings (in the Challenge) in order to encourage further exploration of this particular area. This appears to be more of an association of the therapist. The intervention comes in the middle of the flow of ideas from the patient, and does not appear to be an interpretation as such.

Therapist: I think it's something you want to get rid of this passive woman, you don't know what to do with it and it's like the execution of this same image (laughter) And you do it through the father, through the, in a sadistic sort of executionary way.

Patient: I am I suppose, I think the reason that I've become, I feel quite attached to Niel (the painter), who's the man who has been painting me, I mean I don't suppose he knows at all, but I don' think it would be the same if it was a woman. I know the fact that I have to trust him completely, um, it's ridiculous, and I find it hard to sort of keep it under control.

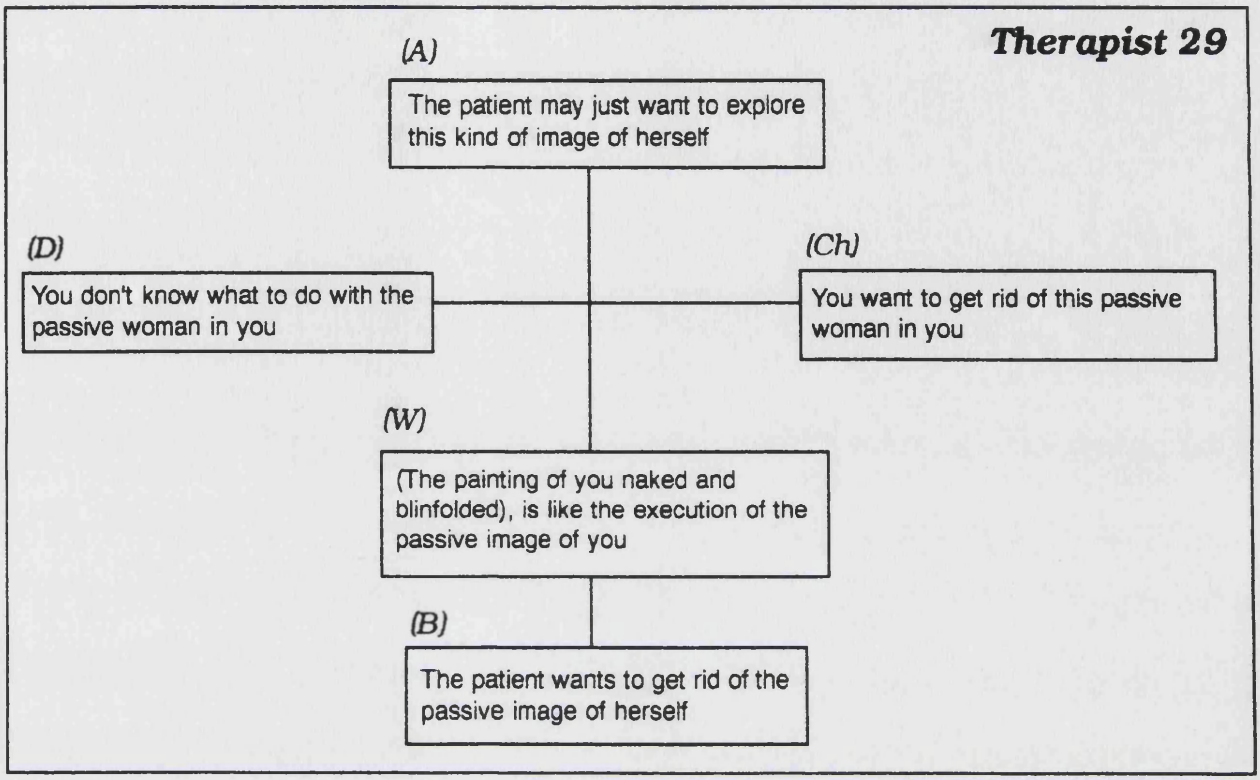


Diagram 29 – Therapist: The Challenge in response to the patient talking of her being painted naked and blindfolded is that it meant that she wants to get rid of the passive woman inside her. The Data is that she does not know what to do with the passive woman inside herself. The Warrant is that the picture is like the execution of the passive image. The Backing is not verbalised, but seems to be an assumption that the patient must want to get rid of this image of her self. A possible Alternative could be that the patient may just for reasons not yet clear want to explore and see this kind of image of her self.

Here it appears that the therapist is attempting to create meaning where the meaning is far from clear. This is an interpretation made too early and thus it is not a very convincing one.

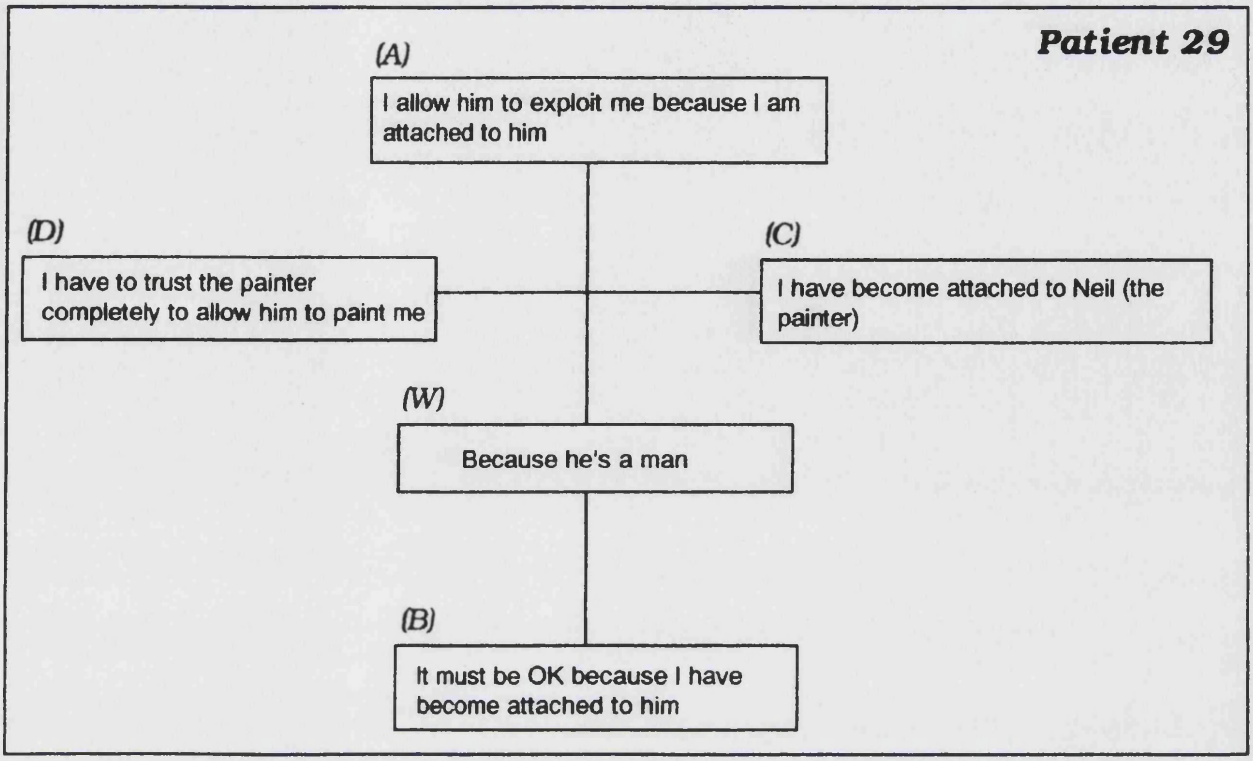


Diagram 29 – Patient: The patient's Claim in response to the above communication by the therapist is that she has become quite attached to the painter. The Data is, because I have to trust the painter completely'. The Warrant offered is, 'because he is a man'. It is not clear what the Backing is for this Claim, however it seems to be an attempt to create a Backing like, 'because I have become attached to him it must be OK'. The Alternative might be, I allow him to exploit me because I am attached to him.

This communication does not easily make much sense, it seems to float in the air, it is not a response to the therapist's Challenge. In fact it is a way of ignoring the therapist's input. It also seems to contain a hint of the opposite. The patient describes a state, which excites her on one hand, but is also about being passive and trapped in abuse, on the other. The Alternative, which is not explored, could be that the patient allows the painter to exploit her because she is attached to him or maybe she is attached to him because he abuses her.

This is a reaction formation against becoming aware of anger with the painter, and a denial of seeing any abuse in the situation by using omnipotent thinking.

Therapist: There's no choice, either you let it go or you are being carried away. What can we - let's just try to explore it a little bit. You say, I'll be carried away or else I won't get into it?

Patient: I didn't really mean it like that. I mean I think because of the sort of difficulties of professional etiquette and what-not um, either you know probably I simply will not see Niel anymore which seems such a shame to me because I, when I've seen somebody whose work I like I feel as if I don't want to let them go. I feel as if it would be a shame if they sort of, if I simply didn't know them anymore. Because it's so rare for me to like what somebody else does. Um.

Therapist: I'd like to for a moment get away from the actual situation that... You know, you met him, he was painting and just think of you're a woman and he's a man and you are attracted to him and then you feel...'I can't trust myself. Why am I attracted? Because I feel I could trust him'. I would like to stay with that.

Patient: Yes, yes. I think I am confused between the situation and whatever kind of inherent qualities he may have. That's why I don't trust myself. I think I am just kind of using him in a way. I think somewhere else in that I just put 'He happens to be more or less the only man who's painted me, I mean during these sittings, certainly the only man who's done so consistently. Would it have mattered if it had been somebody else, you know, would I have felt the same way? I just don't know.

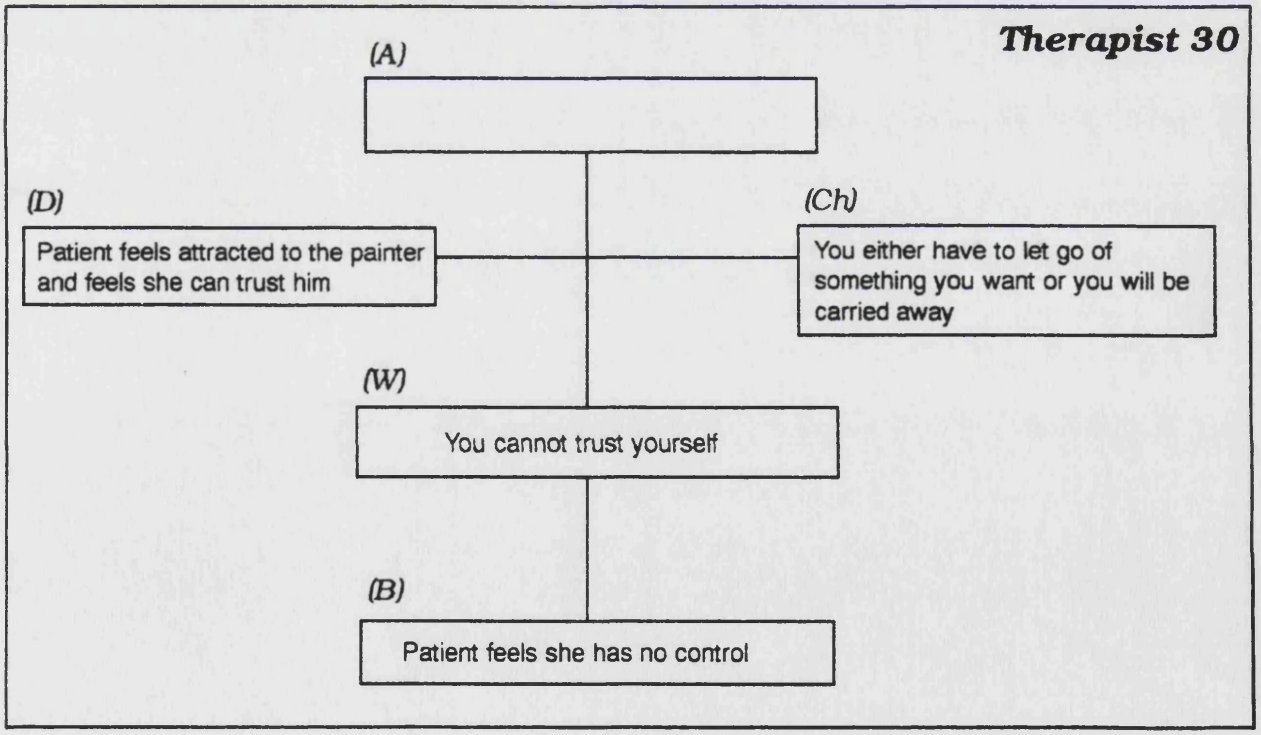


Diagram 30 – Therapist: The Challenge is that the patient feels now that she either has to let go of something she wants or she will be 'carried away'. The Data is not entirely

clear but seems to be based on the patient's material, and is rephrased in the therapist's statement that the patient feels attracted to the painter and feels she could trust him. The Warrant is that the patient feels she cannot trust herself. The Backing, which is not made explicit, is that the patient feels she has no control or choice in what happens to her.

This is an attempt to interpret, however as the interpretation is not well outlined, it is not a very effective Challenge. The communication seems to be designed to encourage further exploration in the area of how much in control the patient feels rather than how much out of control she feels. It appears that the interpretation it rests on contradictory internal argumentation in the therapist. This interpretation invites the patient to turn away from her anxieties and turn to some form of denial.

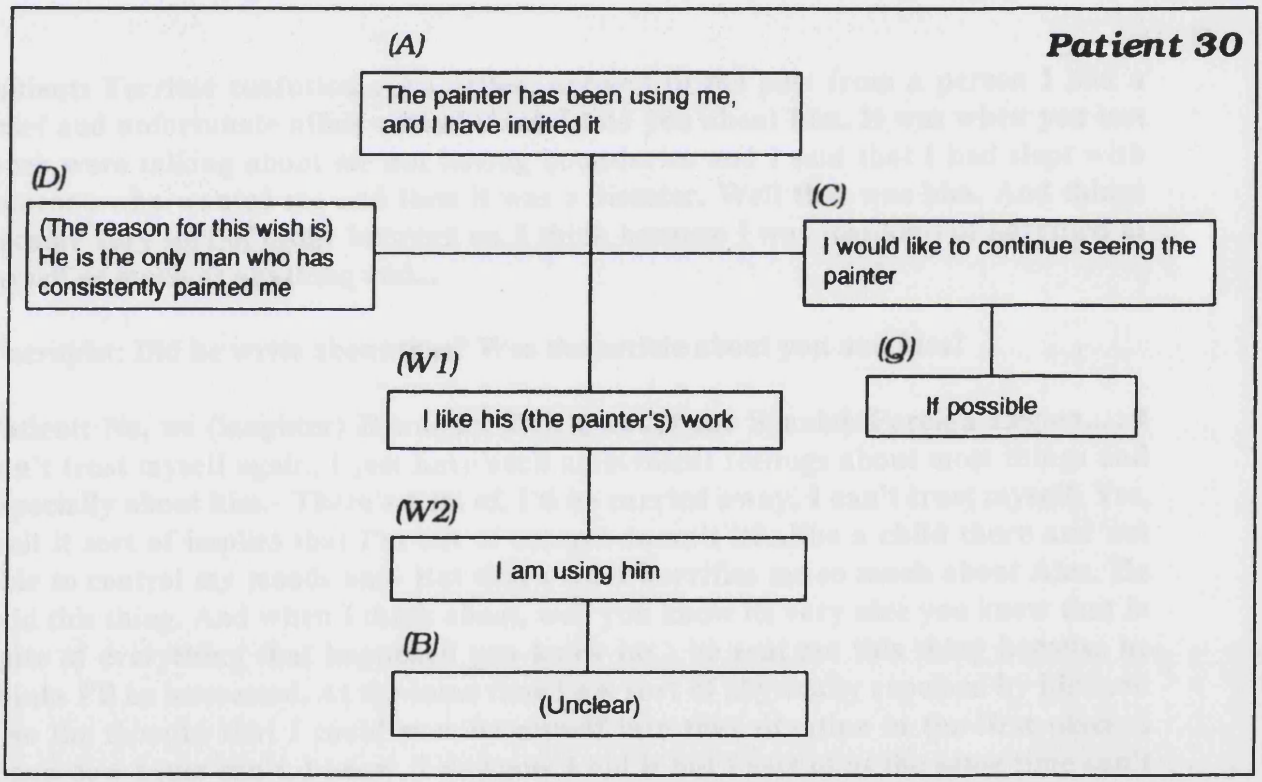


Diagram 30 – Patient: The Claim is that the patient would like to continue seeing the painter who has been painting her. A Qualifier, 'if possible' is added to the Claim. The Data is the reason why she says she wants this, because he is the only man who has consistently painted her. There are two Warrants offered, firstly she says she likes his work and secondly she says she is using him in some unspecified way. The Alternative,

which is not verbalised, is that the painter has been using her and that she has invited it. The Backing is not clear.

The argumentation created here seems to be an attempt to avoid addressing the Alternative, that the patient has been used in this situation. This is a thought which was coming close to consciousness when she was confronted with the picture of herself naked and blind folded. The unacceptable feelings are being located in herself, i.e. she claims that she has been using the painter and not vice versa.

This constitutes an introjection of the exploitation, and a denial of the possibility that she herself is exposing herself to exploitation. This is a form of identification with the aggressor.

Patient: Terrible confusion... An article arrived in the post from a person I had a brief and unfortunate affair with. I think I told you about him. It was when you last week were talking about me not having boundaries and I said that I had slept with someone who wanted me and then it was a disaster. Well that was him. And things became very sort of bitter between us. I think because I was just kind of horrified at myself as much as anything and...

Therapist: Did he write about that? Was the article about you and him?

Patient: No, no (laughter) It was an article about the Spanish Foreign Legion..... I can't trust myself again, I just have such ambivalent feelings about most things and especially about him.- There's a lot of, I'll be carried away, I can't trust myself. Yes, well it sort of implies that I'm out of control doesn't it?...like a child there and not able to control my moods and- But that's what horrifies me so much about Alex. He said this thing. And when I think about, well you know its very nice you know that in spite of everything that happened you know he... he sent me this thing because he thinks I'll be interested. At the same time I am sort of physically repulsed by him and also the thought that I could ever let myself into that situation in the first place. I mean now I just can't, I know, I do know I did it but I sort of at the same time can't understand how I could ever have done that. Therapist: If we are able to try to work on this negative thought I can't trust my feelings, to work on it as a positive view, how would you see that? How could we change I can't trust my feelings by something a bit more positive?

Patient: Only I think by, I don't know, I think only by I just have to not, I mean I have to think more about what I'm doing because I think the reason that I can't trust my feelings is because I don't examine them, and worse still I act on them so that later on when I feel something different I feel as if I've betrayed myself earlier on because I acted on some completely different feelings. Um.

Therapist: So certain feelings should be attached to certain situations?

Patient: I don't know.

Therapist: When feelings change about the same situation it means that you are betraying yourself, you can't trust yourself?

Patient: Um, or feelings change about people, I mean in that instance um, I sort of, I can't talk about it or think about it in any other way than in the immediate and personal and not-you know I can't sort of discuss it as a sort of objective thing without going into all kinds of details of how I felt and how I did.

Therapist: So you can't trust your feelings because they have changed?

Patient: Yes, and they really swing to extremes and I feel almost humiliated when I am at one extreme that I could have thought of other things.

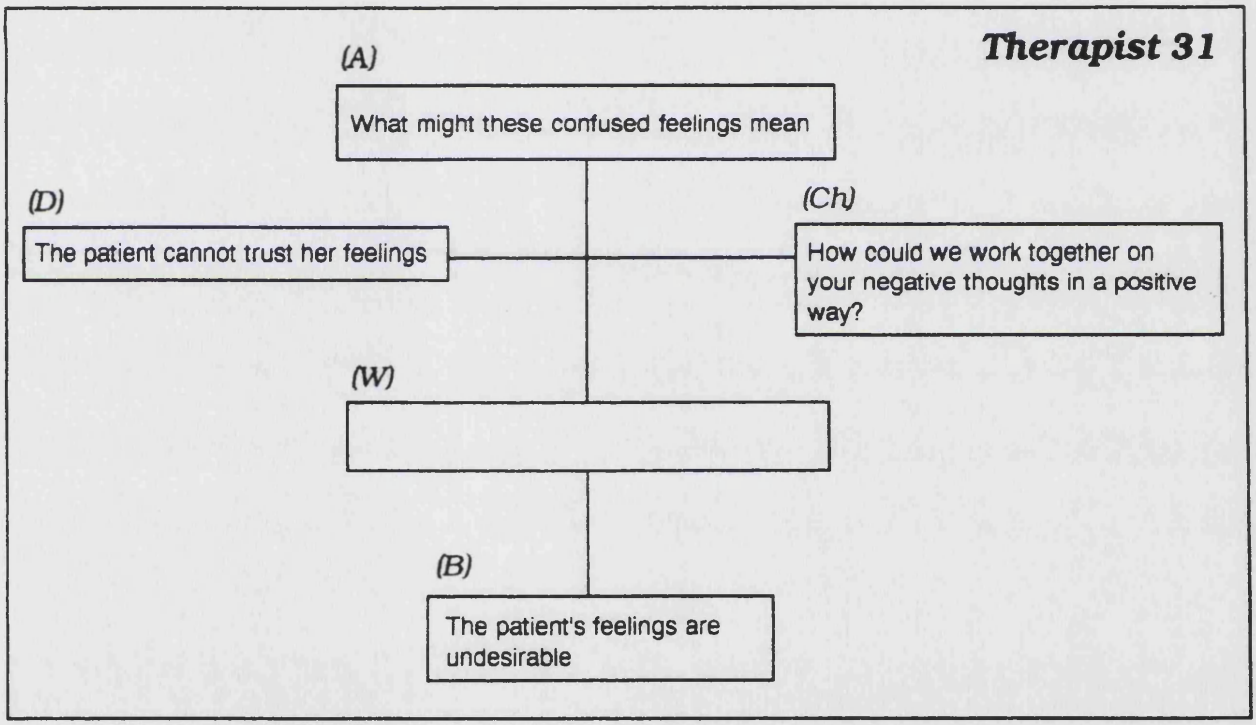


Diagram 31 – Therapist: The Challenge offered here is, how could the therapist and patient together work on what the therapist calls negative thoughts in a positive way. The Data is that the therapist feels that the patient cannot trust her feelings. No Warrant is offered or implied. The Backing is not verbalised but seems to be something like the kinds of feelings the patient is having are in some way undesirable. The Alternative, which is also not verbalised, could be some kind of exploration into what these confused feelings mean.

In this vignette it seems that the therapist is putting some pressure on the patient to have other kinds of feelings from what she is having. In fact the therapist is asking for guidance from the patient, suggesting feelings of helplessness in the therapist, which are possibly communicated to the patient. This means that the patient's feelings are perceived as bad, rather than thought about and used as possible source of information.

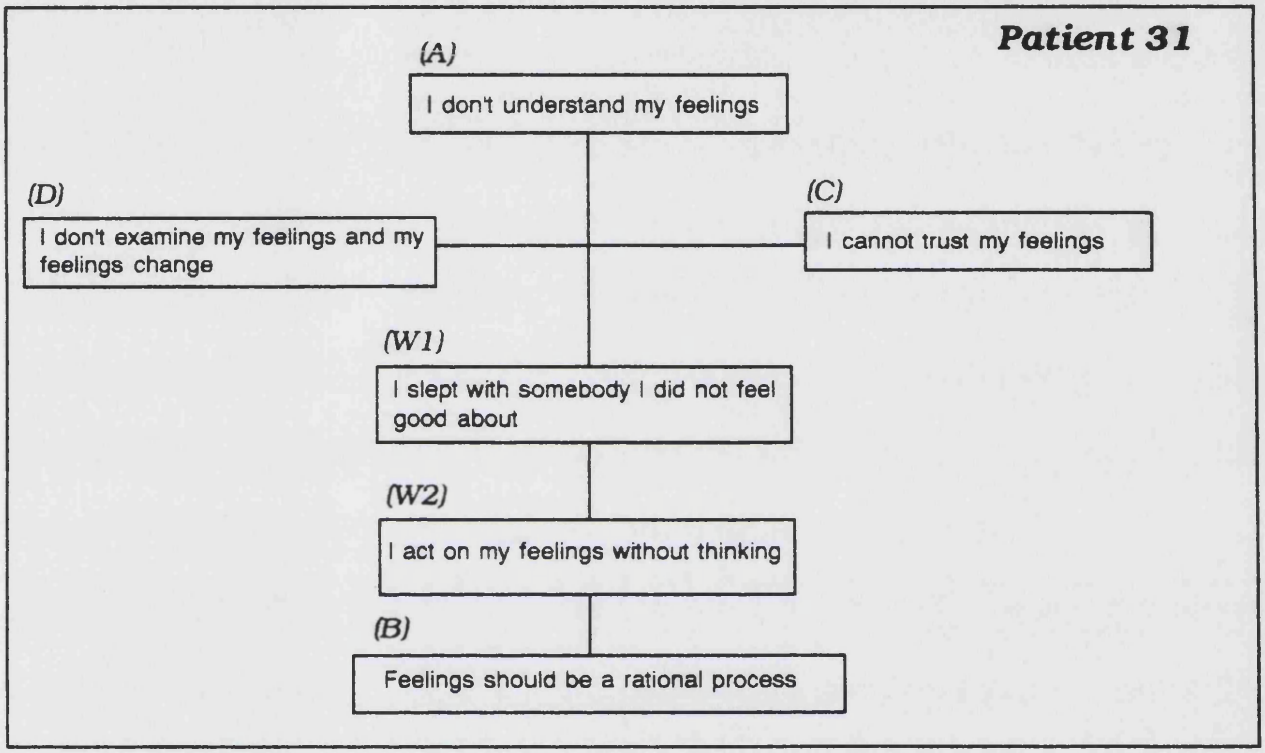


Diagram 31 – Patient: The Claim offered is that the patient feels she cannot trust her feelings. The Data is, according to her, that she does not examine her feelings, and also that her feelings have a tendency to change. Two Warrants are mentioned, she tells a story of how she got herself into a situation she did not like when she slept with somebody she did not feel good about. The second Warrant is that she feels that she acts on her feelings without thinking. The Backing, which is not verbalised, is that feelings should be a rational process. An Alternative, which is not verbalised, is that she simply does not understand her feelings.

The patient is returning to her sense of feeling out of control, as though she wants to remind the therapist that she has got a problem that cannot be covered up. The patient is stating what she feels is her problem, 'not being able to trust her feelings'. This statement

rests on an assumption that feelings are to be somehow 'trusted' i.e. rational, rather than something that carries information, maybe of a confused and conflicting state of mind. What appears to preoccupy the patient in this vignette just like in diagram 30 above seems to be yet another situation where she feels ultimately exploited. This information is however placed in the Warrant, at some small distance and is not the main focus of attention. However this can be understood as an attempt to return to her anxieties

Therapist: Yes you see that reminds me of the situation in your family. When you must have gone from one extreme feeling to another one um, a feeling of maybe you had done something wrong, guilt to defending yourself, nobody else finding about it or to betray your sister or brother or someone because discovering, saving your own skin. Your brother has been punished and you are watching with mixed feeling, a sort of excitement of I got away? Mmm. It's like you are conscious love trust loyalty - pah, pah, pah! Towards the end you can't trust yourself to be a good person or not. I think basically your childhood, that's what it's very much about.

Patient: Yeah.

Therapist: To have a sense of self-worth. To be- Oh, I am, well I know who I am because I do this and I do that and this is where I feel that this is where I am.

Patient: yeah.

Therapist: But when the pressure from the family is so much that almost it makes you do things, drives you to feel this you know, because there's a lot of pressure, you haven't got a space to sort out- 'I can't trust myself- Why couldn't you trust yourself?

Patient: With my - family it...

Therapist: The pressure returns, first of all before you can elaborate you have to fight your...

Patient: I, um I remember seeing something on television. It was an interview with Jung and they asked him when was he first aware of himself as an individual, as a person and he said when I was nine years old and it was like walking out of a mist. And I just thought, I never felt that at all as a child, I never had any sense of myself. I don't remember it anyway. I could never say something like that you know, I remember when I walked out of the mist. I just don't. I am sure I would remember if I had done it.

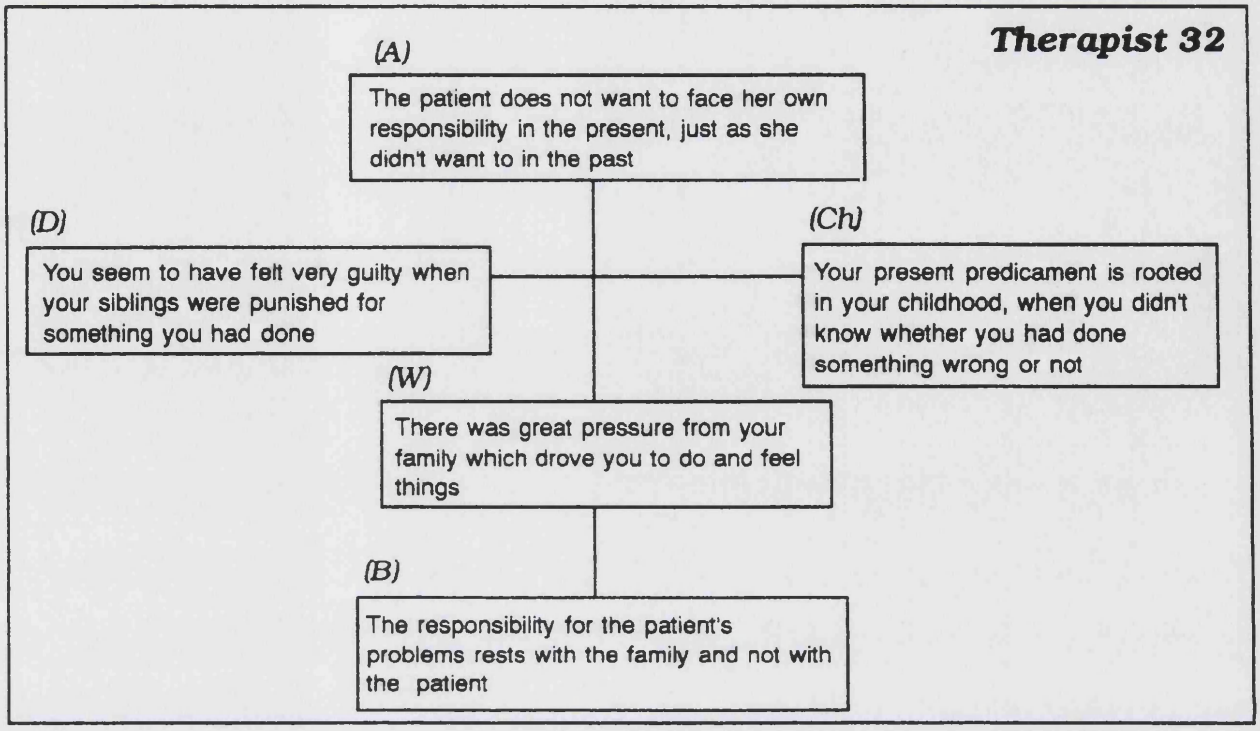


Diagram 32 – Therapist: The Challenge is that the therapist feels that the patient's present predicament is rooted in the patient's childhood, when she didn't know whether she had done something wrong or not. As Data the therapist sees the fact that the patient seems to have felt extreme feelings of guilt when her siblings were punished for something she had done. As Warrant the therapist offers the fact that she feels there was great pressure on the patient from her family, which drove her to do and feel things. The Backing is incorporated in the argument, that is, the responsibility for the patient's problems rests with the family and not with the patient. A possible Alternative is not verbalised, but could be that the patient does not want to face her own responsibility in the present, just like she didn't want to in the past.

The therapist is trying to help the patient 'off the hook' by offering reassurance. The therapist thus promotes the use of projection.

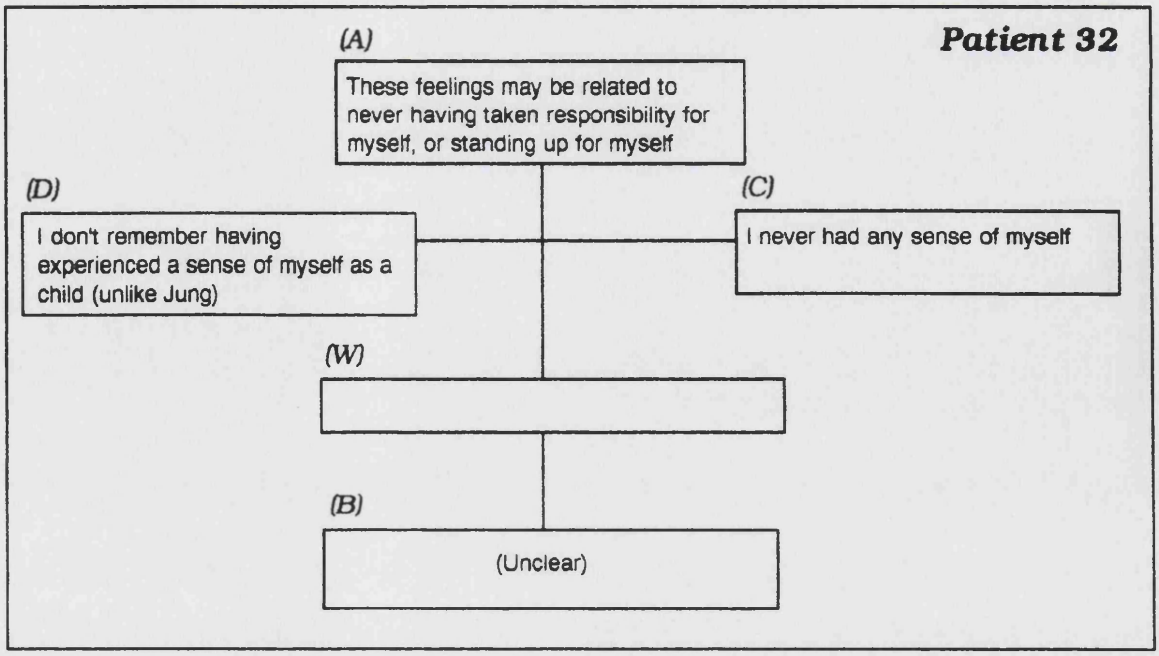


Diagram 32 – Patient: The Claim is that the patient feels she has never had a sense of herself. The Data is that she has no recollection of ever having an experience of a sense of self as a child (unlike Jung). No Warrant is offered or implied. It is not clear what the Backing is. There is a possible Alternative, which is not being explored, that is, that these feelings may be related to never having taken responsibility for herself and stood up for herself.

This communication is not on the surface a response to the therapist's Challenge. It appears to be a statement, not very well substantiated, about the way the patient feel. Another way of looking at it may be that it is absolutely a response to the therapist's communication. The patient seems to be expressing a lacking sense of self in relation to the therapist although expressed indirectly and unconsciously. The patient feels the therapist is preoccupied with her own theory building rather than with the patient, a fact which may indeed be a repetition of the family situation. This could be seen as a re-enactment in the transference of earlier felt confusion.

6.3.1. Session 8

Subjective/Intuitive analysis

This session is introduced with thoughts arising from the impact on Elizabeth of a Brazilian visitor. Elizabeth finds the Brazilian man both attractive and also frightening, because of his capacity to overwhelm her. She feels that meeting him in her own environment, feels different from having met him in Brazil. He is now experienced as more intrusive. The patient feels however unable to express her unease to this man.

'...because he is Brazilian he's very sort of physical with me, which I am completely unused to'.

The therapist is attempting to explore why it seems so difficult for the patient to assert herself, and express her unease. Later in this session the therapist is suggesting links to possible experiences of sexual abuse. These links are made in relation to the life modelling which the patient continues to do. The patient responds by mentioning a friend of hers who had been sexually abused and had also done life modelling. This is possibly an unconscious confirmation of the link. As the session continues the focus becomes the patient's feelings about her body, and how she has felt that her body has been a mystery for her. In the end the patient says that she wishes she were a man.

'...The things that I am attracted to in men, it used to be both physically and intellectually or whatever, were qualities that I wished I had'.

Finally the patient makes the following statement:

I increasingly these days feel as if everything I do is a compensation for something that I didn't get. Like you know doing this live modelling and being able to just walk around the room naked in front of people which I would never do as a child at home which is where you would think you could do it.

Here she is herself connecting her present day life modelling with something disturbing in her childhood.

6.3.2. Argumatics analysis of session 8

Therapist: And you feel that you won't be able to just tell him (the Brazilian) that you feel uncomfortable?

Patient: No, I don't see the point really, particularly since he's only here for four days. He's leaving on Friday. No, I think that would be sort of embarrassing for both of us if I- because it's actually not as bad as all that. I know that I'm um sort of

distracting him and I'm conscious of not being completely comfortable, not - you know of talking more than I usually do but he's never known me to be any different so he probably just thinks that's what I'm like. He's probably not really as conscious of...

Therapist: So you don't mind in fact being uncomfortable in having to do this sort of sport because it's a real sport to try to divert and being like that rather than just - analyse your feelings and think I'm not comfortable and maybe there is something I can do....You have to go along with whatever he wants to do, not with what you want to do. He's Brazilian, he's physical,... so for a while you have to suffer in Brazil what is happening. But he is coming here to meet an English lady. Why does the Brazilian not conform to the English lady's territory?

Patient: Well yes, I suppose so. But certainly his 'physicalness' is not offensive at all, um...

Therapist: But it's a threat.

Patient: I'm sure I'm the only person who would find it so. I mean I don't think any normal person would.

Therapist: Well I don't know what other people would think. The fact is that we are dealing with you and this is not the way, your way.

Patient: No but suppose I don't resist it because I wish it were um, you know I think it's me...it's me who's wrong but I wish that I were much more comfortable with physical contact with people. Um, I mean I think it's partly because I'm English anyway and partly a lot to do with my parents and the complete absence of it. Well except sometimes in great discomfort, eh? The touching was more of a punishment um?

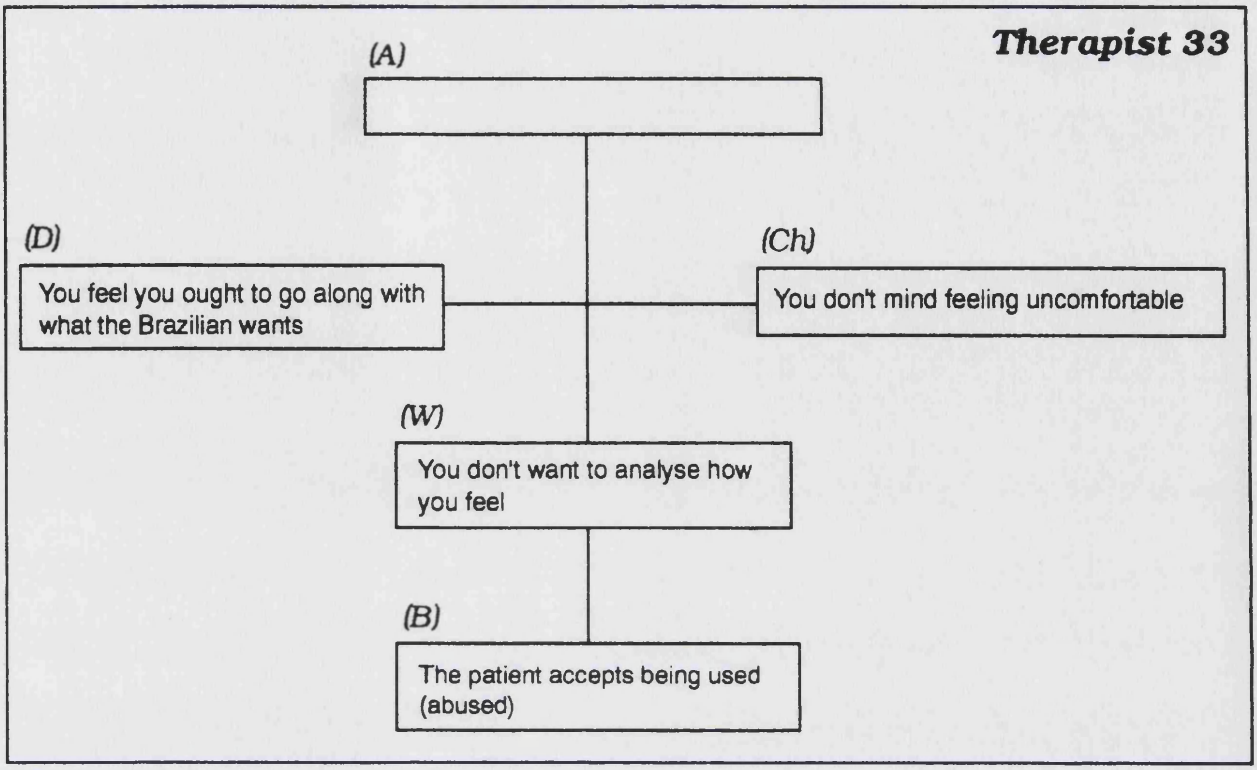


Diagram 33 – Therapist: The Challenge offered is that the patient does not mind feeling uncomfortable. The Data is that the patient feels she ought to go along with what the Brazilian visitor wants, in terms of wanting to be physical. The Warrant is that the patient does not want to analyse and think about how she feels. The Backing is not verbalised but appears to be something like the patient accepts a position in which she is being used or even abused.

The therapist is trying to draw the patient's attention to the Backing indirectly, that the patient is prepared to accept situations which she does not like or feel comfortable in. This constitutes an amplification and clarification of the patient's dilemma.

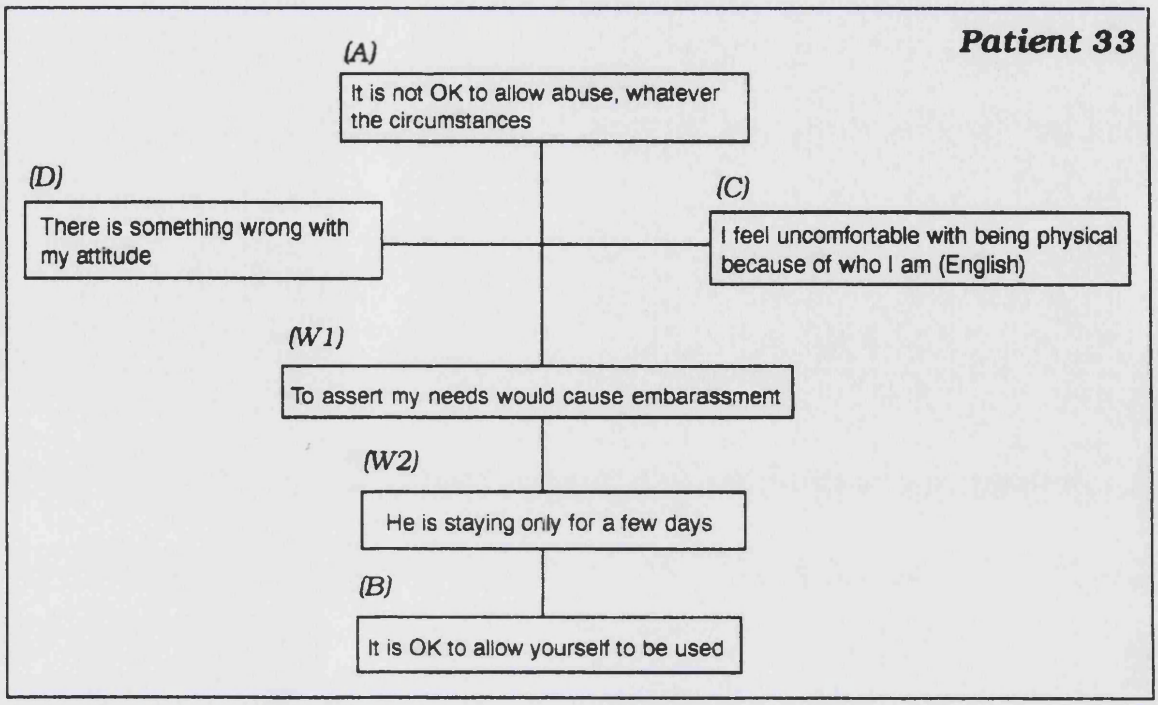


Diagram 33 – Patient: The Claim is that the patient feels uncomfortable with being physical because of who she is (English). The Data offered is that there is something wrong with her attitude. The Warrant is that to assert her needs would cause embarrassment. A second Warrant is that the visitor is only staying a few days. The Backing is not quite clear, but seems to be an attempt to argue that it is OK to allow yourself to be used (if it is because you have a problem) The Alternative which is not explored is that it may not be OK to allow yourself to be used whatever the circumstances.

This shows the patient's confusion. Is there something wrong with her in this respect or might it be OK to follow one's feelings. It appears that she feels she should allow herself to be 'abused'. This is a denial of a need to think about the real problem. This constitutes a displacement of what the real problem is. The problem is presented as inhibition, rather that one of exposing oneself to exploitative situations.

Therapist: I wonder if now you need to say no to authority figures sometimes, if it's necessary because you couldn't do that as a child and actually growing into becoming more spontaneous and freer, because that's what we are talking about. Maybe it starts by saying no to authority, no to the father and the later on once you

respect what you feel, don't forget we thought that it's very difficult to own your own feelings when you're a child. OK you have to protect yourself. So maybe now is the time to say no, respect for yourself, never mind yes more fully we'd like to be free but that's step by step you see. What I'm getting at is that if you do not respect the progression you have to make to grow towards this freedom the you know, what is the good if I just pull out your chair now and I say come on have a jig now? Hmm? If I say it's good for you, pah, pah, pah?

Patient: Yes it's true, situations like that I find it difficult to refuse even if I want to. Yes, I mean I think when I know people better I actually find it easier.

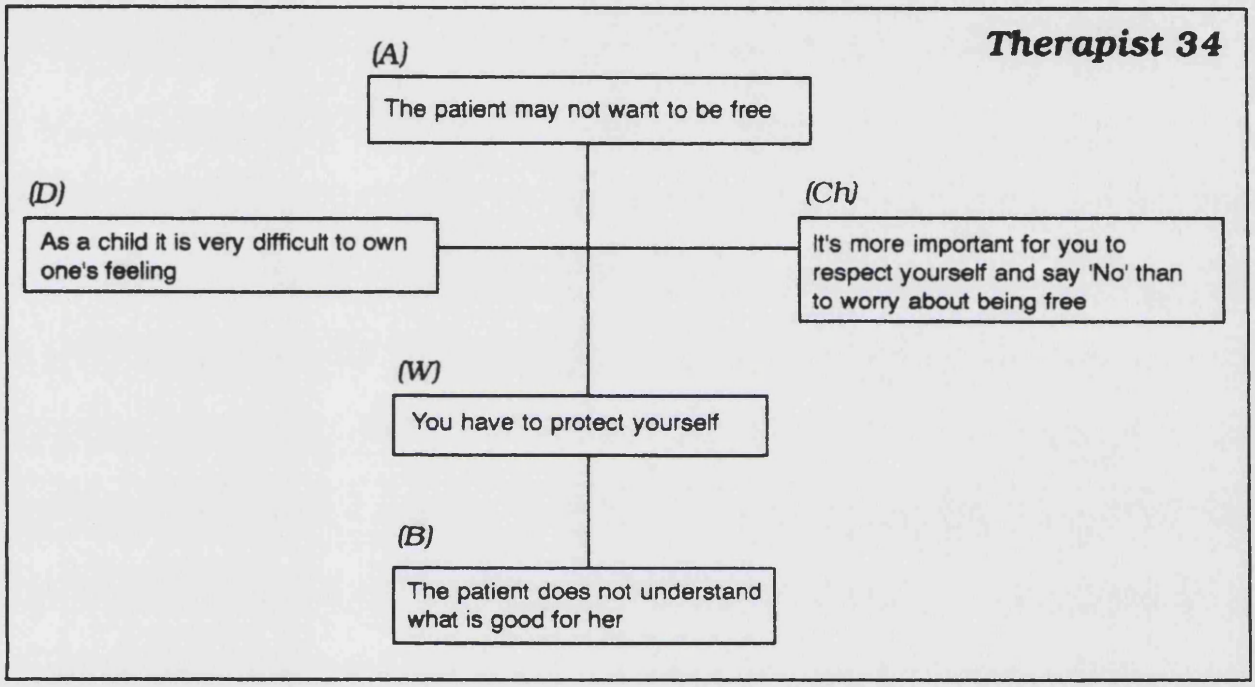


Diagram 34 – Therapist: The Challenge presented is a didactic, it's more important for you to respect yourself and say no than to worry about being free. The Data for this statement is referring to a past discussion with the patient about how as a child it is difficult to own one's feelings. The Warrant offered is that the patient needs to protect herself. The Backing is not verbalised but appears to be an assumption that the patient does not understand what is good for her, hence the didactic nature of the Challenge. The Alternative is not verbalised but could be, 'the patient may not want to be free'.

It appears that the therapist feels disturbed by the material and unable to use it, as she resorts to telling the patient what she should be doing.

The Alternative, which is not being explored, is that the patient may not want to be 'free'.

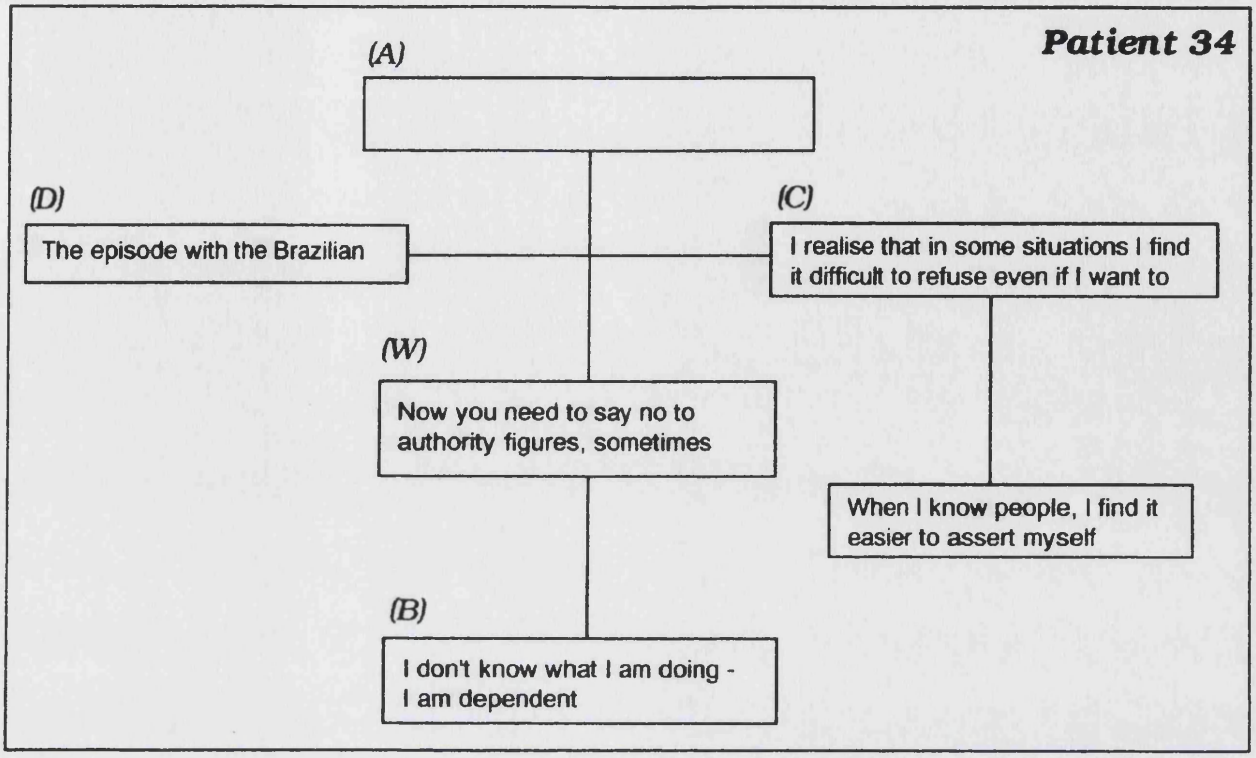


Diagram 34 – Patient: The Claim is an admission that the patient has indeed difficulties in refusing something she finds unpleasant. However a Qualifier is added, that is, that it is easier for her to refuse things when she knows people better. The Data for the Claim is the preceding discussion about her Brazilian visitor. What the therapist is saying acts as a Warrant, however the Warrant is not verbalised. The Backing is not verbalised but appears to be something like 'I don't know what I am doing, (I am basically a dependent person).

The patient is here realising that what is being suggested has some validity. However the presence of a Qualifier suggests that this insight is minimised (it is true only under certain circumstances). The Qualifier allows an escape from further thought. A situation when the issue is acknowledged briefly and then there is a denial of the need for further thought. In fact the acknowledgement in it self allows for the use of the denial to think..

Therapist: The sacrifice of going back - you see I was wondering why in the first instance you went in and sat for this life drawing job.

Patient: It's interesting actually what you were saying about how what my father did was a sort of form of sexual abuse because I was talking to a girlfriend of mine who was regularly and quite seriously sexually abused as a child and she also did life

modelling, which I didn't realise at all. And she said, as I told her that I'd made a suggestion for a picture, she was really shocked and she said that in all the time that she did it she never spoke to the painters and in the intervals she put all her clothes back on. You know she's very sort of private and I am the opposite.

Therapist: I was just wondering if you didn't need to go back into it somehow because the blindfolded picture was as you said quite shocking.

Patient: yes.

Therapist: And like an execution....to just act out again, the abuse you see, but this time you will be in control. There's a big difference.

Patient: What, you think that now I'm in control?

Therapist: Well, I think that now that you have no need to go back. That's why you find people are demanding or whatever. I think you got what you were after. It was about the first session naked, and then the session with the blindfolded thing and then.

Patient: No I don't think it's true, I do want to go back. I mean I'm ambivalent. I want to go back but I also want some time to write and I think one of the reasons I want to go back is that I'm so terrified of sitting down to write and not being able to and I want to avoid it by having something else to do.

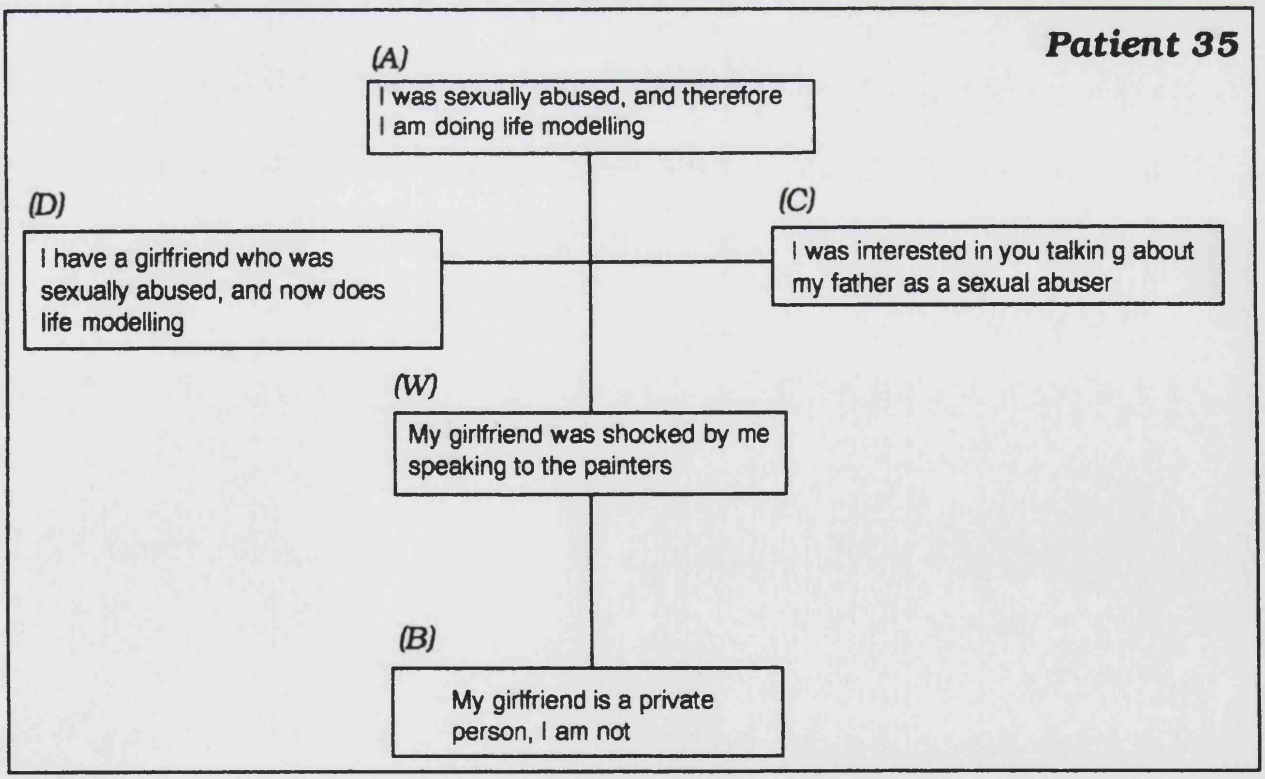


Diagram 35 – Patient: The Claim is that the patient had been interested in the therapist talking about her father as a sexual abuser. The Data seems loosely to be related to the patient having a girlfriend who was sexually abused and now does life modelling. The Warrant is that, the patient's girlfriend was shocked by the patient telling her that she actually talked to the painters. The Backing, which is offered, is that the girlfriend is a private person but the patient is not. The Alternative, which is not explored, is the recognition that maybe this really means that the patient had been sexually abused in some way and that's why she is now doing life modelling.

Anxiety is close to the surface and is threatening to break through in this vignette, however it is defended against by projection/ displacement. The issue has become, being or not being a 'private person', rather than abuse.

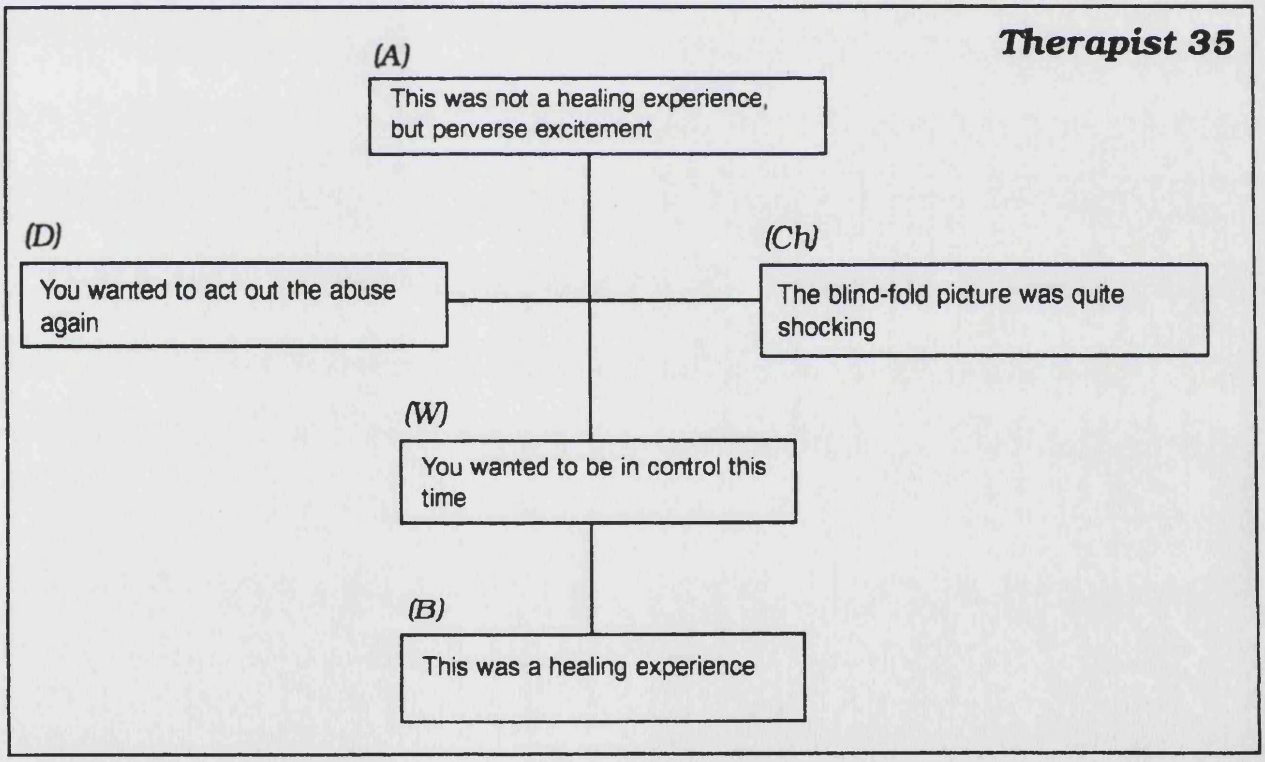


Diagram 35 – Therapist: The Challenge is that the picture with the blindfold was quite shocking. The Data is that the reason for it being shocking was that the patient wanted to act out her abuse again. The Warrant is that this time she wanted to be in control. The Backing is not spelt out but seems to be an assumption that this was an attempt to create a

healing experience. The Alternative, which is not mentioned, is that this was not a healing experience but rather an experience of perverse excitement.

The therapist is amplifying the situation, but adds a positive note, in order to protect the patient from having to think.

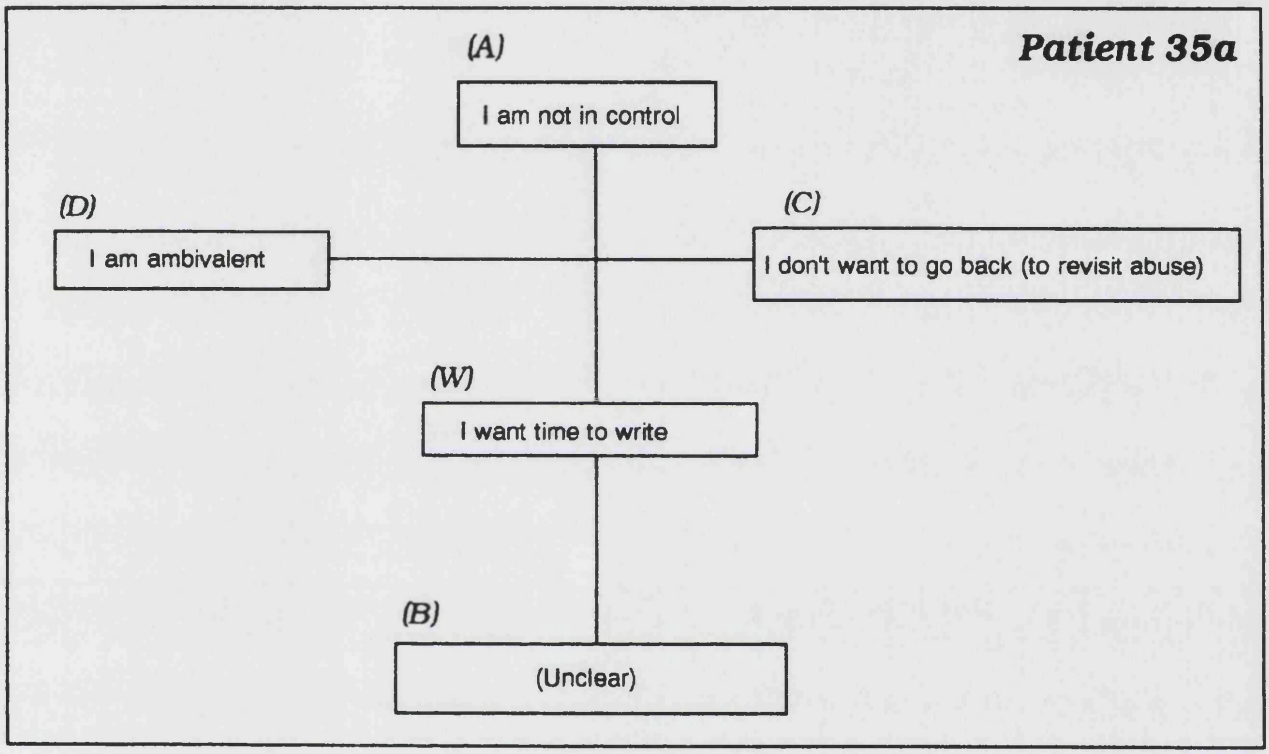


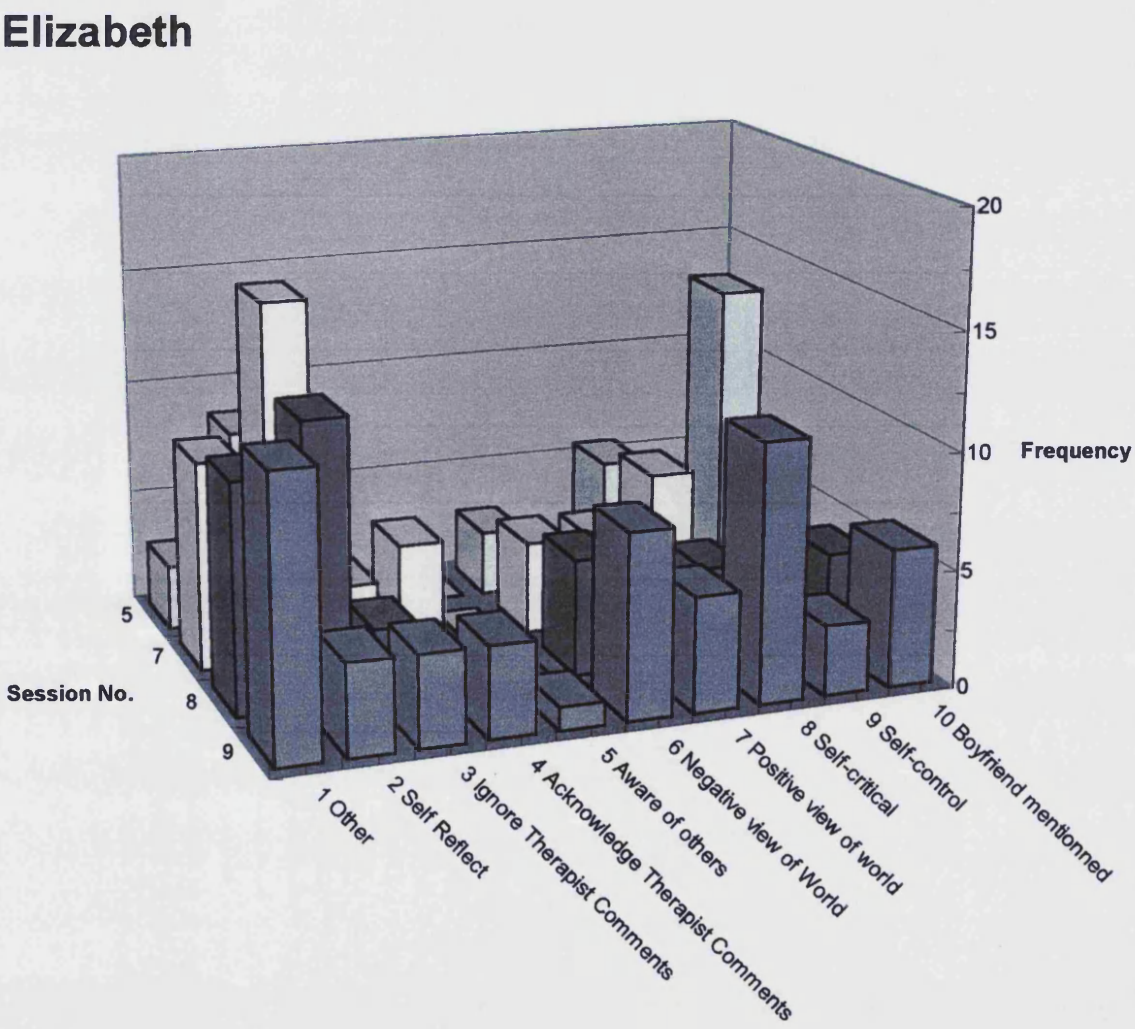
Diagram 35a – Patient: In response to the therapist's intervention, the patient responds with a completely contradictory statement. The Counter-Claim is that she does not want to go back and revisit abuse. The Data is that she is ambivalent. The Warrant is that she wants time to write etc. The Backing is unclear. The Alternative, which is not verbalised, is, 'I am not in control'.

The communication does not make sense, thus it appears that some anxiety is close to the surface. However it is dealt with by introducing confusion and a conscious 'I don't want to'.

6.4. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 5, 7, 8 and 9 are mapped onto the rotated histogram below

The variables in this histogram are as follows: The first column (1) is a catchall category.



The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative

statements. The seventh column (7) shows the number of statements indicating a positive worldview or positive statements. The eighth column (8) shows the number of self-critical statements. The ninth column (9) shows the number of statements referring to concerns about self-control. The tenth column (10) shows the number of times this patient mentions her boyfriend.

The patient's preoccupations did not alter noticeably. The number of times this patient mentioned her difficult boyfriend decreased noticeably

6.5. Independent Psychoanalytic Assessment of Elizabeth (Session 8)

Although the young woman appears accommodating and open, she hardly allows herself to be touched at all by the interviewer. She talks of the lack of touching in her family, and how much emphasis was placed on being covered up. In the session, my sense was that she covers up her perverse sexuality, by denial and by subtly distracting the interviewer. (She describes how she distracts the Brazilian man from noticing she is a woman!) In the section where she describes herself as so naïve that she did not know she had a vagina. I would have expected the interviewer to allow herself some disbelief - but she appears to swallow it. The woman then adds that, she only discovered her vagina through intercourse - here again, can this be true?

She describes herself with the Brazilian man as a teaser, and I thought that the perverse teasing was going on in the session. After all she describes a family in which there is a verbal emphasis put upon covering up and upon the dangers of temptation, and yet at the same time the father is sniffing her knickers. It seemed to me that the interviewer needed a better nose.

I suspect that the pleasant and somewhat entertaining tone of the interview would have changed if the client had been put a bit in touch with what she was doing.

Comment: The independent psychoanalyst comments on the fact that this patient behaves in a very defended way in this session. He also comments on the fact that the therapist does not really challenge the patient and her defences.

6.6. Summary of Elizabeth

The striking thing about this patient, as expressed in the pre-therapy interview (see appendix 3) was how isolated she felt. She was very preoccupied with a difficult relationship, which was in the process of ending at that time. This loneliness was still evident at the post-therapy interview although there was much less reference to the unhappy relationship which had ended. The nature of the interaction with the therapist as evident in the argumatics analysis was rather collusive. This was also commented on in the independent psychoanalytic assessment. The patient reported that she had found her therapy useful. The rotated histogram showed that her preoccupations did not change much. Perhaps this patient found her therapy helpful because it relieved her isolation.

7. Results: Mary

This chapter introduces the fourth of the subjects. Included in this chapter is a short background to the patient. A subjective/intuitive analysis of selected sections of this patient's therapy sessions is included. A detailed argumatics analysis of sessions one, seven and eight were carried out. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in five selected session from the beginning, the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the presented material is included with reference to before and after interviews conducted with the patient for the purpose of this research. Transcripts of the before and after therapy interviews can be found in appendix 3. Notes on Mary's initial psychotherapy assessment can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of Mary's sessions of psychoanalytic psychotherapy are available on the CD-rom, appendix 5, available from the author on request.

7.1. Mary

Mary was undergoing brief psycho-analytical psychotherapy. Sessions one, seven and eight were selected for detailed analysis. It was felt that these sessions were representative of this patient's functioning and that by session seven the patient's insight had increased. However, the customary defences continue to be in evidence although less so. An argumatics analysis was carried out on these sessions.

Mary was a 26-year-old single professional woman at the time of her therapy. She worked as a dietician at a large hospital. She came for therapy because of complex anxiety states arising after her mother's death a few years earlier. At the time of the beginning of therapy these anxiety states were expressed as worries about the safety and well being of her grand mother. She expressed fears about disasters occurring in her house, and at work. These fears forced her into endless checking routines. Her relationships with men

tended to have a superficial quality. Mary fell in love, but as the relationship was developing she fell out of love.

Mary was an only child of a single mother. She felt her father was too weak to stand by her mother when her mother became pregnant with her. Mary had not met her father, although he used to pay maintenance for her when she was younger. She insisted that growing up without a father was no problem. Her grandparents were closely involved in her life throughout her childhood. Mary was academically successful and trained as a dietician after her university degree. She reached senior dietician status and felt valued in her place of work.

Therapy

Mary arrived at her first assessment session in despair, having insisted that her appointment had to be brought forward. In spite of these obvious signs of distress, Mary behaved in a controlled and controlling manner throughout most of her sessions. Initially it was very difficult for Mary to accept any of the several appointment times offered to her. She tended to spend significant amounts of time arguing on an intellectual level about the usefulness of the therapist's interventions. During the early sessions Mary found it almost impossible to talk about the losses in her life, notably about the death of her mother and her grandfather. In fact she tried to persuade the therapist that these areas should not be discussed.

The focus of the treatment was however agreed to be the feelings related to the loss of her mother and father. In spite of her controlling manner many areas were explored, notably her fears of her own destructiveness, in relationships in general and in relation to her mother in particular. Any feelings about the absence of her father, were consistently denied by Mary throughout the treatment, although she did reflect on the fact that she had had several boyfriends with the same Christian name as her father. Mary had great difficulties with endings. She wanted for instance to extend the session times on several occasions.

In spite of her initial anxiety the feelings associated with her mother's death were discussed extensively. The relationship between the therapist and Mary developed in spite of her initial anxieties, in fact there were moments of warmth between patient and therapist, particularly in the middle of the treatment. However Mary was becoming noticeably more restrained during the latter sessions. After the therapy she reported real improvements in relation to her fears. She felt much more able to talk about difficult things. However at the same time Mary did not want to give too much credit to her therapist, and retained her cool controlling and somewhat dismissive stance.

7.2.1. Session 1

Subjective/Intuitive analysis

This was not the first time the patient and therapist have met. This patient had in fact been assessed by her therapist some time earlier.

The session is initiated with the patient talking of finding the presence of the tape recorder difficult. She mentions having found the additional research interview stressful. She then talks of how she is obsessed with worrying about making mistakes at work and being blamed for them.

'Mainly it's children because I may even do a lot more damage there in terms of not not taking care. Also the thing I'm really worried about is making mistakes and being blamed for making mistakes. I'm still overly concerned about that'.

The nature of the expressed anxiety is persecutory. The emphasis is not primarily on concern but on being seen to be making mistakes.

The session continues with Mary saying that she does **not** feel that she might accidentally or otherwise be causing harm but in a curious way she claims that she feels she is a victim.

'What I sort of, see it as something happening to me rather that me doing it to them. I see myself as the victim of circumstances rather than the initiator'.

She continues with a long list of things going wrong for her, such as her car breaking down etc. Then follows another contradiction, the patient claims that in some sense she feels very lucky, a denial of what has been discussed above.

'I also have the feeling that a lot of good things happen to me that don't seem to happen to other people, like every job that I wanted, I have got'.

The therapist points out that the patient does not seem to know what comes from her and what doesn't, destructive or otherwise. This suggestion curiously enough makes Mary reflect on weather her destructive impulses might in any way have been related to her mother's death.

'I don't think there's anything from within me that caused my mother to die'

This is an unexpected response, but shows further the intensity of the persecutory anxiety. Some anger is then expressed towards the mother. Mary feels that if mother had had a more positive attitude to her illness, she might have fought it better. There is almost an implication that it might have been her mother's own fault that she died. The rest of the time in this session is taken up by discussing the inconvenience of the session times, which the therapist can offer.

'It could have been any other day of the week. And why does it have to be those two particular times that really don't suit me'.

The therapist pointed out that he had in fact offered a third time as well

'I didn't feel very good going to work afterwards....'

7.2.2. Argumatics analysis of session 1

Patient: I had quite a bad week from the point of view of of feeling anxious about things. When I first filled in the form and for a couple of weeks after that I was still having quite a lot of problems but for a while after that things were a bit better and I felt I wasn't checking things so much...but last week has been quite upsetting again. I've had quite a lot of difficulty at work last week and making decisions about, about the level of supplements to give premature babies and things like that. I used to make those decisions without any problems at all and I'm having to double-check them now, to double check beyond the range of necessity I think. I'm finding that this week's been quite bad from that point of view.

Therapist: As if you feel what you have decided on, or sorted out, might really be dangerous to these premature babies.

Patient: Yes, yes. Also adults though, it's not just babies it can be adults. Mainly it's children because I may even do a lot more damage there in terms of not taking care. Also the thing I'm really worried about is making mistakes and being blamed for making mistakes. I'm still overly concerned about, about that. I've actually got this dietician who is a grade above me who I've told now that I'm coming here. So I talk to her a bit and she is very supportive in that she lets me check everything with

her.... I shouldn't need to have to do that but I find that very, very wearing that I have to do that.

Therapist: Mm

Patient: That's a very resent thing as well. I mean the last couple of months but also outside work as well worrying about the things that I was worried about before, things like flooding my house, leaving cigarettes burning. I always seem to need to worry about something.

Therapist: But anxious that you may be very destructive, flood the house, burn it down, cause harm to premature babies, who are particularly vulnerable-

Patient: Not as doing it intentionally though. I see myself as doing it accidentally...

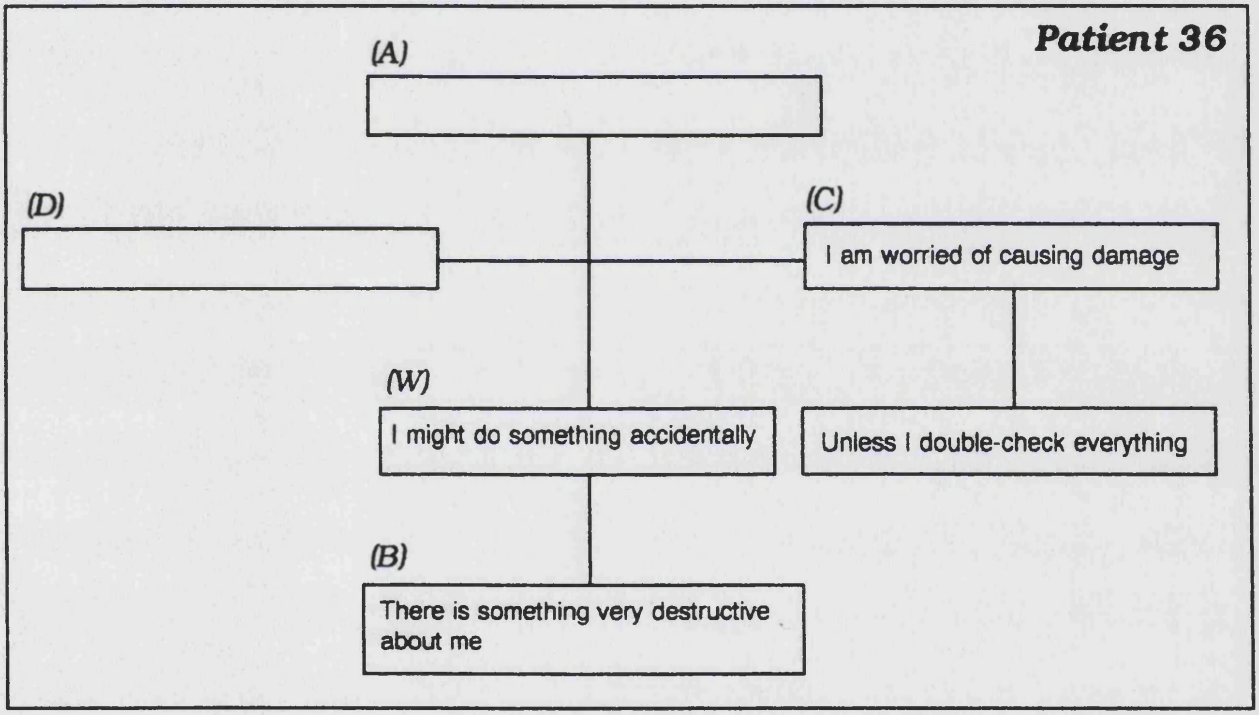


Diagram 36 – Patient: The Claim in this instance is that the patient admits to being worried about causing damage. There appears to be no foundation for this fear, that is, there is no Data associated with this Claim. The Warrant is that something might happen accidentally. The Backing is not verbalised but is something like 'I feel there is something very destructive about me'. A Qualifier is identified, that is she feels she could be destructive unless she double-checks everything.

In this scenario it is possible that the patient has got some Data in her mind, which she is not sharing. Or it is possible that there simply is no Data for this Claim, and as it stands

the irrationality of the Claim seems clear. It is likely that the Backing, which is not verbalised, is something like a deeply held conviction that there is something destructive about her, this belief operates then also as Data. Logically the Claim does not hold water. In this instance there appears to be obsessional mechanisms at work connected to the manic defence. The patient feels persecuted by a fear that she will causing damage and may be held responsible for something. Mary is not being in touch with feelings of concern for her patients, although the possibility of getting in touch with concern is there.

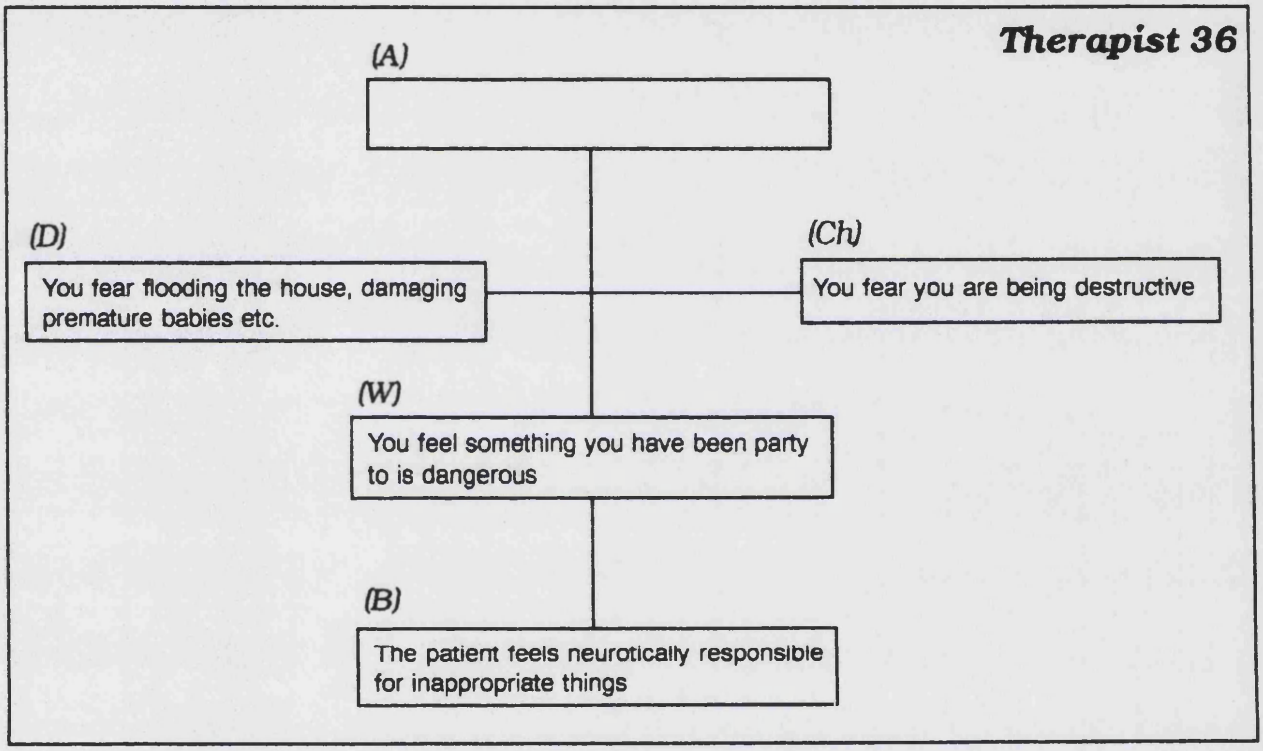


Diagram 36 – Therapist: The Challenge by the therapist is that the patient fears that she is being destructive. The Data is that she fears flooding the house, harming premature babies etc. The Warrant is that she feels that anything she has been involved with can be dangerous. The Backing is not verbalised, but appears to be some idea in the therapist's mind that the patient feels inappropriately responsible for things, neurotically so.

The therapist is restating what the patient has said, but he is not presenting a Challenge as regard to the origin in the patient's mind of these feelings, that is the absent Data in the patient's argumentation. This constitutes an amplification of what the patient has already communicated

Therapist: Mmm... as if you feel you had this potential for harm in you, that you might cause harm although not intentionally, say.

Patient: That's right. I mean I hadn't thought before that there is, it is so destructive, but there is something destructive...the worst that could happen like you know a really bad fire or bad flood or...yeah but I don't get the impression that I want, I don't want to do them. What I sort of see it as though something happening to me rather than me doing it to, to them. I see myself more as a victim of the circumstances rather than the initiator.

Therapist: And yet it's not so clearly about being a victim because some of the things you're afraid of is that you have initiated something that would cause harm.

Patient: Yes. But it's not as if I deliberately set fire to things...I've not put a cigarette out, say that's something that happens to me. I think I have a slight feeling in my life that things have happened to me that haven't been entirely fair and I've been unlucky in such circumstances. Apart from the fact of having, quite apart from the major life events that have happened to me which haven't happened to my peers really. I know very few people who for a start being from a single parent family and lost their mother and grandfather within the space of a year...

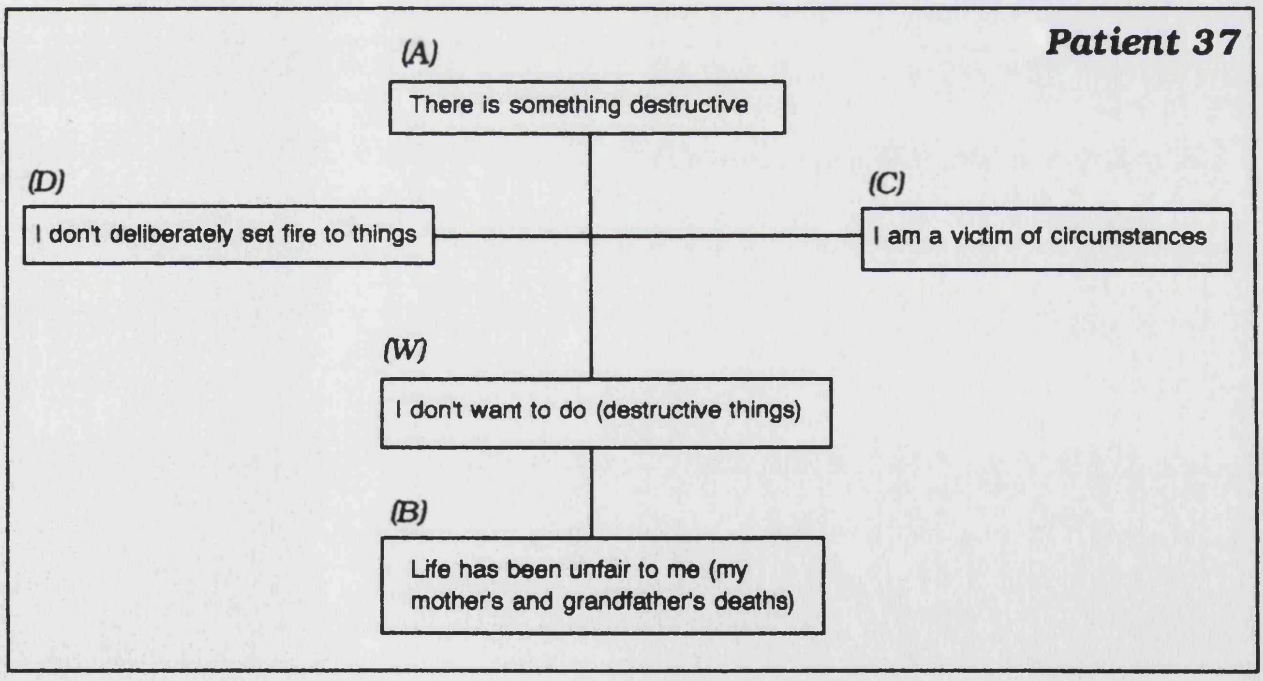


Diagram 37 – Patient: The Claim the patient makes is that she feels she is a victim of circumstance. The Data is that after all she does not deliberately set fire to things. The Warrant is that she does not want to do destructive things. The Backing, which is significantly verbalised in this instance, is that life has been unfair to her, after all she has

lost her mother and her grandfather. The Alternative is vaguely considered in the section, and although somewhat unclear, seem to be ideas about whether there might be something genuinely destructive in her after all.

A switch has clearly taken place here, after being very preoccupied with her possible destructiveness, the situation is reversed. She attempts a defensive argument which would change the complexion of the thinking entirely, she now wants to see herself as the victim not the aggressor. The defensive nature of this manoeuvre is obvious from the desperation. The argument does not hold water, undoubtedly she has suffered many misfortunes, but that does not change whether she is destructive or not. It appears that the preceding exploration caused heightened anxiety and this necessitated the defence of denial of her anxiety about herself and projection. An attempt at reparation by obsessional means, has failed, see Diagram 36 - Patient. Therefore there is a return to persecutory anxiety, the objects that were to be restored turn again into persecutors, in other words a projection of destructiveness has taken place. In the Claim and in the Data she is the victim not the other way around.

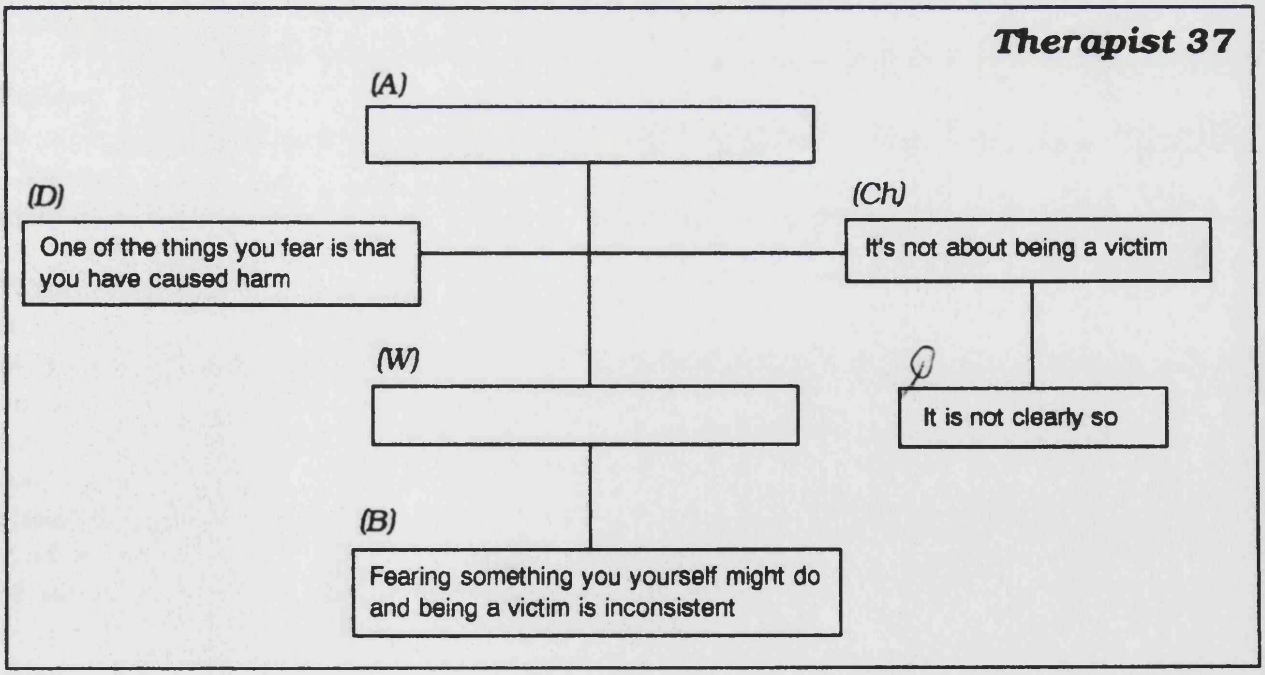


Diagram 37 – Therapist: The Challenge that the therapist is putting forward is that the patient's dilemma is not about being a victim. The Qualifier is, 'it is not clearly so'. The Data for this Challenge is that many of the things she feared were not things that

happened to her, but about her causing somebody harm. No Warrant is offered nor obviously implied. The Backing is not verbalised but could be the principle that fearing something you might do yourself is not consistent with being a victim.

The therapist is here trying to draw the patient's attention to the defensive nature of her Claim. He challenges the projection directly. He adds the modifier 'clearly' because undoubtedly in some sense the patient is a victim of circumstances too. This is an amplification of the patient's situation.

Patient: Yes. I don't feel like attacking you though. I mean I don't feel angry about this or like attacking you, or anxious. I can remember the first time that we talked about this and you asked me if it was an extremely anxiety provoking situation coming here. And it's not you see but it, that, that again doesn't seem logical in that this isn't anxiety provoking for me. Whereas if I go back to work now and I've got to do some.. that would be and it should really be the other way around.

Therapist: But you know when we finished last time you left here I think feeling frustrated that we hadn't come up with a time that was suitable for you.

Patient: Mmm....

Therapist: I offered three times to you.

Patient: I know (laughing)

Therapist: Three times that were equally unsuitable perhaps and you had to make a difficult choice.

Patient: Yes. And I've also had to tell people that, and I didn't want to , no, in order to make it possible for me to come here this time. So yes, I don't, I, I felt at the time a bit annoyed about that as if it was, again it was unlucky that those three times just really don't suit me. I only have one afternoon and that's the Wednesday and I only have one lunchtime and that's a Friday. It just seemed unlucky. So yes, I think that um annoyed about that I don't think annoyed with you, more annoyed with the situation because it's inconvenient in a way. Friday lunchtime is not a good time. And it just seemed to me it was really unfortunate. It could have been any other day of the week. And why does it have to be either of those two particular times that really don't suit me? But I, Again I rationalised it and thought well just bad luck it doesn't suit me and I have to make sacrifices.

Therapist: But the sacrifice you made was you decided to opt for Friday lunchtime, which could mean letting people know, rather than an 7.30 time which got well, too early, having to face the whole day?

Patient: Mmm... I didn't feel very good going to work afterwards quite exhausted you know and then having to work. I don't like early mornings at all. It does not suit me in terms of my thinking.

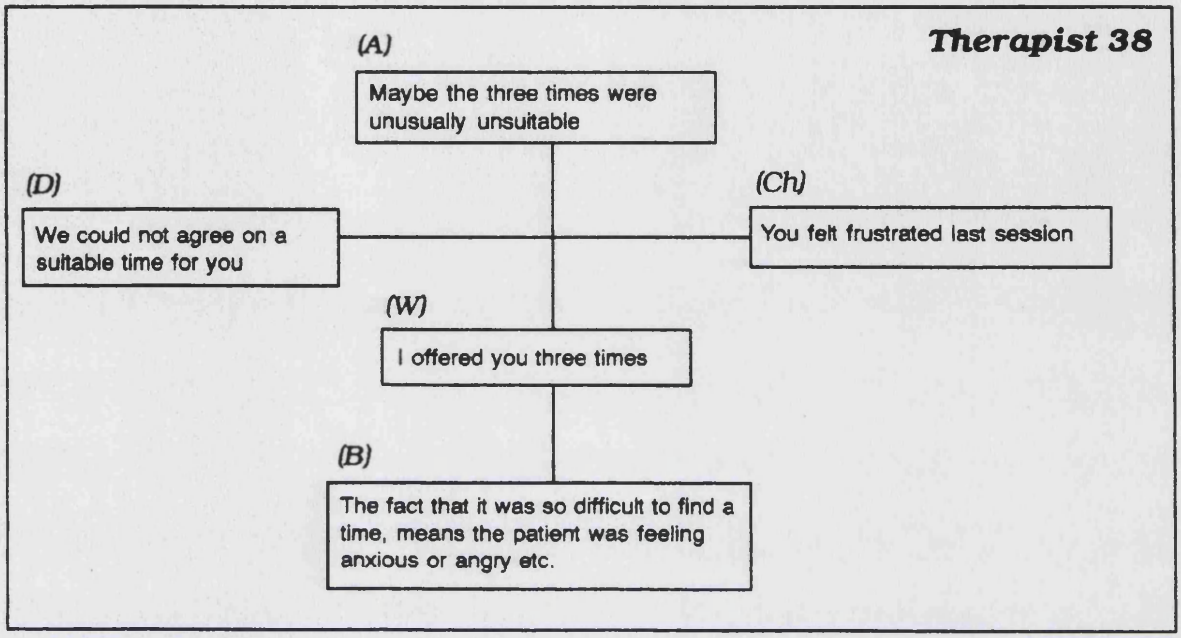


Diagram 38 – Therapist: The Challenge is that the patient felt frustrated the last time they met during the assessment session. The Data is that there had been some considerable difficulty in agreeing a suitable time for the psychotherapy sessions. As Warrant, the therapist points out that he had offered three different times. The Backing is not verbalised, but appears to be an assumption that the fact that the patient had such difficulties agreeing on a time means that she was anxious, angry or felt something similar. The Alternative is touched on, which is that unlikely though it may be the patient's time table might have been such that the three times were genuinely unsuitable.

The therapist is trying to challenge the patient to look at what feelings might be underlying her practical difficulties.

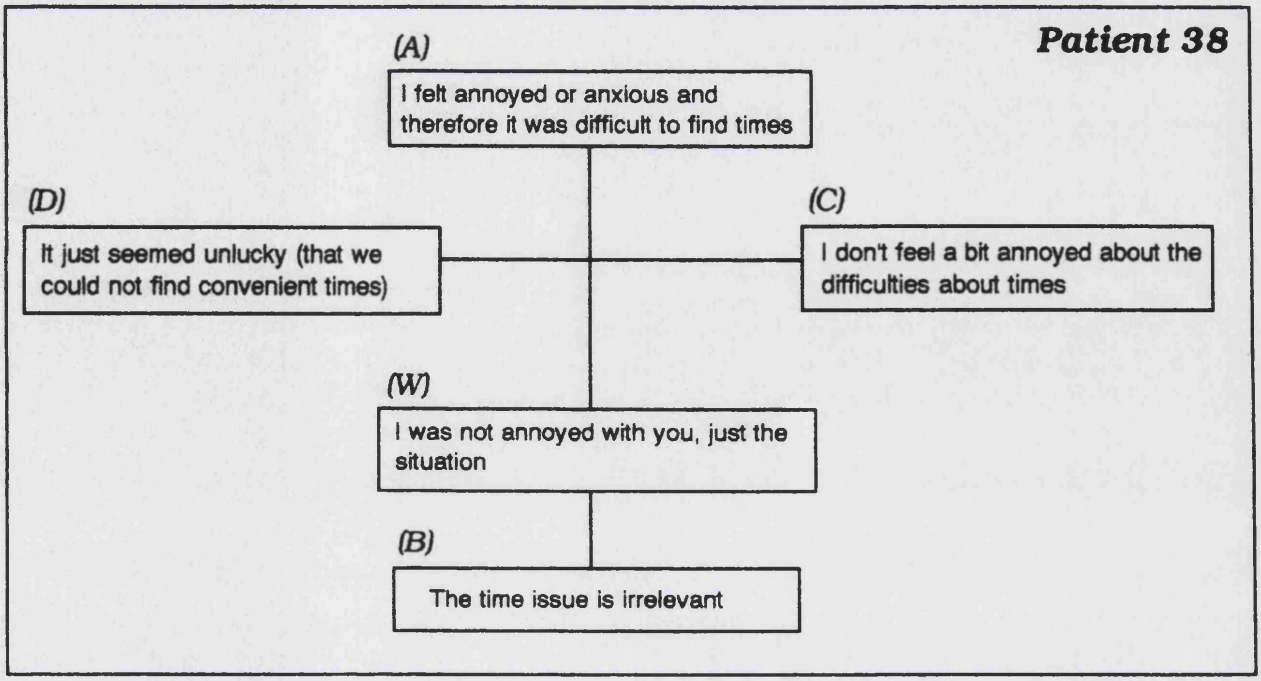


Diagram 38 – Patient: The patient's Claim in response to the above Challenge is that she says she wasn't a bit annoyed about the difficulties about times. The Data is that not finding a very convenient time was just unlucky. The Warrant is that she wasn't annoyed with the therapist, just with the situation. The Backing is not directly verbalised, but strongly implied, that is, she feels that the time issue is irrelevant. An Alternative, which is not explored, is that maybe because she felt annoyed, anxious etc. it was difficult to find times.

The patient is here putting a lot of energy into denying the possibility that the Challenge might be worth thinking about. The annoyance is recognised but projected and displaced onto something called 'the situation', seen in the Warrant. Denial and projection are used. Were the Claim to be true it could have been expected that the patient might have allowed herself to consider the Challenge for a while before rejecting it. There is also a quality of omnipotent triumph over the therapist in this communication indicating possibly the presence of the manic defences.

7.3.1. Session 7

Subjective/Intuitive analysis

This session starts with the patient reporting that she is feeling better. She had not panicked when abroad the way she had expected. This fact seems to confuse her.

'Maybe I am just reacting badly to the pressures that are to do with my job and my house.... But when I went to Spain earlier in the year that was really difficult. I don't think it's just being away from work'.

The therapist suggests that the improvement may have something to do with the therapy. The patient finds this suggestion worrying as it suggests to her that she is not in control. There is talk of how she controls her boyfriend, and some discussion about whether she attempts to control her therapist. The patient denies this possibility and claims that it may be the therapist who controls her.

'I thought that you deliberately suggested that I come in the morning because that was what I didn't want to do. I mean I got the impression then in that case that you were trying to control, control, me'.

It appears that the controlling has been projected onto the therapist. The argument has got an artificial, or even paranoid feel to it. Why should a therapist suggest a time when the patient does not want to come.

The session continues with further explorations about control, who is controlling whom, and is it useful or even desirable. The patient wonders whether the therapist is in control, and suddenly there is a switch in associations for the patient to a reflection of why she is the way she is (presumably controlling).

'I just assume that you have got some ideas of control. That is, the way of control, of structuring things, of directing things. I can't see any ways in which you are particularly directing things. Um I think about this so much that.... I think of my childhood, my mother's death, my recent relationship with my grandmother....'

This is a curious switch, it is not entirely clear what exactly triggered it, however the unexpected nature of it makes it perhaps more significant. What was being said must have made sense in some way and been felt to be convincing in order to cause the switch into reflective thinking. The reflective mood does not however last long. The thoughts and feelings emerging into the patients mind appear to cause some heightening of anxiety and she seeks again refuge in wondering about who is or should be in control.

'I could think about this for a long, long time but in a completely unstructured way. I do keep still feeling that I need some sort of guidance from you...'

After this exchange follows a general discussion about what she expects from the therapist. She mentioned how disturbing it was for her when the therapist did not behave in ways she expected.

'I found it difficult that you wouldn't stand up (at the end of the session). I almost thought that you were doing that on purpose, that you didn't stand up.'

The patient illustrates how disturbing it is for her if things don't go according to expectations, thus her need to control.

The discussion about control is via associations turning into a discussion about what it was like for her to grow up without a father. The patient insists that it wasn't anything that particularly concerned her. This could be true, however it appears that the problems, associated with not having a father are in fact projected.

'I've got friends whose fathers left their mothers when they were early teens and I can remember talking to them about it and how devastated they were that their fathers had left home. And it seems to upset them a lot more that I ever remember feeling upset at not having a father at home in the first place'.

The session ends with reflections on the forthcoming ending of treatment. This creates a feeling of anxiety and suspicion, which is dealt with by what seems to be defensive anger.

7.3.2. Argumatics analysis of session 7

Patient: The anxiety has been much better this week.... Maybe I'm just reacting badly to the pressures to do with my job and my house...But when I went to Spain earlier this year that was really difficult. I don't think it's just being away from work. I can't really think what the... it wasn't accurate that as soon as I was away from England or something I felt OK because I didn't. I still had a couple of irrational moments...but it's not as bad as they have been in the last two or three weeks in England.

Therapist: It seems very difficult for you to talk about the possibility that you may be beginning to face something here or using these sessions in a way that is having some influence on how you are.

Patient: Mm. Maybe I can't see how it is having an influence yet but possibly it is. I mean that, I haven't discounted that possibility, no but...because I mean I went to Spain and I did feel very bad and I've been feeling quite rotten over the last few weeks. A bit better before I came here and then worse again when I first came here

and then really bad the last two weeks before I went away and fine again this week. So no I mean I don't discount the possibility but I can't see how, how it has to happen here. But maybe I do find it difficult to confront that yes. I don't feel in control of it. I feel it's more in control of me than I'm of it.

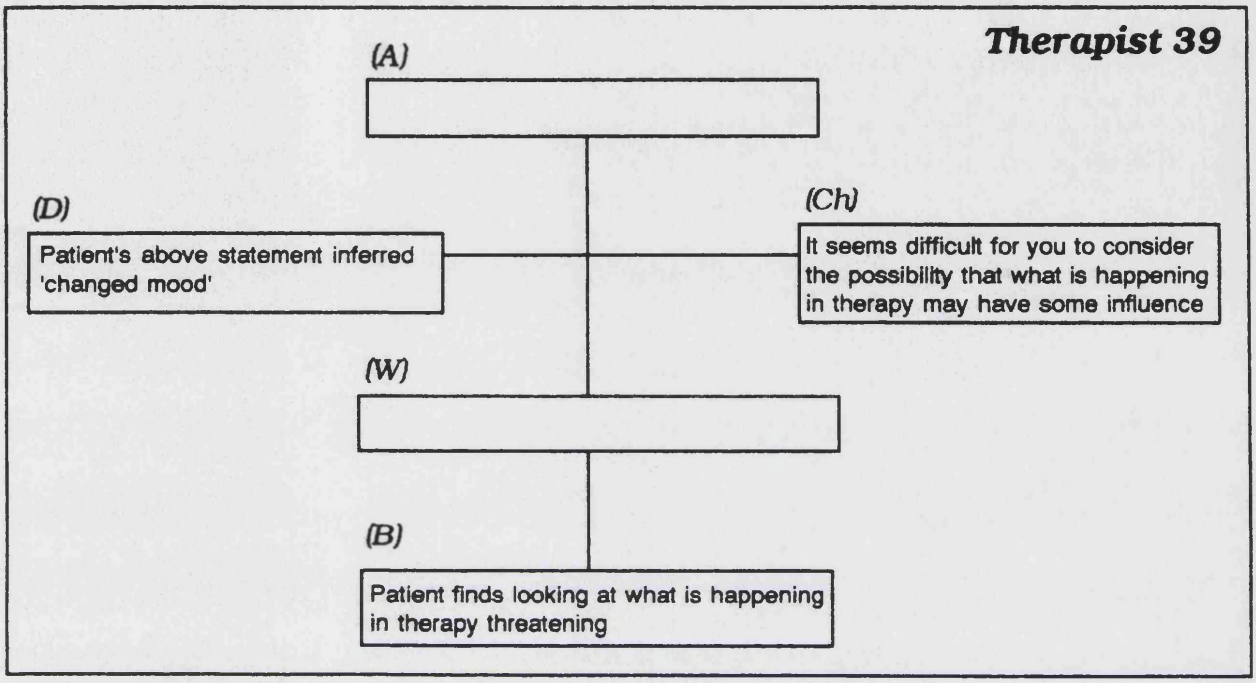


Diagram 39 – Therapist: The therapist is offering a Challenge to the patient that it seems difficult for her to consider the possibility that what is happening in therapy may be having an influence. There is no direct Data for this statement. It appears to rest on what the patient inferred, a change of mood. No Warrant is offered or implied. The Backing, which is implied, is that the patient seems to find looking at what is happening in therapy threatening, in particular if it is felt to be having an effect.

With the Backing in mind the therapist is trying to draw the patient's attention to the transference aspect. That is, that the patient might have found the therapy helpful. This is a Challenge for the patient, to look at the material in a specific way.

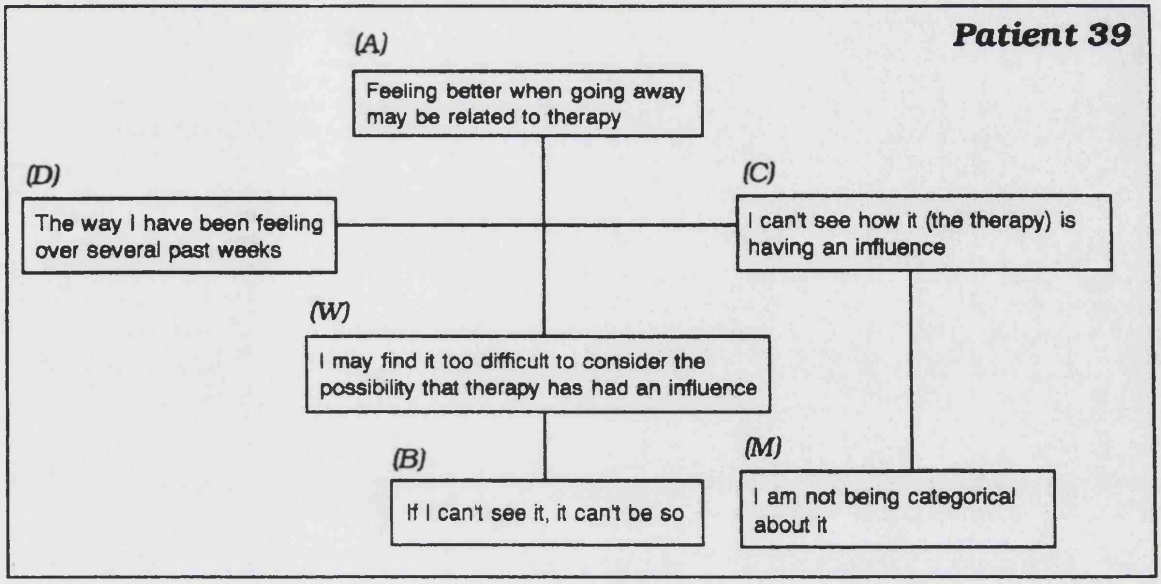


Diagram 39 – Patient: The Claim which the patient is offering in response to the Challenge by the therapist is that, prefaced by a Modifier, 'although she is not being absolutely categorical about it', she 'cannot see how the therapy has been having an influence on the way she has been feeling lately'. The way that she has been feeling over the past few weeks is offered as Data for the Claim. Interestingly an Alternative is verbalised as well, which is that feeling better in the last week **may be** related to events in her therapy. As Warrant, she admits that maybe it is too difficult for her to consider the possibility that therapy is having an influence. However the argumentation rests on a Backing that if she cannot see something to be the case then it cannot be so.

The patient is here putting forward a very confusing argument, seemingly, contradictory Alternatives are verbalised, but not really considered, the Data seems confusing. In order to make this Claim at all, it must rest heavily on the Backing, which is not verbalised, but seemingly strongly felt, that if she cannot see something then it cannot be the case, in spite of contradictory possibilities and confusing Data, which further more is not really considered. This therefore suggests that the Challenge is defended against, by denial, which rests on feelings of omnipotence. The Alternative and the Modifier are verbalised. This is done not in order to consider them, but in order to avoid having to think about them seriously. As if to say, I have already considered them. A defence against a need for the object in this instance the therapist. This suggests that, manic defences are operating.

Patient: But I don't think I am trying to control you. I mean I can't, I don't feel that I want to be able to control what you say or what you do or what happens in these sessions. I might think before I come how I want the session to go, but I mean how, um I do that.

Therapist: Mmm... But you have been wanting the sessions to go on at the end, why can't we go on to half past you wonder.

Patient: Yeah. Well I told you why that was. I mean I, I almost felt sometimes as if its, its important it's something that maybe needs to be resolved as to why, how I react to ending things....ending things. I thought, I mean I thought initially that these sessions were an hour. And I thought that the first two were an hour. I didn't really look at my watch for the time. And after that I thought they were 50 minutes. And I almost thought that was intentional on your part. That you were ending it ten minutes earlier as part of the... you just don't- the other one was when I thought that you'd deliberately suggested that I come in the morning because that was when I didn't want to do. I mean I got the impression that in that case that you were trying to control me. Or seeing how I react to doing something that I didn't want to do.

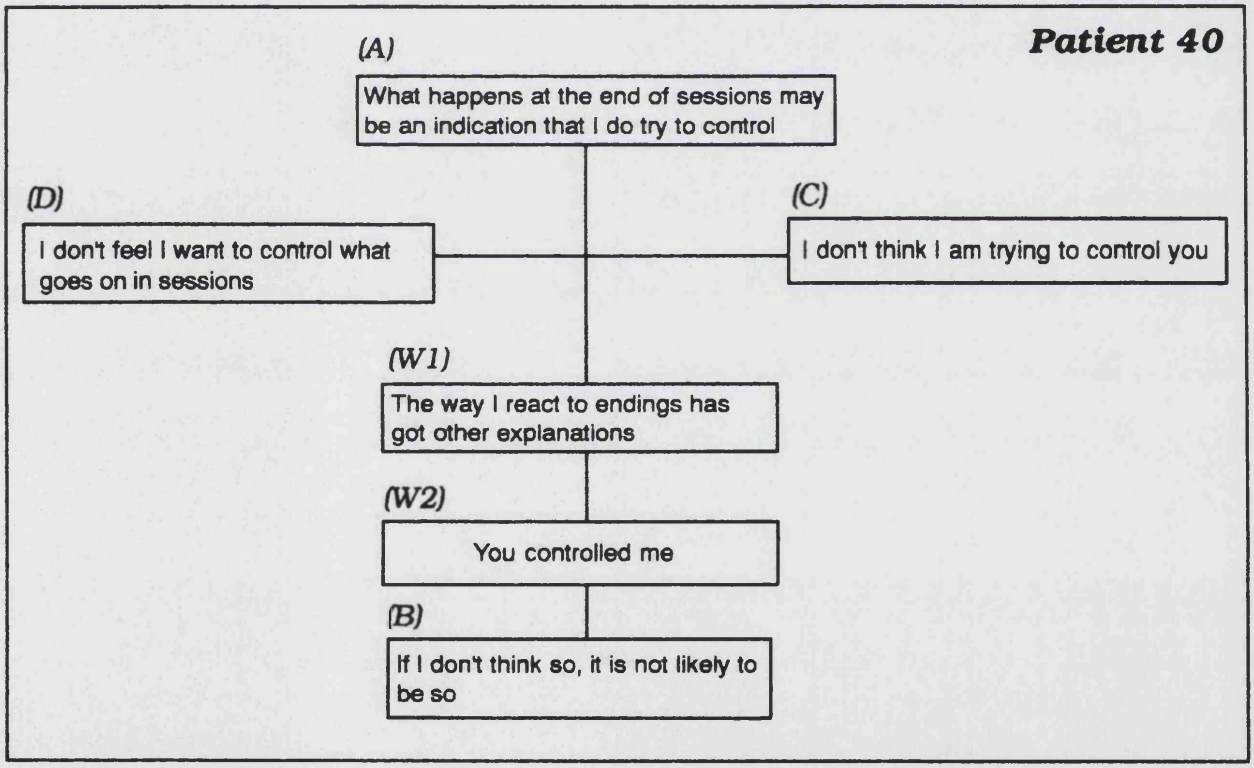


Diagram 40 – Patient: The patients Claim is that she does not think that she is trying to control the therapist. As Data for this Claim she says that she does not feel she wants to control what goes on in the sessions. Two Warrants can be identified, the first one is that although the therapist had pointed out that she has found ending sessions difficult, she feels this has got other although not understood explanations. The second one is that the

therapist is controlling her. The Backing is not verbalised but could be something like if I don't think so then it is likely not to be so. The Alternative, which might arise from the therapist's intervention, could be that the fact that she finds ending sessions difficult (and tries to extend them), indicates that she behaves in a controlling manner in her sessions too.

It appears that the patient employs denial (being controlling with the therapist needs for some reason to be denied). The argument rests on shaky ground, The Data is that she does not feel she wants to control. The first Warrant is a dismissal of the therapist's intervention. The second Warrant is turning the argument on its head, it is seen as a possibility that it is the therapist who is controlling the patient, a projection. The argument can only hold together if it rests on a Backing like 'If I don't think something is the case then it can't be the case. This means in other words, omnipotent thinking. This appears to be part of trying to deny that a relationship is being played out between patient and therapist, thus suggesting the use of defences classifiable as manic defences.

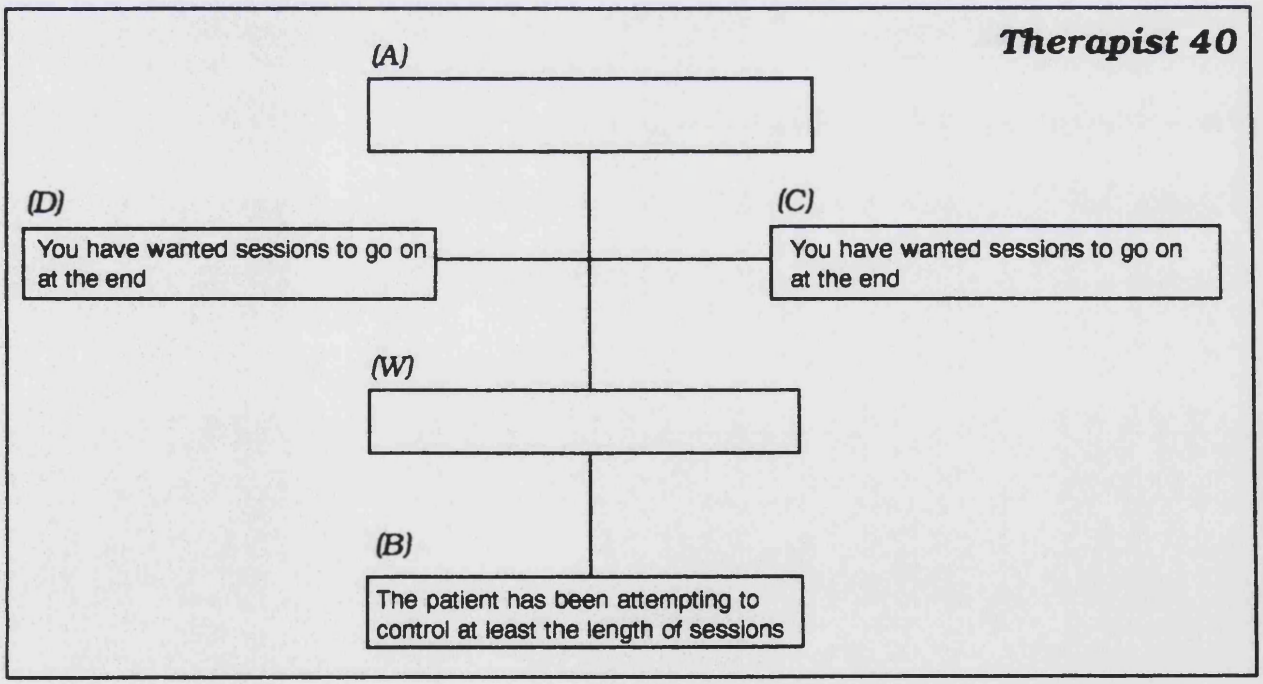


Diagram 40 – Therapist: The Challenge here is that the therapist points out to the patient that although she tries to argue that her controlling behaviour does not extend to the therapy, she has wanted sessions to go on at the end. No Data is offered as such, in

fact the Challenge acts as its own data. No Warrant is verbalised or implied. The Backing is not verbalised, but seems to be a hypothesis that the patient is controlling, at least in relation to the session lengths.

The therapist is pointing out inconsistencies in the patient's communication.

Patient: I went to see my GP first...he said he'd prescribe me some, um I don't know whether it was tranquillisers or anti-depressants um he was trying to treat my symptoms and I knew then that that's what I didn't want, it wouldn't help, it wouldn't make them go away. So I didn't expect to have some sort of treatment like that but the, well maybe I'm just imagining these things from you, things about um changing the session and um finishing at twenty past because I just assume that you have got some ideas of control. That that is the way of control, of structuring things, of directing things. I can't see any ways in which you are particularly directing things. Um I mean I think about this so much that... think of my childhood, my mother's death, my recent relationship with my grand mother and her husband...sort of there's so much apart from just what I said about it in my first discussion....I've become aware that things go back a long, long way. Although I don't know how I would have been if my mother hadn't died. To me it seems like it's only the last six years that are really, really important in affecting how I'm feeling now but maybe it's further back as well. You know I could think about this for a long, long time but in a completely unstructured way. I do keep still feeling that I need some sort of guidance from you in my, my past memories....as to which ones are helpful to think about. Not important, really to work out which ones are important , which ones are helpful to think about in terms of helping me to feel better.

Therapist: And what has come alive in your feelings here in a session today which may or may not go back to past times I don't know, is this feeling that this other person, me, has something that I could give you, I've thought things out...but I don't, I'm not sharing it.

Patient: Mmm.... Yes, I suppose so but I don't um, yeah, that's true. It's not that, I don't know why I think you won't, I mean its true, yes I think you do know something or you've thought of something or you have some feeling about it. I don't know why you won't, I think... sort of now that you're not trying to direct me, and it's difficult for me to, to know where to sort of think myself, what areas to talk about myself. And I don't know if you have got something. I just assume you have actually. I assume you must be able to see the links with my past.

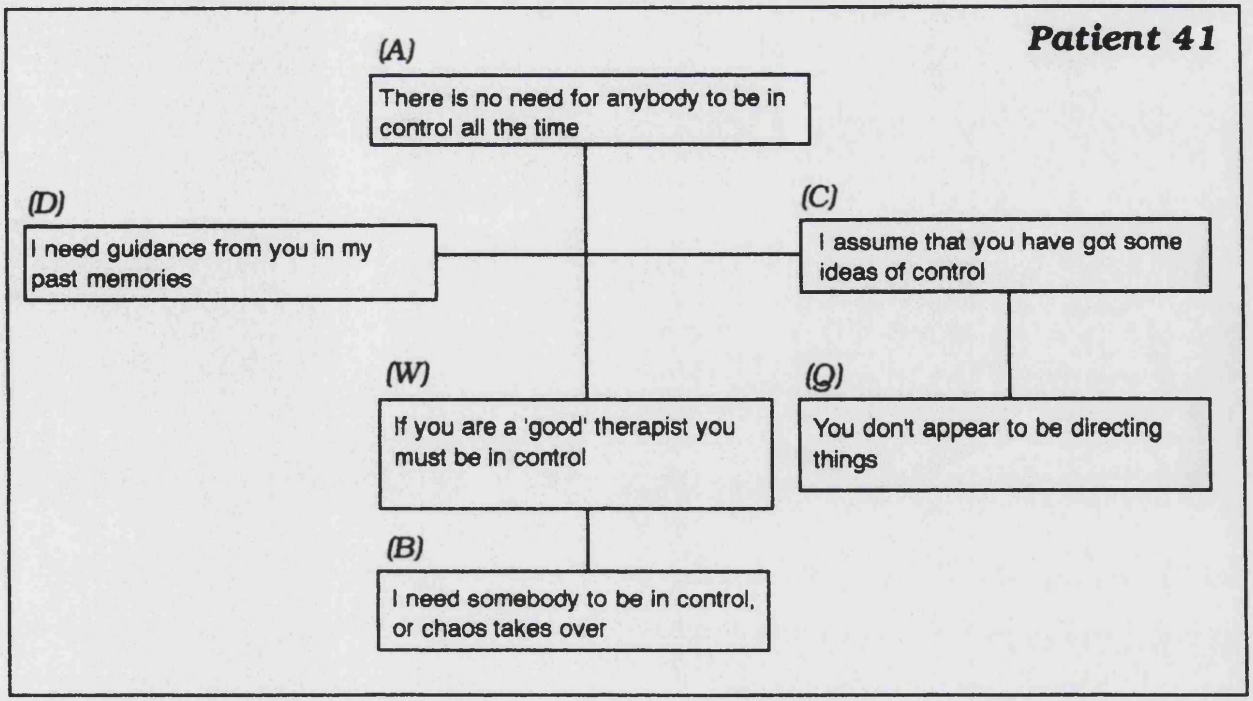


Diagram - Patient 41: The Claim is that the patient assumes that the therapist has got some ideas of control. A Qualifier 'You don't appear to be directing things' The Data is that the patient feels she needs some guidance from the therapist in thinking about her past memories. The Warrant is not explicit but implied, that is if the therapist is a 'good' therapist he must be in control. The Backing is not verbalised but implied, and is something like, ' I need somebody to be in control or some kind of chaos will take over. No Alternative is verbalised but could be 'there is no need for anybody to be in control all the time'.

The patient is struggling with a fear of being overwhelmed. These feelings are expressed in the Claim, the Data and the Warrant.

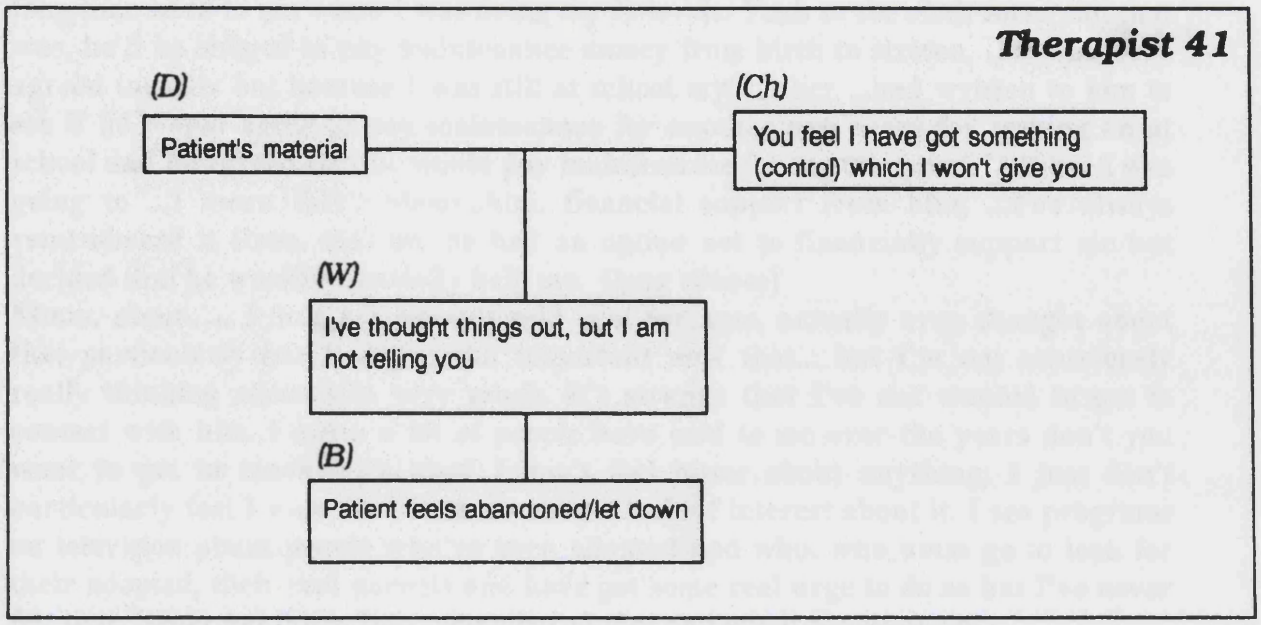


Diagram – 41 Therapist: The Challenge is that the patient feels that the therapist has got something (control), which he won't give or show the patient. The patient's material as presented in diagram (Patient 41), acts as Data. The Warrant is a further comment on what the therapist feels is going on in the patient's mind, that is, she feels that he the therapist has thought things out but is not telling the patient. The Backing is not verbalised, but is an assumption that the patient is wrestling with feelings of abandonment or feeling let down.

The therapist is offering and interpretation and amplifying it in the warrant at the same time.

Patient: I almost get the impression that....that I should be able to see you as being like... And talking to you isn't like talking to them. And I almost feel that that's something that you're trying to suggest that I should be feeling that...

Therapist: Is it John or John? I thought about the first John- (Patient's father)

Patient: Mmm....

Therapist: Because I'm thinking perhaps where does this feeling go back to? Somebody else having something that he could give you, I could give you but I won't.

Patient: Mmm.... I don't think about that very much really. I am thinking about when I was a child and I never... particularly doing that... stayed with me for quite a

long time back to um when I was doing my O-levels. Yeah to the sixth form and that was, he'd be obliged to pay maintenance money from birth to sixteen, that had been agreed initially but because I was still at school my mother ...had written to him to see if he would agree to pay maintenance for another two years for staying on at school and he agreed that he would pay maintenance for my two years because I was going to ...I mean that's about...him, financial support from him, ...I've always remembered it since, that um he had an option not to financially support me but decided that he would financially help me. (long silence)
Mmm, mmm.... I didn't, I haven't said that for ages, actually even thought about that particularly but it does seem important now that... but I'm not consciously really thinking about him very much. It's strange that I've not wanted to get in contact with him. I mean a lot of people have said to me over the years don't you want to get in touch with him? I don't feel bitter about anything, I just don't particularly feel I want to. I seem to have a lack of interest about it. I see programs on television about people who've been adopted and who, who umm go to look for their adopted, their real parents and have got some real urge to do so but I've never felt that. Never anything, just remembered that and about the financial...

Therapist: I suppose it might be important because it represents him giving you something that he didn't have to give you.

Patient: Mmm....

Therapist: He, he cared.

Patient: Mmm....

Therapist: But there's a whole set of feelings about what he didn't give you. He wasn't around for you. He wasn't around for you. He wasn't there to give you the love,...

Patient: I think it would have been worse though if he had been at the beginning and then left. I think everybody over compensated really towards.. in fact I used to have a lot of adults around me... I can never remember actually wanting a father. The first time I can remember was going to school when everybody was saying what does your father do and things like that. I've got friend's whose fathers left their mothers when they were in their early teens and I can remember talking to them about it and how devastated they were that their fathers had left home. And it seemed to upset them a lot more that I ever remember feeling upset about not having a father in the first place. I've obviously consciously worked out there um... seemed a bit odd in that way but I can't remember being really miserable about not having one.

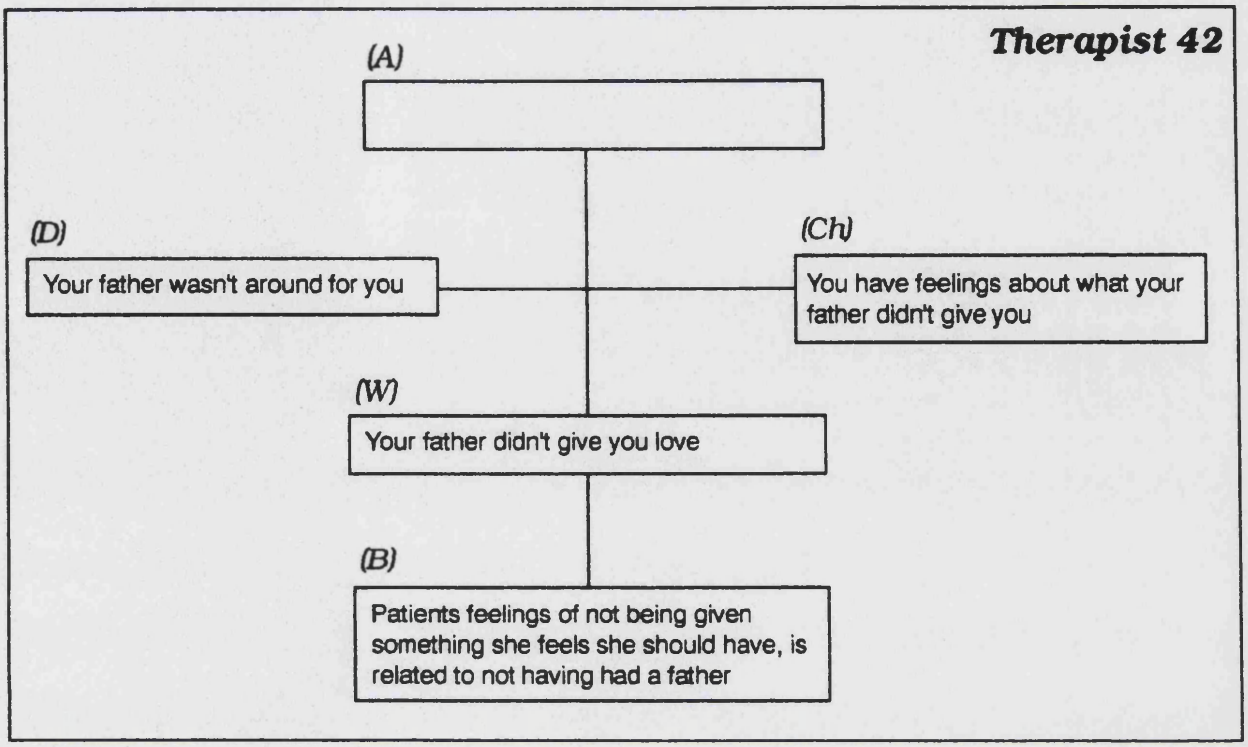


Diagram 42 – Therapist: The therapist is offering the patient a Challenge that she has feelings about what her father didn't give her. The Data for the Challenge is that the patient's father wasn't around for her. The Warrant is that her father didn't give her love. The Backing is not verbalised but implied, that is, that the patient's feelings of not being given something she feels she should have had is related to not having had a father.

The therapist is trying to help the patient to get in touch with feelings about her father. The therapist is doing this by using the material, which has become apparent in the transference, i.e. that she feels that the therapist is withholding something he could give her. This is an interpretation of the feelings the patient is having about her absent father based on the transference, as it has emerged in the session.

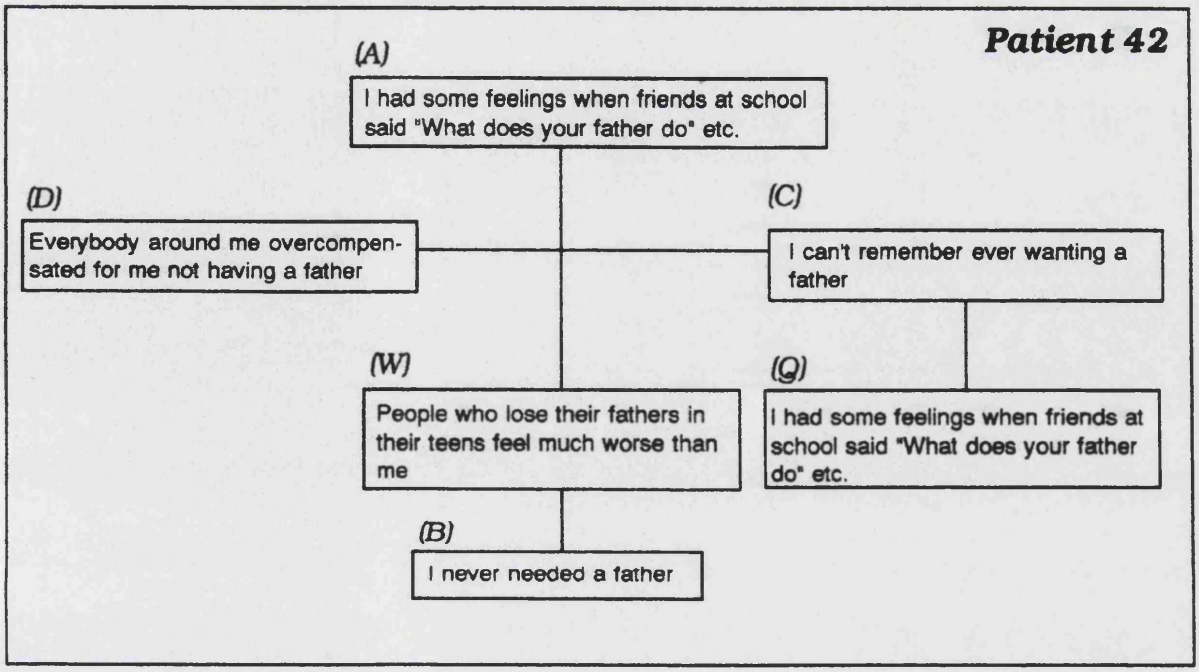


Diagram 42 – Patient: The Claim that the patient produces is that she can't remember ever wanting a father. The Claim does however come with a Qualifier, the patient remembers having some feelings when asked by her school friends what her father was doing. The Data for this Claim is that everybody around her over compensated for her not having a father. The Warrant is that in fact people who loose their fathers in their early teens feel much worse than she does. The Backing is not verbalised, however the argument rests on the assumption that she feels convinced that she never needed a father. The Alternative that she did have feelings about her absent father, in response to her school friend's comments is only touched on but not explored.

The patient is denying the therapist's Challenge. To the denial is added a projection that it is not the patient who has suffered from the absence of a father but somebody else. The Backing is again evidence of omnipotent thinking, that is, she has ***never needed a father.*** *The denial of the potential significance of a relationship suggests that the patient is using denial as a form of ' manic defence'.*

7.4.1. Session 8

Subjective/Intuitive analysis

The session starts with some thoughts about the therapist being late.

'...it just seems like you know it is a shame, ten minutes ...after I made such an effort to get here on time today.'

The patient states that she felt particularly positive that session, really wanted to come. She continues by reflecting on her tendency for controlling behaviour, which she admits to. The reflection leads to thoughts around her grandmother, and how she worries about her. The patient lets the therapist know that she deals with these feelings by attempting to tell the grandmother what to do. She further feels that her grandmother's situation is not helped, by having an unhelpful alcoholic son. This leads the therapist to wondering if the patient might not be feeling that it is the therapist who is being nasty and unhelpful. The patient denies this,

'...that's not the overriding thing I think about you though is being nasty to me. ...I mean yeah, there are some things that you may do that I don't like or don't think are very supportive...'

The therapist's suggestion is not considered, instead the patient continues to talk about her grandmother. Feelings of regret are expressed in relation to her mother and her grandfather, and in particular relating to the time of their death. Anxiety about the grandmother's safety comes up again, and how she tries to cope with these feelings by being controlling. The controlling behaviour is connected to the patient's childhood; she feels nobody ever told her what to do.

'I don't know but something that I think is important is um not ever being told particularly what to do myself'.

The discussion about control leads to thoughts about the therapy. The therapist is wondering why the patient seems particularly accepting and accommodating this session. This is however an issue the patient does not want to discuss. In fact the patient feels there should not be so much discussion around the relationship with the therapist.

'We always seem to spend quite a lot of time talking about the interaction between us, about whether I'm angry with you, whether I'm trying to make you feel good, things like that. Sometimes that's difficult for me to see why that's so important because my life is ongoing, my problems are ongoing and I see this as short term'.

The patient knows some thing about psychoanalytic technique and admits that the therapist may be seen either like mother or father, however, any attempt by the therapist to explore this further is stopped by the patient. In this session, it appears that the patient tries to be more amenable, exploring difficult feelings around her grandmother and her mother's and grandfather's death. However when the therapist attempts to extend this exploration to what is happening in the room the patient retreats into denial.

7.4.2. Argumatics analysis of session 8

Patient: I've gone out and have wanted to go back and check things and I haven't been feeling that for a while...I've been thinking as well it's something do do with, I feel it's out of control, I feel I can't control this thing at all. And even though I know it's completely irrational I just can't control how, how I react to things.... lost control of my feelings and...I mean I keep thinking about the ...control and how to control people by things like what they wear and what they do and how they.... and that sort of thing. And I think that's probably true. I do feel that quite a lot. I mean I'm not sure about controlling through sex though but I mean that might be true but I just can't accept that or see that yet. But certainly I do get the impression that I do try to be quite controlling and I can't seem to control myself in a situation.

Therapist: I wonder if, if that's the real struggle for you and becomes manifest in trying to control things about other people but perhaps what you're trying to control is or are things about yourself that you may see in other people but are really about yourself.

Patient: Could be. I mean yeah I accept that's a possibility. Is um, is having insight into that enough then? I've found that I really can see a lot more clearly how I behave and how I react about a lot of things....things that are discussed here, things that I can - the other one is being defensive and um overreacting to criticism and things like that. I've really found myself stopping before I do that now, not doing it, not being so important, not being so worried about what everybody thinks all the time. So that, I can see how having some insight into that helped me. But... I mean I just don't see how having insight into this control business is going to actually help me get on, I can't translate it into action. I mean I notice that I always talk about my symptoms like my behaviour as if it's not, it's not um, it's not controllable. I always talk in a very passive way like you know I feel when I come in the first thing I always say is how, how things have been for me this week rather that how I've been this week. Sort of detached from it and I just don't see myself as being able to control it.

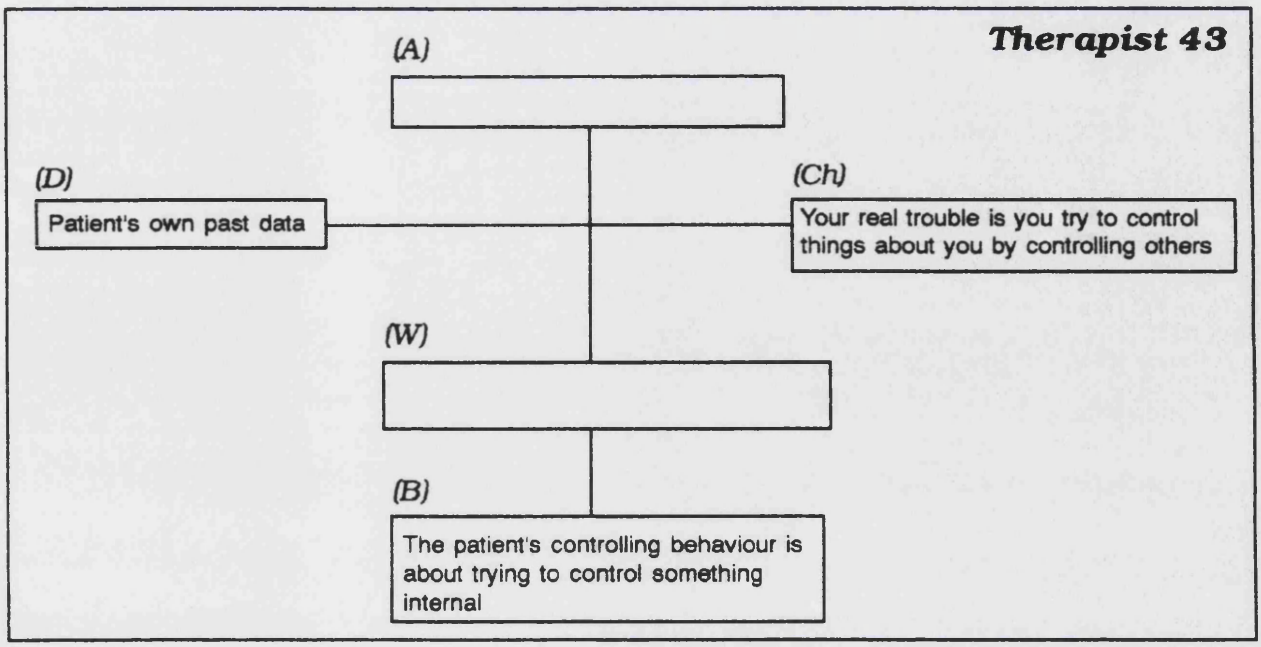


Diagram 43 – Therapist: The Challenge in this instance is an interpretation of the patient's material (Data), hat the real struggle preoccupying the patient is that she is trying to control things about herself by controlling others. No Warrant is offered or implied. The Backing is in fact the same as the Challenge.

The therapist is here open about his thoughts about what he feels might be going on for the patient. He offers an interpretation and a clarification of what he feels is going on.

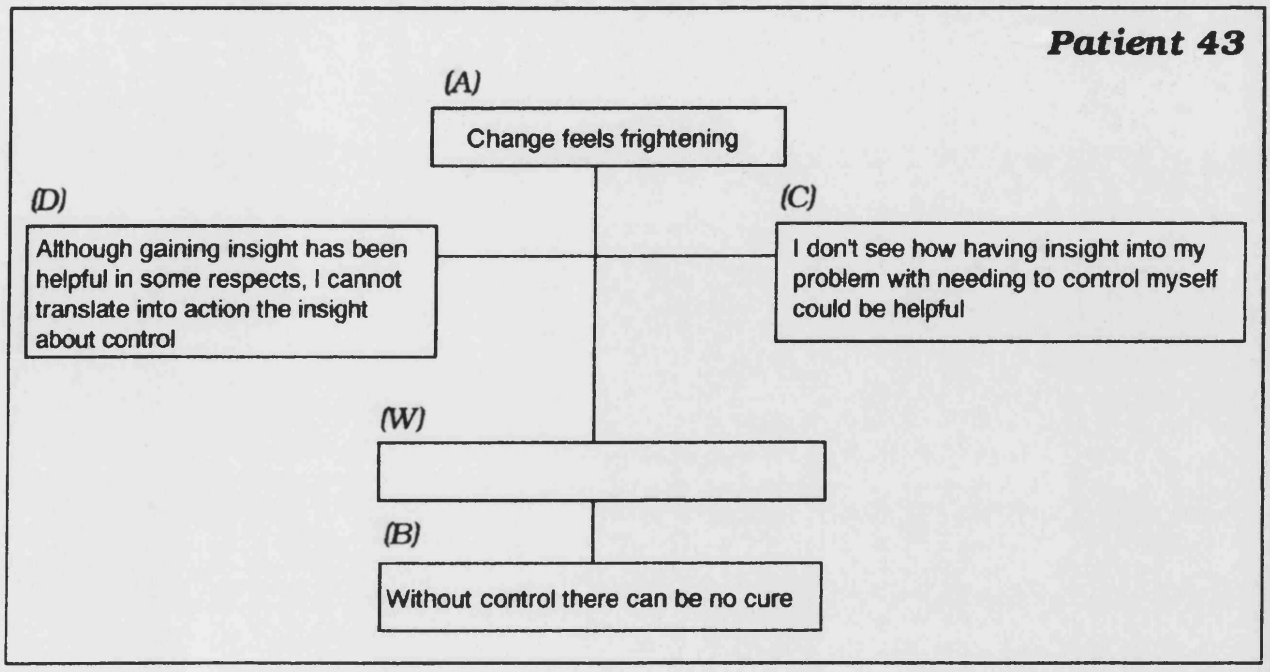


Diagram 43 – Patient: The Claim is that the patient does not see how gaining insight into her controlling behaviour might be helpful. The Data is that although in some sense she has found gaining insight helpful, she feels that in connection with control she cannot translate that into action. The Warrant, which is verbalised in many places in this section, is that she feels she cannot control her controlling. The Backing is not verbalised but is something like without control there can be no 'cure'. There is an Alternative which is not verbalised but could be that, 'change feels frightening'.

In this vignette the patient does not want to hear what the therapist is talking about. Instead, she states that even if she considered, what was suggested, that would be of no use (the Claim). Thus the therapist's intervention has been obliterated. There is also a curious circularity to the argument. On the one hand, she is talking about, looking at her controlling behaviour as a symptom, on the other she feels that the only way forward, with controlling is more control. The Backing. again contains, more control. This indicates that the patient does not believe that a different way of looking at the situation could exist, not involving more control. In other words, anything, she cannot think about, cannot exist. This suggests omnipotent thinking, in the face of her anxiety. There is also a suggestion of competing with and a triumphing over the therapist. The use of omnipotent thinking and triumph suggests use of manic defences against anxiety rooted in feelings of neediness and dependence on the therapist.

Patient: I don't remember coming away last time being angry with you. I've thought sometimes that - I have gone away angry yes, and there was a time I felt... angry because I thought you were rude. But I wasn't nice to you either really... Maybe I do that with people sometimes but I think it's not particularly necessary in this situation. I'm trying to think about the phone call. I was, I wasn't quite sure what you meant there. How, how is it similar to a phone call, me phoning my grandmother? Oh I see, because um I don't, I don't think I wish that she was dead though or I mean I've tried not to anyway. That's very difficult. I find that's one of the most painful things we discussed actually. There's sort of a lot of me doesn't, doesn't want that at all and that's something I, I feel really scared about.

Therapist: Mmm....

Patient: I remember being really troubled by that one on the way home after the session when we discussed that. I felt terrible, I felt really guilty...

Therapist: As if having a thought like that, kills all the other caring granddaughter thoughts...

Patient: Mmm.... Or as if having thoughts like that about her could actually kill her...I think I feel so guilty about my mum's death...what about it, I just keep feeling really guilty, I mean I just keep feeling that I could have done more. Things like I could have left university earlier or I could have cared for her more or I could have known earlier that she was going to die, um been more supportive to her. Same with my Granddad when he died. I mean I'd been there lots of the time, I'd been doing all sorts of things like taking my Grandmother to see him but when he actually died I was, I...had to come away from Cornwall. So I wasn't there when he died. So I wasn't there when my mother died ... I get really frightened about being away or out of the country or something. I just think that my Grandmother is going to die when I'm away. And that is, I think that is a really major fear why I have to keep phoning her and keep checking that she is all right. I just have this feeling that something is going to happen to her and I'm not going to be there. Or you know she is going to be trying to contact me and I'm not going to be able to be contacted.(long silence)..... I just had this feeling that people would hide it from you if anything was wrong with her. She. she would hide it from me, you know she'd say you know I don't want Sid (son) to be worried...sort of thing like she doesn't want me to be worried and yet I end up feeling more worried that is normal concern for her somehow. It's strange how, how it's happened. And I always get this feeling that I'm responsible for her and it's I mean I've got to be sure that she's all right ...I don't give her any control over it herself. I was trying to talk to her last night about this problem and always in the past I sort of say to her well I think you should do this or I think you should do that. I'm used to saying that sort of thing, being very sort of controlling and I think this is the right way to deal with it. I think since being here talking to you I see that that's not very helpful actually. It's actually more helpful to get the person to sort of generate themselves how they think they cope with things or... I can't really verbalise that too well. It's a different approach. I mean I kept expecting you to tell me how to behave, and try and solve my problems. I still have that feeling slightly that you're going to say to me well look I can see what's wrong with you, it's this and you should do this instead. Um I mean for the first few sessions I just felt I was just talking and giving you material and expecting you to find the answer and then tell me what the answer is so that I could sort it out. And that's how I kept sort of talking to my Grandmother...telling her what to do.. advising her what to do perhaps without giving her much sort of her own control to do it. You know if she wants to do it,.. maybe I should just listen to her rather than advising her.

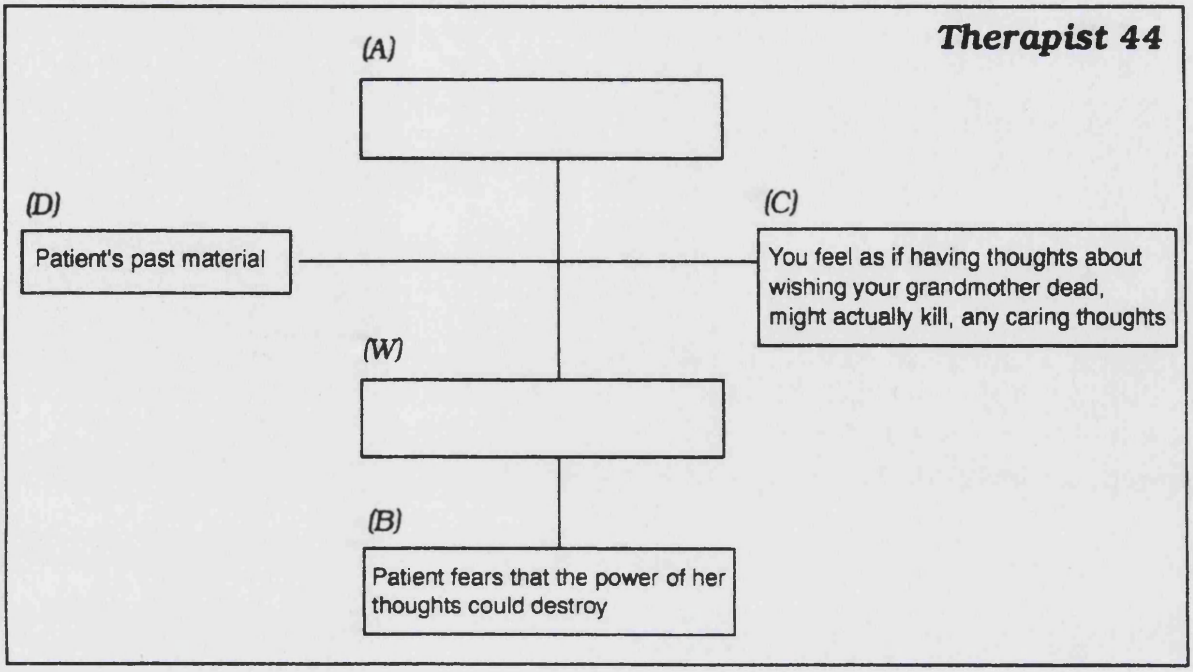


Diagram 44 – Therapist: The Challenge in this instance is that the patient seems to feel that if she has thoughts about wishing her Grandmother dead, then these feelings might also kill off any caring thoughts. The Data for this interpretation is the patient's own material. No Warrant is offered or implied. The Backing is not verbalised, but is implied, that is, the patient fears the power of her thoughts, as if they could destroy.

The therapist is tentatively trying to challenge the omnipotent thinking of the patient.

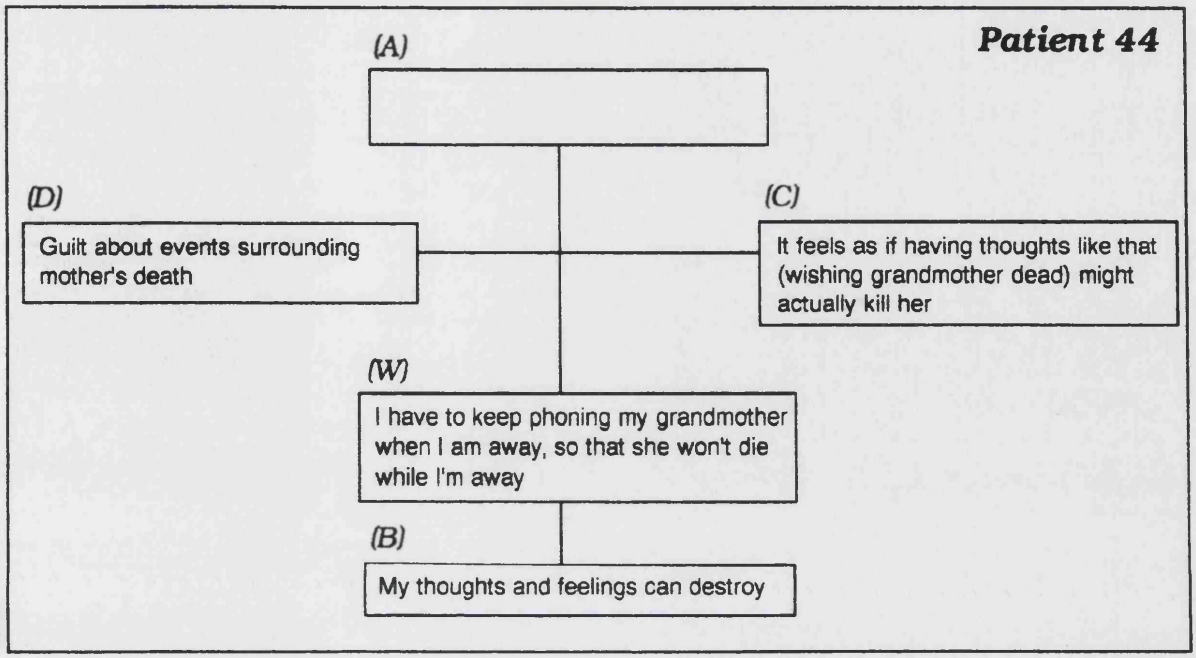
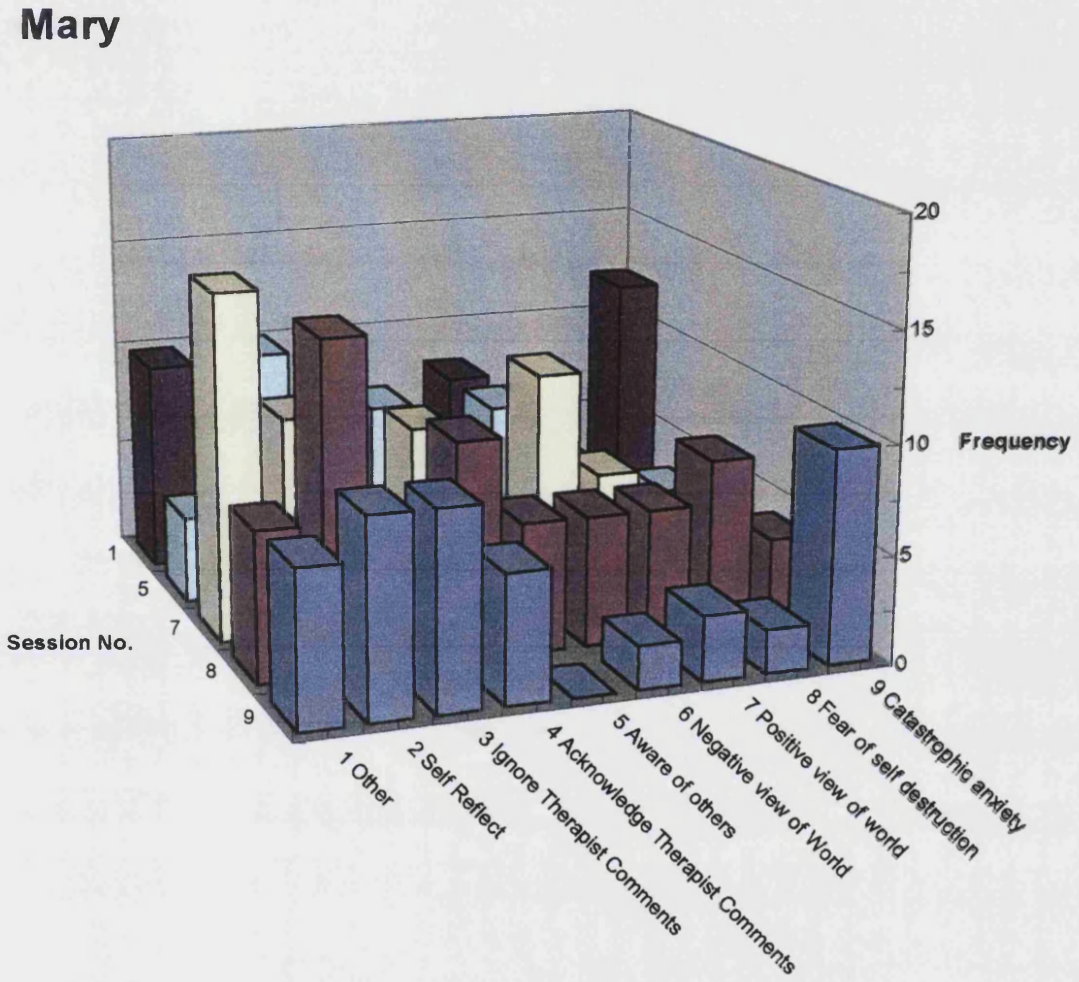


Diagram 44 – Patient: The Claim is that the patient feels that having thoughts like (wishing grandmother dead) might actually kill her grandmother. The Data is the feelings she talks about in relation to her mother's death, guilt in particular. As Warrant she offers the fact that she has to keep phoning her grandmother when she is away. The Backing is partly verbalised in the Claim, that is, that the patient feels her feelings could actually destroy.

Here the patient shows awareness of her feelings, she exposes her vulnerability. However she seems unaware of the omnipotent nature of her beliefs. This is evident in the Claim, Data, Warrant and the Backing.

7.5. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1, 5, 7, 8 and 9 are mapped onto the rotated histogram below



The variables in this histogram are as follows: The first column (1) is a catchall category. The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements. The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative statements. The seventh column (7) shows the number of statements indicating a positive

worldview or positive statements. The eighth column (8) shows the number statements expressing fears of being destructive. The ninth column (9) shows the number of statements referring to catastrophic anxiety.

This patient's statements reflecting a fear of being destructive deceased noticeably. The number of times this patient made reference to catastrophic anxiety decreased during sessions five seven and eight, but increased again in session nine. The patient's capacity to acknowledge the therapist's comments also increased during the middle sessions but decreased again in session nine.

7.6. Independent Psychoanalytic Assessment of Mary (Session 1)

Perhaps the most obvious aspect of the interview was the client's anxiety and her use of obsessional mechanisms to cope with it. Her obsess ional tendencies were evident at the beginning with her emphasis on repetitiveness and also very clear when she spoke of her need to check and her worry about making damaging errors. She had difficulties over decisions, including deciding on a time for her sessions and difficulty in ending the interview.

She is aware that there are destructive elements in her personality although, as she says, she experiences herself as the recipient or the victim of them rather than the initiator. I thought that the references to flooding and burning and harming babies linked to actual early trauma and to her unconscious fantasies of attacks on mother's body. Part of her trauma is the loss of father, which she may, inwardly, feel responsible for, but which actually left her feeling she had to cope with a depressed mother on her own. (Giving some reality to her feelings of being the victim of circumstances). Her anxiety appeared mostly paranoid, giving rise to feelings of being criticised and constant anxiety. She fears cancer - and worries that it was lack of positive feeling in her mother that made her succumb - as well as feeling that her own libidinal impulses are insufficient to overcome her own inner aggression. Her references to not being very good in the mornings are typical descriptions of recurring morning depression.

Comment: The independent assessment of this patient focuses on the nature of this patient's anxiety. She has self-destructive fears and in addition she suffers from

something that could be described as catastrophic anxiety. The paranoid nature of her anxieties is also commented on. There is no reference to the nature of the interaction between the patient and the therapist.

7.7. Summary of Mary

The material of this patient's therapy shows some modest but significant changes. In the beginning of the therapy Mary presents with a number of paralysing anxieties. This is evident in the psychotherapy assessment (see appendix 1), in the pre-therapy interview (see appendix 3) and in the first session. Mary's mother had recently died and perhaps some of her anxieties may be a reaction to this recent death. In the beginning this patient was very defended and openly said that she did not want to discuss for instance her mother's death. The defensiveness decreased over the sessions and her anxiety diminished as can be seen from the rotated histogram. She was able to use her therapy, which is expressed in a lessening of her tendency to ignore or dismiss her therapist's comments.

In the post therapy interview Mary said that she had felt that things had changed for her during therapy. She even made reference to her mother's death and what it had meant to her, unprompted. She also said that she felt the therapy was too short. At the same time she was critical of her therapist.

8. Results: Steven

This chapter introduces the fifth of the subjects. Included in this chapter is a short background to the patient. A subjective/intuitive analysis of selected sections of this patient's therapy sessions was carried out. A detailed argumatics analysis of session one and session fifteen was carried out. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in four selected session from the beginning, the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the presented material is included with reference to before and after interviews conducted with the patient for the purpose of this research. Transcripts of the before and after therapy interviews can be found in appendix 3. Notes on Steven's initial psychotherapy assessment can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of Steven's sessions of psychoanalytic psychotherapy are available on the CD-rom, appendix 5, available from the author on request. Included is also additional material used in Cognitive analytic therapy, such as 'the psychotherapy file', a form of 'mood diary, the therapist's reformulation of the patient's situation, a diagrammatic representation of the patient's dilemma and the therapist's and patient's goodbye letters, these can all be found in appendix 2.

8.1. Steven

Steven was undergoing fifteen sessions of cognitive analytic therapy.

The patient is a police officer in his early fifties at the time of his therapy. His troubles dated back to discovering that his son had had a homosexual relationship with a teacher. There had been a court case against the teacher. However to the Steven's dismay his son testified, in the trial, in defence of the teacher. As a consequence the relationship became tense between father and son, and at the same time Steven was becoming unacceptably aggressive at work. This became so much of a problem that at the time of beginning therapy he had been on 'sick leave ' from work for six months.

Impotence was another one of Steven's problems. After the discovery that his son had had a homosexual affair with the teacher, Steven got involved in an affair with a woman. He was however unable to consummate the affair. His marriage of, 27 years, was distant.

Steven was an only child and he claimed that he had a relatively uneventful childhood. His relationship to his parents appears from Steven's material to have been distant, although he maintained that they were close.

Therapy

When Steven's case was discussed in a supervision group, the hypothesis was put forward was that Steven had difficulties with intimacy between males. It was even suggested that Steven might be a latent homosexual himself. Steven was possibly trying to defend against a realisation of his own homosexual tendencies by attempting an affair. These, probably long standing problems had prevented him from being a loving father to his son. The son in turn had to turn to his teacher for the intimacy and support he yearned. For these reasons it was felt that it was important for Steven to have a male therapist.

The theme most frequently discussed during the actual therapy was Steven's preoccupation with control. He swung from feeling too much in control to losing control altogether and becoming violent. At the beginning of therapy Steven was very preoccupied with his own misery, and with whether he should as a result of this 'illness' retire from the police force. He described several instances when he had felt totally powerless and had then resorted to violence.

The therapist repeatedly pointed to underlying feelings of anxiety. This appeared to enable the patient to think about feelings of inadequacy more openly, such as how he felt about the situation with his son. Steven talked of how betrayed he had felt by the son, who did not value his father's attempts to protect him from having to give evidence for the prosecution.

Steven was able to reflect on how some of the son's behaviour could be understood as a result of Steven's failings as a father. He was in fact expressing deep regret of lost time with his son.

Steven's sexuality was explored, but not in terms of his sexual preferences. Interestingly Steven felt after the therapy that this was one area, which he would have wanted to explore more.

It appears that some progress was made during this therapy, in spite of many issues remaining unclear. Steven decided to retire from the police, and was hoping to have more therapy later. He presented as a sad man after therapy, but was aware of the need to work on his relationships.

8.2.1. Session 1

Subjective/Intuitive analysis

This session took the format of an interview.

The patient started by talking about how he had become short tempered. He had already been signed off sick, from his job as a police man, partly because of this. The patient gave an example of what happens when he loses his temper.

'We were looking for a place to eat and we saw a place where she didn't want to go to and I got angry with her, more frustrated with her than angry, and anyway eventually she went into a MacDonald's which I hate and I was furious and I sort of stood about while she ordered and on the pavement outside were a group of youngsters on motor-cycles and they sort of got in my way and I just took hold of one guy and just pushed him over'.

On being questioned as to when the patient felt his problems had started, he referred to the time when his son was involved in the court case of the schoolteacher.

The relationship is now tense between father and son, with some sporadic correspondence (the son is at this time at university). The patient talked of feeling betrayed, but also of feeling frightened that he might loose his son completely.

'I am sure I've lost him, there's no, no sort of communication there and uh, it's not so much anger it's a sadness about it. And in truth I don't really know how to cope with it, tragic'.

This leads to associations about the patient's own childhood, which the patient describes as uneventful and 'happy'. The only down side seems to have been the long absences of his own father.

The therapist continues the session, with probing questions about the patient's marriage. The patient describes a fairly distant marriage. He says that he feels some anger towards his wife for reasons, which aren't entirely clear. He also says he feels bored with his marriage. When ever the therapist isn't directing the session the patient goes back to talking about how he felt in relation to his son. The patient felt very persecuted about the events; he fears that his son is homosexual etc.

'Well I was angry but not to the point where I was going to do that sort of thing. I just felt betrayed. I didn't, I was at a total loss'.

The patient feels like a victim in the situation. Persecutory anxiety is predominant. There is no evidence of concern, for either his son or his wife at this stage.

As this session is primarily an interview, only a small section will be analysed in detail.

8.2.2. Argumatics analysis of session 1

Therapist: You must have been very angry about that, felt very betrayed.

Patient: The betrayal came later in that I told him that I didn't think that- I told him that I was going to try to avoid him being involved in the situation, that I would do my best to keep him out of what was happening. And I told him that he shouldn't mention this to any of his friends, you know. Anyway I subsequently overheard a telephone call as I came in whilst he was on the phone. I opened the door and I heard him repeating to a friend, I don't know who, what I'd been saying to him. That he was being kept out and so on. That's when I felt betrayed. I felt really betrayed and...I don't know what else he may have told him...but at that stage I felt hurt and betrayed. And I confronted him then, I said I overheard your conversation, you know...what I told you in confidence. ' I don't care, I don't care what you think'. And I had to walk away. I was so upset and angry that I had to walk away.

Therapist: Did you feel the same way that you sometimes feel when you get angry- with the kid on the motor-bike outside the Wimpy bar or something?

Patient: Well I was angry but not to the point that I was going to do that sort of thing. I just felt betrayed. I didn't, I was at a total loss. I really didn't know what to say to him. I didn't know how to cope with him from that point onwards. I just didn't know how to approach the situation at home any longer. It just seemed to me apparent that, at the time anyway, that he had no respect for me at all, ...and that his

loyalty to his friend and the teacher were greater than his loyalty to me. To a point I still feel that is probably the case but I felt it very strongly then and that devastated me.

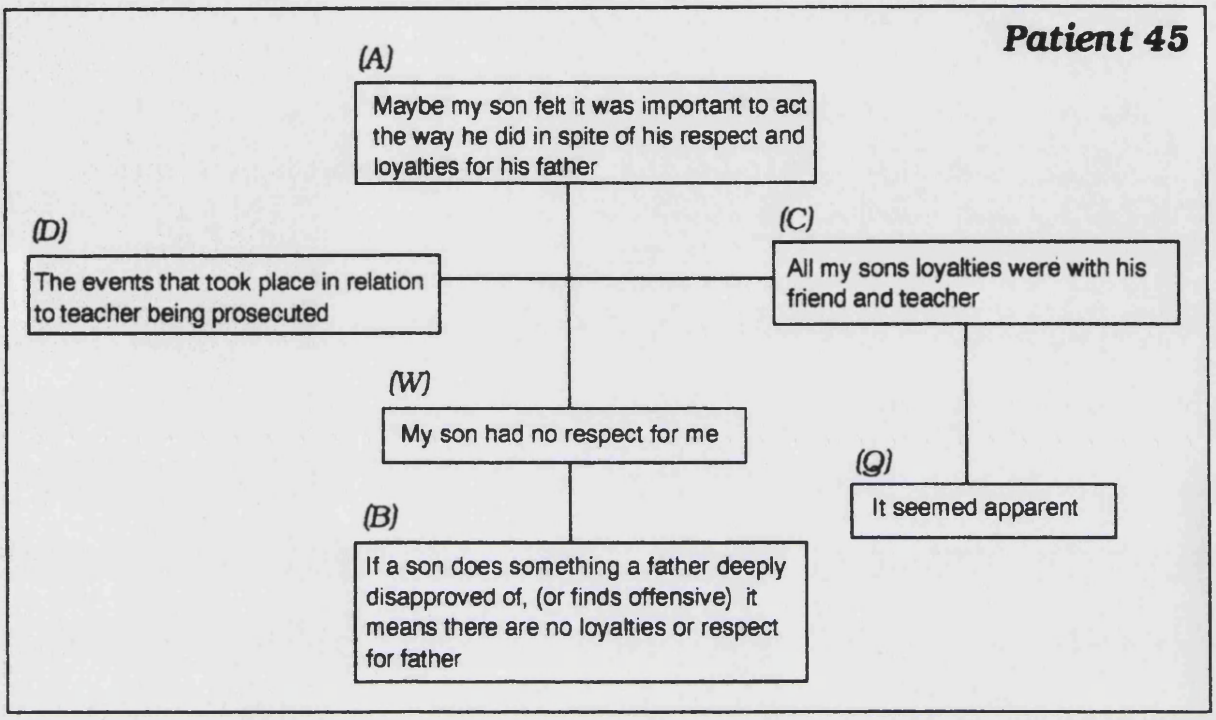


Diagram 45 – Patient: The Claim is that it seemed apparent (Modifier) that all the patient's son's loyalties were with his friend and his teacher. The Data is the events that took place in relation to the teacher being prosecuted. The Warrant is that the patient feels that his son has no respect for him. The Backing is not verbalised but seems to be that if a son does something the father deeply disapproves of or finds offensive, that means there are no loyalties with, or respect for the father. There is an Alternative, which is not considered by the patient, which is ' Maybe the son felt it was important to act the way he did in spite of his respect and loyalties for his father.

The argumentation is one created in order to keep the patient as the victim in the story, in other words he has been wronged in the Claim and the Data. The Alternative is not considered, because were it to be thought of, it might open up uncomfortable questions such as why was it so important for the son to act in the way he did. For instance the teacher must have provided the son with something important, which perhaps the father should have provided. Persecutory anxiety is very evident and is to some extent reinforced by the therapist (his opening comment at the beginning of this vignette). There

appears to be some projection of guilt, it is the son who is not being respectful, although one could argue that the father shows no respect for his son's undoubtedly brave action.

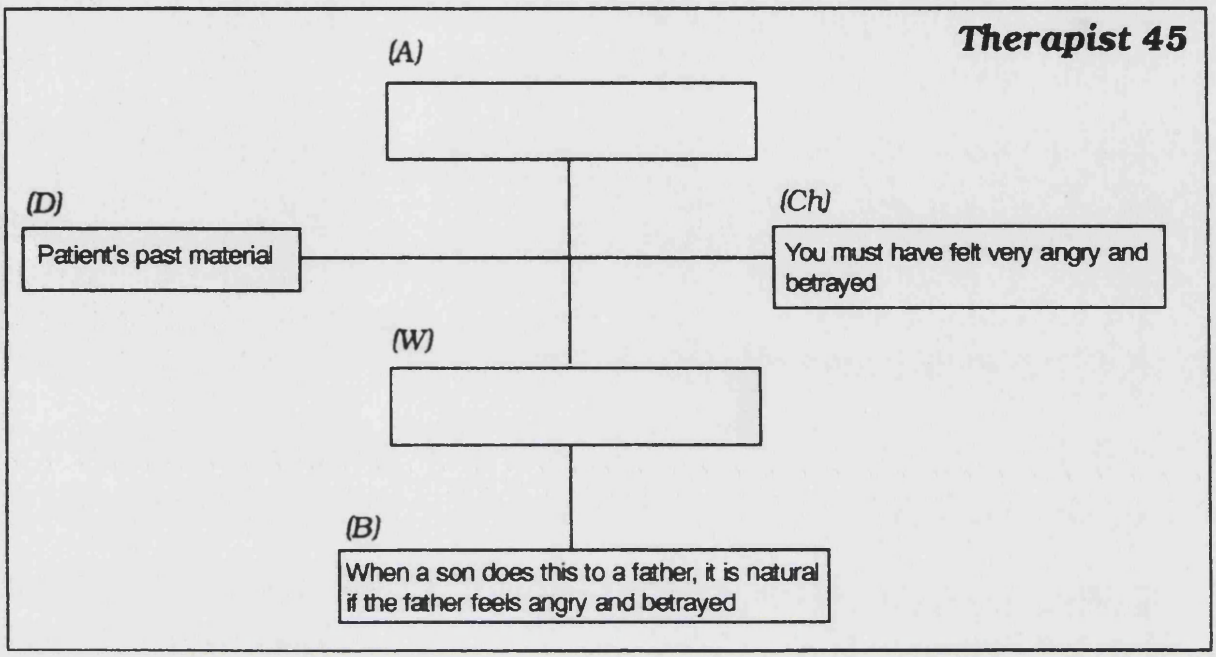


Diagram 45 – Therapist: The Challenge offered is that from what the patient has talked about (Data) it seems he must have felt very angry and betrayed. No Warrant is offered or implied. The Backing is not spelled out, but implied in the Challenge, that is 'if a son does this to a father it is natural that a father feels angry and betrayed.

The Challenge is based on its Backing and acts in a collusive way with the patient's feelings of having been wronged. The therapist encourages no new thinking.

8.3.1. Session 15

Subjective/Intuitive analysis

This was the penultimate session of this treatment. The patient initiates the session by talking about having been on a course, and the experience had according to the patient been one of 'being on the outside'.

'I felt a bit strange really in many ways. But you can see what's happening and you feel right you've got to make the effort to fit in here'.

The therapist enquired if the patient had felt in control on the course. This question takes the patient via his association to thinking about a friend of his. The friend in question has had major health problems; and so has the friend's wife, in addition these problems had

lead to marital tension, for the couple in question. The friend's wife has turned to Steven for support. Steven felt, however, that in the past he could have done something to help his friend but now as a result of the therapy he does not know what the right thing to do is.

'But it seems to me I've lost something of me um, and in a way I feel its part of being here too that had I not come here um I feel that I would have been able to do something more about the situation than I'm now able to do'.

The therapist wonders if that makes him angry. The patient responds to this only indirectly. There after the patient wonders whether it isn't the friend who needs therapy. This seems to suggest the patient is using projection in order to divert his thoughts from his own continuing wish for therapy, as at this point Steven's therapy is about to end. The communication also gives pointers to some of the reasons for the feelings of helplessness, that i, projection of responsibility.

'I could have been more helpful had it not been for the therapy'

In other words the blame for the feelings of helplessness now rests with the therapist.

'I suspect he needs the same sort of help I'm getting in truth.'

More thoughts follow regarding other people having a difficult time. This suggests more projection. The discussion then turns abruptly, initiated by the therapist, to the patient's sex life with his wife. This topic is treated by the patient with some detachment. He is not very interested in his wife sexually. Towards the end of the session the discussion turns toward the therapy and what it had meant. The patient reflects on his behaviour, he expresses his problem in the following manner.

'Yes I can't now...but be in control or not to be in control is not a choice. You're either in control or...if you're out of control in a car with no hands on the steering wheel, no foot on the break going who the hell knows where...So I'm not sure that um,..I can not, not be in control.'

The son is not mentioned at all in this session.

It seems that this session was an attempt by the patient not to address the imminent ending of the therapy. Instead he concentrates on other people in trouble, or in any case in greater trouble than he is. In other words projection is used in order not to have to deal with the feelings, which the ending may have provoked. The feelings relating to the ending may have to some extent been expressed in the beginning of the session, when the patient talked of feeling an outsider on a course he had attended.

The flavour of the session seems to be a denial of neediness and any feelings of sadness about the ending of therapy, suggesting that the defences used in this instance can be understood as the manic defences.

8.3.2. Argumatics analysis of session 15

Patient: There was something else I wanted to talk to you about because in a way it affects me and in a way it doesn't but I came back from that on Friday and I have another friend who is a doctor and he works down in Rye and his wife phoned and spoke to me on Friday as soon as I got back. He about 18 months ago had open heart surgery.... bypasses and so he's retired as a doctor of medicine and ...he's got all sorts of personal problems. And as I said his wife phoned and said that he's had a sort of minor operation on that and is distressed and he was crying a lot and and breaks down at home and has told her that he wants her to leave and get out and go...and um I really thought it was a call for help from her. Um now a year ago I would probably have said come on now you've got responsibilities, you've got commitments, stop sitting around and feeling sorry for your self and start being supportive to your wife. A year ago, I'm not sure I can do that now. You've in a way put doubts to me about whether that's the right thing to do. So I now feel at something of a loss. I really don't know what to do about the situation and I feel, and I don't know I feel quite peculiar about this too in a way that's how I feel about myself and my ability to cope with that sort of situation. Over a year ago I could have handled it, not necessarily well, but could have handled it and I don't feel that I can now and in a way feel that I'm letting her and him down. ..It seems to me I've lost something of me um, and in a way I feel it's part of being here too that had I not come here um, I feel that I would have been able to, have done something moor about the situation than I'm now able to do.

Therapist: Do you feel angry about that?

Patient: It's not necessarily good. It's quite difficult to accept too. I suppose in a way it's something to do with my perception of me I seem to be a lesser person because I can't handle things any more. In the past supporting a friend, now I feel...

Therapist: Why

Patient: Because I just make supportive noises...

Therapist: This feels to me apart from the actual situation, it feels to me it is about the therapy coming to an end.

Patient: Pardon.

Therapist: It feels to me as if it is also about the therapy coming to an end.

Patient: Yes...I think... All I know is there are two friends there that I'd like to be supportive to, I find it very difficult um, and I don't know...I suspect he needs the same sort of help I'm getting in truth.

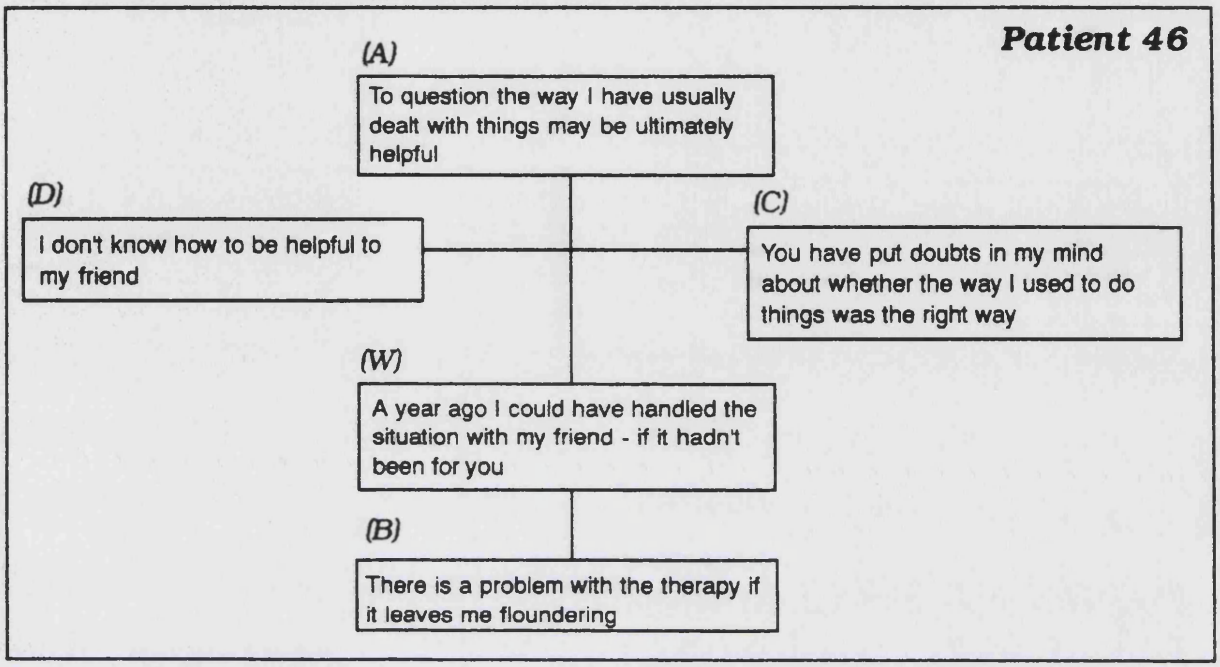


Diagram 46 – Patient: The Claim is that the therapist has put doubts in his mind about whether the way he used to do things was the right way. The Data is that he does not now know how to be helpful to his friend. The Warrant is that a year ago, the patient felt he could have handled the situation with his friend better. The implication is **before therapy**. The Backing is not verbalised, but implied, that there must be some problem with the therapy if it leaves the patient feeling like this. There is an Alternative, which is not considered by the patient, that maybe to question the way the patient has usually dealt with situations like this might ultimately be helpful (lead to better ways of dealing with situations).

There appears to be quite a lot of anger, towards the therapist. This is most obvious if we look at the Backing. It appears that the patient is projecting his power to change things onto the therapist, and at the same time the responsibility. The patient finds himself once again in a helpless position. This is evident from the Claim, Data and Warrant. He presents a situation, where the implication is that in some ways he feels worse now at the ending of therapy. Another way of looking at it is that the patient feels he is not yet ready to stop treatment. Steven's old coping mechanisms have to some extent been dismantled,

but he feels he has not got anything else in their place. This suggests persecutory anxiety. It also suggests that the patient is desperately trying to deny that the ending of therapy might be painful. If the therapy can be seen as unhelpful, there is no issue about it coming to an end'. This constitutes a triumph over the therapist and can be seen as denial as a form of 'the manic defence'.

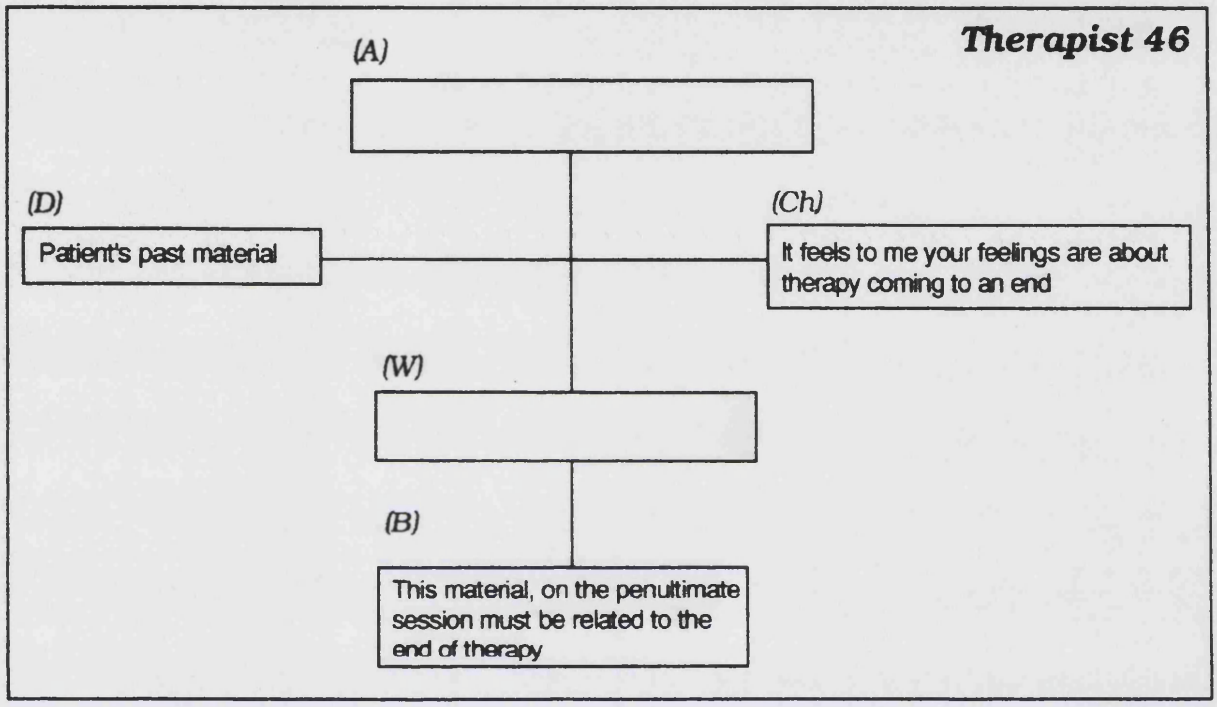


Diagram 46 – Therapist: The Challenge offered is that the therapist feels that what the patient is expressing is related to the therapy coming to an end. The therapist does not point to any particular Data, but the implication is that the patient's material provides the Data. No Warrant is offered. The Backing is not verbalised, but seems to be that this material on the penultimate session must be related to the ending of therapy.

The impression is that the therapist is trying to bring in the issue of the ending of therapy, but is not sure, how to tie it to the material. It could have been more successfully linked to the patient's Backing. This is an interpretation but as it stands it appears rather theoretical.

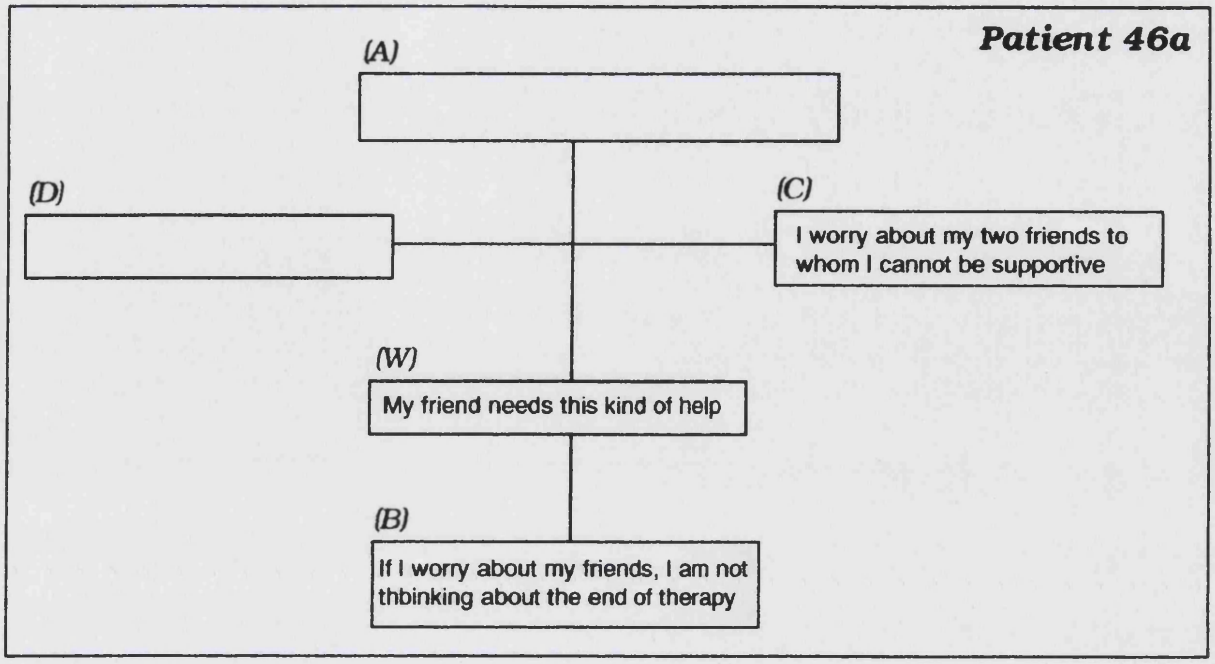


Diagram 46a – Patient: The patient ignores the Challenge. The Counter-Claim is in essence a repetition of the previous Data, that he worries about not being able to be supportive to his two friends. No new Data is produced to back this Claim. The Warrant, which is offered, is that his friend needs this kind of help (therapy). The Backing is not verbalised, but could be,' if I am worrying about my friends, I am not thinking about the ending of therapy'.

In this instance it appears that the patient is hanging on to his story, and ignoring the therapist's intervention. The therapist has to repeat his interpretation twice. The need for therapy is then located in the friend, a projection, see Claim. So there is a denial of the ending of therapy being a problem, and a projection of the need for (further) therapy onto the friend, suggesting a form of 'manic defence'.

Therapist: I wanted to ask you about, has there been any sexual contact with your wife?

Patient: We have hardly any sexual contact but I would say that our relationship was very good. I suppose we both accepted each other now. Yes. I don't mean physically or...but I think we're more comfortable with each other...We don't - it's mainly my problem but um, we haven't had sex for I can't remember how long...and I have to say in truth that I have very little, she has very little sexual attraction for me.

Therapist: You have for her or she has for you?

Patient: I, she hasn't for me. I mean I sort of sit down and, we've been married almost 30 years and there is a good deal of familiarity and...so I don't know, maybe the desire has just died....We've explored most of the sexual avenues if you like...together and there doesn't seem to be anything left. She isn't a very imaginative person sexually and I don't know it's just like there's nothing there. Now that' leads me into a bit of a loss in that I do care about her, she has supported me...she has been very supportive, so I don't know about seeking sex elsewhere. First of all I'm not sure I perform adequately and so maybe there's a feeling of the unknown there too. But the other aspect of it too is that I wouldn't consciously wish to hurt her. So I seem to be in a sexual limbo at the moment, which again is quite worrying. I don't really want to think that my sex life is finished...but again...Yes I would say that aside our relationship is fairly comfortable in general apart from the children and so we don't have many.

Therapist: I think it's important not to sort of lose that. You haven't lost it. It's waiting to be discovered again so that it can take effect. Now it seems to me a week ago it was too threatening to look at, but now trying to look at this, means moving into a situation where there's new strength to control it.

Patient: Well, that would be valid if I could see any strengths there but as I explained earlier on you tell me there are strengths there maybe I'll...

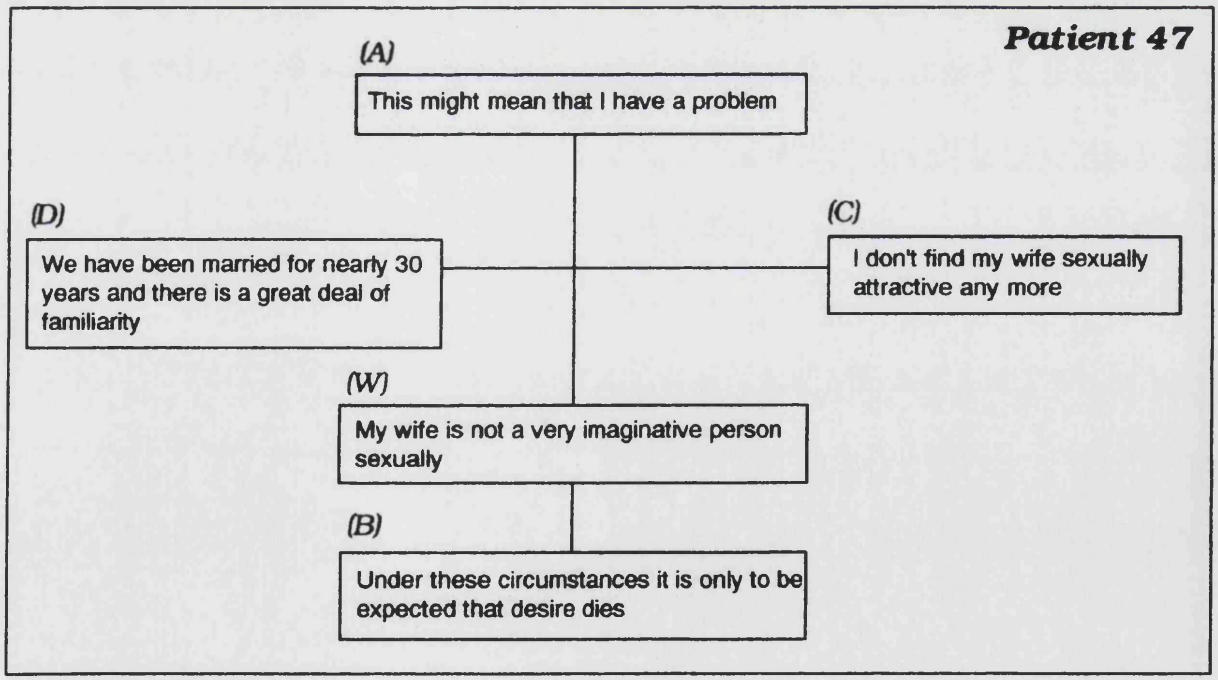


Diagram 47-Patient: The Claim is that the patient does not find his wife sexually attractive any more. As Data is offered the fact that the patient has been married for nearly thirty years and that there is a great deal of familiarity between him and his wife.

The Warrant is that the patient feels his wife is not a very imaginative person, sexually. The Backing is not verbalised, but implied, that under the circumstances outlined (having been married for a long time etc.) it is only to be expected that desire dies. The Alternative is not verbalised or considered but could be that all of this means that the patient is having a sexual problem himself.

This is a communication in response to the therapist's question. It is an admission that there are sexual problems, however they are seen as either a consequence of a long marriage or as the wife's 'fault'. This represents a projection onto the wife of anything that may be wrong, see Warrant.

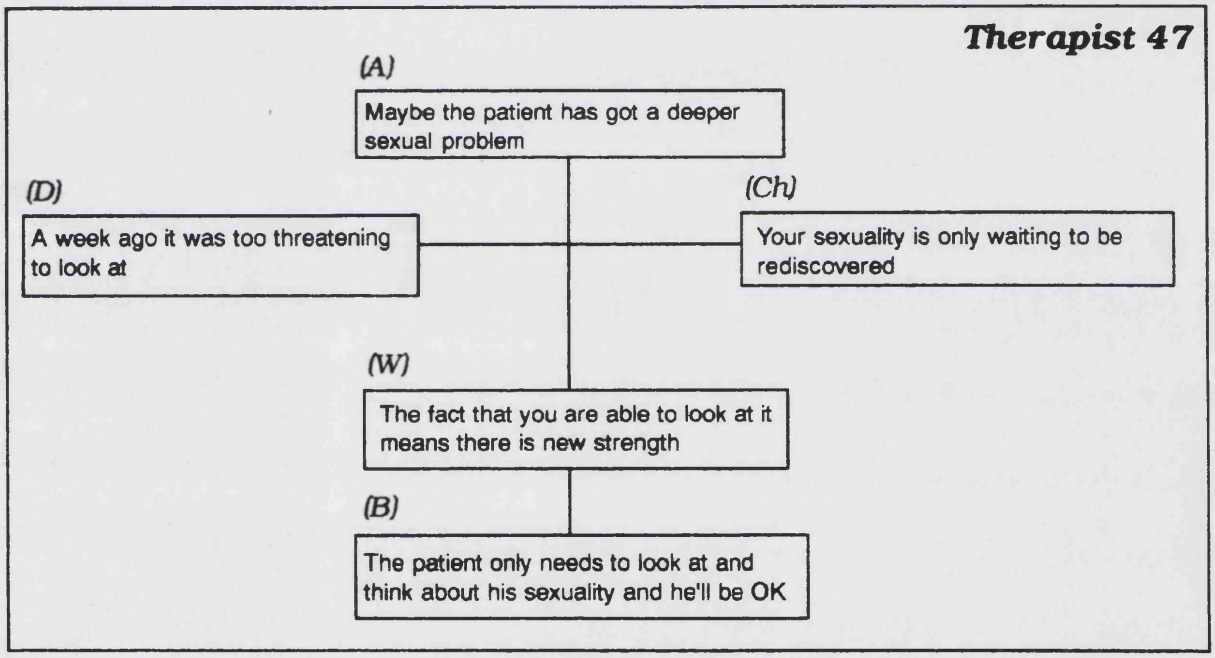
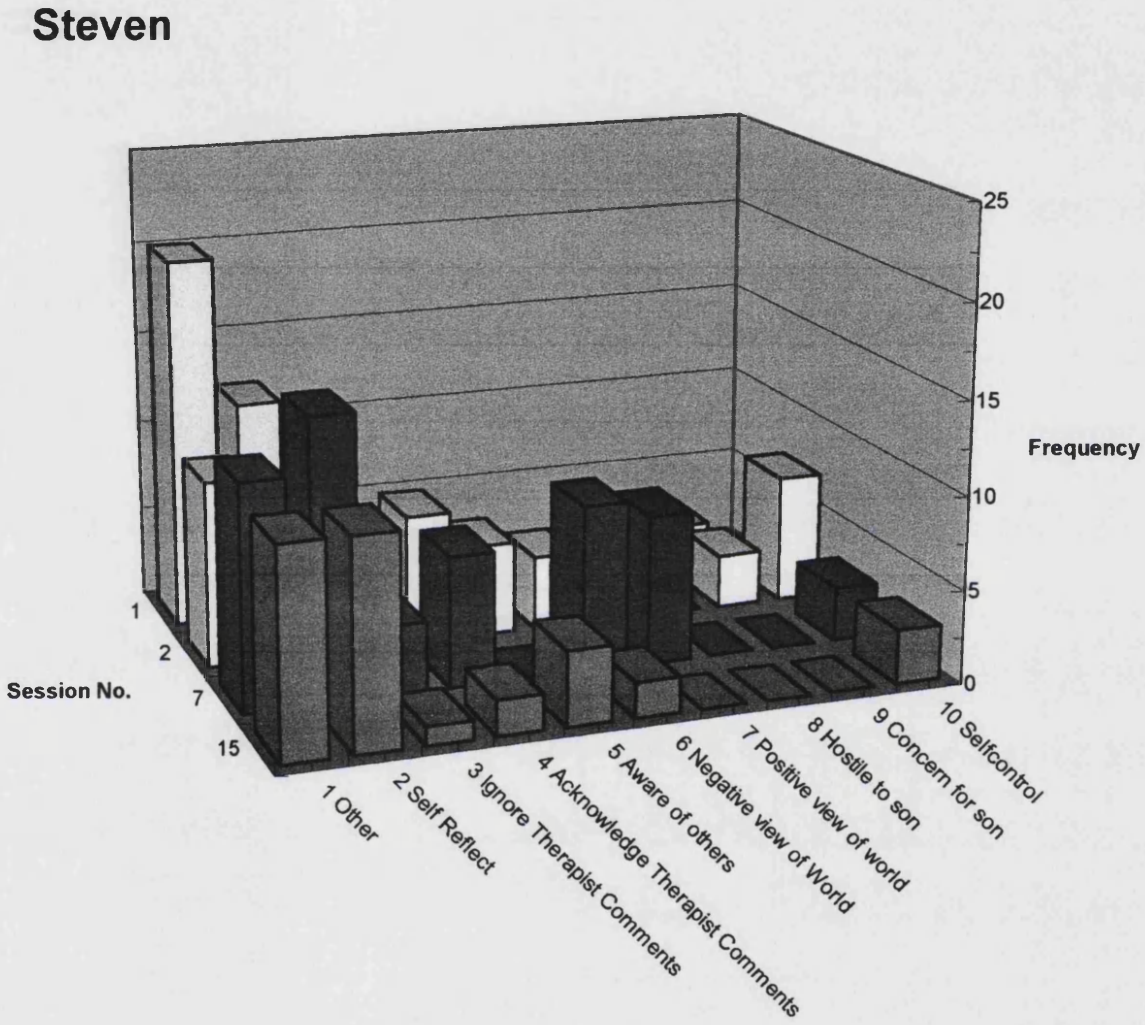


Diagram 47- Therapist: The Challenge is that the patient's sexuality is only waiting to be rediscovered. The Data is not quite clear, but the therapist feels it is significant that only a week ago the patient found his sexuality too threatening to look at in therapy. As Warrant he offers the fact that the patient is now able to look at it, meaning according to the therapist that that there is now new strength. The Backing is not verbalised, but seems to be an assumption that the patient only needs to be able to look at his sexuality, and this will make it OK. The Alternative is not mentioned, that is, possibility that the patient has got deeper sexual problems.

In this section the therapist opens up the issue of the patient's sexuality. It seems the patient reluctantly responds, but is not really looking at his own feelings, instead he rationalises and projects any possible problems onto his wife. The therapist, does not exactly collude, but offers instead something like reassurance, (see Challenge) that this is not a big problem. There is no exploration of the feelings.

8.4. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1, 2, 7, and 15 are mapped onto the rotated histogram below



The variables in this histogram are as follows: The first column (1) is a catchall category. The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements. The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative

statements. The seventh column (7) shows the number of statements indicating a positive worldview or positive statements. The eighth column (8) shows the number of statements expressing hostility towards Steven's son. The ninth column (9) shows the number of statements referring to concern for Steven's son. The tenth column (10) shows the number of statements referring to concerns about self-control.

There were only a few noticeable changes in Steven's preoccupations. Both hostile references and also statements expressing concern for the son disappeared by the end of therapy. Statements indicating anxiety about self-control decreased.

8.5. Independent Psychoanalytic Assessment of Steven (Session 1)

The feelings he conveys in this session are frustration, anger, violent wishes and suspicion. These feelings combined with his homosexual anxiety, seemed to me to make for a paranoid atmosphere. He seems to believe he is not at risk, although it is hard to think from reading the interview that he is not; he does appear to fear losing his job.

The interviewer keeps his own feelings and those in the interaction quite reasonable, which is both understandable, and which the client himself is able to co-operate with. Should the relationship in the room intensify, I suspect that the feelings of reasonableness, would inevitably collapse, and give way to paranoid, perhaps even dangerous elements.

One key point of the session is conveyed in what Steven quotes as having said to Dr P. I'm not hurt, I'm in a mess". One question might be; could Steven tolerate a relationship in which the task was to understand the sort of mess he is in. He shows in his descriptions of incidents in which he has used violence, that his violent feelings are internal. As things stand, he seems potentially dangerous, because he uses external pretexts to produce an opportunity to channel his violent impulses.

Comment: The independent assessment focuses on the frightening anxieties expressed by Steven. He fears losing control of himself. He fears the nature of his feelings. There is some reference to the fact that the therapist is not in this session challenging Steven to think about his feelings more deeply.

8.6. Summary of Steven

Steven has entered therapy as a result of being overwhelmed by feelings of anger and frustration. The trigger for these feelings is described in his psychotherapy assessment (see appendix 1) as connected to discovering that his son had had a homosexual relationship with his teacher. In the pre-therapy interview (see appendix 3) there was very little reference to his son, but several references to physical violence.

The therapy focused on trying to make Steven feel better about himself. References to Steven's son, either hostile or caring ones disappeared towards the end of the therapy. It is not clear if Steven just decided not to think about his son or if he felt better about him. Also references to violence or fear of violence decreased.

In the post-therapy interview Steven said that he felt 'more relaxed', but felt that he did not think the relationship with his son had changed.

9. Results: Carol

This chapter introduces the sixth of the subjects. Included in this chapter is a short background to the patient. A subjective/intuitive analysis of selected sections of this patient's therapy sessions and a detailed argumatics analysis of session one was carried out. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain authenticity of the therapy process. Included also is a rotated histogram showing changes in the patient's preoccupations as expressed in four selected session from the beginning and the middle of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the presented material is included with reference to the pre-therapy interview conducted with the patient for the purpose of this research. Carol was not available for a post-therapy interview. A transcripts of the before therapy interview can be found in appendix 3. Notes on Carol's initial psychotherapy assessment can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of Carol's sessions of psychoanalytic psychotherapy are available on the CD-rom, appendix 5, available from the author on request. Included is also additional material used in Cognitive analytic therapy, in Carol's case the therapist's reformulation of Carol's situation.

9.1. Carol

This patient was undergoing cognitive analytic therapy. Only one session, the first one was analysed in detail as this showed this patient's typical functioning.

Carol is a woman in her mid-thirties at the time of the therapy. She grew up in an ambitious Jewish family. Her parents were ambitious, both in their own professional lives and for their children. Carol was no more than averagely successful at school. She reported that she had suffered from low self-confidence for as long as she could remember. At fifteen she had developed anorexia nervosa.

The distress, which Carol had displayed when she was younger was according to her largely ignored by her parents. She never received any professional help for her eating

disorder. Her mother felt she needed to eat more sweets and chocolate, and bought these for her frequently.

In spite of her difficulties, Carol did eventually qualify as a solicitor. She did a law degree at a Polytechnic university, and her articles at her father's law firm. She had at the time of therapy only practised as a solicitor for six weeks.

Carol married a Dutch man in her mid- twenties, with difficulties of his own. Her husband had also suffered from low self-esteem. He was a chef by training, but worked infrequently and drank too much. The couple have three children. The first child was born with severe mental and physical handicaps. Carol claimed that the handicaps were caused by medical negligence during the birth.

The marriage had been rocky from the beginning. The birth of the children added to the stress in the marriage. Carol and her husband had tried to live in Holland but Carol felt too unhappy there and returned, initially without her husband, with two of her children. Her husband had recently joined them in England. Carol tried initially to care for her handicapped daughter herself, but when the other two children were born, she found it too difficult. The handicapped child is cared for in an institution in Holland.

Carol appeared fairly immature and very dependent on her parent's approval. She was in particular dependent on her mother's opinion. At the same time she was very angry with her mother about how she felt her mother had treated her in her childhood. She has had a couple of attempts at therapy before for post- natal depression after the birth of her third child. This time her GP had suggested further psychotherapy, because Carol suffered from strong guilt feelings about having left her first child in an institution in Holland.

Therapy

The patient clearly appreciated the opportunity to talk about herself. She frequently mentioned that she felt she needed much encouragement, which the therapist often provided. The sessions were dominated by persecutory guilt, she felt guilty about almost everything. In fact she gave the impression that she took on inappropriate guilt, to such a

degree that it could not really be thought about. At the beginning of therapy, she started her first job since the birth of her children. This job, a clerical job caused her much anxiety, and further guilt, as she had to leave her children in the care of someone else. Carol continued to have an eating disorder, she was now overweight and binge ate. Carol felt that this arose as a result of her mother's attempt to 'cure' her anorexia with sweets.

The eating problems were interpreted as the patient's attempts to fill the gap caused by feeling that she was an unloved child. In the supervision group it was also felt that the Carol had developed a fear of success. To fail was seen as her way of asserting herself in relation to her parents. At the same time Carol had a great need to please her parents.

The therapist tried to get the patient to explore the nature of her anger towards her parents. It was felt that Carol's tendency to shout at her children was a displacement of this anger. The issue of Carol's poor emotional separation from her parents became the focus of the therapy. Issues relating to Carol's feelings about her children and in particular her feelings about her handicapped daughter were explored less.

The therapy consisted mainly of the therapist trying to provide emotional support and encouragement. Very little challenging of defences took place. The interaction between the patient and therapist had a curious quality, namely that the patient and the therapist followed a different agenda. The patient tended to ignore the therapist's intervention and in a parallel fashion the therapist discussed the patient's dilemma from a rather 'theoretical' standpoint. Little seeking of new meaning of the patient's actual presented material took place.

9.2.1. Session 1

Subjective/Intuitive analysis

The session was introduced by the therapist enquiring about the patient's week. The patient gives a description of how she has felt in her new job

'I was sometimes feeling that I was doing reasonably well and at other times feeling very stupid and inadequate when they asked just simple things which I found difficult...and not quite knowing what was expected of me'.

This vignette gives a flavour of the kind of feelings preoccupying the patient a lot of the time. The persecutory nature of the feelings is already present in this section. The discussion continues with thoughts about her children, and how bad she feels, as she has to leave them in the care of an au-pair. This in turn leads to associations about her mother.

'But I still because of my childhood when I feel that I was terribly neglected because my mother found work very important and stimulating, and I think that's why if I start to enjoy my work I feel guilty...'

The guilt is dealt with by a projection onto the mother. However this leaves the patient with a dilemma, she must not enjoy her work, because she feels the projection might return and she will feel that she is like her own mother a 'bad mother'. Carol relates a recent row with her mother about Carol's daughter's reading difficulties, as follows.

'...my mother had been doing something with her and she turned around to me afterwards and she said Joanna has got a reading problem. And I got very angry with her that she wasn't to put her down in any way and that she wasn't to do to her what she dared to try to do to me'.

It seems the patient is angry about what she feels her mother did to her, and less about what was happening to her daughter.

The session continues with Carol describing several bitter memories from her childhood, when Carol had felt she was badly treated by her mother. Carol does however recognise that she feels very dependent on her mother at the same time. She feels that she cannot make any decisions without discussing it first with her mother. She admits that this tendency has caused friction in her marriage. This angle is not, however, explored further. To explore it further would lead the discussion towards Carol's contribution to her difficulties, therefore it isn't surprising that she returns to her anger with mother. The session continues in the same way throughout.

The direction of the session was largely determined by the patient, at the same time the therapist did encourage this type of thinking. The patient was displaying persecutory anxiety, all feelings were experienced in a persecutory way. Somebody needed to be blamed all the time, sometimes the patient herself, although she could not tolerate these feelings for long. The blame was quickly projected onto the mother. In essence a situation

was created where things could not be thought about. For instance it was not possible to think about whether her children were really suffering, and if so how might Carol be able to alleviate the children's difficulties.

9.2.2. Argumatics analysis of session 1

Patient:....I just kept making so many mistakes and felt so bad that I just quit and sort of run away and I think that's quite a common thing in me, that if I can't cope with the situation I just up and run.

Therapist: Mmm... so you feel very anxious-

Patient: Yes.

Therapist : You have to cope with, with the anxiety which will immobilise the action and one tends to feel it is a bit like an exam, and examinations, you might have studied very well then sitting to answer all these questions and then fail to understand what the question means eh...?

Patient: It also um is quite a lot of adjustment for me at this time because of going out to work er... I have mixed feelings about working. I want to work and I enjoy being busy in work but I feel guilty because I feel this week that I haven't been able to give enough time and attention to my children and I feel torn between the two. I haven't really seen my little girls at all. I think that they are coping quite well with it. They don't seem to be at all miserable. The middle one is a bit...and she's tending not to go to sleep very well during the week. She's been sort of staying up or getting out of bed until about nine a clock and wanting to talk to me to make sure that I'm there and I'm still with her, which I understand. And the young one just seems to be OK, she takes most things in her stride.

Therapist: Mmm...

Patient: And er... I think that we made quite a good decision. It's quite difficult because my husband being a chef he goes out to work about half past three in the afternoon so there was a period of time between three- thirty and getting home from work when there was nobody to look after the children and from financial necessity I had to work full time so I tried earlier on to have childminders and it hadn't worked out at all well and I felt the children suffered as a result. So when my husband came over at the beginning of September to...he suggested that we got an au-pair and I was a little bit nervous because I had a lot of experience of au-pairs in my childhood and they weren't always good ones and they tend to be coming and going. But I decided we would try it but we would have somebody who would be there just to look after the children we, not to do housework or anything like that, or very little. And we got a girl and all I really asked her to do is to look after the children and I think she's doing really well. She's very kind with the children and I think that at the moment this situation is going to work out well. But I still because of my childhood when I

feel that um I was terribly neglected because my mother found work very important and stimulating and I think that's why if I start to enjoy my work I feel guilty.

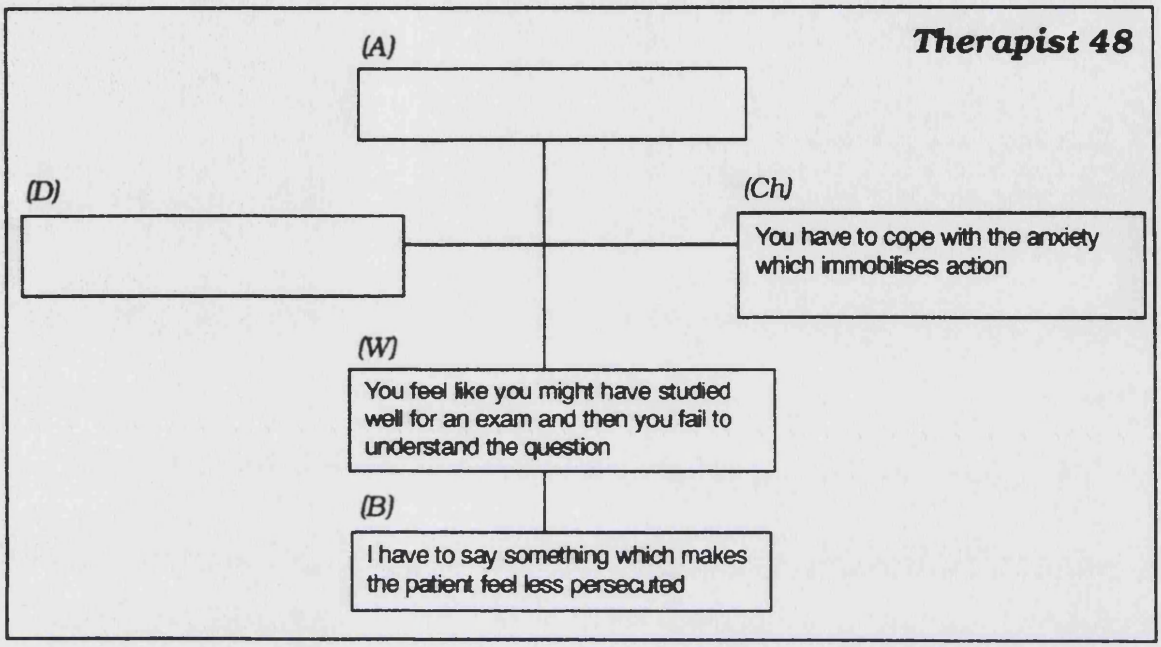


Diagram 48 – Therapist: The Challenge is that the therapist feels the patient has to cope with anxiety, which immobilises action. It is not clear on what Data the therapist bases this Challenge on, which in any case is less of a challenge and more of an attempt to name something the patient is trying to talk about. The Warrant is in the form of an analogy, 'You feel like you might have studied well for an exam and then you fail to understand the question'. The Backing is not verbalised, but seems to be a belief that the therapist has to do something to alleviate the patient's feelings of persecution.

It seems that the therapist responds to her own anxiety. It seems too unbearable for her to dispassionately listen to the patient's story, this seems evident from the Challenge and the Warrant. The therapist appears to be involved in a kind of 'reframing' of the patient's situation. It seems that the therapist has a need at this point in time to be seen to be a 'good therapist' and she says what she believes the patient will find soothing. She may act in this way possibly as a result of the pressure she experiences from the patient. The therapist is acting out, amplifying the patient's feelings of helplessness.

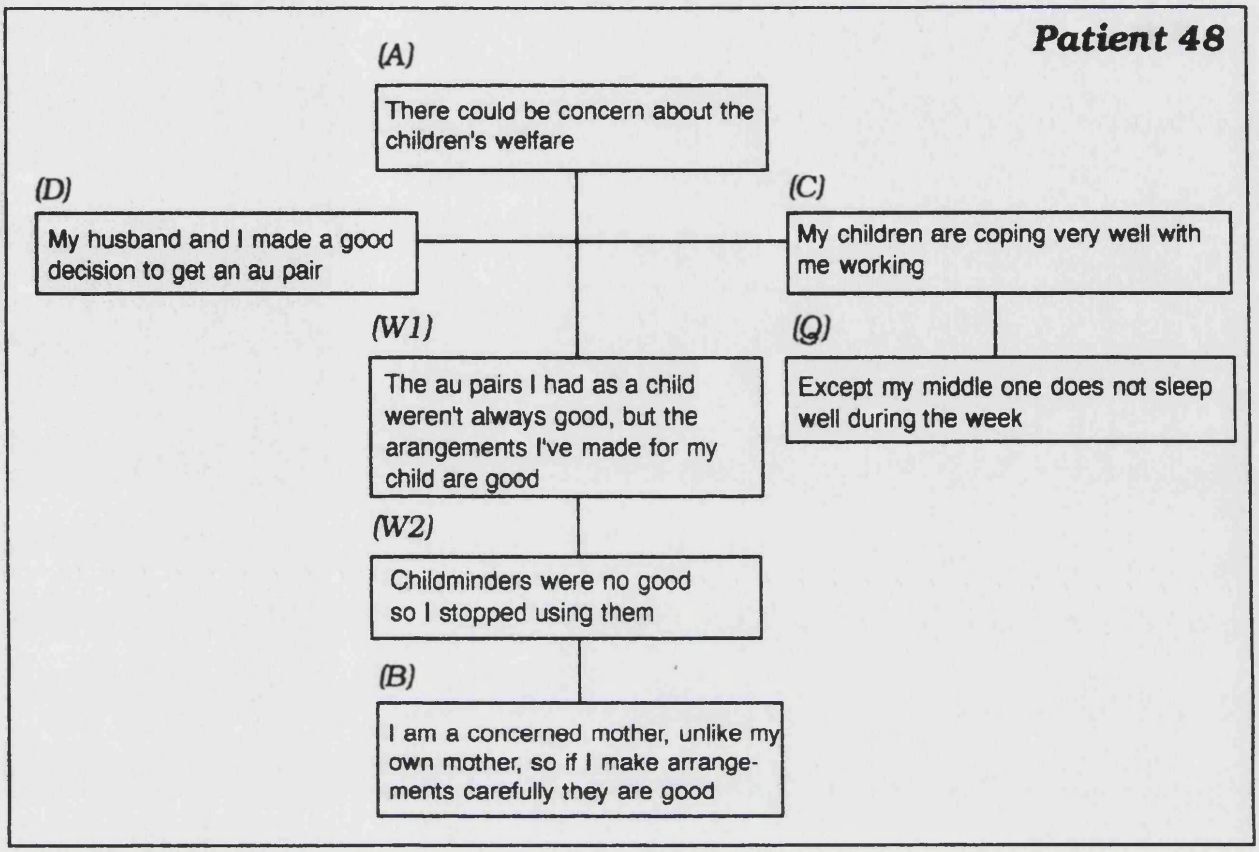


Diagram 48 – Patient: The Claim is that the patient feels that although she is working her children are coping well. A Qualifier is added, that this is true with the exception of her middle child who does not sleep well during the week (when she works). The Data for this Claim is that, this is the case because she and her husband had made a good decision in getting an au- pair. The Warrant curiously is that the au-pairs she had as a child weren't always good but in contrast the arrangements she has made for her own children are good. A further Warrant is offered, which is that she had also tried childminders but found them no good so she stopped using them. The Backing is not verbalised, but is implied, that is, the patient is a concerned mother. If she makes careful arrangements they are good, unlike her own mother (who made bad arrangements). The Alternative that there could be real concern about the children's well fare is not mentioned.

The patient is, in a rather contradictory manner trying to argue that she is a good mother, and importantly, better that her own mother. The uncertainty is obvious from the Qualifier, the Warrants and from the fact that the Alternative is not mentioned. This

could be seen as part of the process of convincing the therapist of her position, and that she does not willingly want to consider another position. This is a denial of anxiety and projection of the notion of ' the bad mother' onto her mother (see Claim and Warrant).

Patient: ...my mother was very critical and I said to her, 'Why is it that you can't say look, you've done well or you've managed this well?' She said, 'I don't need to say that to you. It's not necessary. And I thought that was very unkind of her.

Therapist: Mmm.... Yes because it seemed you have learned a lot of skills. But you needed to when you were growing up to have this reassurance, because I think that when a child does something you know children of two or three, they do something entirely wrong 'Look Mummy what I have done' and mother is a mirror I feel, in a way and er... it's very, this rapport is very important.

Patient: Well I had a, an argument with my mother recently. Um my little girl who's the middle one, she's six, going on seven and she...is learning to read at school, in fact she's been learning for about a year because we were living in Holland before and they don't start reading so early as they do here.

Therapist: Yes.

Patient: And so she was, I don't think you can say behind but she started later than other children so she's perhaps not quite as advanced as some of them are and er... I've been doing reading with her. Every evening I tend to try and read a book with her and I think she has come along reasonably well and I spoke to her teacher regularly in... last year and um just a few weeks ago, half-term I spoke to her teacher about it and she said that Joanna was doing reasonably well that she could read but she didn't always concentrate very hard and um then we were at my mother's, staying overnight and my mother had been doing something with her and she turned round to me afterwards and she said that ER... Joanna has got a reading problem. And I got very, very angry with her about that and I told her that she wasn't to put her down in any way and that she wasn't to do to her what she dared to try to do to me and um we really had a really bad row about it. Um I was trying, whatever she does I try to, to make the most of whatever she is doing with Joanna-

Therapist: Yes

Patient: I know that she is doing well, I've tried to monitor her progress properly with the teacher, which is the best I can do. And ER..... she said she was... she was in need of some kind of help because she was behind in her reading and that she... needed some special tuition, and I just got so mad because that is so typical, that she feels you're underachieving or that there is something wrong. She did that a lot to us as children. We never, academic achievement was very important to my parent's for their own reasons. I think partly because of their being Jewish, that was very important to them, Jewish people, to do as well as possible. And secondly because my mother when she was at school um was very bright but because of various circumstances wasn't able to go as far as she wanted to. To go to university and that

sort of things and she's always felt um that she missed out on that and so she pushed my sister and I extra hard to make sure that we were able to get the things that she herself hadn't been able to have, really that we were going to achieve what she hadn't been able to achieve herself or what she wanted for us, anyway.

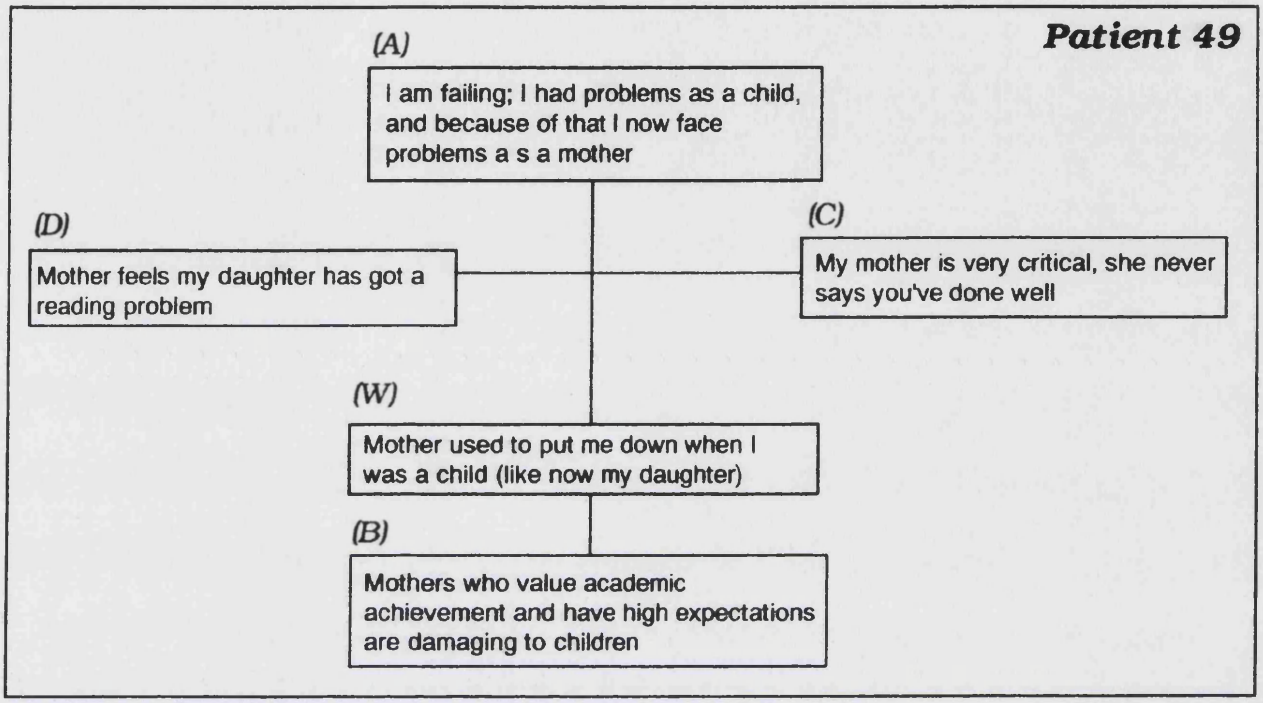


Diagram 49 – Patient: The Claim is that the patient feels that her mother is very critical. She never says anything like 'well done'. The Data is that the patient's mother feels that the patient's daughter has got a reading problem. The Warrant is that the patient feels that her mother used to always put her down, like she now feels that she is doing to the patient's daughter. The Backing is not verbalised, but is implied, that someone who values academic achievements and has high expectations is damaging to children. The Alternative idea that she now faces problems as a mother and that these might be related to her problems in the past, is not explored.

The patient is constructing an argument, trying to convince her therapist that her mother was a 'bad' mother and now a 'bad' grandmother. This is a projection of the idea of 'bad mother' onto her own mother (see Claim and Warrant).

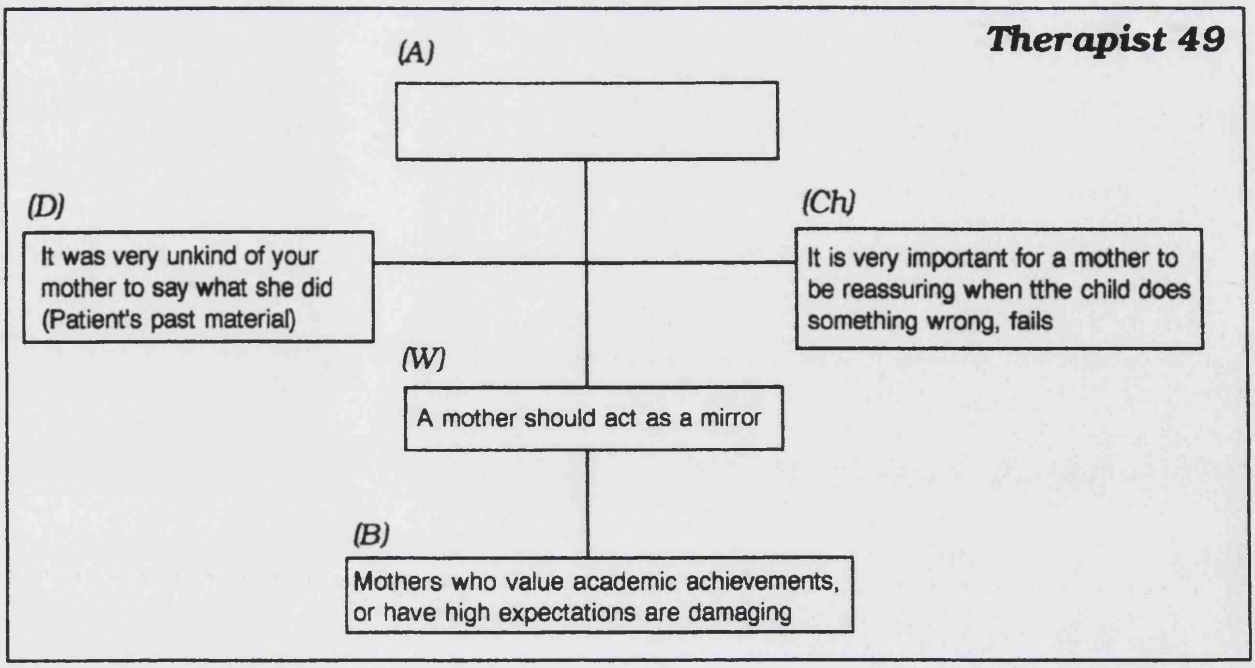


Diagram 49 - Therapist: The Challenge is that the therapist feels that it is very important for a mother to be reassuring when the child does something wrong. The Data is referring back to the patient's communication, but is essentially an agreement that what the patient's mother had done was unkind (i.e. suggesting that the child might have a reading problem). The Warrant is a statement that the mother should act as a mirror. The Backing is more or less the same as the patient's, that is, mother's who value academic achievement or have high expectations are damaging.

The therapist is colluding with the patient. It is not clear where the Warrant fits in, in this context. However it seems that the therapist is attempting a kind of mirroring. There is no real Challenge or encouragement to explore in this communication. It appears that the therapist is being put under some pressure, perhaps as a result of fear of aggression from the patient, or the therapist wants to avoid being experienced as a 'bad' therapist. This would constitute a repetition in the transference of the issue of 'the bad mother'. It might have been more helpful for the patient to be given an opportunity to explore what having a 'bad mother/therapist' might be about.

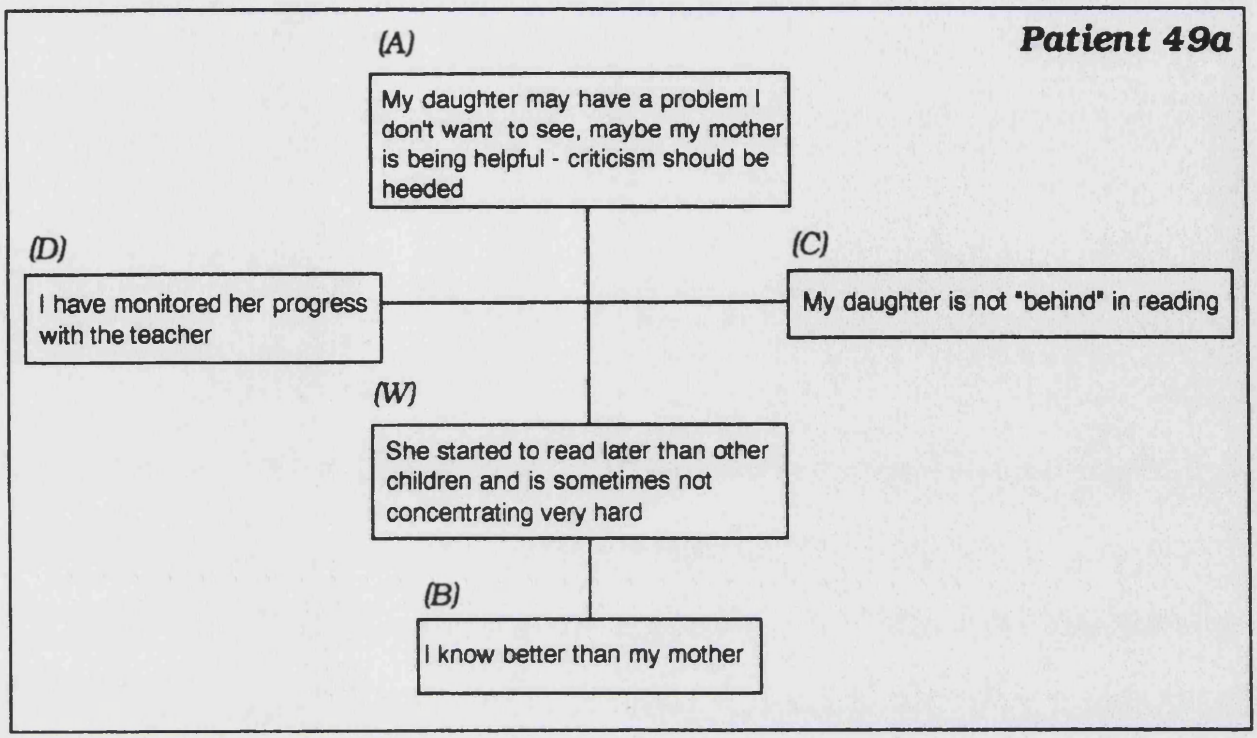


Diagram 49a – Patient: The Claim is that the patient feels that her daughter is not behind in reading. The Data is that the patient has together with the daughter's teacher monitored the child's progress. The Warrant is that (it may seem as though she is behind because), she started to read later that the other children, and she is not concentrating very hard. The Backing is not verbalised, but implied, that is, she the patient knows better than her mother. The Alternative, which is not considered, is that maybe the daughter is actually having a problem, which the patient does not want to recognise, and maybe her mother is actually being helpful.

This is a curious communication, as it is not really addressed to the therapist, it is more a dialogue with her mother, encouraged by the therapist's collusion. It is not surprising that the Alternative is not considered. The defensive process is deeply splitting, the mother is seen as all bad, and the patient is the concerned mother. The bad feelings are projected onto the mother. This can be deduced from the Claim, Data, Backing and from the context. The therapist is in this instance strengthening the defences.

Patient:.... From eating far too little then I just started stuffing myself and thought what a nice idea it was. I think it was Christmas time, I'm pretty sure it was, and she bought me some of these Christmas, a Christmas pack and I started just to guzzle that and I, that idea still gives me, I still enjoy that.

Therapist: So your parents and your mother especially, she has great power. It seems like you have no will of your own. If she, with father you slim and you become anorexic and with mother you started to want to treat yourself. She buys you sweets and starts you on and carry on bingeing after or whatever. It's very extreme, it's like everything they say or they do has a very extreme effect on you.

Patient: Mmm...

Therapist: What about you, do you affect a lot of people in your family. Are you a powerful person.

Patient: I don't think so, I don't think so. I think I grew up with this feeling that I was not a very nice person from very small. When I was at school I found it very difficult to make friends. I can remember in school reports when they were saying... it said that I found it very difficult and I was a very unpopular child. And um I think that has continued all through my life. I feel that people don't like me, that I've said the wrong thing and that's put people off, that there is something lacking in my personality which puts, which makes it so that people don't want to have contact with me. The people that I feel most comfortable with are my children because I know we've got a good relationship.

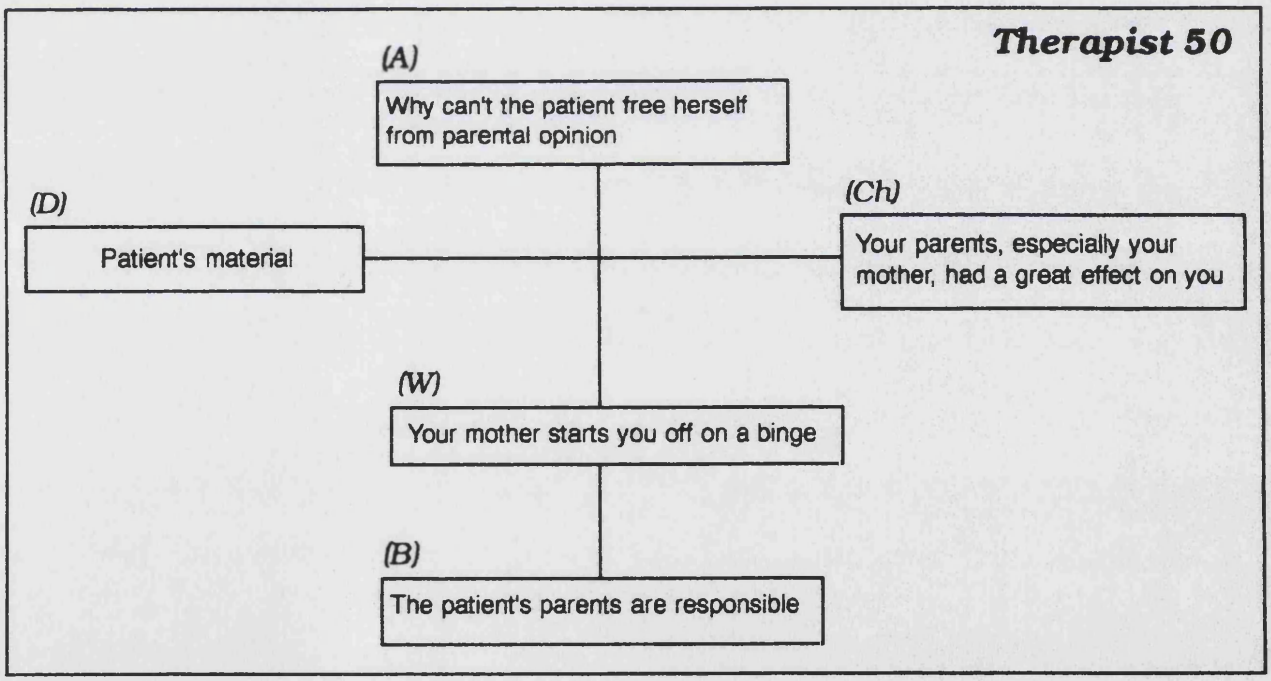


Diagram 50 - Therapist: The Challenge is, ' your parents, especially your mother, had a great effect on you'. The Data is the patient's presented material. The Warrant is that it was the patient's mother who started her off on a binge. The Backing is not verbalised, but appears to be that the patient's parents are responsible for the patient's difficulties.

The Alternative is that, the issue is now that the patient cannot now free herself from, her parent's opinion.

The therapist is colluding with the patient that the responsibility rests with the patient's parents and not with her. The therapist is strengthening the patient's tendency to use projection to maintain splitting. This is evident from the Challenge, Data, Warrant and Backing.

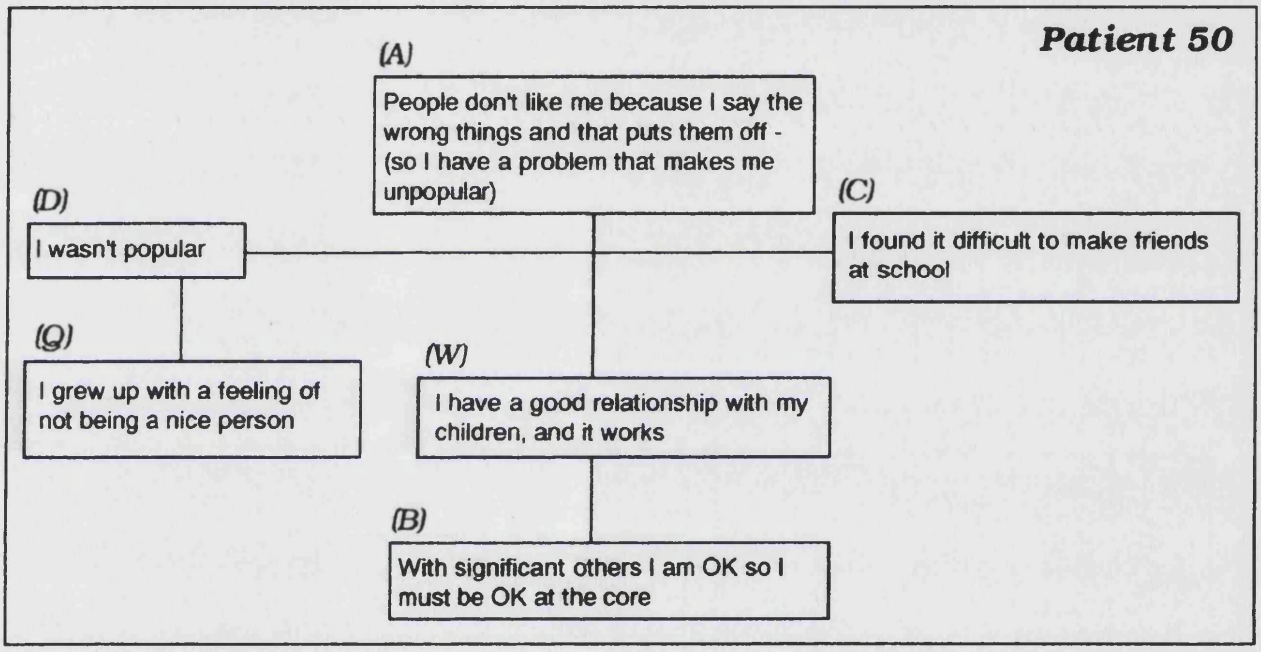


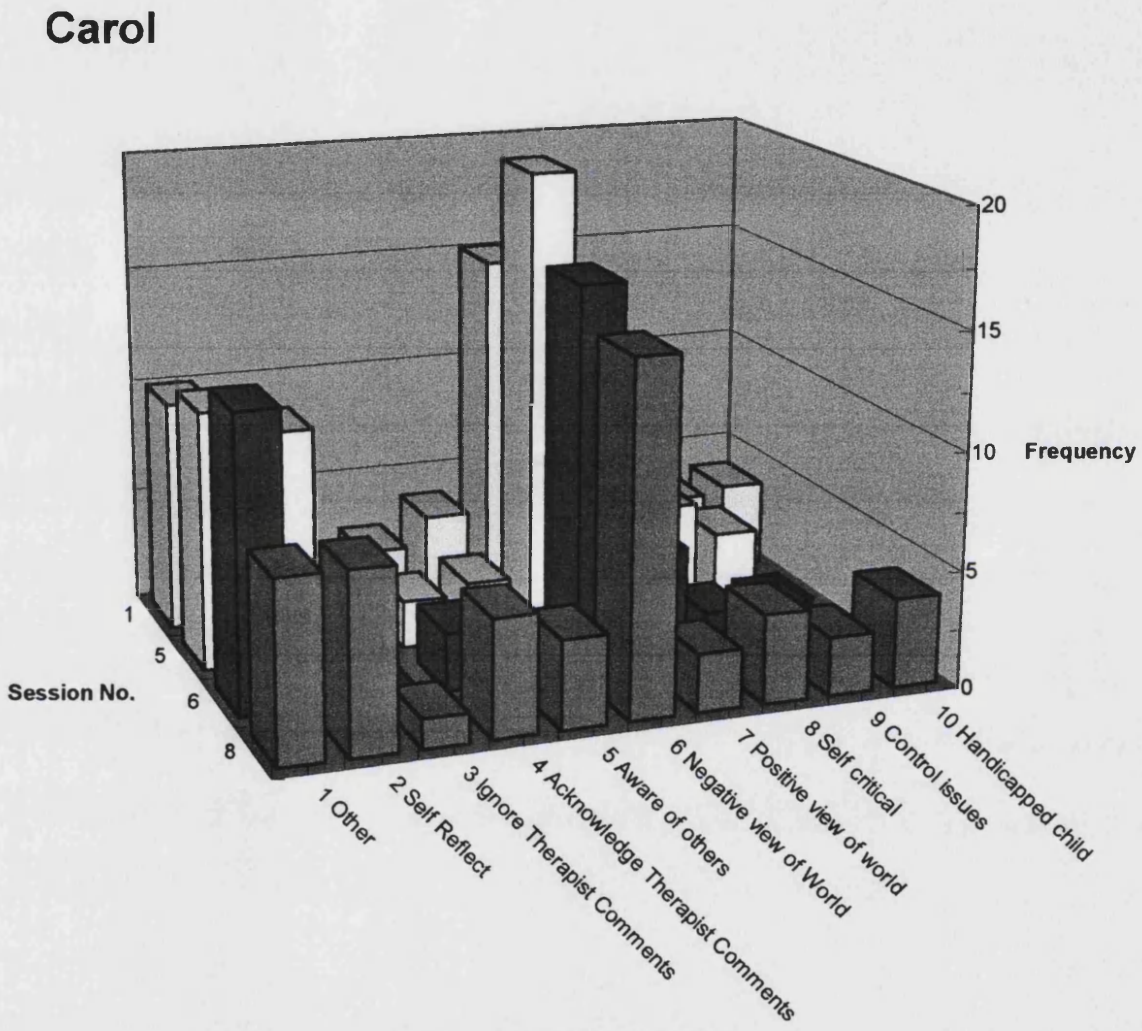
Diagram 50 – Patient: In response to the therapist's question of whether she felt she was a powerful person, the Claim is that the patient found it difficult to make friends at school. The Data is that she wasn't popular, with a Qualifier I grew up with a feeling that I wasn't a nice person. The Warrant is that she does feel that she has got a good relationship with her children. The Backing seems to be that in spite of her feelings about herself she must be OK at the core as with significant others she is OK. An Alternative is beginning to be verbalised, she says she feels people don't like her as she says the wrong things. The implication of this is not spelt out but could be that the patient has got a problem and that makes her unpopular.

The patient has been encouraged into more defensive thinking by the therapist. She is nevertheless trying momentarily to bring out some of her anxieties, however denial is

immediately resorted to in the Warrant. There is some awareness that something might be wrong in the Claim, but at the same time the possibility that something 'big' might be wrong is denied.

9.3. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1, 5, 6, and 8 are mapped onto the rotated histogram below



The variables in this histogram are as follows: The first column (1) is a catchall category. The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements. The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative

statements. The seventh column (7) shows the number of statements indicating a positive world- view or positive statements. The eighth column (8) shows the number of self-critical statements. The ninth column (9) shows the number of statements relating to control issues. The tenth column (10) shows the number of references made to Carol's handicapped daughter.

There is very little change in any of the variables listed above. There is a slight decrease in self-critical statements.

9.4. Independent Psychoanalytic Assessment of Carol (Session 1)

The woman presents a complex clinical picture, with the sorts of complications typical of the anorectic. She conveys great conflict between the need to achieve in work and feeling of guilt about her personal and family life. However, she conveys that although she is in conflict she can barely face her conflict, and also has difficulty in facing guilt. Fortunately she has attained some recognition of how her hatred of guilt drove her to beat her children.

She presents her mother as always criticising her and never offering her ordinary encouragement. Even if true, and it may be, it disguises Carol's hatred of criticism, and her hatred of having to face the reality of problems. The interviewer keeps everything very reasonable and so is, in this interview, seemingly unaware of how she is being controlled and being made to offer re-assurance. The woman describes how she controls her object into telling her she is doing right - when it may not be true. To break free of her control and present her with reality or real criticism will incite her rage and hatred. Some picture of this is provided by her description of father, who like her evades and withdraws, and cannot bear to be shown the truth of what is wrong (i.e. in the photo). He also produces rages or tantrums.

Internally she is very dissatisfied and this often combines in her with cruelty and greed making for the self-destructiveness of anorexia. I suspect that she not only has a distorted and confused body image, but also distorts what she hears to be in line her harsh and cruel super-ego.

Comment: The independent assessment focuses on this patient's conflict between being a mother and going out to work. It highlights her hostility towards her own mother. It also picks up the collusive nature of the interaction between the patient and therapist. The patient cannot bear to hear anything else said except 'supportive' things about herself.

9.5. Summary of Carol

In the pre-therapy interview Carol described in detail the circumstances around the birth of her handicapped daughter. She felt it was the hospital's fault. She also described both her relationships with her mother and her husband as very unsatisfactory.

In the therapy Carol presents in a vulnerable yet controlling, manner. The argumatics analysis shows how she engages her therapist in her world-view, that her difficulties are someone else's fault. The histogram shows that there is very little change over the sessions. Carol did not want to be interviewed after the ending of her therapy.

10. Results: Andrew

This chapter introduces the seventh of the subjects. Included in this chapter is a short background to the patient. A subjective analysis of selected sections of this patient's therapy sessions and a detailed argumatics analysis of sessions one only was carried out because this session showed the typical functioning of this patient. No new information would have been gained about the mechanisms employed by analysing further sessions in detail. The text in bold is the verbatim interaction between the therapist and patient. It often contains repetitions, hesitations and clumsy language. These have been kept to retain the authenticity of the therapy process. Included also is a rotated histogram, showing changes in the patient's preoccupations as expressed in four selected session from the beginning, the middle and the end of therapy. An independent assessment of session one by a senior Kleinian psychoanalyst is included and discussed. Finally a summary of all the presented material is included with reference to the pre-therapy interview conducted with the patient for the purpose of this research. Andrew refused to be interviewed again after the ending of his therapy. The transcripts of the pre-therapy interview can be found in appendix 3. Notes on Andrew's initial psychotherapy assessment can be found in appendix 1. The interview schedules used for the before and after interviews can be found in appendix 4. The complete transcripts of the recordings of Andrew's sessions of psychoanalytic psychotherapy are available on the CD-rom, appendix 5, available on request from the author.

10.1. Andrew

Andrew was undergoing brief psychoanalytic therapy. The material from session one was analysed in depth.

At the time of his therapy, Andrew a homosexual musician was in his thirties. He sought therapy because of relationship problems. His relationship of fourteen years, to an older priest was breaking down as a result of Andrew having fallen in love with someone else.

It was difficult to ascertain any details of the patient's childhood. He came from a working class background. His father was Polish. He had an older brother, who was adopted by his family. When asked, Andrew described his childhood as uneventful.

It was notable that Andrew found it difficult to discuss his past, because of the feelings of shame that he felt about his origins. He found his parents 'common' and embarrassing. At the same time he felt some guilt about these feelings. In addition Andrew felt that he wasn't somehow good enough, and he felt trapped and sad. These feelings related mostly to his sexual practises.

Andrew was in the habit of visiting public toilets, in search for casual encounters. The habit had arisen according to him, because he wasn't able to enjoy sex with his long-term lover.

Andrew had never been sexually involved with a woman, although he claimed that he once was in love with a girl, who rejected him. He discovered that he was homosexual after a chance encounter in a public toilet when he was twelve.

Therapy

Andrew was initially assessed more than six months before a therapy vacancy became available. He started his therapy feeling angry, and suspicious. He was noticeably concerned about his sessions being taped. He expressed anxiety about confidentiality In fact he gave an impression of somebody much troubled by persecutory anxiety and even paranoid feelings.

When the therapy eventually started the new love in Andrew's life was fading. The old relationship was continuing in so far as Andrew was still sharing a house with his previous lover. One of Andrew's lovers had at this point fund himself another boyfriend, so now Andrew felt jealous in addition to the feelings of shame and guilt which he connected to his sexual practises.

In the early sessions the discussion centred very much on Andrew's sexual difficulties. In fact he filled the sessions with thoughts about sex to such an extent that the therapist felt that the talk of sex acted as a defence against something else. The focus of the treatment was to try to steer the patient into thinking about his relationships in a more complex way.

During the sessions it emerged that the patient was in fact very frightened of rejection. He worried that his lovers would find him unattractive etc. In fact he felt that these feeling were one of the reasons why he tended to choose older men as lovers. Even during treatment it was very difficult to explore Andrew's childhood. He did however wonder during one session about what might have caused his homosexuality. He wondered weather his father might have sexually interfered with him, although he had no memory of anything like this. What Andrew did express on several occasion, was how he despised his parents.

The relationship to his male therapist was apparently following the pattern of his other relationships. Initially there was great excitement, but towards the end of therapy, the therapist was no longer seen as interesting.

Andrew felt great relief, as he was not being criticised about his sexual practises, by the therapist. It led to some trust developing between patient and therapist, which enabled some deeper exploration. This exploration centred on the feelings of fear of rejection, in particular in relation to the patient's long term lovers. Intense desire to try to sort out this relationship emerged, but finally feelings of despair surfaced, as it was far from clear weather this relationship was viable.

The patient's initial preoccupation with sex was understood as his attempt to keep feelings of fear of rejection and hopelessness at bay. Towards the end he was able to talk a little about his feelings about his parents. He lived in fact in constant fear of their death. Andrew found it difficult to work on the ending of therapy, and it seems the end was again experienced as another rejection, which, needed to be defended against. The defences most in evidence were, projection and denial. There was a lot of persecutory

anxiety, reaching paranoid levels at times. However, as it became clear that what was defended against was an awareness of anybody's importance in the patient's life, some of the patient's defensive strategies could be located as lying somewhere towards the depressive position, and the defences presented could be seen as manic defences.

10.2.1. Session 1

Subjective/Intuitive analysis

The session starts with some discussion about what could usefully serve as a focus for the sessions to come. The therapist points out that the two assessment session had been very much about sex and very little else, thus he suggests that they should look at the 'wider aspects of the mind, and other difficulties in relationships'.

The patient responds by saying that to him the sexual side rather dominates, and he goes on to give examples.

'Um so going to a strange town now would sort of go round libraries and take an interest in the town but there would always be at the forefront of my mind you know, where are they(public toilets)'.

On prompting from the therapist the discussion moves to how the patient feels in his more permanent relationships.

'I just wanted to be there and it was very difficult and I had to tear myself away and leave him, it was terrible, I used to dread leaving the flat and having to go out to...it was awful'.

Some of the underlying fear of separation is expressed. The session continues by the patient thinking about what his relationships mean to him. His recent shorter love affair is fading somewhat, and the patient feels that after all he has got more in common with his long- standing lover, with whom he still lives. Andrew then remembers what it was like when he first met his long-standing lover. Great emphasis is laid by the patient on having been young and desirable and on how important if felt when this older man fell in love with him. The therapist is picking up the theme that being desirable seems to be an issue. The patient responds by,

'Um I would be lying if I said I didn't want to be desirable. On the questionnaire that I filled in, one paragraph said I'm fat and balding. I can't do anything about the balding...the fat side...I have lost an awful lot of weight and gone back to where I was when I was when I was twenty one but I can't do anything about hair. So yes of

course I want to be desirable. I don't like being – er.... find myself physically unattractive. It's not very pleasant being rejected but you know, that's just something you have to grow up about'.

In this vignette the patient is showing some of his insecurity, and the underlying fear of rejection. The issue about rejection is clearly a difficult issue for the patient. This becomes clear as the therapist tries to explore further what happens in the patient's relationships. Andrew tells his therapist that he finds it difficult to be faithful to one person. Something happens fairly soon in a relationship which makes him lose interest.

'I'm only rejecting Sandy (new lover) physically, I'm not actually rejecting him. I just don't want him any more - the need doesn't really arise anymore'.

This sentence is a denial of the patient's rejection of his latest lover. At the same time a projection of who is to feel rejected has taken place.

Some discussion about what relationships the patient has had with women takes place, however without much thought. Finally the patient turns to his therapist as he feels he is not sure if he is on the right track.

'I hope that perhaps you might be able to say something (laughter) to put me on the tracks again, on the railway line'.

Some insecurity is expressed about the relationship with the therapist. The session ends with a discussion about this comment. The therapist is drawing parallels with what happens in the patient's relationships, when initially the love object is idealised, and seen as someone to contain Andrew, and prevent him from feeling out of control.

10.2.2. Argumatics analysis of session 1

Therapist: But that still figures quite strongly now. Because I feel to some extent you feel, or at least the impression you have given me is that you feel that you've regressed back to square one with sex.

Patient: Er... yes, I think I have gone back to square one. Going out sex always comes winging, often winging to the forefront, just sort of sitting on the tube or going from A to B. It's very peculiar.

Therapist: This is what I was trying to get at earlier on.
Patient: I don't know, I don't want to sound... why the sexual drive constantly comes to the forefront. I mean obviously at home I'm not thinking of sex all the time. I'm not, but out, if ever there's a possibility I will jump at the chance. This thing about

public lavatories, gosh it's like a drug sometimes. If I go to a strange town it's almost an obsession that I have to find out where it is. Peculiar.

Therapist: So if you went to a strange town, what would you do?

Patient: Find out where it is.

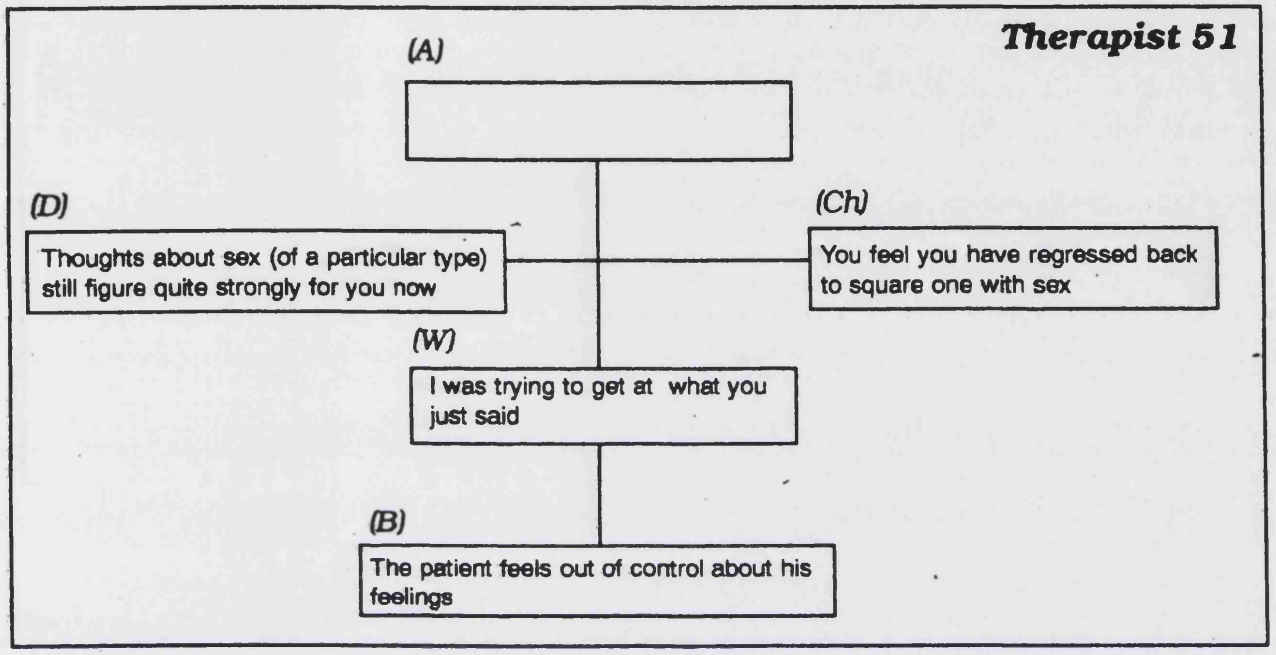


Diagram 51 - Therapist: The Challenge is a statement about where the therapist feels the patient finds himself emotionally, 'you feel you have regressed back to square one with sex'. The Data is that 'thoughts about sex (of a particular type) still figure quite strongly for you'. The Warrant is that the therapist was trying to get at what the patient had just said. The Backing is not verbalised but seems to be an assumption that the patient feels out of control about his feelings.

This is an exploratory amplification of what the therapist thinks that the patient is feeling at that point in time, a form of clarification.

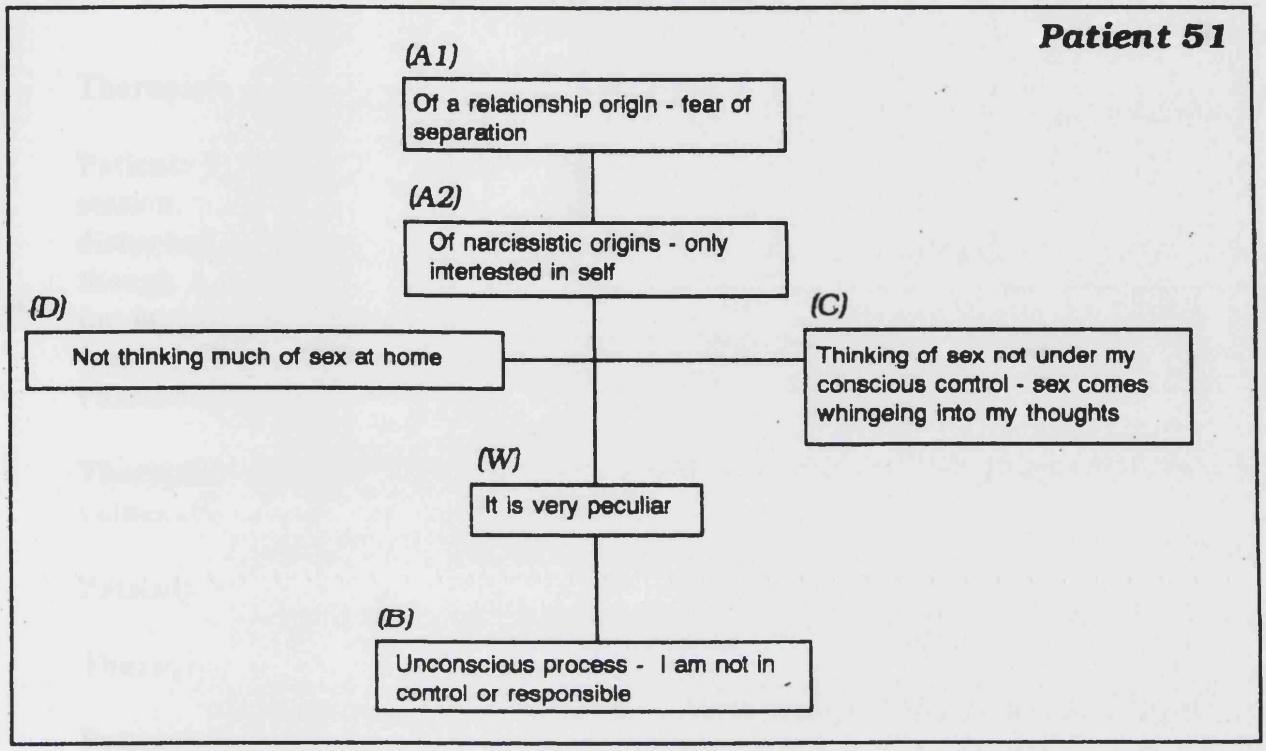


Diagram 51 - Patient: As a Claim in response to the therapist's Challenge the patient says 'thinking of sex is not under my (conscious) control- sex comes winging into my thoughts'. The Data is not very clear but seems to refer back to him not thinking much about sex at home. The Warrant is that this state of affairs is very peculiar. The Backing is not verbalised but seems to be an assumption that this is an unconscious process and he is not in control of or **responsible** for it. There are two possible Alternatives, neither of which are verbalised. The first one is that this issue is of a relationship origin, fear of separation, or the other one is that it is of narcissistic origin, that he is ultimately only interested in himself.

The patient is denying and projecting responsibility of his feelings (see Claim and Backing), although it is not clear what or on whom he is projecting. This could be seen as a statement rooted in the paranoid-schizoid position where relationships are only part object relationships, as in Alternative number 2 or it could be an expression of triumph over the object and a denial of dependency on anybody in which case it can be seen as a manic defence.

Therapist: What was so awful about it?

Patient: I felt lost. I remember the first doctor I saw here. She said in the second session, well perhaps you're leaving home? And that knocked me terribly. I was very disturbed by that and I sort of tried to think about it when I left Sandy, it was as though I was leaving some sort of security and thrown back into the world to fend for myself. I suppose you can, perhaps you can read a little bit into that but I just wanted to be with him and leaving him was a terrible wrench. I felt very lost, very vulnerable and I just couldn't stop thinking about him.

Therapist: But why should you feel vulnerable just because you were leaving? Is it vulnerable that you weren't going to have sexual encounters?

Patient: No

Therapist: Or was it just a protective figure, a father figure?

Patient: Yes

Therapist: But Peter in some ways was also a father figure.

Patient: Yes

Therapist: Why should you feel vulnerable?

Patient: I don't know. Because I wasn't at that stage of being in love with Peter any more, and I'm not at that stage now. I'm not in love with him.

Therapist: It's almost as though you've got to the same stage now with Sandy as you have been with Peter for some time.

Patient: Yes except that I have probably more in common with Peter than I do with Sandy. I can see that quite clearly now...

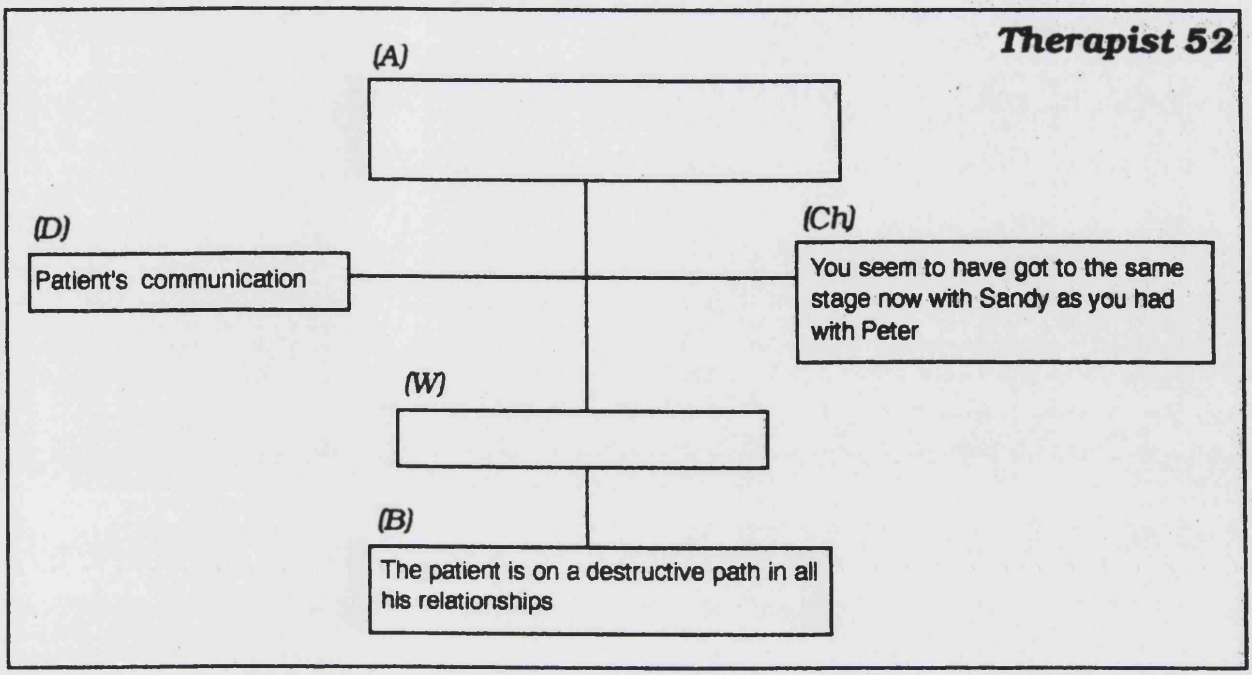


Diagram 52 – Therapist: The Challenge seems to be that the patient feels he has now reached the same stage with Sandy as he had with Peter earlier. The Data is the patient's past communication. No Warrant is offered. The Backing is not verbalised but seems to be an assumption that the patient is on a destructive path in all his relationships.

The therapist is amplifying and clarifying what he feels is happening in the patient's life right now, without spelling out the Backing, which could have been useful. In this instance the communication remains ambiguous if the Backing is not verbalised.

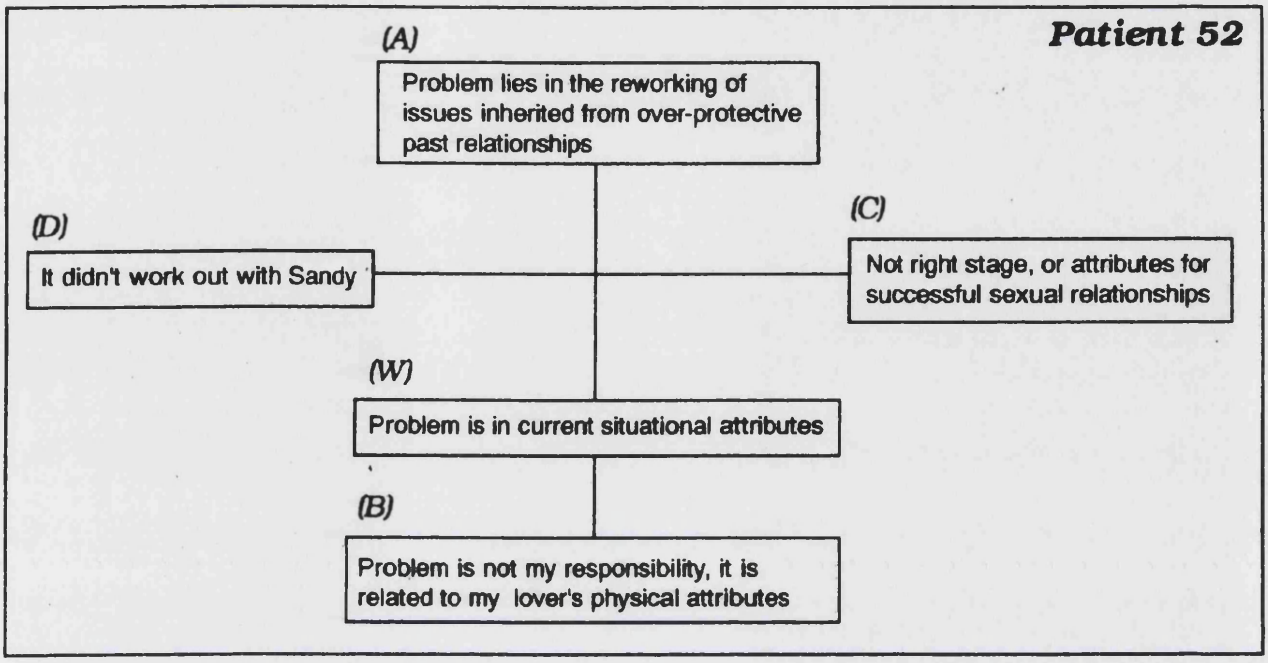


Diagram 52 – Patient: The Claim is implied, something about this is not 'the right stage', or there are not the right attributes available for a successful sexual relationships. The Data is that it didn't work with Sandy. The Warrant is implied and it is something like the problem lies in the current situational attributes. The Backing is not verbalised but is something along the lines of, 'it isn't my responsibility, and it is more related to my lover's physical attributes'. A possible Alternative could be, that the issue is much more about a need to rework issues from past relationships.

This constitutes a denial of responsibility, and a displacement and projection of any significant factors onto external issues e.g. someone else's physical attributes (see Claim), an externalisation. This suggests part object functioning.

Therapist: I was wondering if you are playing the part of being in charge and therefore you reject others. I mean you sort of rejected Peter and now you are rejecting Sandy.

Patient: I'm only rejecting Sandy physically, I'm not actually rejecting him. I just don't want him any more - the need doesn't really arise any more. I think it's unfortunate because I would much rather be faithful to one person than have to go round whatever. The desire to be faithful is very strong.

Therapist: But what is missing, what doesn't allow you to remain faithful to one person? What's missing ? There must be something that drives you away from that person. It seems as though initially you are besotted by that person, as though it's

almost, you almost put them on an altar. You know that it is, they're almost like a god as it were initially and there is nothing that they can do that is wrong until the great love affair that is so fantastic it's almost unreal and yet that seems to fade with time, probably quite rapidly by the sound of it.

Patient: Yes, but only the physical. My relationship with Sandy has deepened in the past nine months I do feel it's deepened but I do feel you know it's almost two separate things and the sex always the big problem you know. I don't know, I don't know why. I don't know if there is anything that can be done about it. I just accept that and try to make the most of a bad job because that's better than trying to work it out all the time.

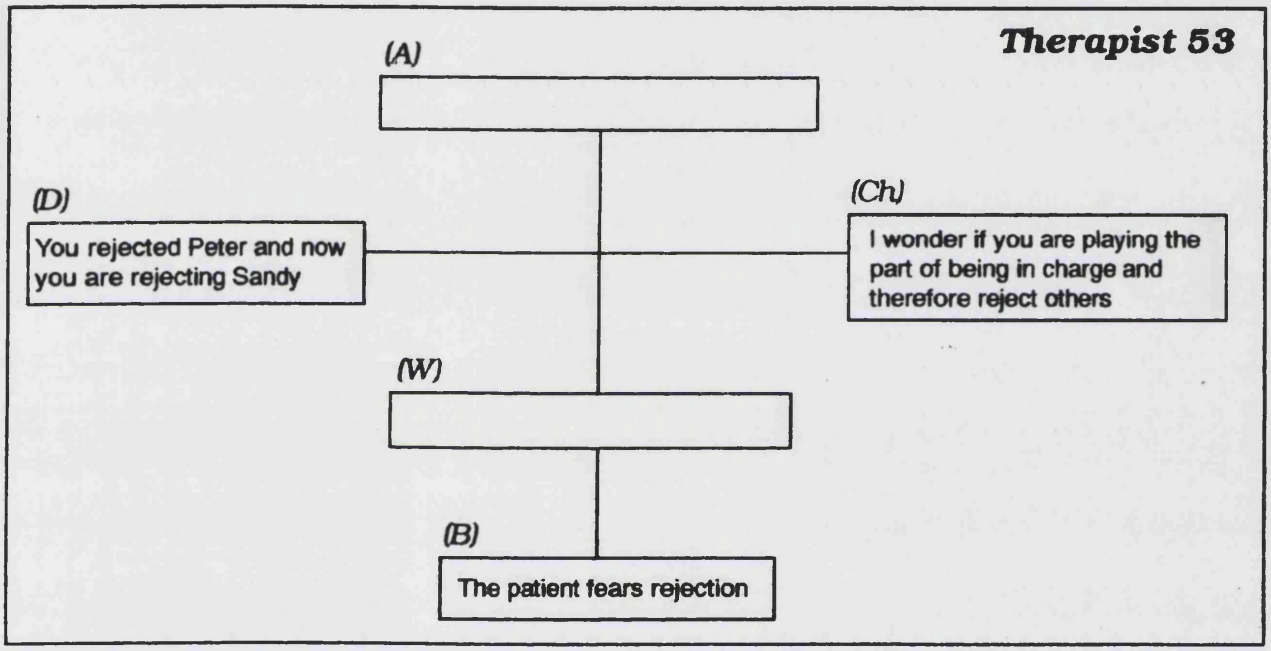


Diagram 53 –Therapist: The Challenge is that the therapist is wondering if the patient is playing the part of being in charge and therefore rejecting his partners. The Data is that first the patient rejected Peter and then Sandy. No Warrant is offered. The Backing is not verbalised, but seems to be an assumption that the patient fears rejection.

Here the therapist is trying to draw the patient's attention to his behaviour, and encourage him to think about it. This is an amplification of the patient's behaviour.

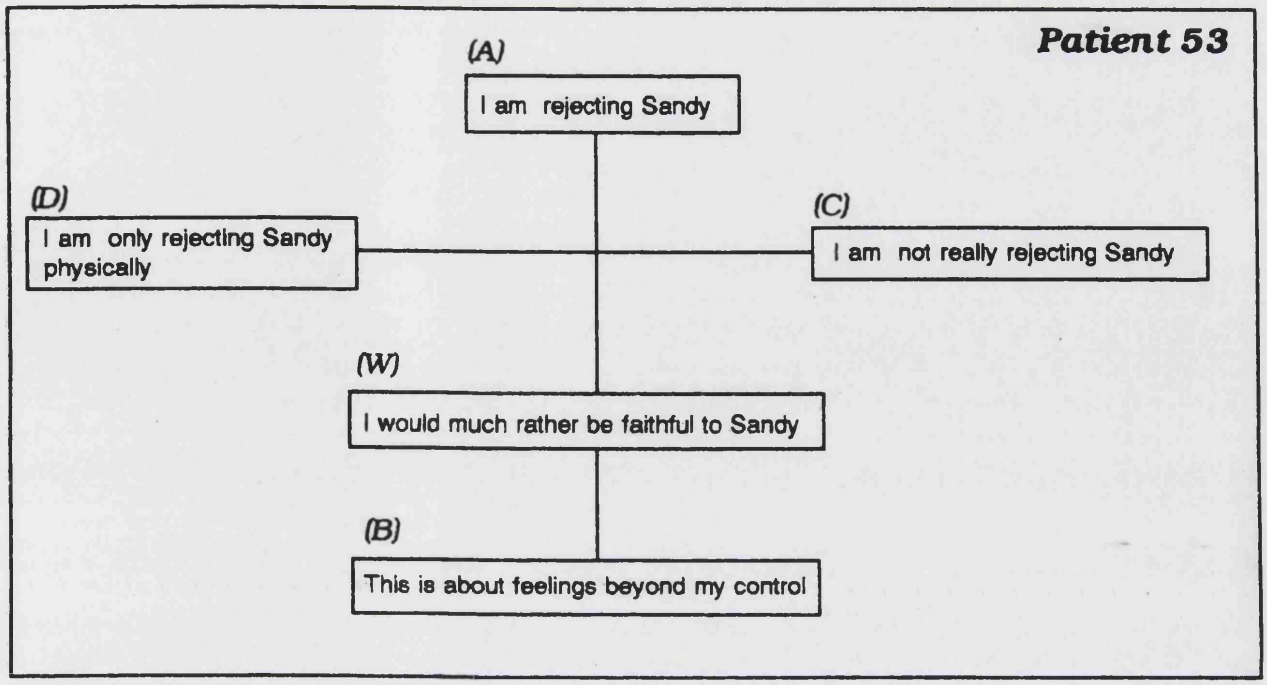


Diagram 53 – Patient: The Claim in response to the above Challenge is that the patient feels he is not **really** rejecting Sandy. The Data behind this Claim is that the patient is only rejecting Sandy physically. The Warrant is that the patient says he would much rather be faithful to Sandy. The Backing is not verbalised, but implied, that is, these feelings, are experienced by the patient, as being beyond his control. The Alternative, which, is not considered, but was verbalised by the therapist is that the patient is indeed rejecting Sandy.

This represents a denial of responsibility for rejection, by the patient. The denial is achieved by a redefinition of the category rejection (see Data), and thereby a situation is created where the patient does not have to take responsibility for his actions.

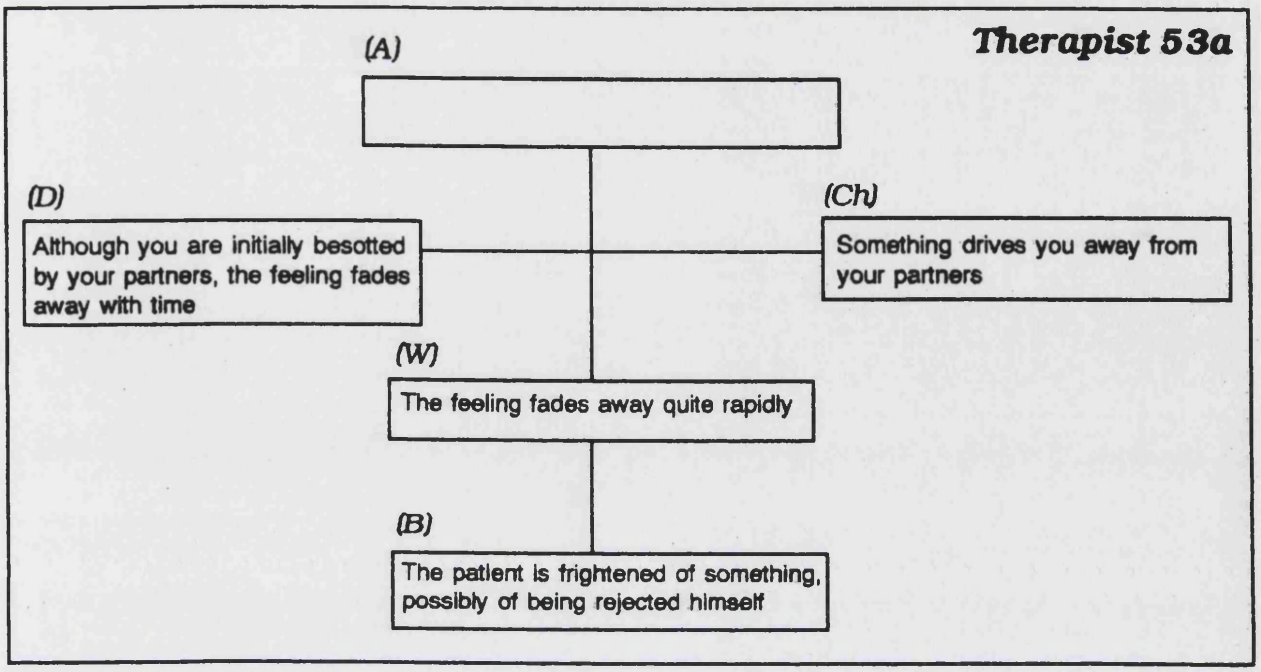


Diagram 53a – Therapist: The Counter-Challenge in response to the above Claim is that something drives the patient away from his lovers. The Data is that although initially the patient seems besotted with his lovers the feeling then fades away. The Warrant is an underlining of the fact that this fading away does seem to happen rather quickly. The Backing is not verbalised, but implied, that is, that it seems this happens because of some fear in the patient, such as fear of rejection.

The therapist is pursuing the issue that the patient is doing some rejecting although Andrew is attempting to deny it. This constitutes a Challenge to the patient's thinking (see Challenge).

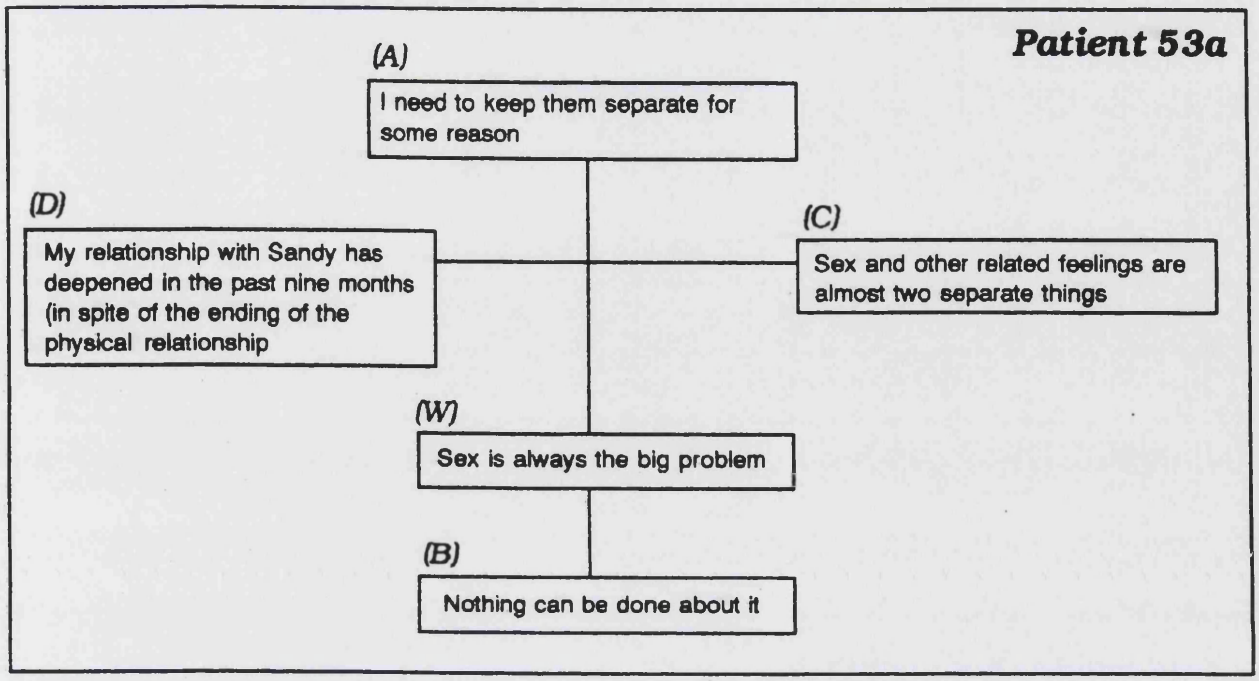
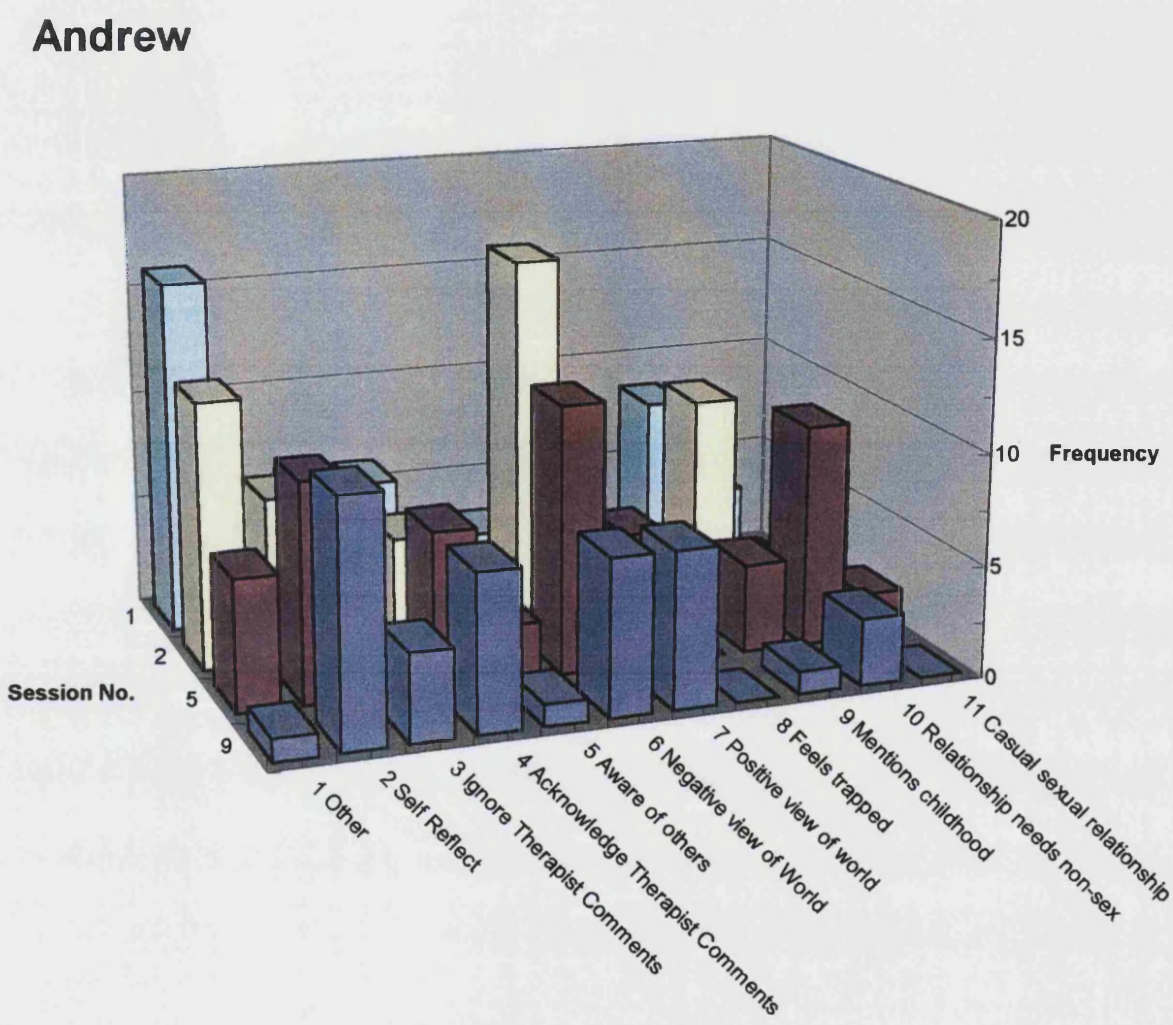


Diagram 53a – Patient: In response to the therapist's communication, the patient's Counter-Claims is that for him sex and other relationship feelings are almost two separate things. The Data for this Claim is that the patient feels that his relationship with Sandy has deepened in spite of the ending of the physical relationship. As Warrant Andrew offered a statement that he feels that sex is always a big problem. The Backing is verbalised, and is that he feels there is nothing that can be done about this. The Alternative, which is not considered, is that perhaps the patient needs to keep sex and other feelings separate.

The patient is resisting the therapist's Challenge and it appears that he does not want to consider the possibility that this might mean something and that it might be something he should take some responsibility for. He continues to use denial to create splitting in order to keep these possibilities far apart (See Claim).

10.3. Rotated Histogram showing changes in the patient's preoccupations over time

Changes in the patient's preoccupations from sessions 1, 2, 5, and 9 are mapped onto the rotated histogram below



The variables in this histogram are as follows: The first column (1) is a catchall category. The second column (2) shows the number of statements indicating self-reflection. The third column (3) shows the number of statements indicating that the patient is ignoring the therapist's statements. The fourth column (4) shows the number of statements indicating that the patient is acknowledging the therapist's statements. The fifth column (5) shows the number of statements indicating some awareness of others. The sixth column (6) shows the number of statements indicating a negative worldview or negative

statements. The seventh column (7) shows the number of statements indicating a positive worldview or positive statements. The eighth column (8) shows the number of references to feeling trapped. The ninth column (9) shows the number of statements relating to Andrew's childhood. The tenth column (10) shows the number of references to non-sexual needs. The eleventh column (11) shows the number of references to casual sex.

This patient's ability for self-reflection increased. He was more able to think about his therapist's statements over time. His negative worldview decreased. His references to feeling trapped decreased. Similarly his preoccupation with casual sex decreased.

10.4. Independent Psychoanalytic Assessment of Andrew (Session 1)

Although the interviewer repeatedly touches on serious matters, the emotional tone is heightened, rather excited, almost hyper manic. It seemed to me that this was indicative also of a high level of anxiety, and that this is not noticed by the interviewer. The client's anxiety is conveyed in his constant need for sex, which he says in nothing more than glorified masturbation. In fact the interviewer, unwittingly, whilst trying to be serious, becomes rather moral and hence plays into the excitement in the room. I thought there was at the beginning a sense of the interviewer pursuing the client, an attitude of "certain things you are not really telling me...".

The client talks of his vulnerability, his need for re-assurance, his loneliness from which he longs to find (and believed with Paul he had found) an ideal partner and an ideal place. He conveys how rapidly he becomes dependent and that his needs become romanticised and idealised, only too soon, to break down.

At the point where the client says he had lost track. I do not think the interviewer noticed that he had just been giving an account of himself having a girlfriend. This of course is for him a different track and one, which he has, through homosexuality and masturbation, lost his way in. I also thought (the subject is touched on at the beginning of the session), that some attention to the client's background is important. It may indeed provide some pointers to where the track was lost to a heterosexual development.

A further aspect is this client's awareness to his losing his youth. It appears that although he could once turn to his desirability and to sex, without those he has little or nothing to turn to. This may be a hazardous time for him.

Comment: The independent psychoanalytic assessment focuses on the assumption that this patient's preoccupations are covering up feelings of loneliness and a need for reassurance. It also highlights how the therapist gets drawn into something. It is suggested that this is a rather perverse interaction, reflecting the patient's functioning in his external relationships.

10.5. Summary of Andrew

Only the beginning of this patient's therapy was analysed in detail. It did show however the typical preoccupations of this patient. He was very concerned about whether he was still attractive. He did deal with his anxieties by concentrating on thinking about casual sex. He was very uncooperative during his pre-therapy interview (see appendix 3). He was a lot more communicative with his therapist. This may have been a reflection on the fact that his therapist was a man and of the fact that, his pre-therapy interview was conducted by a woman. The changes in the variables outlined on the rotated histogram indicate that this patient did change in some respects during his therapy. It would have been interesting to discuss the therapy with this patient, but he refused to participate in a post-therapy interview.

11. Mechanisms as evident in the data

This chapter describes the different mechanisms as evident in the data. In addition instances of absences of defensive mechanisms will be described as suggested by the results. The instances of each mechanism, or absence of mechanism are described with reference to each analysed vignette hereafter referred to as frame (these include both the diagrams referring to Patient and Therapist). The elements of the frames outlining mechanisms, or absence of mechanisms will be described using the elements of the argumatics analysis. That is Claims, Challenges, Data, Warrants, Backings, Rebuttals, Alternatives, Qualifiers, and Modifiers.

The differences that occur between the patients and in the different interactional contexts will be highlighted. The patterns that emerge are critically discussed, in terms of the usefulness of these categories, their correspondence with the descriptions encountered in the literature, the function of the identified patterns in the interaction, and the usefulness or not for both the patient and the therapist.

New subcategories of the defence mechanisms will be introduced as suggested by the Data. Many instances fit several categories. When this is the case the instance or events will be described in detail under the category under which it first appears and in less detail under the subsequent categories.

The way this categorisation has been achieved was by looking at the mechanisms by answering the question, what are the mechanisms in question achieving? In the context of the therapy a related issue, which is addressed, is, 'what kind of activity is both the therapist and the patient engaged in'.

11.1. Concrete thinking

This constitutes both a denial of psychic reality and a destruction of meaning in a characteristic way demonstrated here. In addition it often also constitutes a denial of having to think about or consider what has been suggested. Can these 'events' consistently be identified?

Most of the examples come from the analysis of John's therapy as described in chapter 4. The first example can be found in frame 1 pp77-80. The therapist is asking if the patient is prepared to entertain the possibility that his difficulties may have some psychological meaning. The patient responds by, in detail, dividing his symptoms into ones caused by 'stress' and ones not caused by 'stress'. This position is then justified by which symptoms came when. Thus he responds to the Challenge 'literally' or concretely, as opposed to allowing his mind to absorb the suggestion that there might be something new in what the therapist is suggesting. To consider the therapist's suggestion would have increased anxiety at this point, thus to employ old familiar ways of thinking 'feels safer'.

The therapist's intention of trying to get the patient to 'think psychologically' is evident from the diagram (Therapist 1) p78. The verbalised Challenge and the accompanying Data constitute an amplification of the patient's style of communication, in the hope that this would make the patient reflect on it himself. The patient does not take up the Challenge, He responds by talking of the physical symptoms (Patient 1) p79. In this instance the Warrant and Backing in the patient's argument shows that the patient is neither interested, willing nor able to think of any meaning of his symptoms. He is only willing to think about their nature, presence or absence.

The therapist is trying to talk to his patient about *the nature of the patient's thinking*. The patient as described above does not respond on the same level. A form of 'miss-communication' takes place. In talking about the nature of the patient's communication the therapist has identified the fact that the patient is employing, a in this context unhelpful form of thinking. This can be seen in the diagram (Therapist 1), both in the Challenge, Data and in the implicit Warrant and Backing.

The second example is described in the section relating to frame 2 pp80-82. In the first session the therapist is recalling their earlier meeting during the assessment period. The therapist asks the patient, using a simple metaphor, what has the patient had to hold onto lately. The patient, responds by claiming that he feels better, Claim. The Warrant is that he feels better 'because he can now hold onto church furniture'. This changes the level of communication and destroys the original meaning in the presented Challenge. It provides the patient with a way out of thinking about the meaning of the question. This happens by

responding to the Challenge in a concrete manner. The therapist continues to try to speak to the patient about the patient's psychological reality. This can be seen in diagram (Therapist 2) p81, Challenge, Data, Warrant, Backing, and in the Alternative. The Alternative is a different take on the patient's situation, a possible way of empathising with the patient, or suggests a possible next comment by the therapist. The diagram (Patient 2) p82, shows in the Claim, Data, Warrant, and Backing the concrete nature of the patient's response. He talks of actual furniture rather than a state of mind, the Alternative is not considered, but suggests a way that the patient could progress his thinking. The Qualifier shows that there is a doubt in the patient's mind that the way his thinking is organised is ultimately a good way of dealing with anxiety. In this example like in the one before, the therapist and the patient are *not talking about the same thing.* This is evident from the disparity between the patient' and the therapist's Backing.

The next example is from the same patient and the same session. The relevant vignette is discussed in frame 3 pp83-85. The therapist is commenting on the fact that the patient appears to find it difficult to think of psychological explanations, thus the therapist has identified that there is something inappropriate about this patient's thinking. The patient responds, not by thinking about the Challenge, but by making a tangential Claim, 'I've got a mind that works on physical processes'. The Challenge is an invitation to the patient to think about why this might be the case or perhaps to consider, could there be some validity in what the therapist is saying. The patient does agree with the therapist, but retains the concrete quality of thinking. The therapist wants the patient to question his way of thinking, but the patient agrees superficially but does not question it. There is more communication between patient and therapist in this instance as there is a closer correspondence between the Backing of the therapist and the patient. However at the same time the patient is not co-operating. There is an adversarial atmosphere between patient and therapist. The therapist's Challenge, Data, Warrant, and Backing are all global descriptions of what he feels the patient's thinking is like. An Alternative is not considered, but had it been considered it might have enabled the patient to co-operate.

The next example is described in frame 4 pp85-87. The therapist challenges (Challenge, Therapist 4) p86 the patient to think about the nature of his reasoning, by amplifying the patient's statement that to be a priest is in his opinion the same as being anything else.

The patient responds in a 'literal' sense by saying in his Claim, 'for me it is of equal value as BR might be for someone else and 'misses' the Challenge by sticking to the concrete level. He thus destroys the communication, he does not consider the therapist's Challenge and denies the psychic reality, which the therapist is referring to. The therapist is commenting on both the form of the patient's reasoning, Data and Warrant. In both form and content the patient has expressed that to be a priest is the same as to be something else. The therapist is trying to get the patient to rethink this assumption by amplifying what the patient has conveyed to him. The patient avoids thinking and co-operating by adopting an argument that rests on a very different Backing from the one used by the therapist. The concrete quality of this argument is most evident in this instance in the Warrant. In addition the diagram shows that the Data although used, as Data and the Warrant do not in themselves support the Claim. The statements in the Data and Warrant are merely unsupported Claims in themselves. The Backing is verbalised and is supposed to support the rest of the arguments. The argumatics technique has enabled the disconnected quality to become apparent.

In frame 5 pp87-91, the therapist continues to 'Challenge the patient's thinking' by talking of the patient's difficulties of knowing whether to be a priest is right for him or not. This constitutes a denied by the patient. Finally the patient presents a Counter-Claim see diagram (Patient 5a) p91, he says, 'If my symptoms continue, I may not be able to continue as a priest'.

The type of thinking that is evident enables the patient not to address himself to the direct question, which the therapist puts to him in the Challenge. The patient's previous Claim is used by the therapist as Data for the Challenge. The therapist Alternative suggests a possible next comment. The patient implicitly denies that there is a difficulty by not addressing the therapist's question. The denial becomes clear if we look at the interaction. This constitutes yet another example of concrete thinking, and removes the need to think about the meaning or possible doubts that the patient may be having.

The concrete nature of the statement can be seen in the Data and Warrant. They are Claims in themselves and do not necessarily support the Claim. The patient's argumentation in this instance would not necessarily need to be characterised as concrete.

However in the interaction, that is if one looks at both diagrams (Patient 5 and Therapist 5) pp 87-91 together the concrete quality becomes evident. There is a, 'it's just the way it is' quality to it. In diagram (Patient 5a) p91 the concrete elements are clear in the Data and Backing. The lack of communication becomes clear when we look at the very different Backings in diagrams (Therapist 5), (Patient 5) and (Patient 5a). In (Patient 5a) it is possible to see how, although some doubt has crept into the patient's mind, it has all become transformed into a concrete physical problem, see Data and Backing.

The following example is described in frame 6 pp91-93. The therapist continues to try to engage the patient in a discussion about how he the patient handles doubts. The patient responds by, 'There are certain things beyond understanding of everyone', (Patient 6) p93 Claim. Although on the surface this is a response to the therapist's Challenge, it has the same concrete quality as in the examples above. At the same time it can also be seen as a projection onto an external something which makes these things inherently 'beyond understanding'. This constitutes a denial of having to think. The concrete quality is evident in (Patient 6) in the Claim, Data, Warrant and Backing. All the statements could be described, as 'that is just the way it is'.

The next example is found in frame 7 pp93-95. The therapist has challenged (Therapist 7) p94 Challenge, the patient to discuss his reservations about coming to therapy, in the light of the patient's tendency to seek physical explanations. The therapist tries to invite an exploration about why might it be that the patient does not want to consider psychological explanations and favours physical ones. The response described in diagram (Patient 7) p95 Claim, is, 'I see the body in its physical sense'. The Claim shifts the level of communication onto a concrete, 'what his mind is made of' level'. Possibly to deal with anxiety the patient uses his form of concrete reasoning (Patient 7) Claim, Data and Warrant. This means that he does not answer the question he speaks of something else. This time the reasoning is not quite as closed as in the other examples as some doubt is expressed in the Qualifier.

In frame 8 pp95-98, the discussion continues, by the therapist wondering about why the patient has sought this kind of treatment given his physiological explanations. By trying to talk to the patient about his 'bias', the therapist is aware that the patient is employing a

defensive style of communication. The therapist says, 'Why are you seeking psychological help now' (Therapist 8) p97 Challenge. He is however not addressing the effect of creating a mis-communication directly with the patient. The patient pulls the communication onto a concrete level by answering 'I feel the solution must be a mixture of treatments' (patient 8) p98 Claim. The patient seems determined not to think about his contradictory behaviour and communication. The avoidance of thinking is achieved by insisting on shifting the level of communication to something concrete. The patient's argument is logical in the sense that, 'if one tries everything one is likely to find the right solution', but concrete in response to the specific Challenge which the therapist has presented.

In the second session the same patient spontaneously talks of his anxiety and he makes a Claim in the section relating to frame 14 pp115-118. He says, 'Allowing some anxiety to trickle through is like going into children's pool before the big pool' (Patient 14) p116 Claim. This sounds like a metaphorical statement, however the need to anchor it to a concrete level is revealed in the Warrant, 'people go into the children's pool first in F'. (Patient 14) Warrant. The therapist challenges this by trying to bring in the possibility that maybe this rare, metaphorical statement might have wider meaning in the patient's life (Therapist 14) p117 Challenge. The patient responds by saying, 'mentioning the children's pool was of no significance' (Patient 14a) p118 Claim. The concrete quality becomes apparent in Warrant. The patient maintains,' it's just about breakdown of two levels of water' (Patient 14a) Warrant. By returning to this concrete level the potential communication has been destroyed by the patient and the patient has returned to familiar concrete thinking. In this frame the patient came close to thinking differently and therefore his anxiety increased and thus he firmly returns to the concrete level in Diagram (Patient 14a).

In frame 15 pp120-123, the patient initially expresses his anxiety directly about what might be wrong with him in (Patient 15) p121, Claim, Data, Warrant, Backing, Modifier, Qualifier. As the patient is actually expressing anxiety, his reasoning makes more sense in that Data, Warrant and Backing are not disconnected statements, but act as support for the Claim. The therapist amplifies what the patient has just said (Therapist 15) p122 Challenge. This intervention by the therapist however, increases the patient's anxiety

level beyond his tolerance and he returns to a position of denying the bit of his own psychic reality he has just momentarily been in touch with. In Diagram (Patient 15a) p123, he has returned to his customary concrete thinking, by presenting a new Claim, 'I only mentioned schizophrenia as it is the only mental illness I have heard of (Patient15a) Claim. The Data, Warrant and Backing are again somewhat disconnected additional Claims, not supporting the Claim in question. The argument in (Patient 15a) has a quality of, 'that's just the way it is'. The moment of thinking together has now past and the previous communication has been destroyed.

The next examples come from another patient, George as described in chapter 5. In the section relating to frame 23 pp154-156, the therapist challenged the patient about the rather passive style the patient has adopted in the session, (Therapist 23) p154 Challenge, Data and Warrant. The therapist's comment is that the patient seems to view the therapy situation a bit like an interview situation (Therapist 23) Challenge. The therapist has to do the work of extracting information from the patient. The patient's response is: 'I am used to an interview format' (Patient 23) p155 Claim. On the surface this seems to be a reasonable comment, especially as the patient is a journalist by profession. However it is quite clear that the therapist is trying to talk about the patient's style of interacting with her. The patient however chooses to ignore the Challenge, and he does this by adopting a very concrete response with a quality of ' its just the way it is', thus destroying the meaning of what is being suggested, and above all providing himself with a way out of having to think about what is being suggested. This constitutes a destruction of the meaning of what the therapist is talking about. In fact diagram (Patient 23a) p156 Claim, shows how the patient has retreated into concerns about himself as he says, 'I need new stimulation, fresh challenges. This is said immediately after the therapist has offered him a Challenge, which he has destroyed.

To think about what is being suggested would have involved a possible revaluation of this patient's self-image as a 'person of action', and thus would have given rise to uncomfortable feelings.

Another instance even clearer than the previous one is described in the section relating to frame 25 pp160-163, diagram (patient 25a) p163. The background to the defensive

manoeuvre is described in diagrams (patient 25) p161 and (therapist 25) p162. The patient describes his troubles to his therapist, in fairly general terms. Some anxiety is hinted at when the patient is saying that he does not want to run the risk of 'snapping as in the past' (Patient 25) Claim. The therapist spells this anxiety out by amplifying what the patient has just said; the therapist suggests that the patient may be frightened of having a real breakdown (Therapist 25) Challenge.

At this point it seems the anxiety, which was hinted at, threatens to break through into the patient's consciousness and he falls back on defence. He, as it were, redefines the concept of 'breakdown', by calling it 'complete collapse'. He says ' I have never suffered a breakdown in the sense of complete collapse myself' (Patient 25a) Claim, in fact he continues by saying he does not know what having a breakdown involves (Patient 25a) Warrant. What the patient has done in this instance is to redefine 'breakdown', in a very concrete way. In this instance the Data, Warrant and Backing are Claims in themselves and do not support the Claim in question. This manoeuvre provides a way out of having to consider the possibility that he actually fears a breakdown. It doesn't matter whether he in any objective sense is in danger of a breakdown or not. If he were able to tolerate the anxiety that this thought would generate he might in fact be able to think about his situation in such a way that he could potentially feel more in control and therefore less fearful of a 'breakdown'. There is also a suggestion of projection in this statement, as the patient suggests that **he** has not suffered in this way, so the suggestion is that somebody else, not specified, has.

Concrete thinking creates splitting, a significant part of 'the equation' is not considered and remains eclipsed behind the concreteness of the interaction. It introduces a controlling quality to the interaction.

Concrete thinking was frequently seen in the therapeutic discourse of John and also in the therapeutic discourse of George. It is clear that the use of concrete thinking almost invariably destroyed the communication between patient and therapist. It resulted in the therapist and the patient communicating on different levels, talking about different things. In both these therapies, the therapists tried repeatedly to talk about issues, which they felt were relevant to the patients. An increasing sense of frustration was evident on the part of

the therapists'. However the therapists did not show the patients what this type of communication was doing to the therapy relationship. There were some attempts by the therapist to get the patient to reflect on the nature of the patent's communication in frames 7 pp93-95 and 8 pp95-98. Perhaps it would have been more fruitful, had the therapist spelt out the situation in terms of what was happening to their relationship there and then. Sometimes the instances of concrete thinking also incorporated another defence such and denial or projection.

The argumatics analysis showed that the concrete aspects could be found in, the Claim, Data, Warrant or the Backing of the patient's communication. It was usually not found in a Qualifier if it was verbalised and also not in the Alternative, which were never verbalised in the above frames.

Sometimes the concrete style of the patient's communication could be identified from a single diagram, from the disconnected nature of the, Data, Warrant, Backing and Claim. Out of context it is not possible with conviction to state that these were actual examples of concrete thinking. However in the interaction, when one looks at the therapist and patient diagrams together in a frame, the concrete and destructive nature of the communication becomes clearer. In addition if one looks at the effect this type of communication has on an interaction it becomes clear that these are not just idiosyncratic communication patterns adopted by these patients.

How does this fit with descriptions of concrete thinking in the literature? Steiner (1987), desribed concrete thinking as part of paranoid-schizoid functioning. He says that as a result of splitting the predominant anxiety is paranoid and the preoccupation is with the survival of the self. This was certainly the case with both John and George. Both patients are very preoccupied with their own survival and there was very little or no evidence of concern for anybody else. This can be seen in the rotated histograms for John and George, in the results chapters for John and George. In fact there appears to exist very little discussion about the role of concrete thinking as a defence in the literature. McDougal (1982) describes the destruction of meaning, which occurs in 'alexithymic' patients. The concrete thinking described above does indeed constitute a destruction of meaning with an omnipotent quality. In addition the two patients John and George do both exhibit psychosomatic symptoms coupled with persecutory anxiety and difficulties with symbolic thinking, as did McDougal's patients. Although the defensive use of concrete thinking in

an interaction has not been much discussed the results from this research suggests that it plays a central role in obstructing communication and serves a defensive purpose by protecting the patients from anxiety.

11.2. Projection

The first instance is described in frame 12 pp108-110. The patient has come for his second session of therapy after having written to the therapist saying he wasn't sure whether to continue the therapy. The feelings surrounding this are discussed in frame 11 pp106-108, where the patient reports that he has nothing to say. In response to the therapist's comment that the patient appears now to be stressed about how the therapist might feel. (Therapist 12) p110 Challenge, the patient replies, 'I don't want you to feel distressed at my not being able to help you to help me' (Patient 12) p109 Claim. From the beginning of this session, the patient expressed 'dis-eas' with being in the therapy situation, however his way of avoiding thinking about what this might mean is to place the 'dis-eas' firmly with the therapist and not with himself. The patient does not offer or imply any Warrant and the Backing is not clear. However the Data is *'all the stress I was under is now gone'*.

Why is this projection? It seems very unlikely that the therapist would feel distressed at not being able to help his patient as early as in the second session of even a brief therapy. For this to be the case, the therapist would have rather omnipotent expectations of his abilities to quickly 'cure' the patient. It is much more likely that the feelings of distress and anxiety belong to the patient. If we also look at how this Claim is constructed in frame 12, it becomes clear that this statement has no substance to it, is not based on any evidence, in fact the Claim comes, so to speak, out of thin air. However the Data gives a clue about what may have happened. The therapist is felt to be distressed, (Patient 12) Claim and (Patient 12) Data tells us that, all stress the patient was under is now gone. If this can be understood as reflecting the state of affairs at that very moment, then one could argue that, all stress has now gone, because it is now felt to be located in the therapist. The defensive quality of this type of thinking is strengthened if we look at the interaction, as there is no evidence of the therapist being distressed. At the same time there was some suggestion that the therapist did find this patient frustrating in the first session. It is also evident that there is by now some evidence that this patient John does

not want to face his anxieties very easily. In fact in this example we could be talking about what has been described as projective identification by Rosenfelt (1983).

> 'The projective identification used for purposes of ridding oneself of unpleasant or unbearable mental content is essentially related to denial of psychic reality and the analyst or other objects which are used for this purpose are meant to condone the evacuation and denial'.

The next instance is described in frame 23 pp154-156. The setting is described in the related section of text. The material comes from George's therapy. The instance described, has already been discussed under the heading of concrete thinking, but it fits also into this category. The patient can be said, by not responding to the therapist's communication on the same level to be projecting his responsibility onto the therapist, in this instance 'of keeping something going between them'. The clue is to be found in (Patient 23) p155 Warrant. It is of course possible that the patient genuinely needs help to say anything else. At the same time the situation is one where the therapist *is, or is meant to be, in the process of trying to help and encouraging* the patient to express himself. One could argue that she is not doing this very well. In the interaction the responsibility is placed with the therapist by the patient.

The next instance of projection is described in diagram (patient 23a) p156, in frame 23. This patient feels very unappreciated at work. He is very angry with his employers. The preceding therapist's communication is unfortunately unclear, but the patient makes a statement in the context of him expressing frustration with the therapist and with his own job. The statement is ' I've got the kind of mind which need fresh stimulation, otherwise it will atrophy' (Patient 23a) Claim. The Data to support this statement is that 'I've been getting rather stale'. This can be seen as an attempt to shift the responsibility onto 'somebody out there', his existing employer or a potential new one. There is no thought about what this means, in terms of his own state of mind. A potentially nurturing, motivating but also neglecting internal object is projected onto the therapist or a potential employer.

The same patient provides the following example. In the text relating to frame 24 pp156-160 the therapist is suggesting that the patient may be experiencing tensions in his marriage as well as his already known difficulties. The patient denies this, but admits that there is one small issue between him and his wife, their dog. The (Patient 24a) p160

Claim is 'what goes on at home is of no relevance to my problems'. The Data is that 'the only problem at home is the dog'. This served as the Claim in (Patient 24) p159, and the Data is ' My wife is normally very understanding'.

From the context it seems that the patient is struggling to convince the therapist and perhaps himself that there is no need to think about his marriage, there is only the dog. This represents a projection onto 'the dog' of troubles at home, as if to say if only we didn't have the dog everything would be perfect. In the therapy relationship, the therapist's enquiry is deflected and not considered, so there is lack of co-operation with the therapist. The destructive aspects are projected onto the dog, so potentially painful thoughts need not be thought about.

The next example comes from Elizabeth's therapy as described in chapter 6, frame 35 pp198-201. Elizabeth is beginning to reflect on the fact that a friend of hers who had also been doing 'life-modelling' had been sexually abused in the past. The possibility is emerging in this patient's mind that, she may also have been in a situation where she had allowed herself to be abused in some way. She does however quickly decide that this is not her problem it is her girlfriend's. She does this by introducing a distinction between herself and her girlfriend. In diagram (Patient 35) p199 the patient is beginning to make connections and associations in relation to what has been talked about in therapy. The connection is evident in the Claim, Data and Warrant all of which are connected by the theme of abuse. However in the Data and Warrant the abused one is someone other than the patient. The intention of not wanting to think along these lines can be seen in diagram (Patient 35a) p201 Claim. The sequence started by the therapist having amplified the previously expressed feelings by the patient that 'the blindfold picture was quite shocking' (Therapist 35) p200 Challenge. This is now given a new connotation by the therapist, that is, that the reason it felt shocking was that the patient wanted to *act out abuse*. This connection by the therapist could of course be pure speculation. What is of interest however is that the patient does consider it for a moment, although it is then quickly felt to be her girlfriend's problem not hers.

The next example can be found from Mary's therapy as described in chapter 7. In frame 37 pp211-213, the therapist is making an observation that the patient appears to fear that

she has caused some harm (Therapist 37) p212 Data. The patient starts by agreeing, but no sooner has she agreed before she turns away from that thought and it's implications, and attributes the harm-causing agent onto something called circumstances. She Claims, 'I am a victim of circumstances' (Patient 37) p211 Claim. The Data for this Claim is 'I don't deliberately set fire to things'. The Warrant is that she does not want to (be destructive). The Backing on which the argument rests is that, life has been unfair to her. From the diagram it is clear how she tries to create an argument of why what she fears isn't true.

It seems that the therapist's observation and the patient's own response, raised the patient's anxiety because the suggestion was that she needed to think about her actual or potential destructiveness. Thus the idea, which had already entered consciousness, had to be defended against. The patient contradicts herself. This fact alone points to the presence of a defence. The destructive element is located in something called circumstances. The therapist is trying to rectify the patient's distortion by commenting that fearing that one has cased harm is not about being a victim. Thus the therapist has recognised the patient's use of defensive thinking and is trying to make that clear.

The next example is from the same patient Mary. It can be found in frame 38 pp213-215. In response to the therapist's comment about the fact that Mary seemed to have felt frustrated in the previous session (Therapist 38) p214 Challenge, as they could not find suitable times for the therapy sessions (Therapist 38) Data. Mary responds by denying that she felt annoyed (Patient 38) p215 Claim. The Data for this Claim is that 'it just seemed unlucky, but then says she only felt annoyed 'with the situation' which serves as a Warrant. The focus of annoyance is now not the therapist but something called 'the situation'. She has thus got out of confronting the therapist about the fact that, she felt annoyed. She has got out of confronting something like annoyance or frustration in a present relationship. The therapist has offered her a chance to openly express her negative feelings about the therapy situation. She however turns this opportunity down. The feelings no longer belong in a relationship, but somewhere else.

The next example can be found from Steven's therapy as described in chapter 8. In frame 45 pp241-243 Steven was talking about his son giving evidence in defence of his teacher. The statement containing the projection is contained in the Claim, 'All my son's loyalties were with his friend and teacher' (Patient 45) p242 Claim. The related Data is reference to the events. The Warrant 'my son had no respect for me', shows how the aggressor is felt to be the son and not the patient.

The patient feels very persecuted and let down by what he considers to be his son's betrayal. The communication comes, not prompted but in the context of the therapist encouraging the patient to tell his story. The argumentation, which Steven is building, is one aimed at portraying Steven as a victim rather than someone who needs to take some responsibility. The Warrant and Backing demonstrate this. The argument is constructed in this fashion in order for the patient to avoid having to look at his part in the events. Maybe the son turned to the teacher because he did not get what he needed from his father. The therapist either does not recognise the patient's communication as defensive or chooses not to comment on it. Instead he echoes in a collusive way what the patient is saying. The therapist says, 'you must have been very angry and betrayed'. (Therapist 45) p243, the Challenge.

The next example comes from the same patient, frame 46 pp245-248. The issue is a consideration of what has been achieved in the therapy. The patient describes a friend in need whom he feels he has not been able to help in the way he had hoped. The distortion is expressed in the section related to frame 46. (Patient 46) p246 Claim is that the patient feels that the therapist has put doubts in his mind about whether the way he used to be going about things is the right way. The Data is that now the patient does not know how to be helpful to his friend In this instance, like in the previous one the responsibility for any difficulties does not lie with the patient but in this case with the therapist. The patient has become a victim of the therapist. His world continues to be black and white, that is split, and a general atmosphere of feeling persecuted has been maintained. The presence of persecutory anxiety is evident.

The patient continues in the same fashion. In the section relating to (Patient 46a) p248 he responds to the therapist's comment that maybe some of the feelings may be related to the session being almost the last one (Therapist 46) p247 Challenge, by repeating the Claim that he feels he cannot be supportive to his friends. The use of projection is clear if one looks at the Warrant. The patient says in the Warrant that his friends need this kind of help, that is therapy.

This manoeuvre changes the idea of someone needing help, away from him onto someone else, in this case his friends.

The same patient continues to relocate responsibility away from him in frame 47 pp248-251. The therapist introduces thoughts about the patient's sex-life with his wife. The therapist is asking if there was any sexual contact between patient and his wife at this time. The patient's response, discussed in diagram (Patient 47) p249, shows how the whole argumentation is based on not wanting to think. The Claim is that the patient does not find his wife sexually attractive any more. The Data is that they have been married a long time. The Warrant is that the patient feels that his wife is not very imaginative. In other words a way of saying, things are not good but that is not in any way my responsibility, but if anybody is to blame it is the wife.

The above example of projection may very well have arisen from the fact that the therapist opens up very sensitive areas so late in therapy. It may be that the stress of discussing sensitive areas at this time leaves the patient no choice except to fall back on his customary defence. However this patient's characteristic defensive style is evident in all the examples quoted above.

The following example can be found in frame 49 pp262-265. This example comes from Carol's therapy as described in chapter 9. In this frame the patient is concerned about her marriage and her children. Unprompted she starts to discuss her own mother with the therapist. (Patient 49) p263. The Claim is, ' My mother is very critical, she never says

you've done well'. This suggests that the notion of 'bad mother' is located somewhere other than in herself, or it could be argued represents a projection of the notion of a bad mother onto her own mother. This frees her from considering her anxiety about whether she is a 'bad mother'. As Data the patient offers the fact that her mother believes that her granddaughter, the patient's second child has got a reading problem. The argument is further supported by the Warrant that when the patient was a child her mother used to put the patient down.

Why is this a projection and not simply fact? One of the reasons why Carol wanted therapy was because of her guilt feelings about having left her first child, who was handicapped, in care. The Alternative, which could have been that the Grandmother was expressing concern about her grandchild, is not considered. Additionally the statement in the Warrant supports the idea that the patient's mother is put in the position of the 'bad mother'. Finally from the passage it is clear that to put forward this argument gives the patient some relief from anxiety. As discussed above the effect on the relationship of the use of this kind of distortion is that it puts not only the patient in a black and white situation, but it also forces the therapist if he/she is to remain in touch with the patient's material also in a black and white situation, where he/she may end up colluding and then not helping the patient, or he/she must confront the distortion, and that may create tension in the therapy relationship. In fact in this instance the therapist colludes with this defensive manoeuvre, by criticising to the patient's mother, see diagram (Therapist 49) p264.

The final examples of projection come from Andrew's therapy as described in chapter 10. Andrew is a homosexual musician, concerned about why his relationships don't last. The first example is to be found in frame 51 pp276-278. The (Patient 51) p278 Claim is that he is not in control of his thoughts about sex. The therapist has presented him with a (Therapist 51) p277 Challenge to think about why the patient's thoughts in the therapy are dominated by sex. In other words the therapist has challenged the patient to reflect on the nature of his own thinking. The patient refuses to do this, he says in (Patient 51) Claim, 'Thinking of sex is not under my conscious control – sex comes whingeing into my

thoughts'. In this Claim the patient says that he cannot take responsibility for his thoughts, the control is located somewhere else. The Warrant 'it is very peculiar', gives some suggestion that indeed there is something strange going on. The Backing spells out the situation. It is clear that the patient does not want to reflect on his thinking or to take responsibility.

The next example is very similar, it is described in frame 52 pp279-281. The therapist is commenting on the nature of Andrew's relationships in (Therapist 52) p280 Challenge, with an underlying assumption in the therapist's Backing that the patient's relationships are on a destructive path. There has been a couple of failing relationships in Andrew's life lately. The patient responds by denying any responsibility for these failures. In (Patient 52) p281, the Claim he indicates, 'Not right stage, or attributes for successful sexual relationships. The Warrant shows where he locates the difficulty, 'the problem is in current situational attributes'. The Backing spells out the need not to take responsibility, 'problem is not my responsibility, it is related to my lover's physical attributes'. In other word's it was his lover's 'fault'.

In all the above examples of projection the patients are trying to deal with distressing feelings, which have arisen in the relationship with the therapist. They are doing it by either a direct response to something the therapist has said or as an association to something that has been said by the patient or the therapist. In some instances the distress has been projected onto the therapist there and then as in frame 12 pp108-110. Responsibility has been projected onto the therapist as in frame 23 pp154-156. When the distress has been projected onto the therapist is has been easy to recognise, as the additional information from the interaction has made it possible to check it out. In the instances when difficult feelings such as aggression or a need to think has become located somewhere else like in something called circumstances as in frame 37 pp211-213, or in the patient's mother as in frame 49 pp262-265, it is not necessarily possible to check out with certainty that the patient isn't talking of external reality. The argumatics analysis has however made it possible to isolate difficult feelings belonging somewhere else, and the effects of doing this on the patient's thinking.

This way of thinking had a consistent effect on all the patients described above. They all were left with a feeling of being victims in a black and white world. While the projections were active they reached a form of cul-de-sac in their thinking, nothing new could be thought about.

The effect on the therapy relationship was evident. The patients created an either-or situation. In these instances the therapists were faced with a choice, if they recognised what was going on. Either the therapist had to address the patient's defensive thinking or to collude with it. To address the defensive thinking would of course mean that tension might arise in the relationship, so pressure to collude may have been felt by the therapist. However to collude meant that the therapist joined the patient in the cul-de-sac Claim. In one instance the therapist solved this dilemma by introducing a, in this context unrelated topic frame 46 pp245-248.

In psychoanalytic language, projection and projective identification creates splitting and persecutory anxiety. Laplanche and Pontalis (1973) quoting among others Sigmund Freud, note that the effects of projection are feelings of paranoia. The examples quoted above would support this as the patients all felt like victims or potential victims. The effect on the interaction has only been discussed in the literature in connection with projective identification, when an unwanted feeling state is induced in the other party. It has not been possible to identify in this research whether any discomfort experienced by the therapists in the interactions have been induced by the patients, but it has been shown that it has a characteristic effect on the interaction, creating a dilemma for the therapist in the manner described above.

Different types of uncomfortable feelings were projected by the different patients. John was projecting something felt to be stressful. George was projecting responsibility for his difficulties. Elizabeth was projecting feelings arising from a suspicion that she was or had been used or abused. Mary was projecting feelings of anger and destructiveness, which Melanie Klein would call projection of the death instinct. Steven was also projecting aggression, which in Kleinian terms can be understood as, projection of the death instinct. He was also projecting responsibility and feelings of neediness. Carol was projecting 'the

unhelpful, bad mother'; in Kleinian terms this could also be an example of projection of the death instinct. Andrew was projecting responsibility and aggression, again in Kleinian terms this constitutes projection of the death instinct.

11.3. Denial

Denial was one of the most common defences encountered in the analysis. The incidences of Denial encountered will be subdivided according to what is denied. The following subcategories were suggested by the analysed material: Denial of inner or Psychic reality, which means denying significant feeling states, denial of a need to think, denial of responsibility which is often accompanied by Projection, denial of external reality or some aspect thereof. Many of the instances of denial had a distinctly omnipotent quality. In fact where omnipotent thinking was evident without a specific expressed denial, this denial was nevertheless evident from the context. Many of the instances can fit under more than one heading. Many instances of denial will also constitute a denial of the significance of a relationship on which the person relies, thus constituting a *manic defence* as described by Melanie Klein 1946 and Rosenfelt 1983.

Denial of inner or psychic reality

The first incident can be found in frame 1 pp77-80 (Patient 1) p79 of John's therapy as described in chapter 4. This incident has already been described under the heading of Concrete thinking. The therapist is challenging (Challenge), the patient John to think about which part of his symptomatology could have a psychological root. This happens in an atmosphere, in which it appears that the patient is not at all prepared to entertain any possibility that psychological factors might be at work. The patient responds in a very concrete way, by dividing up his symptoms. In the section related to (Patient1), the patient says in the Claim 'The hyperventilation and shaking had been caused by stress (psychological), but the feeling of unbalance was not'. The evidence for this was that the feelings of unbalance had been there before, the Warrant. In the relevant vignette, the patient is changing the meaning of the therapist's communication, by making it very concrete. Inner reality is denied and split off.

The next example is from the same patient John in frame 2 pp80-82. This incidence has been described under the heading of concrete thinking. The therapist asks metaphorically what the patient has had to 'hold onto' in the Challenge. The patient responds in a concrete manner that he has had church furniture to 'hold onto ' in the Claim. He is thus changing the level of communication and thus denies his psychic reality.

The next example is from the same patient John in frame 4 pp85-87; this incidence has been described under the heading of concrete thinking. The therapist is challenging the patient in the context of the patient talking about the meaning of being a priest. He talks as though it had the same meaning for him as his previous job with the railways. The patient responds in the section related to frame (Patient 4) p87 in the Claim, by saying that for him it is of equal value to work for the railways, as it is to be a priest. He verbalises a Backing that the idea of priesthood being something different is a modern idea. What has taken place here is that the issues of spirituality which the therapist tried to talk about have been lost by turning this into something concrete and denying, both the issue and at the same time the psychic reality of the possible conflicts in the patient's mind about being a priest.

The following example comes from the same patient John. In his second session he says in the Claims in frame 11 pp106-108 (Patient 11) p106, that nothing of relevance is going through his mind. He provides a Warrant for this statement by saying, 'I have gone through the ground to its limits'. There is the same quality to this statement as there was in the previous one, the patient really believes what he says, although the statement is unlikely to be true. Coming to your second session of therapy, it is unlikely that nothing goes through the patient's mind. Thus this constitutes a denial of his psychic reality.

The next example comes from the same patient John and can to be found in frame 14 pp115-118 (Patient 14a) p118. This incident has been described under the heading of concrete thinking. The patient has used an analogy as he was describing approaching anxiety provoking thoughts. The therapist has tried to expand on what the patient has just said. This however has created too much anxiety in the patient's mind and he immediately reverts to concrete thinking by saying ' It is only about breakdown of two levels of water and of no significance, (Patient 14a) Claim. He has thus not only reverted to concrete

thinking but also denied the aspect of his psychic reality which he only moments earlier had tried to introduce.

In frame 15 pp120-123 the same patient John has started to talk about his anxiety. This incidence has been described under the heading of concrete thinking. The Patient tells his therapist that he fears his symptoms could lead to a frightening mental illness like schizophrenia. The therapist amplifies the patient's fear. This increases the anxiety to intolerable levels for the patient and he denies his anxiety by saying, he only mentioned schizophrenia as it was the only mental illness he knew about (Patient 15a) p123 Claim.

In frame 16 pp123-125 the therapist has made an interpretation that the patient John had felt frustrated in the previous session. The patient denies this in (Patient 16) p125 Claim, in a rather omnipotent way as he says he did not feel frustrated, he provides the Data, because he knew that the therapy had a two-fold purpose, 'to get rid of what was wrong and to help research'. Why should these reasons mean that he could not be frustrated?

In frame 17 pp125-128 the patient John says in the Claim that there are no more particular worries 'as all terrifying worries have been checked out'. This denial is presented in the context of a lot of anxiety having been expressed, such as in frame 15. This denial has an omnipotent quality.

An even more extreme example of denial by use of **omnipotent thinking** can be found in frame 18 pp128-132 of John's therapy. The discussion centres on anxieties, which have been hinted at by the patient. He has mentioned that he has had fears of major mental illness, as shown in frame 15. This is however denied in an omnipotent way in frame 18 (Patient 18) p129 Claim. The patient says in the Claim that he now knew that he did not have schizophrenia, he adds as Data, because the Schizophrenia Society was meeting in the Church Hall. This meant that he had learned about it and had thus been able to eliminate it, a Backing that is verbalised. He adds that it was just a name that popped into his mind as a Warrant. Later in the same frame (Patient 18a) p131 he introduces the Claim that not only has he 'eliminated schizophrenia but also depression'. At the same time he has to admit that his symptoms still continue. The patient is denying his anxiety, his state of mind.

In frame 19 pp135-138 from John's therapy, the context is that some thinking has taken place and some anxiety has been tolerated as the patient has realised that his symptoms have a psychosomatic aspect. The therapist makes a transference interpretation that the patient wants the therapist to reassure him (Therapist 19) p137 Challenge. This is denied by the patient in (Patient 19) p136 Claim. He is thus denying the emotional reality of feeling vulnerable and needy in the face of his anxieties. The patient is now defending not only against his anxieties but also against an awareness of the importance of the therapeutic relationship, thus this defensive manoeuvre could be seen as constituting a *manic defence*. Rosenfeld (1983), discussed how the manic defences are aiming, not only to deny an inner reality, but also the value of anybody the person actually depends who is then experienced as bad in some way.

The next example is described in frame 20 pp138-141 of John's therapy. Towards the end of this therapy the therapist is suggesting that, as he feels that something important had taken place between them, the patient might feel some alarm about ending (Therapist 20) p139 Challenge. The patient responds in (Patient 20) p140 the Claim by denying that there is any alarm, the Data is that his most alarming symptom had not gone, he adds a Warrant that he didn't think it would go. In this instance an inner reality is denied, and not thought of as a possibility or Alternative. This is another example of a *manic defence.* The patient is defending against an awareness of the recognition that the relationship between him and the therapist might have had some value and may therefore be missed.

The next example comes from the therapy of George as described in chapter 5, and can be found in frame 25 pp160-163. This incidence has been described under the heading of concrete thinking. The patient is expressing anxiety that he might 'snap like before', the Claim. The therapist is trying to amplify this statement by suggesting that the patient might fear a breakdown, the therapist's Challenge. This however heightens the anxiety too much and the patient reverts to concrete thinking and denial of the anxiety he has just expressed by saying that he has never experienced breakdown in the sense of 'complete collapse', (Patient25a) p163 Claim, and further more he says he does not know what it involves, (Patient25a) Warrant. He is thus implying that if he does not know what it is he

cannot fear it. He has thus denied his anxiety, which he has expressed only moments before.

The next example can be found in frame 26 pp164-168 from the therapy of George. The context is that the patient has expressed an assumption that the therapist must be very familiar with the therapy situation. The therapist has suggested that the patient may feel 'quite' out of control in the therapy situation, (Therapist 26) p164 Challenge. This prompts the patient to respond as a (Patient 26) p165 Claim by saying he feels *completely* in control. This constitutes a denial of his psychic reality. After all he has produced some evidence that he does feel at least to some degree out of control such as in frame 25. The use of the word 'completely' in this context suggests that this denial has an omnipotent. The discussion is centred on the relationship between the patient and the therapist, and thus the denial in this context suggests that the defence is a form of *manic defence.*

The next example comes from Elizabeth's therapy as described in chapter 6. In frame 30 pp185-187 there has been discussion of Elizabeth's relationship with men. She is thinking about an incident when she ended up sleeping with a man she did not want to sleep with. The patient provides the Claim, that, 'I cannot trust my feelings', this is accompanied by the Warrant that her feelings change and that she does not normally examine her feelings. In other words she has feelings she does not want to think about, whether changeable or not, thus she wants to deny the significance of her confused contradictory feeling. She is thus denying her internal reality.

The next example comes from Mary's therapy as described in chapter 7, The mechanisms, which are evident in frame 37 pp211-213, are also described under the heading of projection. The context is that the patient has talked at some length about how she fears that she will cause some damage. In response to the therapist trying to explore this she changes her story (Patient 37) p211 to saying that she is a victim of circumstances in her Claim, she then adds that does not *deliberately* set fire to things as her Data. She is now *the victim of circumstances.* Thus she has moved from expressing her anxiety to denying the bases or the psychic truth in it.

The next example comes from Mary's therapy and is described in frame 38 pp213-215. This instance has been described under the heading of projection. In the previous session there had been some difficulties in agreeing the times for the sessions. The therapist points out that this seemed to have caused the patient some frustration, the Challenge. The patient responds (Patient 38) p215, by saying that she did not feel a bit annoyed about the difficulties with times in the Claim. The Data is that it was just unlucky, and the Warrant is that she was just annoyed with the 'situation'. Thus there is a denial of any possible feelings of disappointment, in the relationship with the therapist, and the annoyance is projected onto something called 'the situation'. In other words the patient does not want to address the internal reality of the situation. That is the fact that the therapy relationship has had meaning and value.

The next example is from the same patient, Mary and is described in frame 39 pp217-219. The context is that the patient reports that she is feeling better, but she tries at the same time to find a multitude of reasons for this. In (Patient 39) p219 Mary reluctantly considers the possibility that coming to therapy might have been a factor, the Alternative. The main Claim is that the patient denies this by saying 'I cannot see how it (therapy) is having an influence yet'. The idea that if she cannot see it, 'it cannot be', the implied Backing. She does however introduce a lot of uncertainty in her statement as in the verbalised Alternative, although a lot of other explanations are sought. The patient is trying to maintain some form of *manic defence* and tries to deny the significance of her relationship with her therapist.

The next example comes from the same patient Mary and is described in frame 40 pp220-222. The patient denies that she is trying to control the therapist, in the Claim, although he gives examples of her wanting sessions to go on longer, his Challenge. She does not want to consider to possibility that the therapist might be right, because this would lead to a recognition that something important was taking place between them, so this has to be denied. Thus a part of her internal reality is denied. This is another example of a *manic defence.*

The next instance comes from the therapy of Mary and is described in frame 42 pp224-227. The context is that the therapist has been interested in what being a child from a single parent family has meant for Mary. Mary has never known her father. Mary makes a Claim that she can't ever remember wanting a father. This was made in the context of Mary talking about how she felt at school when other children talked about their fathers. A desire to be guided was at the same time emerging in the therapy relationship (transference). Thus it is reasonable to assume that denial is at work here, although her statement has got a Warrant that, all other adults around her had made up for her not having a father. In fact this instance has an omnipotent quality. This can be seen as another example of the m*anic defences* as what is defended against is the potential significance of a relationship.

The next example can be found from Steven's therapy as described in chapter 8. The incident can be found in frame 46 pp245-248. The material comes from the penultimate session of the therapy. The patient implies that he feels worse now than before. The (Patient 46) p246 Claim is that the therapy has put doubts in Steven's mind about whether the way he used to be was the right way and (Patient 46a) p248. The Claim is that now he does not know how to be helpful to his friends. In other words he feels more helpless as a result of his therapy. This suggests that he feels anger towards his therapist. If he can leave therapy feeling it was unhelpful, he does not need to acknowledge any sense of loss of his therapy or therapist. Thus this constitutes a denial of the loss of his therapy, and a denial of any positive significance of the therapeutic relationship. In fact it has a quality of triumphing over the therapist. Thus another example of the *manic defences* as the significance of a relationship is denied. In the post therapy interview Steven was able to recognise that something valuable took place in his therapy (see appendix 3).

The next instance can be found from the therapy of Carol as described in chapter 9. This mechanism is evident in frame 48 pp259-262. This patient suffered from guilt after having left one of her children, a handicapped daughter in an institution. The context is that the patient wants to believe that her other children are coping very well with her working, the Claim. At the same time she is talking about how the au-pairs who looked after her as a child were no good, that is her Warrant1, however she maintains that her arrangements are good for her children, that is the Data. At the same time she reports as a

Qualifier that one of her children is not sleeping well. This constitutes a denial of her own concern that maybe her children are finding her absence while working difficult.

The next example comes from the therapy of Carol and is described in frame 49 pp262-265 (patient 49a) p265. This instance has already been described under the heading of projection. Carol Claims that her own mother was critical, this constitutes the Claim. The Data is that that her daughter is not behind in reading'. The Warrant is that the patient complains that her mother used to 'put Carol down as a child '. The essence of the argument is that Carol feels that her mother is putting Carols daughter down, by saying that she is behind in reading. Carol mentions at the same time that there has been some concern voiced by the teacher as well, but the teachers concerns are explained away. It is clear that under the circumstances the kind of concerns raised by Carol's mother are bound to raise anxiety. Carol does deal with her anxiety not by thinking about whether her mother might have a point. Instead she denies that there is a problem and by doing this she denies her own conflicting feelings. Instead she projects 'the problem' onto her mother. Thus her own conflict is denied.

The next example from the therapy of Carol and is described in frame 50 pp265-268. The therapist has inadvertently made the patient reflect on her relationship difficulties in a wider sense. Carol admits that she found it difficult to make friends at school as her Claim. However the feelings of discomfort are quickly removed as the patient adds in the Warrant that as she has good relationships with her children. From this follows a Backing that she must be OK. Thus from having momentarily been in touch with conflicting feelings about herself, she quickly returns to a defended position, denying the anxiety.

All the above examples of denial have risen in response to a therapist's Challenge. They are usually located in the Claim of the patient. They have been identified as denial, by looking at both the therapist's and the patient's statements together. Additional evidence for the fact that this might be a denial has been sought from the context and the patient's argumentation. The nature of the Data and the Warrant has shown whether the patient's Claim has substance.

In the relationship this mechanism has a similar effect to projection, either the therapist leaves this particular exploration thus colludes or he/she continues to Challenge the defence creating tension. There has been a considerable overlap with other categories, suggesting that many other defences also constitute a denial.

Denial of a need to think

The next subgroup has less of an omnipotent quality. It could be characterised as a 'pre-stage to full denial. These are instances which arise when a form of contradiction is present, or when the patient's argument does not quite 'add up'. Thus these are instances necessitating a need to think. In Freudian terms the material is probably preconscious. This does not mean necessarily that what is denied is the truth, it may also mean that it is somehow close by association to something which creates anxiety, thus to think about what is discussed may be useful but is avoided.

The first example is from the therapy of John (chapter 4). The example is described in frame 5 pp87-91 (Patient 5) p90. This incident has been described under the heading of concrete thinking. In the context of talking about his thoughts about being a priest John claims (Claim) that in spite of his difficulties (which might force him to give up the priesthood), he says, 'It is my place to be a priest (rather than something else). The question, which has emerged in the therapy, is whether the patient's symptoms, which might jeopardise his future as a priest, might have arisen because in some way the patient does have doubts about his choice of profession. No answer is necessarily suggested, but it seems that the idea might be worth thinking about. As shown above the patient denies the need to think about it.

The next example is from the same patient John and is described in frame 11 pp106-108. This has already been discussed under the heading of denial of psychic reality. At the beginning of the second session, when he reluctantly returns to his therapy, the patient claims (Claim) that he thought that the patient and therapist had 'more or less agreed that they had covered all the ground that it was possible to cover'. This was not what happened in the session before. Thus to make a statement like this means that some feelings or ideas were touched upon, that might require thought, but this is denied.

The next example comes from the therapy of George (chapter 5), it is described in frame 23 pp154-156. This describes one of the earliest interactions between patient and therapist. Here the therapist comments of the patient's style of communication. This incident has already been described under the heading of concrete thinking and under the heading of projection. The patient responds by saying the interview format is what he is used to, and he seemed to expect the therapist to keep things going between them, (see Claim and Warrant). There seems to be no willingness to reflect on his own functioning, thus this constitutes a denial of the need to think.

In the next example comes from the therapy of George, it is described in frame 24 pp156-160. This incident has been described under the heading of projection. The therapist is wondering if the patient's problems might have had an effect also on his marriage as her Challenge. There were suggestions in the material that this might have been the case. Whatever the truth of it might be, it is reasonable to assume that it is an idea worthy of thought. However the patient claims (Claim), that the only real problem he and his wife have is the dog. He has thus denied the need to think about the therapist's suggestion any further.

In the same context George claims (Claim) in the same frame 24 (patient 24a) p160 that, 'What goes on at home is of no relevance to my problem'. In effect reinforcing the denial that his state of mind and his home situation and marriage might be interrelated, or at least that it might be something worthy of thought.

The next example comes somewhat later in the session. It is described in frame 26 pp14-168 (Therapist 26a) p166 and (Patient 26a) p167. The therapist comments on the patient's style of arguing in the Challenge. The therapist comments that the patient has got a very intellectual approach to things. The patient's response is to Claim that he is a very intellectual person. The Data is that he tries to be rational, and the Warrant that he has no experience of therapy. It could be argued that the therapist did not express her Challenge in a very helpful way to this patient who displayed a narcissistic personality, and greatly valued his intellectual achievements. However unwittingly this enabled the patient not to reflect on what is being suggested. The therapist tried to draw the patient's attention to the fact that there seemed to be very little feeling in the way he presented himself. Thus it

amounted to a denial of a need to think. This instance has also been classified under the heading of concrete thinking.

These instances have been identified in the argumatics analysis in the same way as the instances of a denial of a significant feeling state, described above.

Denial of Responsibility

This category, emerged from the material found in the Data. It was observed that the patients in this sample frequently showed a tendency to put forward an argument such as 'it is not my fault or my responsibility'. This was often but not always accompanied by a projection of the responsibility onto someone or something. Most of these instances have already been mentioned above under the heading projection, when the underlying denial has been dealt with by projection. At the same time these patients relinquished on those occasions their power to influence their lives in important respects.

The first incidence can be found in frame 24 pp156-160. The example comes from the therapy of George (chapter 5). This incident has already been described under the heading of projection. The therapist is wondering if the patient's difficulties have caused tensions in the patient's marriage (Challenge). The patient denies the presence of problems at home (Claim). He admits that there is tension between his wife, but 'only about the dog'. Thus he denies any responsibility of being part of creating tension, instead the cause of tension is displaced/projected onto the dog (Patient 24a) p160.

The next examples come from the therapy of Steven (chapter 8). This example is described is described in frame 45 pp241-243. This incident has already been described under the heading of projection. The therapist is encouraging the patient to tell him about the traumatic events, which took place in connection with Steven's son having been sexually involved with his male teacher. Steven talks of how angry he is with his son, evident in the Claim, Warrant and Backing. There is no thought of how the patient may have contributed to his son seeking intimacy with his teacher. As a result the patient feels persecuted, angry and helpless, but not responsible in any way. Thus there is denial of responsibility and a projection of this responsibility onto the son. In this instance the therapist is colluding with the defence by amplifying how the patient feels.

The next instance comes from the same patient Steven, and is described in frame 46 pp 245-248. This incident has been described under the heading of projection. This is the penultimate session of this therapy. The patient feels he now feels more confused than before his therapy (Claim). The patient feels he cannot now he helpful to his friend in the way he used to, (Warrant). The implication is that the therapist has 'done' something to make things worse for the patient. Thus the responsibility for the patient's emotional state is denied and projected onto the therapist. The therapist is trying to connect these feelings to the ending of the therapy (see Challenge), but the patient is not able to use this interpretation. The patient's defensive manoeuvre amounts to a triumphing over the therapist, thus this could be understood as another example of the *manic defences*.

The next example is from the same session of Steven's therapy. It is described in frame 47 pp 248-251. This incident has been described under the heading of projection. Steven is discussing his sex life with his wife. He feels that their sex life is bad or non-existent *because of his wife,* (see Claim and Warrant). Thus he denies his responsibility, and projects this onto his wife.

The next example comes from the therapy of Andrew (chapter 10). The first incidence is described in frame 51 pp276-278. This incident has been described under the heading of projection. The therapist has commented that the patient is very focused on sex (see Challenge). The patient responds by denying responsibility, by Claiming that he can't help it. He says 'It is not under my control – sex comes winging…', the Claim. He has thus not only denied responsibility, but has also changed the level of communication, and is not reflecting on *why* this might be the case.

The next example is from the same patient, Andrew and is described in frame 52 pp 279-281. This incident has been described under the heading of projection. The therapist is inviting the patient to reflect on yet another breakdown of a relationship. The Patient responds by blaming his lover's physical attributes, thus denying his responsibility and projecting it onto his former lover, (see the Claim, Warrant and Backing).

The final example comes also from Andrew's therapy and is described in frame 53 pp 281-285. The therapist is continuing to try to get the patient to reflect on what he does in his relationships. He wonders if the patient rejects his lovers as an attempt to be in control, (see Challenge). The patient says he has not really rejected he latest lover as a Claim, he has only rejected him physically as Data. He adds a Warrant that he would much rather be faithful to his latest lover. The Backing is a suggestion that this state of affairs is not his responsibility. Thus he is denying responsibility for his rejection. He continues to create this split between a physical and an emotional relationship (Patient 53a), p285 he says 'Sex and feeling are two separate things' and he claims (Claim) that his relationship with his former lover has in fact 'deepened'. Thus moving even further away from taking responsibility for his rejection.

These incidents have been identified in the argumatics analysis in the same way as denial of significant feeling states, described above.

Denial of Aspect of external reality

There is only one examples of this type of denial.

This example can be found in John's therapy (chapter 4) and is described in frame 13 pp110-114. The patient claims (Claim) that he thought that there had been some kind of agreement between him and the therapist that they had covered all the ground, which it was possible to cover. He does not base this statement on anything, except he says, from talking to the therapist he had reached the conclusion, this is the Data. This statement has got a distinctly omnipotent quality. Nothing of this sort had in fact taken place so this represents either a conscious or an unconscious denial of external reality.

This instance has been identified in the argumatics analysis in the same way as the above forms of denial.

The sub-categories used in this analysis emerged out of the analysed material. The first category of denial of a significant feeling state can de described in Kleinian terms as a denial of inner reality. Klein describes how this form of denial is intrinsic to what she calls the m*anic defences*. This means that significant feeling states are denied and importantly the significance of a relationship is denied.

By far the largest identified sub-category was denial of significant feeling states. In many instances this involved also a denial of the significance of a relationship. The instances of denial of the significance of a relationship usually involved a denial of the significance of the therapeutic relationship. The sub-category of denial of responsibility also involved a denial of the significance of a relationship. Under this sub-category was included also several instances of denial of a significance of external relationships. Many of the sub-categories of denial were often accompanied by a projection and could be seen as a first step in the process of projection. The category of denial of a need to think arose because it was frequently observed how the therapist's Challenges were ignored or by-past without thought. All the examples quoted under this sub-heading shows the characteristic 'lack of thought', at the very moment when the subjects were challenged to reflect.

The final form of denial, which was observed, was the denial of external reality. This one was the easiest to identify and corresponds most closely to what has been described as classical psycho-analytic denial. There was only one instance of this form of denial described in frame 13 pp110-114. The patient makes a statement about what had happened between the patient and the therapist the previous session. The material from the previous session however shows that nothing of the sort took place. However it is also possible to understand the nature of this defensive manoeuvre by looking at the interaction described in frame 13. This instance comes closest to Sigmund Freud's (1925) original idea of negation.

The incidents of denial were observed as events in the therapeutic relationship and have in the argumatics analysis been identified **in the interaction**. It is of course possible that the therapists are simply on the wrong track and that a denial is appropriate and not a defence. The defensive nature of these instances has been deduced from the nature of the argumentations, which the patients were using and how the patients were substantiating their Claims.

I have described each instance of denial as an event in the therapeutic relationship, which colours the interaction between patient and therapist. It stops further exploration unless the defence is in it self challenged. The sub-categories can serve as a suggestion of how these may be challenged.

11.4. Destruction of meaning

All the incidents described under the heading of concrete thinking can also be categorised under the heading of destruction of meaning. However there are also other examples of destruction of meaning. An example of this can be found from Andrew's therapy (chapter 10) described in frame 51 pp276-278. This incident has also been described under the headings of projection and under the heading of denial of a need to think. The destruction of meaning in this example happens when the therapist is challenging (Challenge) the patient to reflect on how the patient is thinking in the session and how his thoughts are dominated by sex. Instead of engaging in thinking, the patient responds as in the examples categorised under the heading of concrete thinking **by changing the level of communication** or retreating into a helplessness created by a denial of responsibility. In this instance the patient retreats into a form of 'I can't help it', when he implies that it just happens (Claim). The Challenge is not addressed, the issue of why this might be the case is not thought about.

What is destroyed, is the fact that the therapist is trying to talk of the **meaning** of this behaviour. This can be deduced from the fact that in the argumatics analysis of the patient's communication there is no reference anywhere to the idea of meaning while the therapist's communication shows some attempt to think of meaning, (see Warrant).

11.5. Displacement

Laplance and Pontalis (1980) described Displacement as follows:

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

Most incidents, which could be described as displacement in this analysis, have been described under the heading of projection. There appears little distinction between projection and displacement as presented in the interactions between the patients and therapists participating in this research. There was only one incident where the focus of the disturbance shifted in such a way that to describe it only as displacement seems more appropriate. This incident is described in frame 28 pp180-182 of Elizabeth's therapy (chapter 6). In this frame Elizabeth describes her feelings of shock as she saw the painting of herself naked and blind folded. She moves from getting close to feelings that she has been exploited (see Claim and Data) to feelings that she does not like what her body looks like, the Warrant. In other words the focus of the disturbance has shifted from feeling disturbed about the possibility that she has been subjected to some kind of abuse to feelings that she is ugly. This could also be understood as an *internalisation* of what is felt to be ugly.

The displacement is seen in the movement from the Claim and its impact to the Warrant, which gives it a different emphasis, and also to a different Backing, focusing on what the patient felt her body looked like.

Thus projection can be seen as a displacement but displacement can in itself be something different from projection, depending on where the disturbance comes to be located.

11.6. Reaction Formation

Laplance and Pontalis (1980) describe reaction formation as follows:

> Psychological attitude or habitus diametrically opposed to a repressed wish, and constituted as a reaction against it.

What could be described as reaction formation was only observed in the therapy of Elizabeth (chapter 6). The first incident is described in frame 27 pp177-180 (Patient 27)

p178 and (Patient 27a) p180. The patient is telling the therapist of how confused, disturbed and passive she felt as a result of seeing the completed painting of herself naked and blind folded (Patient 27) Claim, Data, Warrant and Backing. The therapist (Therapist 27) p179 reinterprets the patient's confusion by giving it a positive connotation by saying that maybe she was trying to be more active, in the Challenge. The therapist's intervention opens the way for the patient to use reaction formation. The patient can now say that as she had *wanted* to be painted like that it meant that she was in control. Thus feelings of being out of control have been transformed into feelings of being in control (Patient 27a) p180 see Claim, Warrant and Backing. The movement in the patient's mind takes place from the communication described in (Patient 27), aided by the therapists intervention, the Challenge, to a complete turn around in the communication described in (Patient 27a). The shift can be seen in how, although the patient is describing the same issue the Backing in (Patient 27) and the Backing in (Patient 27a) has changed into its opposite.
The next example comes from the therapy of Elizabeth and is described in frame 29 pp182-184. The patient and the therapist are continuing to discuss the painting. The therapist suggests that the purpose of modelling for the painting may have been the patient's way to get rid of ' the passive woman within her', the Challenge. This leads the patient (patient 29) p184 to move from getting close to feelings that the painter had abused her somehow as happened in frame 27 and 28 to her saying, 'but I like the painter', the Claim. Thus feelings of maybe anger and resentment become feelings of 'liking'.

To identify this instance it was necessary to use the material described in frames 27 and 28 as a background to see how the feelings have changed from feeling disturbed to 'being in control'.

In fact to identify this mechanism of how feelings change into their opposites it is necessary to look not only at the interaction in any one frame but also at several frames at the same time. The interaction shows in these instances how the defensive manoeuvre is achieved by the help of the therapist.

It is not clear from the examples above if this is a defence against an unconscious wish, but the defensive thinking does appear to protect the patient from anxiety.

The function of this mechanism in the therapeutic relationship does not appear to be one of obstructing or not co-operating as has been the case with many of the other mechanisms described above. In fact the therapist and patient seem to be working together in creating defences, in these instances.

11.7. Identification/ Introjection

These two mechanisms were put together as both in the literature and in the analysis there appear little distinction between them. Laplance and Pontalis (1980) describe them as follows:

> Identification is a psychological process whereby the subject assimilates an aspect, property or attribute of the other.
>
> Introjection is a process whereby the subject transposes objects and their inherent qualities from the 'outside' to the 'inside' of him/herself.

There were only two examples of this defence from the therapy of Elizabeth described in chapter 6. The first can be found in frame 28 pp180-182. This instance has already been described under the heading of reaction formation. The context is that Elizabeth has been wondering about if she has exposed herself to abuse by doing life modelling. The Claim is that the painting looked bizarre The Data is that this was because of the combination of nakedness and the blindfold. The Warrant however is that 'the fleshiness of a woman's body was somehow disturbing. The implied Backing then becomes that the disturbing element was her own body. Thus she had moved from a position that what was disturbing was something which happened between her and the painter to what was disturbing was her body.

The second instance comes also from the same patient's therapy and is described in frame 30 pp185-187. As above the patient and the therapist have been talking about whether the patient has felt used or even abused by the painter for whom she has been modelling. In this section Elizabeth says that she would like to continue to meet with the painter as ***she feels she has somehow used him.*** In other words she has identified with whom she has felt the painter to be. This could be seen as an example of what is known as identification with the aggressor. Elizabeth has introjected an aspect of her Object.

This instance has the same quality as the instances of reaction formation described above. But the turning things into its opposites has in this instance been achieved by the patient 'taking into herself' the aggressive qualities. In order to identify this instance, it has been necessary to look at several frames, 27 to 30 to get the transformation of the expressed feelings.

11.8. Manic defences

In the analysed material as presented in this chapter a number of defences have been used in ways which correspond to what Klein and Rosenfelt described as the *Manic defences*. These have been highlighted as they occurred. The theory suggests that it is a state of affairs which occurs at the threshold of the Depressive Position when the awareness of the importance of a given relationships becomes possible. The individual finds this threatening and denies his own psychic reality and denigrated or triumphs over or devalues his Objects so that he does not have to become aware of his/her dependency on his/her Objects. The Data from these patients suggests that there can be a denial of psychic reality even when there is no suggestion of an awareness of the value of the Object. This was the case at the beginning of John's therapy. However there were several instances of what could be seen as corresponding to the description of the *Manic defences*, where the need appeared to be to defend against a true recognition of the value of the Object. This was the case for instance with Mary, who did not want to recognise the value of her therapist.

11.9. Another Defence

Most incidents of defence encountered in the Data can be classified under the above headings. However there was one instance where it could best be described differently. In the therapy of John (chapter 4) in frame 10 pp100-102 John is Challenged to think about his murderous feeling towards a colleague. He accepts the Challenge and does indeed recognise that he has had these feelings, but he defends against the impact of this realisation by making it 'a special case'. He does a type of isolating exercise, and says this does not happen under **any other** circumstances. This mechanism has been identified by comparing the Claim, and the Warrant in the diagram (Patient 10) p102.

11.10. Tolerance of anxiety/ thinking

In contrast it can be useful to examine some of the incidences where the patients were able to tolerate anxiety even for a short while so that some thinking could take place and the possibility of insight was there. Hanna Segal 1980 shows how psychoanalysis has as an aim to increase the patient's freedom of thought, she says:

> Freedom of thought-and at best, I think we still have very limited freedom in that respect-means that freedom to know our own thoughts and that means knowing the unwelcome as well as the welcome, the anxious thoughts, those felt as 'bad' or 'mad', as well as constructive thoughts and those felt as 'good' or 'sane'. Freedom of thought is being able to examine their validity in terms of external or internal realities. The freer we are to think, the better we are to judge these realities, and the richer are our experiences. But like all freedoms, it is also felt as a bind in that it makes us feel responsible for our own thoughts.

These are incidents when the value of another person could be recognised. All patients except Andrew and Steven had moments where anxiety could be tolerated and thought about. In the following I will give an example from each of the five patients and references to more examples.

In John's therapy (chapter 4) there was evidence of a capacity to tolerate anxiety in frames 9, 15, 17, 21, 22.

In frame 22 pp142-144 in one of the later sessions of John's therapy the therapist suggests that the patient may sometimes have felt truly desperate, in the Challenge. The patient

agrees and admits to having felt something like suicidal at times, as he remembers times when he woke up feeling truly desperate in his Claim. He backs this up in the Data by saying he would not have minded if he had some deadly disease. The Backing is implied, that is, that John must have felt suicidal, thus it is consistent with the Claim and Data. In this instance John is tolerating anxiety and feels safe in the presence of the therapist to think about difficult feelings.

In George's therapy (chapter 5) there was only one brief moment when George could allow some recognition of his internal state. This is described in frame 25 pp160-163 George admits that at times he feels 'a knot' inside himself and feared that something might 'snap like before', the Claim. The therapist's amplification, the Challenge, of these feelings however leads to George returning quickly to his defended position.

In the therapy of Elizabeth (chapter 6), Elizabeth made many attempts to explore her anxieties, these are described in frames 27, 31, 32, 33, 34, 35. However in this therapy it appears that Elizabeth's therapist was not helping to bring out these anxieties but was her self defending against the emerging anxieties. At the same time it appears that Elizabeth was on occasions introducing confusion and anxiety in order not to think, as in frame 33 pp193-196.

In frame 35 pp198-201 Elizabeth recognises that there has been some value in thinking about how abusively her father had behaved in the patient's childhood, the Claim. She does not defend against this realisation but states later (patient 35a) p201 that she does not want to 'revisit abuse', in the Counter-Claim.

In Mary's therapy (chapter 7), Mary shows evidence of tolerating difficult feelings in frames 36, 41, 44.

In the section relating to frame 41 pp 222-224, Mary expresses her vulnerability by saying in the Claim, 'I assume that you have got some ideas of control', and in particular in the Data supporting the Claim by saying, 'I need some guidance'. At the same time she also says that she assumes that the therapist is in control. In doing this she has some recognition of her dependence on the therapist.

In Carol's therapy (chapter9), Carol only tolerated anxiety for one fleeting moment. This was described in frame 50 pp265-268.

In response to the therapist asking Carol if she felt she was a powerful person in the Challenge. Carol momentarily reflects on the fact that she had had difficulties forming relationships when she was a child, in the Claim. For a moment she does not blame her difficulties on someone else. However she cannot tolerate this very long and in the next sentence she 'forgets' and says she has no difficulties with her children, this is offered as a Warrant.

These instances have been identified from the argumatics analysis from the patients' statements usually from the Claims arising in response to a demanding Challenge from the therapists. The patients have in these instances been able to consider the therapists' Challenges. When these moments have been analysed the patients' diagrams show a degree of consistency in the Claims and Data at least. In the above mentioned examples there was further broad agreement also in the Warrants and Backings in frames 22, 25, 33, 35 and 41.

These are not moments when the patients are simply complying and just accepting some 'guilt', but moments when they are struggling with uncertainty. These are also events when there is a correspondence between therapist's level of communication and the patient's level of communication, when they are so to speak ' speaking about the same thing'. This has been established by looking at the therapists' and patients' communication together in each frame.

This chapter has described each mechanism in detail as identified by the analysis. The mechanisms as identified here bear a resemblance to the defence mechanisms as described in the literature, however additional subcategories have also been identified under the heading of denial. In some instances mechanisms have been categorised under several headings. The therapist's styles had clearly a bearing on how the mechanisms emerged. Moments of relatively undefended communication have also been described. These were moments when some thinking took place paving the way to new meaning.

The next chapter will describe the different therapists' styles as they emerged from the analysis.

12.Therapist styles

This chapter will describe each of the different therapists and their idiosyncratic styles as they emerged from the analysis. The patients/subjects in this study were seen by five different therapists. Two of whom were CAT (cognitive analytic therapists), these were therapist, J. and A., and three were medically trained psychotherapy registrars, these were therapist K., I., and G .

Therapist J.

This female therapist treated two of the patients, Elizabeth and Carol. This therapist's interventions, can be seen in frames 27 – 35 (chapter 6) and frames 48 – 50 (chapter 9). Therapist J. was trained in counselling and was treating both the patients under supervision, using a CAT (cognitive analytic therapy) model. Her style was rather collusive and it does not appear that she was aware of the patients' defensive communications. She was principally engaged in an activity, which could be described as 'positively re-framing the patients dilemmas'. This happened for instance in frame 29 pp182-184. In this frame the patient was beginning to worry about what she was doing to herself. The therapist did not help the patient to keep on thinking, instead she re-interpreted the patient's situation in a positive way, giving the message that 'things are really OK and no further thought is required'. This is evident in the Challenge, Warrant and Backing of frame 29 (Therapist 29) p183. For instance the Warrant is verbalised to the patient as follows '(the painting of you naked and blindfolded) is like the execution of the passive image of you'.

In frame 49 pp262-265, the therapist actively supported the patient's projection. Carol had started to talk about her own mother as the 'bad mother'. The therapist supported the patient's view. This is evident in the Challenge, Data, Warrant and Backing (Therapist 49) p264. It is of course possible that the therapist recognised that the patient was defending against thinking about her own failings as a mother, but the therapist chose not to challenge the defences. This may have happened as a result of pressure from the patient. The impression remains however that this therapist was not able to recognise or willing to help her patients to discover new meaning.

The independent psychoanalytic assessments with regard to Elizabeth, on p203, supports this view. The independent psychoanalyst commented on the rather cosy atmosphere in the session, he said, ' I suspect that the pleasant and somewhat entertaining tone of the interview would have changed if, *the client had been put in touch with what she was doing'*.

He also commented on the interaction between Carol and therapist J. on p270 as follows, 'the interviewer, keeps everything very reasonable and so is, in this interview seemingly unaware of how she is being controlled and being made to offer re-assurance'.

In the post therapy interview, see appendix 3, Elizabeth reported that she liked her therapist. Maybe she liked her because she did not challenge her but broke her isolation at least for a while. At the same time Elizabeth may have been aware of an unhelpful collusion as in frame 32 pp190-192. Elizabeth insisted that something was wrong. The histogram showing frequencies in pre-occupations on p202 did not reveal any significant change. Carol refused to be interviewed after the therapy but her histogram on p269 showed that very little change had taken place during the therapy.

Therapist A.

Therapist A. was a male therapist treating Steven. Therapist A. was a psychiatric nurse without specific training in therapy but he had some experience of treating patients using the CAT model. He was treating Steven under supervision by a senior colleague experienced in CAT. His interventions can be seen in frames 45-47 (chapter 8). Therapist A. used a mixture of interventions, such as amplification of the patient's feelings as in frame 45 pp241-243. The patient had just expressed his anger and disappointment about his son. Therapist A. merely restated that the patient must have been very angry. He did this in a rather collusive way, and thus he legitimised the patient's feelings. There was an attempt to interpret in frame 46 pp245-248, as he tried to connect the patient's feelings to the therapy situation. In frame 47 pp248-251, therapist A. offered the patient reassurance in the context of discussing the patient's sex life. Therapist A. said: 'your sexuality is only waiting to be rediscovered'. There is little evidence that the therapist had recognised the patient's defences and he certainly did not challenge them effectively.

The independent psychoanalytic assessment, on p253, supports this view. The independent psychoanalyst said; 'the interviewer keeps his own feelings and those in the interaction quite reasonable, which is both understandable, and which the client himself is able to co-operate with. Should the relationship intensify, I suspect that feelings of reasonableness, would inevitably collapse, and give way to paranoid, perhaps even dangerous elements'.

When interviewed after the therapy, Steven did however report that he had found the therapy helpful (see post-therapy interview, appendix 3). He also said that that he was now more able to reflect on things. His feelings about his son did not change according to Steven.

Therapist K.

Therapist K. was a male therapist treating John and Mary. His interventions can be seen in frames1 – 22 (chapter 4) and 36 – 44 (chapter 7). Therapist K. was a psychiatrist by training. Therapist K. was at the time in psychoanalytic training. He was treating John and May under supervision using a psychoanalytic brief psychotherapy model with a focus. Therapist K. made many attempts to address the patients' defensive manoeuvres. For example in frame 3 pp83-85, he tried to draw the patient's attention to the patient's concrete way of thinking. The patient has said that he feels better, because he had got church furniture to support him. Therapist K. tried to draw the patient's attention to *the way he was thinking* by saying, 'It appears very difficult for you to entertain a psychological explanation'. He made interpretations, such as in frames 9 and 12. In frame 9 pp98-100 he made an interpretation that the patient needed to hold onto his symptoms, that they served a purpose for him in some way. This interpretation was made in the hope that it would start the patient thinking. He tried to encourage the patient to stay with thinking about difficult things such as in frame 14 pp115-118. The patient has given an analogy about how he deals with anxiety. Therapist K. tried to keep the patient thinking, by suggesting that that the analogy may also have been about his childhood as the patient had talked a lot about his childhood.

In the therapy with Mary he challenged her defensive thinking in frame 37 pp211-213. He did this coherently by presenting the patient with both the Challenge together with the Data. The Data was a rephrasing of the patient's statement, that she feared causing harm.

The Challenge was a different conclusion from the patient's conclusion, which was that she felt she was a victim. Therapist K. maintained that the patient's dilemma was not about being a victim. In frame 39 pp217-219, he encouraged the patient to reflect on her thinking processes as presented in the therapy and thereby tried to encourage the patient's awareness of her defences. In frame 40 pp220-222 he challenged (Challenge) the patient's denial. The patient had maintained that she did not want to control her therapist. Therapist K. challenged this by pointing out how the patient has tried to control the length of the sessions.

The independent psychoanalytic assessment on p146, mentions with regard to John's therapy that the therapist struggled to achieve meaning, and tried to name missing feelings. The therapist's interventions are not commented on in the independent psychoanalytic assessment of Mary.

The histograms representing changes in pre-occupations on p145 for John and on p235 for Mary showed decreases in the frequency of the most troublesome reported symptoms, for both of these patients. John did not however acknowledge that the therapy had been of much help although he felt more positive about his life at the time of the post therapy interview (see appendix 3). Mary was able to acknowledge that changes had taken place as a result of her therapy in the post therapy interview (see appendix 3).

Therapist I.

Therapist I. was a female therapist treating George. Her interventions can be seen in frames 23-26 (chapter 5). Therapist I. was a psychiatrist without previous experience of acting as a therapist. She was treating George under supervision by senior colleagues, using a psychoanalytic brief psychotherapy model with a focus.

Therapist I. tried to address the patient's defensive style in frame 23 pp154-156, when she commented on the fact that the patient was approaching the therapy session as if it were an interview, see Challenge and Data p154. She tried to keep the patient thinking about his anxieties in frame 26 pp164-168, by amplifying what the patient has just communicated, that the patient had indicated that he felt out of control. However it appears that the amplification was excessive as the patient withdraws again into defensive thinking.

In the independent psychoanalytic assessment on p170, the therapist is described as 'struggling to think as a result of being in receipt of feelings of failure and inferiority, actively projected into her'. The patient's preoccupations did not change much as represented by the histogram showing changes in preoccupations on p 169.

Not surprisingly George did not feel that his therapy had been very helpful at the time of his post therapy interview (see appendix 3).

Therapist G.

Therapist G. was a male therapist treating Andrew. His interventions can be seen in frames 51 – 53 (chapter 10). Therapist G. was a psychiatrist treating one of his first psychotherapy patients. He was treating Andrew under supervision by senior colleagues using a psychoanalytic brief psychotherapy model with a focus.

Therapist G. was not directly challenging, or demonstrating Andrews's defences. He tried to encourage the patient to think by clarifying the patient's situation as in frame 53 pp281-285. Andrew has talked about how yet another relationship had not worked out because of the attributes of the partner. Therapist G. tried to put a different interpretation on the patient's behaviour by suggesting that the patient had a need to be in charge. The patient did not take up this suggestion.

In the independent psychoanalytic assessment on p287, the therapist is described 'as being drawn into becoming rather moral'.

The histogram showing changes in frequencies of pre-occupations on p 286 shows some important changes in Andrew's preoccupations. There were fewer references to casual sex and an increase in reflective statements. Andrew refused to be interviewed after the therapy ended.

It appears that the therapists in general found it difficult to identify and/or use the opportunities which arose, to show the patients how and when the patients were unable to think, and used defences instead. It is not always possible to be sure if this was the case because the therapists were unable to identify the mechanisms or chose not to challenge the patients or even felt under pressure from the patients not to do so. In many instances

one gets the impression however that the therapists were unable to identify the mechanisms used by their patients and were therefore ineffective in their interventions.

In other words not interpreting or demonstrating the defensive functioning constitutes a missed opportunity. This appears to have been the case in frame 49 pp262-265, mentioned above. Had therapist J. been able to interpret the patient's projection, so that the patient's underlying anxiety could have come into view, (that of the patient fearing that she is a 'bad mother'), this anxiety could have been explored and possibly modified.

Similarly therapist G. missed an opportunity to demonstrate Andrew's use of denial in frame 53 pp281-285. Although therapist G. invited the patient to reflect on his behaviour, therapist G. was not actually challenging the defence, in such a way that would have made it possible for the patient to think about his situation in a different way.

When comparing the CAT therapists with the psycho-analytic therapists, the most striking difference appears to be that the CAT therapists behaved in a more collusive fashion with their patients.

The suggestion emerging from this research in general is that when therapists are not interpreting the patient's defensive styles at least some of the time, they do in fact deprive the patients from an opportunity to discover new meaning.

This chapter has described each therapist's style as it emerged from the analysis. The very real difficulties that the therapists had to face have been highlighted. Only therapists J.A. and K. had some significant experience in treating patients in therapy.

The next and final chapter includes conclusions about each mechanism, a brief description of each therapy as it emerged in the analysis together with a discussion about the methodology and finally suggestions of possible implications of this research.

13. Review and Conclusion

This chapter reviews how observations have been made in this thesis, including a discussion about how the argumatics methodology has been adapted to capture the relevant processes. The nature of the observed mechanisms in general is discussed, together with a specific discussion about the nature and effect of each mechanism as it emerged in the analysis. Each patient's course of therapy is briefly reviewed. Finally, the implications of this research and possible future uses of what has emerged are discussed.

13.1. How observations have been made

In order to track closely what takes place in the consulting room between patient and therapist, this research is rooted in the relatively new tradition of examining and understanding the **process** of the therapist patient interaction. This has not been done primarily in terms of examining frequencies of occurring events. It has been done by identifying and examining **events in context**. It has paid particular attention to patterns of interaction, which correspond to what is described in the psycho-analytic literature as 'defence mechanisms' in the sense that these patterns of behaviour appear to create a distortion which enables the patients to avoid uncomfortable feelings as they occur in a relationship. Greenberg and Pinsof (1986) put is as follows:

> *'The event in context is a generic methodology that can be realised with various research designs and statistical procedures. It is rooted in an epistemology that asserts that nothing can be known o or ultimately even exist independently of the context in which it occurs.'*

In general, this has been an exercise in identifying the effects of unconscious psychological mechanisms as **patterns of process in a particular context**. The context in question is the therapy process or the interaction between the patient and therapist.

The task of the analysis in this thesis has been two-fold, firstly it has been an attempt to evaluate how useful the theoretical descriptions found in the psycho-analytical literature are in understanding the defence mechanisms used by individuals. Secondly to attempt to map out what actually happens in the therapeutic situation, or not as the case may be.
The patterns under investigation have been arrived from the argumatics analysis applied in chapters 4-10, in developing the results for each patient- therapist pair. The argumatics analysis involved taking sections of transcribed therapy and isolating the argumentation

patterns of both the patient and the therapist. The patients' statements have been analysed in terms of the nature of the argumentation and how this has been substantiated or not as the case may be. The patients' statements have then been examined in the light of the related therapists' statements, which, have in turn have been analysed in terms of the elements of the argumentation. In other words it addresses, the questions of 'what does the patient need to consider' or 'what is he/she challenged to consider at any point in time' and 'how is the patient rising to this challenge?' On many occasions this has involved analysing not just a specific argumentation frame, but several frames occurring both before and sometimes after the frame in question in order to clarify the context of the interaction. Also, subsequent frames have sometimes provided confirmation of the conclusions. The interpretations, however, have involved the use of specific psycho-analytic skills, which have been demonstrated in the analysis section of each analysed frame. To quote Greenberg and Pinsof (1986) once more,

> 'Different investigators may perceive the same pattern without finding the same meaning in the same in the pattern. This is well illustrated in interpretation of X-rays or microbiology slides. First one needs skills to even see the patterns. Second, the pattern has particular meaning for the trained observer. Explanation of a pattern is therefore arrived at by a human act of interpretation in which the observed pattern and the construed meaning are used to help in the discovery of new features of reality.'

At the same time the reliability of constructing the diagrams of the argumatics analysis has been tested by three researchers thus cross validating the tools as described in chapter three in section 3.3 p64. In addition, the general reliability of the psychoanalytic interpretations of the subjects' material has been checked by obtaining independent assessments of samples of each patient's material from a senior Kleinian Psychoanalyst. His comments on this material can be found at the end of each of the results chapters (4-10).

13.2. Differences between normal and pathological defences as evident in the Data

In summary of the findings of chapter 11, it might be helpful to review the type of mental mechanisms, which we are concentrating on. The focus of this thesis has been primarily the pathological use of defences. The assumption that what we have encountered in the

analysis of the data has been pathological was deduced from the effects of the 'defensive clusters', or 'defensive organisations' in the therapeutic discourse.

The concept 'defensive organisation' was introduced by Willi Hoffer (1954), and discussed by O'Shaughnessy (1979).

> 'The defensive organisation unlike defences which are –piecemeal, transient, recurrent and part of normal development, a defensive organisation is a **fixation**, a pathological formation when development arouses irresolvable and almost overwhelming anxiety. Expressed in Kleinian terms, defences are a normal part of negotiating the paranoid-schizoid and depressive positions; a defensive organisation, on the other hand, is a pathological fixed formation in one or other position, or on the border between them'

The distinction of normal and pathological use of defences is not always clear. However the use by the patients in this study of the observed mechanisms/defences were revealed to create a number of additional difficulties for them, as when any attempt to approach anxieties were met with the use of yet another defence. Specifically, the defence mechanisms as identified in this study resulted in the following complications for their users:

1. They uphold dilemmas, and prevent the individual from moving towards a solution. This was true for all observed patients.
2. They create cognitively contradictory situations, and give rise to a subjective feeling of 'being stuck'. True of many defences but particularly so of the observed instances of projection, as seen in the therapies of George (chapter 5), Mary (chapter 7) and Steven (chapter 8).
3. They disturb reality perception. This was true for all the observed patients to varying degrees.
4. They make adopting a 'spectator' position in relation to the self, impossible or limited. This was true for all the observed patients.
5. They make taking responsibility for your own feelings and actions difficult or impossible and therefore create a feeling of not being in control. It is believed that it is only by taking responsibility for ones feelings and actions, that enables the individual to effect change. This was true in particular when projection or denial

were heavily relied upon, such as in the therapies of George (chapter 5), Steven (chapter 8) and Andrew (chapter 10).

6. They disturb the individual's capacity to think. This was true of all the observed patients.
7. They interfere with the individual's ability to adapt to change. This was true of all the observed patients.
8. They destroy communication. This was true of many of the defences, but distinctly so when the patients were heavily reliant on using concrete thinking defensively, as was the case in the therapies of John (chapter 4) and George (chapter 5).

In conclusion, the use of defences as observed in this research created a variety of difficulties for the patients in this study both in their lives and in therapy. Therefore it is reasonable to assume that these are not examples of normal, piecemeal transient uses of defences, but examples of pathological fixed formations.

13.3. Summary of evaluation of mechanisms

Each one of the following mechanisms will in turn be discussed according to how they present themselves in the data. How the patients employed these and what effects they were observed to have.

Concrete thinking

Steiner (1987) summarises the circumstances under which thinking can be observed in concrete form as follows. Also discussed in Chapter 2 pp33-34.

> 'In the paranoid-schizoid position anxieties of a primitive nature threaten the immature ego and lead to the mobilisation of primitive defences. Splitting, idealisation, rudimentary structures made up of idealised good objects kept far apart from persecuting bad ones. The individuals own impulses are similarly split and he directs all his love towards the good object and all his hatred against the bad one. As a consequence of the projection, the leading anxiety is paranoid, and the preoccupation is with survival of the self. *Thinking is concrete* because of the confusion between self and object which is one of the consequences of projective identification (Segal 1957)'.

Although, in the literature concrete thinking is presented more as a consequence rather than a defence, in this study it stands as an easily recognisable marker and has got distinct consequences. In the analysis concrete thinking was easy to recognise as it tended to

occur in response to a therapist Challenge of a more open ended kind, if you like following an invitation by the therapist to explain or expand on the meaning of underlying but in all likelihood conscious feelings.

Each instance as it occurred has been described in chapter 11.

Concrete thinking means, as observed in this study that difficult feelings have been dealt with in a specific way. To follow Segal (1957), the feeling content has been evacuated by the use of projective identification. It is not possible to ascertain as it were where the feelings have gone, but the thinking has undoubtedly become concrete and thereby limited. In Kleinian terms, **splitting** has occurred. At the level of the analysis carried out of the communication, a more flexible thinking has been replaced by a rigid concrete variety. For the patients it has meant that the underlying anxieties remained unaltered, as they could not be thought about. The patients' reality perception has become altered in so far as the patients have moved from being aware of anxiety to there being no anxiety worth thinking about. The patients cannot, as it were, look at themselves 'from the outside'. They cannot take responsibility for their feelings as the connection with the anxiety has become severed. They cannot think about their life and feelings in a realistic way, which might help them to adopt new possible solutions. Finally it has destroyed the communication between the patients and their therapists.

The presence of concrete thinking creates what, in the literature, is referred to as **splitting**. A significant portion of the mental content is lost to consciousness and cannot therefore be thought about. With concrete thinking the other person in the interaction, in this case the therapist is then felt to be a threat. In correspondence with the literature, the patients' focus of concern is the self. Concrete thinking has not been considered as a defence in the psychoanalytic literature, but more as a consequence. Therefore typically the analyst is not looking out for this type of thinking in this sense, as was the case in George's therapy described in Chapter 5.

John, as described in chapter 4, relied heavily on the use of concrete thinking. John's therapist however did became aware of the nature of John's thinking and its' defensive quality early in therapy. This is evident if you look at frames 2 and 3. This study strongly suggests that concrete thinking is used as a defence and has to be addressed as such in

order for the therapy to progress. John's therapist instinctively attempts to do this and subsequently there is some progress, whereas George's therapist does not appear to be equally able to show George his defensive thinking and thus there is less progress in this therapy.

Projection

Freud described projection as the distortion of a normal process by means of which we seek the *cause* of our effects in the outside world. Later in the Schreber (1911) case the appeal to causality appears as an *a posteriori rationalisation* of projection: '...the proposition I hate becomes transformed by projection into another one: He hates me, which will justify me hating him....' Here it is the affect or instinct itself, which is projected. Finally Freud also describes Projection in terms of what is bad or hated gets projected. For Klein, the thing projected is the phantasied 'bad' object, as though it were necessary, if the instinct or affect is to be truly expelled, for it to become embodied in an *object*. For a more detailed discussion of the psychoanalytic literature relating to projection see chapter 2 pp31-33.

In this study, projection was recognised through argumentation such as: 'it is not my fault but....', or 'I am not bad but someone else is....', or 'the problem isn't mine it is someone else 's....' The patient's circumstances often provided additional evidence for the fact that projection was at work.

There was evidence of use of projection in all the therapies examined in this thesis. John projected feelings of un-ease. He projected feelings, which he felt were intolerable, such as in frame 12 pp108-110, chapter 4, when the distress becomes located in the therapist not in the patient. George felt that the only problem in his marriage was 'the dog', see frame 24 pp156-160, chapter 5. The dog came to embody the bad aspects of his marriage and were thus trivialised and seen as a consequence. Thus George did not have to think about or take responsibility for any difficulties. Elizabeth had disturbing feelings about possibly allowing her self to be abused. These feelings were hard to think about and were therefore projected onto her friend as in frame 35, pp198-201, chapter 6. Mary had difficulties with thinking about her own aggression. She feared causing damage. She could not however think about these feelings for long before she projected them as in frame 37, pp211-213 chapter 7, onto something she called circumstances. . However

while Mary projected these feelings she could not think about them in order to discover perhaps that things may not be as bad as she feared. Thus her dilemma remains while the defence predominates.

Steven, Carol and Andrew also showed evidence of use of projection. Steven was a very angry man and felt the victim of aggression from his son, among others. However the material suggests that it is Steven who is projecting his aggression and responsibility, see frame 45 pp241-243 (chapter 8). Carol felt that it was Carol's mother who was 'the bad mother', not Carol, see frame 49, pp262-265 (chapter 9). Had she been able to face her anxiety about what kind of mother she was she may have been able to discover that either she was not a 'bad mother' or alternatively she could think of how to become a better mother. However while the problem is projected no productive thinking can take place.

Andrew struggled with feelings of being out of control in his relationships because his partners were felt to be lacking in important respects, see frame 52, pp279-281 (chapter 10). Andrew therefore felt justified in behaving badly and the situation was unlikely to change.

Projection creates **splitting** in the same way as Concrete thinking described above. The instances of projection, which were identified in this study, confirm the descriptions found in the psychoanalytic literature as reviewed in chapter 2 pp31-33. The analysis did however highlight the difficulty of distinguishing between real external reality and projection. It was clear that enough supporting evidence has to be collected and then shared with the patient in order for the therapists' interventions regarding projection not to be experienced as persecution. Equally it became clear that the therapists in this study were often unable to identify and demonstrate the use of projection, such as in the therapy of George (c.f. chapter 2).

Denial

Freud understood denial (also described as Disavowal, German Verleugnung) as primarily directed towards external reality (Freud 1938). Freud also used Negation (German Verneinung) to describe a 'Procedure whereby the subject, while formulating one of his wishes, thoughts or feelings which has been repressed hitherto, contrives by disowning it, to continue to defend himself against it'.

Klein (1946) described the mechanism of denial as connected with the fantasy of annihilation, and an actual loss of part of the ego and object. Hinshelwood (1991) points out that there is a tendency for Kleinians to use the term 'denial' where the Freudians refer to 'repression'. There is in practice little clarity about this matter. (For a review of the psychoanalytic literature of denial see chapter 2 pp29-31). Brenner (1981) points out that there is an element of denial in all defences. It was therefore felt to be helpful to divide the identified instances in the following subheadings suggested by the data: denial of inner or psychic reality, denial of a need to think, denial of responsibility and denial of external reality or some aspect thereof. This way it has been possible to highlight both the nature of the anxiety and the way in which it is avoided. It was felt that this sub-division added clarity, which, could be helpful to the patients and therapists with regard to understanding the use of denial. Whereas with regard to the other defences it was felt that to outline the defence in detail was sufficient.

Denial of inner or psychic reality

This corresponds most closely to what has above been described as negation, or by Klein as involving an actual loss of the ego. Whether it also involves a loss of the object, as Klein suggests, is not clear from the data.

In frame 18 pp128-132 chapter 4, the patient John had barely finished telling the therapist how he feared some major mental illness before he denied the essence of his fear by saying he now knows he hasn't got schizophrenia because the Schizophrenia Society meets in the Church hall; it was just a name that popped into his head. The contradictory thinking is here clear. This type of denial as encountered in the data frequently had an omnipotent quality. The analysis suggests that, this defence was used by John, George, Steven and Carol. It does correspond to aspects of Melanie Klein's concept of the **manic defences** as described in chapter 2 pp38-39. Sometimes this defence was easily identified, as in frame 18 where the expressed anxiety was immediately followed by a contradiction, and in these instances the therapists were also usually able to point this defence out to the patients, as was indeed the case in frame 18. However in many instances the situation was not as clear. These were often instances when the defence could be classified under several headings. In frame 14, pp115-118 chapter 4, the patient creates the denial by reverting to concrete thinking.

Denial of a need to think

This form of denial had a quality of 'unfinished business'. The therapy had highlighted possible dilemmas, which the patients were facing. The patients however did not want to think about these and denied that there was anything to think about. George in frame 24, pp156-160 claims that, 'what goes on at home is of no relevance to my problems', although this was far from the case.

As in many other instances of denial, denial of a need to think was sometimes accompanied by projection and sometimes involved concrete thinking. This form of denial was used by John and George. Examples of these can be seen in frame 5 pp87-91, (chapter 4) and in frame 24 pp156-160, (chapter 5).

Denial of responsibility

The patient Andrew relied heavily on use of this type of denial. The therapist tried to encourage him to reflect on what he does in his relationships in frame 52 pp279-281, (chapter 10). Here yet another relationship has broken down for Andrew. Andrew claims that it wasn't his fault it was *because of the lover's attributes'*. Thus he denies any responsibility for what has happened. The denial of responsibility deprives the individual of any power to change things or to make reparation. This form of denial was also used by George, Steven, Andrew and Carol.

Denial of aspects of external reality

There was only one example of this type of denial in frame 13, pp110-114 (chapter 4). This form of denial radically distorts reality, thus blocking any possibility of gaining a necessary appreciation of ones situation. It inhibits thought and thus prevents possible change.

The patients in this sample were not patients who suffered from major psychiatric illness, so this type of denial of external reality is less likely to be used. Denial of external reality is more common among psychotic patients. This is the form of denial most easily identified by therapists. However this study shows that this type of denial does not occur very often in a pure form, in contrast to the other forms of denial discussed in this section.

Denial, as encountered in this research, was often a way of not acknowledging the significance of a relationship on which the patients relied upon. Under these circumstances the instances of denial corresponds to what Melanie Klein called the **manic defences**.

Psychotherapists often intuitively feel that denial is taking place, however unless the therapist can demonstrate how and why this is happening, the intervention appears to be ineffective. In frame 26 pp164-168, (chapter 5), George has indicated that he feels out of control, which he immediately denies. The therapist seems to be aware of the patient's denial, but is not able to demonstrate it in an effective way.

Destruction of meaning

This mechanism was described by Bion (1958) and By McDougal (1982) as an attack on linking and a hatred of emotion, see chapter 2, pp34-35. Destruction of meaning was employed by John, George and Andrew. These incidents have already been classified under Concrete thinking and in Andrew's case under denial of responsibility. Destruction of meaning is not described as a defence mechanism as such in the literature although the above-mentioned authors describe clinically how destruction of meaning is a way of avoiding psychic pain and it is therefore felt to fit the description of defence mechanism. The effect of destruction of meaning is to break emotional links, such as in frame 14pp115-118, chapter 4, when John's therapist tries to expand on John's idea that when approaching difficult things it makes sense to do it gradually or 'like going in the children's pool before the big pool'. The patient however withdraws at that point and says 'it was just about breakdown of two levels of water'. The meaning and with it the emotional content of the idea has been attacked. The meaning of the analogy has been destroyed. The attempt by the therapist to be helpful has also been attacked.

Displacement

Displacement, is an original concept of Freud's described as a shifting of the focus of disturbance, see chapter 2 pp35-36. Most of the incidents, which can be described under this heading, can also be described under projection. For example in frame 28 pp180-182, chapter 6, Elizabeth appears to transfer the focus of disturbance from thinking about why

she is offering herself as a nude model to feeling disturbed about feeling that she looks ugly. Here the disturbance has not been projected, but rather displaced.

Reaction Formation

This is one of the classic defences described in detail by Anna Freud in 1936. Reaction formation is a defence whereby feelings are turned into their opposite, (see chapter 2 p 36). This was only observed in the therapy of Elizabeth, for instance in frame 27 pp177 – 180 chapter 6, where feelings of being out of control are turned into being in control. This instance could equally be described as a denial of the real state of affairs. This mechanism has the effect of preventing thought as it distorts reality, thus constituting an obstacle for change.

Identification/Introjection

The concepts of Identification/Introjection refers broadly speaking to a state of affairs when a subject assimilates an aspect of the other, see chapter 2 p37. There were very few examples of this mechanism. In frame 30 pp185-187, (chapter 6), Elizabeth changes thoughts about 'being used' into 'her using someone else'. 'The thought of being used' become internalised and, as a result, there is a form of identification with the aggressor. As in the above, this distorts reality prevents thought and thus becomes an obstacle for change.

Manic Defences

This is not described in the literature as a discrete defences but more defences occurring at the threshold of the depressive position (Melanie Klein 1935, 1940). The patient has a need to deny psychic reality and the importance of good objects, and thus deny feelings of dependence. These are defences that can also be seen in mania and hypermania. In addition there is an omnipotent quality to these defences. According to Klein, to these defences belong denial, disparagement, control and idealisation, (see chapter 2 pp38-39).

In this study only denial has been specifically identified as used in this context. The analysis that has been carried out indicates that all the subcategories of denial observed in this study have, as a main purpose, the denial of the importance of psychic reality and the importance of objects in the patient's world. The data further suggests that there are also instances where projection is used in order to deny the importance of the Object, such as

in frame 46 pp245-248 (chapter 8) where the need for therapy, or a therapist, has been projected onto Steven's friends.

Another defence

Not all defences encountered in the data could easily be classified under existing classifications found in the psychoanalytic literature. In frame 10 pp100-102 (chapter 4), the patient John protects himself from the emotional impact of realising that he has had murderous feelings towards his colleague by arguing that it was a special case.

This is reminiscent of what Freud (1926) described as something he called isolation. That is, when the patient is defending him/her self from the impact of an idea by isolating it from its context by means of a pause 'during which nothing further must happen'. Freud calls this technique magical. The mechanism encountered in the data is indeed a form of isolating, however it does not have the hallmarks of isolation as described by S. Freud.

In conclusion the mechanisms, which were observed in this theses, were **events in a relationship**. They were identified by observing the process as it was unfolding between the therapist and the patient. The mechanisms were rarely discrete from each other, they could often be categorised under several headings, thus contradicting Sigmund Freud's description of defences, see p20 chapter 2. They were directed against psychic pain, the source of which, may have been be either internal or external. The psychic pain which, was being activated by something, which took place between the patient and the therapist. They created distortions, which prevented the patients from effectively working with their therapists towards a thought out solution to their problems.

As described in the literature, defences can be both normal and pathological. It is impossible to categorically draw conclusion about where the boundary goes between normal and pathological defence, however it is possible to say that the defences which were observed generally constituted an obstacle to the work that the therapist and the patient was engaged in. It is equally impossible to categorically claim that these mechanisms are unconscious. However the manner in which they appeared in the discourse that is, spontaneously, leads to the conclusion that they are unlikely to have been consciously generated.

13.4.Case summary of each patient

This section consists of a brief case summary and review of each patient. Reference will be made to the mechanisms used by each patient and to any change observed. Although this is not an outcome study, reference will be made to the success or otherwise of the therapies as reported by the patients and deduced form the analysis. Conclusions will be drawn about the identification of defences, their effect on the therapeutic discourse, and whether identifying these mechanisms can explain success or failure of the therapeutic process.

John

John received brief psycho-analytical psychotherapy. As John started therapy he was much troubled by psychosomatic symptoms with little physiological cause. He used concrete thinking in order to avoid considering what was suggested to him by his therapist. He used projection to rid himself of feelings of confusion. He used denial of inner reality, denial of a need to think and even denial of external reality in the same way. He also used a form of isolation not to experience the full impact of what was talked about. His extensive use of concrete thinking constituted a destruction of meaning of what the therapist tried to offer him. His therapist, K. tried hard to bring into focus the nature of John's defensive thinking. This work did seem to pay off as in the later sessions there was some evidence that John did tolerate anxiety long enough to do some thinking. John even expressed appreciation of the therapy in the later sessions. The frequency of referring to physical symptoms deceased by session 12 as evident in the histogram on p145. John reported in his post- therapy interview (appendix 3) that the therapy had had no effect. However he reported at the same time that his life was more comfortable. He was less worried and had fewer symptoms. The preoccupation with him self, which was very evident in the early sessions and the persecutory nature of his anxiety, did lessen during the therapy but there was no noticeable increase in his awareness of other people or their needs. There was a slight increase in his awareness of his therapist towards the end of therapy, see histogram on p145. The identification of the mechanisms used by John was quite easy. It was possible to map out how John moved from one defensive manoeuvre to the next and how these made it difficult for him to progress in thinking. Identifying the mechanisms clarified John's dilemma, and explained some of John's anxiety. It appeared

that the need to constantly avoid thought created a continuing source of anxiety all of its own.

George

George received brief psycho-analytical psychotherapy. At the beginning of his therapy his complaints centred on feelings that he had not received the recognition at work he felt he deserved. In addition he was troubled by a number of psychosomatic symptoms. He used concrete thinking in order not to consider the therapist's suggestions, he used projection of his difficulties and he also used denial of both psychic reality and denial of a need to think as defences. His therapist, I., made some tentative attempts to address these mechanisms. However she did it in such a way that George appeared not to have been able to use his therapist's interventions. Very little seemed to have changed for George during his therapy, in fact his worldview appears to have become more negative by session 11, (see histogram on p169). George did not feel that there had been much change at the time of his post therapy interview (appendix 3). However in the same interview he expressed some awareness of his wife's difficulties for the first time. George's anxiety was and remained persecutory in nature. George's therapist was not able to demonstrate George's defensive manoeuvres to him although she may have had some awareness of these. The question remains, would this therapy have been more successful had the therapist been more aware of and been able to help George to reflect on the nature of his thinking, by demonstrating George's defences to him.

George's suffering can be understood as primarily arising out of deep conflicts, possibly feelings of inadequacy etc, but secondarily his sense of persecution was increased by his habitual use of defences in the same way as was the case with John.

Elizabeth

Elizabeth received a course of cognitive analytic therapy (CAT). At the beginning of therapy she suffered from what could be described as deep loneliness. She was at a loss in her life as her significant relationship was failing and she lacked direction in her working life. During therapy she became preoccupied with why she was doing life modelling for a group of painters. She used projection, displacement, reaction formation and introjection to deal with a range of difficult feelings. Not a single incident was identified when Elizabeth's therapist demonstrated an awareness of or confronted her with the above,

mentioned defensive mechanisms. There was very little change in the level of Elizabeth's preoccupations during the course of therapy. There was less preoccupation with self-control during session 9, (see histogram on p202). At the time of her post- therapy interview (appendix 3) Elizabeth reported that she still had difficulties, which she attributed to external causes. At the same time she said that she was pleased she had had the experience of therapy and that she felt relatively good about her therapist. Her preoccupations with her self, which were evident throughout her therapy, were still evident during the post- therapy interview. The nature of her anxiety was and remained persecutory in nature.

Elizabeth felt that she was a victim, and felt that there was very little she could do to improve the quality of her life. Her use of defences created a situation where she felt stuck and unable to influence things. It seems that it was the actual use of the defensive mechanisms that maintained this status quo in her case. Had her therapist been able to show how her thinking got stuck, this might have provided an opportunity for change.

Mary

Mary received brief psycho-analytical psychotherapy. Mary suffered from fears about her own real or imagined destructiveness. She used projection and denial of psychic reality to avoid feelings which emerged both as a result of the relationship with her therapist and through her associations. She had a great need to maintain an illusion that she did not need anyone. Thus in this instance these mechanisms can be understood as manic defences. Her therapist, K. tried to confront her about her use of these mechanisms on many occasions. There was a lessening of her catastrophic anxiety during the therapy already by session 5, (see histogram on p235), but the catastrophic anxiety was increasing again by session 9. This may have been a response to the impending ending of the therapy. At the time of her post- therapy interview (appendix 3) Mary felt that the therapy had been helpful, although she regretted the fact that it had been so short. The nature of Mary's anxiety was persecutory at the beginning of therapy. The persecutory quality had lessened at the time of the post- therapy interview.

It seems that Mary was still grieving for her mother as she entered therapy. Her defences can be seen as a way of dealing with this grief. The analysis made it clear that the defences were in her case in particular an attempt to convince her self that she did not

need anyone. Perhaps this was in order to try to ensure that she would suffer no further losses. In Kleinian terms this would mean that she was using her defences as manic defences, that is, directed against the awareness of the value of 'the object'. Mary was possibly the 'healthiest' of the patients in the sample and the one who benefited most. This conclusion was drawn from the fact that she was able to express appreciation of her therapy and the nature of her anxiety changed.

Steven

Steven received cognitive analytic therapy (CAT). At the time of starting therapy Steven suffered from depression triggered off by a series of events relating to his son having had a homosexual relationship with his teacher. Steven showed intense persecutory anxiety at the beginning of his therapy. He used projection, denial of psychic reality and denial of responsibility to deal with what appeared to be confusion and hurt. In the analysed sections there is no suggestion that his therapist was aware of or confronted Steven with his defensive manoeuvres. In fact there was a rather reassuring quality to therapist A.'s interventions. There was not much suggestion of change occurring in this therapy. There continued to be a glaring absence even by session 15 of a capacity for concern in Steven's material, (see histogram on p252). Steven's preoccupation with self-control had lessened slightly at the time of the post- therapy interview (appendix 3) and Steven felt there had been some beneficial change. He felt that his way of looking at many situations had changed. He felt sorry that not more areas had been covered in more depth. There was still however no evidence of concern for his son at that time. Steven's anxiety was strongly persecutory at the beginning of therapy. He was less persecuted at the time of his post -therapy interview (appendix 3). It appears that Steven had 'a nice time' with his therapist and therefore he felt better and he was pleased about his time in therapy although there was very little evidence that his way of thinking changed.

Steven's difficulties can be understood as a determination to push any responsibility away. This led him to feel helpless. His heavy reliance on projection led to an intense feeling of not being able to influence his life. Had he been confronted with his defensive way of thinking, he would have no doubt resisted, possibly quite intensely, but there might have been a greater opportunity for change.

Carol

Carol received cognitive analytic psychotherapy (CAT). Carol came into therapy with feelings of inadequacy. She felt very guilty about her handicapped daughter. Carol used projection, and denial of psychic reality in the analysed sections of her therapy. Carol's feelings of helplessness were possibly created by or at least maintained by her need to project. Carol's therapist J. not only did not confront Carol's defensive mechanisms but also colluded with Carol in such a way that the observed defences were probably strengthened. Carol's negative worldview decreased slightly during therapy but overall there was little change in the frequency of preoccupations during Carol's therapy as evident in the histogram on p269. Carol refused to participate in a post- therapy interview. From the available material, it appears that Carol's anxiety was persecutory in nature and remained so throughout therapy.

As in the cases of John and George, Carol had painful underlying issues to think about. However her use of defence mechanisms created further suffering for her, and her sense of persecution remained. Had she been confronted with her defensive way of thinking she might have been provided with some opportunity to change.

Andrew

Andrew received brief psycho-analytic psychotherapy. Andrew came into therapy because of relationship difficulties. He used projection, denial of responsibility and destruction of meaning as ways of coping with the threat of becoming aware that he might in some sense have been party to creating his difficulties in his relationships. Andrew's therapist, G. did try in a general way to confront Andrew with his defensive manoeuvres. However these attempts were rather vague, and it is not clear if Andrew was able to use what his therapist tried to show him. Andrew's preoccupation with casual sexual encounters lessened significantly by session 9, (see histogram on p286), and also his feelings of being trapped. The nature of Andrew's anxiety was very persecutory at the beginning of therapy. Andrew refused to participate in a post-therapy interview, possibly an indication that he continued to feel persecuted.

As in the cases of John, George and Carol, Andrew's difficulties were deep rooted but his reliance on the above, mentioned defences made his sense of persecution worse. Had he been confronted with his defences there might have been more opportunity for change.

In conclusion the therapies were not very successful. This may in part be due to the different therapy approaches or to different therapist styles. There is however the suggestion that more tangible change happened in the therapies where the therapist was aware of the defensive manoeuvres used by the patients and tried to demonstrate these to the patients.

13.5.Implications of the findings

These can be divided into implications for therapy and implications for understanding interactions outside the therapy relationship. The implications for therapy will be discussed here.

Since its' outset, psychotherapy in general and psychoanalysis in particular has been surrounded by controversy. Outcome studies have come up with conflicting results. Psychotherapists have been accused of meaningless meaning making. At the same time countless patients have felt helped by psychotherapy. In other words the therapy process seems to be surrounded in mystique. It has been notoriously difficult to describe what goes on in therapy of any kind. It is however possible that by dissecting the therapy process in the manner done in this research, it could be possible to begin to describe the therapy process more accurately and thereby to demystify the process.

As a result of training, therapist are as a rule aware of defences and other related mechanisms in a theoretical or static way. It is however not always the case as is demonstrated in this thesis, that therapists are equally aware of these as they occur in the **process**. This work suggests that it would be helpful if therapists could be taught about defences in a dynamic fashion, in order to make it easier for therapists to recognise these mechanisms as they occur in the therapeutic discourse. This work confirms the assumption that it is necessary to recognise defences in order to transcend these so that the therapy can progress and the underlying problems can be thought about.

By using the methodology adapted for this thesis, it may be possible to be more precise about what is achieved in therapy. Indeed it may be possible to begin to formulate where the therapy is going and what changes are taking place. Indeed it may be possible to explain why one therapy works and another one doesn't.

In other words the methodology as applied in this research can be adapted to become a tool in the therapist's armoury, which could aid the therapist in recognising the different elements in the interaction between patient and therapist.

Greenson 1967 emphasised the need to systematically analyse the resistance (defences) in order to help the patient. He describes the following necessary steps in the analysis of resistance:

1. Recognise the resistance
2. Demonstrate the resistance by allowing the resistance to become demonstrable, and by intervening in such a way so as to increase the resistance; helping it become demonstrable
3. Clarifying the motives and modes of resistance

The need to have a clear understanding of what happens when a patient is defending against difficult feelings cannot be overstated. The therapies discussed in this research were relatively unsuccessful. The fact that the therapists could not be more effective could be understood as a function of the fact that they were not sufficiently aware of when the patients were employing which mechanism. Had they been able to identify their patient's modes of resistance and to demonstrate these to them, the outcomes of the therapies may have been more successful.

One could also question whether these seven patients were actually all suitable candidates for brief psychotherapy. It is possible that, had the initial interviews included an assessment of the prevalent defences using the methodology used in this thesis, together with an assessment of the patients' abilities to reflect on these, some of the patients would not have been considered suitable. Thus the methodology, which, has been used and demonstrated in this research, could be modified and used as an aid in training therapists to be more precise and effective in their assessments and interventions.

References

Ainsworth M. (1991) Attachment and Other Affectionate bonds across the Life-cycle, in Parkes C. Stevenson-Hinde H. and Marris P. (ed) Attachment Across the Life Cycle Routledge London

American Psychiatric Association 1994. Diagnostic and Statistical Manual of mental disorders Washington DC.USA

Antaki, C. 1994 Explaining and Arguing: The Social Organisation of Accounts. Sage London

Antaki, C. & Leudar, I. 1992 Explaining in Conversation: Towards an Argument Model, European Journal of Social Psychology, 22. pp 181-194

Balint M. 1968, The Basic Fault, Therapeutic Aspects of Regression, Tavistock Publications Ltd, London

Ball, W.J 1994 Using Virgil to analyse public policy arguments: A system based on Toulmin's informal logic. Social Science Computer Review, 12, (1), pp 26-37

Bauer M. and Gaskell 2000 Qualitative Research with Text, Image and Sound A Practical Handbook, Sage London

Benoit, W.L. 1992 Traditional conceptions of argument In W. L. Benoit, D. Hample & P. J. Benoit (eds.) Readings in Argumentation (pp 49-67). Foris Berlin

Bion W 'Attacks on linking', International Journal of Psycho-Analysis 40. pp 308-15 London

Bowlby J. (1969) (1973) Attachment and Loss V.1 V.2 London, Hogarth Press

Brenner C. 1981, Defence and Defence Mechanisms, Psychoanalytic Quarterly L

Briggs S. 1987 Growth and Risk in Infancy London Routledge

Brown B., Pedder J.1979. Introduction to Psychotherapy, Tavistock Publications, London

Burgoyne B. & Sullivan M. (eds.) 1997. The Klein-Lacan Dialogues Rebus Press London

Cioffi F. 1998 Freud and the question of Pseudoscience Open Court Publishing company Illinois U.S.A.

Cooper S. 1989 Recent Contributions to the Theory of Defence Mechanisms: A Comparative view, Journal of the American Psychoanalytic Association V 37, part 4

Couch A. 1995, Anna Freud's Adult Psycho-Analytic Technique: A defence of classical analysis, Int. J. of . Psycho-Anal. V 76, 153

Eemeren, F. H. van, Grootendorst, R. & Kruiger, T. 1987 Handbook of Argumentation Theory. Foris Dordrecht, Holland

Eemeren, F. H. van, Grootendorst, R., Jackson, S. & Jacobs, S. 1993 Reconstructing Argumentative Discourse. Tuscaloosa: University of Alabama Press

Eemeren, F.H. van, Grootendorst, R., Jackson, S. & Jacobs, S. 1997. Argumentation. In T.A. van Dijk (ed.) Discourse as Structure and Process. pp208-229, Sage London

Ekins and Freeman 1994. Centres and Peripheries of Psychoanalysis Karnac Books London

Fenichel O. 1945, The Psychoanalytic Theory of Neurosis, Chapter 9, The Mechanisms of Defence, Norton, New York

Ferenzci S 1932, Confusion of tongues between adults and the child, Read before the International Psycho- Analytic Congress, Wiesbaden

Flach F.ed.. 1989. Psychotherapy, Norton & Company New York

Fonagy P. Grasping the Nettle: or Why Psychoanalytic Research is such an Irritant, Paper presented at the Annual Research Lecture of the British Psycho-Analytical Society on 1st of March 2000

Freeman, J.B. 1991 Dialectics and the Macrostructure of Arguments. Foris Berlin

Freud A. 1936 The Ego and the Mechanisms of Defence. Hogarth Press, London

Freud S. 1911 Psychoanalytic Notes on an Autobiographical Account of a case of Paranoia (Dementia Paranoides) Standard Edition Vol. 12, Hogarth Press, London

Freud S. 1912 Recommendations to Physicians Practising Psycho-Analysis. In Standard Edition. Vol. 12, Hogarth Press London

Freud S. 1925. Negation, Standard Edition Vol.19, 233-9, Hogarth Press, London

Freud S. 1926 Inhibitions, Symptoms and Anxiety. Standard Edition, Vol. 20, Hogarth Press, London

Freud S. 1926b. The Question of Lay Analysis, Standard Edition, Vol.20, Hogarth Press, London

Freud S. 1938 An Outline of Psycho-Analysis, Standard Edition Vol.23, Hogarth Press London

Goldstein K. and Sheere M. 1941. Abstract and concrete behaviour; An experimental study with special tests. Psychol. Monogr. 1941, V53, No 2

Govier, T. 1987. Problems in Argument Analysis and Evaluation. Foris, Dordrecht, Holland

Greenberg, L. and Pinsof W. (ed.) 1986 The Psychotherapeutic process, a Research Handbook. The Guilford Press, New York

Greenson R. 1978. The Technique and Practice of Psychoanalysis, The Hogarth Press and the Institute of Psycho-analysis, London

Higgins M. and Chester R.(ed.) 1972. Reich speaks of Freud Condor, Souvenir Press(educational)& Academic Ltd, London

Hinshelwood R.D. 1991, A Dictionary of Kleinian Thought, Free Association Books, London

Hinshelwood R.D.1994, Clinical Klein, Free Association Books. London

Hogberg,O. 1984. Argumentation: A case study of the Swedish Energy Debate. Stockholm: Department of Business Administration, Stockholm University.

Ihilevich and Gleser,1986, Defence Mechanisms, Their classification, correlates, and measurement with Defence Mechanisms Inventory, DMI Associates, Michigan

Hoffer, W. (1954) Defensive process and defensive organisation: their place in psycho-analytic technique. International Journal of Psycho-Analysis, 35, 194-8

Humphreys P., Oldfield A., Allan J., Intuitive handling of decision problems: A five-level empirical analysis.

Isaacs. S. 1939. Criteria for interpretation, International Journal of Psycho-Analysis, 20, 148-60

Kitcher P. 1993 The Advancement of Science, Oxford: Oxford University Press

Klein M. 1935. A Contribution to the Psychogenesis of Manic –Depressive States, in Love Guilt and Reparation & Other Works, Hogarth Press, London

Klein M. 1940. Mourning and its Relation to Manic-Depressive States, in Love Guilt and Reparation & Other Works, Hogarth Press, London

Klein M. 1946. Notes on some schizoid mechanisms, Int. J. Psycho-Anal V. 27 pp. 99-110

Klein M.1952. The Origins of Transference, in Envy and Gratitude & Other Works, Hogarth Press, London

Klein M. 1958. On the development of Mental functioning, in Envy and Gratitude & Other Works, Hogarth Press, London

Lacan. J. 1977, The Four Fundamental Concepts of Psycho- Analysis, Hogarth Press, London

Laplanche J.,Pontalis J-B., 1980, The Language of Psycho-Analysis, The Hogarth Press, London

Levine, L. 1991. The Argument on Language and the Language of Argument: Kenneth Burke and Wilbur Samuel Howell. PhD Thesis. Department of English, Carnegie-Mellon University. Pennsylvania, USA

Malan D. 1975. A Study of Brief Psychotherapy. Plenum Press. London

Main M. 1997 Attachment Narratives and attachment across the lifespan. Paper presented at the Fall Meeting of the American Psychoanalytic Association, New York

Malan D. 1979. Individual Psychotherapy and the Science of Psychodynamics. Butterworths. London

Marouda, A. 1995. The Process of Representation and Development of Knowledge in Career Decisions Making and Counselling. PhD Thesis. Social Psychology Department, London School of Economics.

Meltzer D. 1967 The Psycho-Analytic process, Culnie Press Perthshire Scotland

McDougall J. 1982. Alexithymia: a Psychoanalytic Viewpoint, Psychother. Psychosom. 38: 81-90

Miller, Luborsky, Barber, Docherty 1993, Psychodynamic Treatment Research, A Handbook for Clinical Practise, Basic Books, New York

Myers, Briggs I. 1962 The Myers-Briggs type indicator. Manual Princton N.J. U.S.A. Educational Testing Service

Niiniluoto I. 1999 Critical Scientific Realism, Clarendon Library of Logic and Philosophy, Oxford University Press

Nissim L, Robutti A. 1992. Shared Experience, the Psychoanalytic Dialogue, Karnac Books, London

Novey,S. 1968. The Second Look, John Hopkins Press, Baltimore

O'Shaughnessy, E. 1979. A clinical study of a defensive organisation. Int. J. of Psycho-Anal., 62, 359-69 (1981)

Pereleman, C.& Olbrechts-Tyteca, L. 1970. Traité de l' Argymentation: La Nouvelle Rhétorique. Bruxelles: L' Universite Libre de Bruxelles. 2nd edition

Popper K. 1963 Conjectures and Refutations London Routledge

Reich W. 1950. Character Analysis. Lowe & Brydone (Printers) Ltd. London

Reik T. 1948Listening with the third ear: The Inner Experience of a Psychoanalyst,

Rice, L. and Greenberg, L. (ed.) 1984 Patterns of Change, Guilford, New York Farrar, Straus, New York

Rustin M. 2001 Reason and Unreason, Psychoanalysis, Science and Politics, Continuum London

Rycroft C. 1958. An Enquiry into the Function of Words in the Psycho- analytical Situation, International Journal of Psycho-Analysis,39, 408-15

Rycroft C., 1979, A Critical Dictionary of Psychoanalysis, Penguin Books Ltd, Harmondsworth, Middlesex, England

Ryle A. 1992, Critique of a Kleinian case presentation, British Journal of Medical Psychology (1992), **65,** 309-317

Ryle A. & Beard 1993, The integrative effect of reformulation: Cognative analytic therapy with a patient with borderline personality disorder, British Journal of Medical Psychology (1993), 66, 249-258

Sammallahti P. 1997, Ego Mechanisms of Defence, an empirical study, PhD thesis Department of Psychiatry, University of Helsinki

Sandler J., Dare C., Holder A., 1973, The Patient and the Analyst, George Allen& Unwin Ltd. London

Sandler J., Sandler A-M. 1978, On the Development of Object Relationships and Affect, Int. J. Psyco-Anal. 59, 285-96

Ed. Sandler J. Sandler A-M, Davies R. 2000 Clinical Observational Psychoanalytic Research:Roots of Controversy, Psychoanalytic Monograph 5 Karnac Books London

Schonbach, P. 1990. Account Episodes: Management of Escalation of Conflict. Cambridge University Press

Segal, H. (1957) Notes on symbol formation. Int. J. Psycho-Anal. 38, 391-97

Segal H. 1964, Introduction to the Work of Melanie Klein, The Hogarth Press and The Institute of Psycho-Analysis, London

Segal H. 1986, The work of Hanna Segal – Delusion and Artistic Creativity & other Psycho-Analytic essays Free Association Books, Maresfield Library, London 1986

Steiner J. 1987, The interplay between Pathological Organisations and the Paranoid-Schizoid and Depressive positions, Int. J. Psycho-Anal. 68, 69-80

Symington N., 1986 The Analytic Experience, Free Association Books, London

Toulmin. S. 1958. The Uses of Argument. London: Cambridge University Press.

Toulmin, S., Rieke, R. & Janik, A. 1997. An Introduction to Reasoning. Macmillan New York

Valiant G. 1992 Ego Mechanisms of Defence- A Guide for Clinicians and Researchers, American Psychiatric Press, Inc Washington, US

Wallerstein R., Fonagy P. 1999 Psyco-Analytic Research and the IPA: History, Present Status and Future Potential, Int. J. of Psycho-Anal. V80, 91

Winnicott D. W. 1960 The theory of Parent- Infant relationship, in The maturational Processes and the Facilitating Environment, Hogarth Press London

PSYCHOTHERAPY ASSESSMENT REPORT

PATIENT: LOCATION: CASSEL HOSPITAL

ASSESSOR: DR. K DATE OF ASSESSMENT: 28 JUNE 1989

Reverend John is a 44 year old Anglican priest, referred by his GP, Dr. because of panic attacks associated with paroxysmal tachycardia. These attacks seem related to the death of his Mother followed by that of the Father, as well as other traumatic incidences at the same time. Dr. had prescribed Inderal and Lorazepam and sought help for Rev. l so that he may finally withdraw Lorazepam and at some stage Inderal as well.

Rev. John filled out his Form A very comprehensively giving it a lot of thought and care and was grateful to be able to consider the problem in an organised manner and to provide a framework for the appointment he had with me. He struck me as quite an obsessional controlling man from his manner of filling the form.

He arrived on time and is a chubby, pleasant and charming 44 year old man. After my introductions, he talked straight away about his physiological problem. His para-sympathetic nervous system could not damp down his sympathetic, over activity. This had been explained to him by the Doctors at St. Peters in Chertsey, where he had attended for a cardiograph. I agreed with his physiological explanation, which suggested he was perhaps here today to try and explore what might lie behind this. He spoke of the traumatic times he has had for the past couple of years. His Mother died 2½ years ago, he moved jobs and joined the priesthood, he left his family home for the first time, he had a difficult relationship with a priest colleague who was nervous, edgy and miserable. He felt as if his nervous system had responded to this colleague taking on symptoms because of him (this seemed to have a paranoid flavour). He said his symptoms come on when free-standing in public but then explained they happen in all situations not just in public. I responded to his physiological physical language with a psychological language exploring what it felt like to be standing on his own, having left his family situation and the security he felt there.

He opened up more about his background. He was adopted at the age of 2 months and cared for by an all female environment for the first 4 months of his life. He had a happy home and a splendid childhood environment. His Father was very laid back, his Mother suffered from asthma from the time he was 9 years old and in the latter years of her life, was on a lot of medication and consequently full of adrenalin and edgy. He found it very difficult to recall anything unpleasant from his childhood. His natural Mother had had to give him up because the French/Canadian aircraft man she intended to marry was shot down in the War. He still thinks about her and would like to see her from a distance. He didn't do this up to now because he wondered about the effects on his parents, as if this might partialise their parenting of him. I had a strong feeling that he feared very much hurting his parents if he wanted his wants and wishes met.

He spoke of his homosexuality. He has never had any sexual longings for a female. From the age of 21 to 25 he had a number of short term homosexual relationships with various men who have now since married. He still has homosexual longings but would like it if someone came his way - he doesn't want to actively seek out anybody. Again he appeared to avoid his own active wants and wishes. He spoke of the difficult relationship he had with his older, nervous, edgy priest whom at times he admitted to wanting to throttle. He was frightened however, that

Cont/d .....

Rev. JOHN - Cont/d

this priest might actually die if he showed any anger towards him. I tried hard to explore similar angry feelings towards either his Father or Mother. He seemed closer to recalling some irritation and anger towards his Mother who had been apparently quite difficult and edgy, particularly within the family business towards the end of her life.

His parents owned a hotel in Dover and a house three doors away in which Gary had a flat on the top floor, his sister and his grandmother separate flats on the middle floor and his brother, a flat on the bottom floor. All led relatively independent existences although, still very much part of 'the family community'.

JOHN had entered theological college in his teens but was advised to get a profession behind him by the Archbishop after he failed examinations. He was interested in rail and sea travel and got a job in the hovercraft in Dover. He enjoyed this work and devoted a lot of his time to it. When exploring possibly angry feelings towards his Mother, he once again adopted an intellectual, physiological explanation of how she was. We were coming towards the end of the session when I suggested the possibilities for treatment open to him: group, brief individual or longer term private individual therapy and said we needed to meet again to discuss these further. He sought reassurance that psychotherapy could help with these physical problems. I commented he may feel very frightened that he would end up feeling unhelped and worse if he were to explore his sexual and his angry feelings within a relationship. We arranged to meet again in two weeks time.

Impression

Reverand JOHN is a superficially charming, pleasant man. To maintain his pleasantness I suspect he has had to restrict his aggresive and sexual feelings markedly. I am not sure of the connection with his current symptomatology. It's interesting that his symptoms are worse when he goes on holiday or is feeling relaxed and has time to think about himself. It's as if he represents both an expression of the autonomic component of anger or sexuality and also a severe restriction on the expression of these feelings. Brief focal therapy may help him explore his fear of such feelings further. He may or may not wish to continue exploration in longer term therapy. He suggested this may be possible through his Church.

Dr. K
Senior Registrar in Psychotherapy

KH/AM
29.6.89.

SECOND ASSESSMENT SESSION REPORT

PATIENT: Rev. JOHN THERAPIST: Dr. K

LOCATION: Cassel Hospital DATE:

JOHN began by saying he'd thought about our last meeting but felt we had covered nothing new. He had talked with Chris and thought about all of these things before - I commented he had not found it very useful? - and he said 'no, it wasn't.' He appeared very relaxed and I was conscious of feeling angry with him. He went on to talk about his problems being the same, the anxiety and dry mouth are particularly worse in the mornings. He had started his own programme to try and de-sensitise himself to these symptoms. I wondered about the morningtime and if these symptoms were related to his dreams - I asked of any recurrent dreams he had. He said yes, he dreams on a number of themes - the first one involves friends and they are going away and he is losing them. I wondered if it involved specific friends or if he would tell me about a specific friend - he said I can't, it's just them, they're interchangeable. I was feeling very angry and attacking by this stage and felt like jumping in with interrogating questions. The second main theme in his dreams is of happy, social, domestic situations - I asked for an example and he said, eating in the lounge or going out to visit. I wondered if he meant eating alone and he said no, eating with his family and having very happy memories of this. My anger and interrogation were dissipated by a thought of him being a very lonely man with no friends or no relationships.

He went on to talk about his friends and mentioned one who is blonde and with whom he shares an interest in model railways, shipping and his former work. Ian is now married - he used to fancy and he felt I knew this and was pleased about it. All the girls at his work used to tease JOHN about being gay. He then returned to talk more of his symptoms for some minutes.

I asked him about what options of therapy he had been thinking about - he said he wants help with his symptoms, otherwise he is very happy with his career and his parish work. If he hadn't symptoms he wouldn't be here. I offered him three choices as I saw it; firstly to continue as at present sorting himself out, doing his own de-sensitising, secondly to be referred via his GP to a clinical psychologist who would work out a behavioural programme for his symptoms with him or thirdly, psychotherapy, which would involve 12 individual sessions over the coming months and would include efforts to encourage him to reduce his medication. He responded saying he just needs to change the symptoms - he thought psychotherapy could restore his equilibrium. I commented that it may help him to change to a new equilibrium. He asked me what I felt about the best option, I commented on his suppressed anger and sexuality and his fear of being destructive if he expresses these. He said this is not so, he is assertive at work but agreed that he might be frightened of this within relationships. I commented that he has made a lot of changes in his life and his career and may wish to think about changing also in psychotherapy. I wondered if he was feeling frustrated or angry with me for going on about what

Cont/d .....

CONT/D

he felt was not useful to him. He commented that talking of sexuality is something that's new for him. He hadn't been able to do this before. He agreed with me on that. While he was talking about this he was staring intently at me , sitting very comfortably looking at me - I felt uneasy - I looked away by choice. I commented on the links between physiology and his feelings, suggesting that his symptoms may be an autonomic link to hidden sexual and angry feelings. This seemed to make a lot of sense to him and he latched on to it for some time. We had three minutes left and I asked him for a decision. He wondered if psychotherapy would help, I said it might, it might not - neither of us knew. I asked about the research option, he said he would have no problem about this. We arranged that he would write and let me know within the next week if he wished to take up the offer of 12 sessions.

Impression

I think 12 sessions with him will be very difficult work. The focus will be to shift his talk of symptoms to reflection on his inner world, particularly he might be helped to face his destructive, angry, loving and sexual feelings, which he has kept supressed and inhibited.

I will write more fully to his GP when I hear from

DR. K
Senior Registrar in Psychotherapy

The Cassel Hospital

1 Ham Common, Richmond, Surrey TW10 7JF

JB/ms

(GEORGE) Appendix 1
Notes on Psychotherapy Assessmen.

Dear Dr.

Re: _____

Thank you for referring the above named man who has been seen by myself on two occasions at the Cassel Hospital. As you say in your referral letter, he has been in the last year a victim of certain power struggles at the BBC, and as a result became quite depressed last Summer and also began to have episodes of apparent hyper-ventillation with further physical consequences. His symptoms have been controlled only partially with Prothiaden and Motival, although he has seen a dramatic improvement in his overall condition, as you say. He would however like to come off his medication and he is worried about a recurrence of his symptoms.

George presented on both occasions to me as a pleasant and very articulate man of large dimensions. I got the impression very early on that he was able to give me very concrete details about his past life in terms of his successes in all aspects of his life and, in particular, his ability to be successful in the academic intellectual world. He found it far less easy to talk about his emotions and on occasions wanted to reassure me that what he was telling me was the truth and at other times told me that he was feeling extremely uncomfortable "in his gut" about exploring some of his feelings, particularly around his childhood. I became aware that he was quite dismissive of the difficulties that he and his wife had experienced a few years ago in trying to conceive and also the lengthy investigations which both of them had undergone, it seems, to try and locate the reason for their infertility. He tried to assure me that there were really no problems in this area for him in a very unconvincing fashion.

In terms of his early relationships he says that he had a very close relationship with his mother who was a very strong character and a gregarious nature. He said that he liked his father very much but was unable to bring any further deeper emotional feelings around his relationship with his father. Prominent in the family history given was a sense that the family had made a lot of themselves from not very much and that his father often used to show him to parental friends as a academic show piece. In our second session together he was able to explore a little of his anger towards his father in this regard but it was very much muted in the guise of a small bourgeois rebellion when he was in his teens. His family's upward social mobility appears to interest him greatly and he took some time telling me of the family's roots as farmers in Yorkshire two generations ago.

In terms of a plan for future management George found it very difficult to explore possible avenues for himself and very much wanted me to tell him in which direction to go. I explored possibilities of either long term individual treatment or brief psychotherapy over 12 sessions.

I also suggested that there was a possibility of a more behavioural or cognitive approach from the Psychology Department [illegible] Hospital. In many ways this latter suggestion linked him best with the expectations that George had brought early in his sessions in terms of his treatment hopes. He wanted to be able to understand why the physical symptoms occur and to be able to anticipate them and control them when they happen without the need for drugs. At the end of our second session he stated that he would like to try a brief focal psychotherapy with the possibility of also having some cognitive input from the Psychology Department. I think this is a reasonable way to go about things. However, it would appear that neither of these options could commence before the beginning of August when George returns from a holiday.
There is also the aspect of a waiting list for a psychology assessment.

I have arranged to begin a brief focal psychotherapy for George in the middle of August which will last over roughly 12 weeks and will have as its focus his relationship with his father. I have enlightened George as to the possibility of him requiring individual long term therapy after this and I have also suggested that if the need for either this approach or a psychological approach changes in any way before the middle of August that he should let us know and we could reconsider this position.
In terms of asking for a psychology assessment I would have thought that it would be sensible if you refer George directly to Charing Cross Psychology Department to see whether they could offer a behavioural approach to these psychosomatic problems. I will, of course, let you know the outcome of my brief focal psychotherapy with George and if you require any further information on our consultations or are not in agreement with the plan then please do not hesitate to contact me.

Yours sincerely,

Dr. T

FOLLOW UP CONSULTATION

I saw George six months after finishing brief psychotherapy with Dr I who was unable to do the follow up herself as she has now left the hospital George , had confirmed the appointment but had specified that he was unsure who he was seeing and hadn't received my letter explaining why it would be me rather than Dr I He brought with him a large file from which he extracted various letters from the Cassel Hospital in a rather aggressive way as if to indicate incompetence on my part. He was also annoyed that having seen Mrs Calvert for a follow up in January, that his time was being wasted and that he felt that he had said everything to Mrs Calvert and this rather aggressive, truculent stance was difficult to deal with and left me thinking what a very insecure man he must be that he needed to hide behind such a blustering and overbearing facade.

When I wondered with him how things had been over the last six months he proceeded to give me a narrative account, which I was not allowed to interrupt at any point, and which went on for about 10 minutes in great detail, explaining all the treatments that he'd had which included treatment at the Lipid Clinic for High Cholesterol Levels and Cognitive Psycho-therapy at Charing Cross, with intermiitent outpatient appointments with Professor He also let me know that he had been offered another job at the in November involved with the televising of and he seemed convinced that I would have seen him on Television earlier this week, almost as a measure of how important his new job was. All of this was actuall very irritating and I began to get a sense of his underlying vulnerability whe he spoke of how he had to come to terms with the fact that he would never be promoted in a managerial capacity and that he'd really reached the top of the ladder, and would have to accept that and be content with the security of tenure and this prestigious post. He spoke about how senior management wouldn let him manage and of the ageism in broadcasting, so that all the senior jobs were going to people in their thirties. At this point I felt he rather glared at me, as if I too were guilty of being in my thirties. He clearly felt very strongly that the treatment that had helped him the most was the Cognitive Psychotherapy that he had had with the psychologist He foun it very difficult to admit to how disappointed he had be... in Dr I 's ppro He was anxious to tell me that he was a rational, analytical man and felt that even though the Cognitive Psychotherapy had been the most valuable to him, bec it seem,ed the most relevant, nevertheless it may not have been that that had produced the greatest change.

Overall he was feeling much better. His hyperventilation attacks had finished He now feels he can manage his anxiety in a much more constructive way. He wa more at peace with himself. He had changed his diet and was exercising frequently, although he was still concerned about the risk of heart disease and his cholesterol levels seemed to have increased rather than decreased on his new regime. Everything, he assured me, was alright at home. He said he had settled back into a niche in the All in all he thought he'd weathered a crisis and come through the storm. In fact, he told me proudly, a lot better than other colleagues in a similar situation had coped.

He had brought along a file of useful pamphlets on Cognitive Therapy which he was quite happy to show me if I wanted to see them. I was able to reassure him that I have an understanding of the nature of Cognitive Therapy. It was almost as if he felt he wanted to teach me a superior technique to that adopte

.....

at The Cassel. Rather surprisingly he then went on to ask whether there was anything he could do to help The Cassel in its current predicament. After all, he had many Parliamentary contacts and knew nearly all the MPs.

He was very irritated that a letter he had sent to Dr [redacted], enclosing a copy of the Hansard transcript of the debate on The Cassel and a note offering to help, had not been answered. I explained that perhaps it was lost in the system. I did let him know that I would pass on his offer of help [redacted], the Chairman of the [redacted].

We finished rather more amicably, I think he having had the sense of being more a benefactor than a patient, with an understanding that he didn't wish to have further treatment at the moment and knew that he could be referred back to The Cassel in the future should the need arise.

I have written to the GP.

Your ref .....
Our ref ID/SG .....

(ELIZABETH) Appendix 1
Notes on Psychotherapy Assessment

Dear Dr. J

Thank you for your letter about ELIZABETH whom I saw for psychotherapy assessment earlier this month.

ELIZABETH is a 29 year old, single woman who presents at a time of stress because of a disintegrating relationship with her boyfriend of six years standing. She offered a dramatic presentation with marked polarisation in relation to many life issues. Initially she told me that she didn't know whether she should look for psychotherapy or for a ticket to Brazil. She had just returned from Brazil where she had enjoyed herself and felt that she was offered "a different perspective there". She feels that it is impossible for her to leave the relationship with her boyfriend, [redacted], while she remains in Britain and that to do so she would need to go abroad. "If I stay here it will just drag on". In the past ELIZABETH attended a Counsellor for three years while she was in art college [redacted]. She says that at the time she found this counselling helpful but in retrospect felt that she spent most of her time "wingeing and full of self pity".

ELIZABETH offered a colourful picture of her family. She said that her father who is 65 years of age is a reserved man but somewhat like herself, in that he is "superficially quiet but a massive egoist underneath". She says that he is religious and very inhibited. He enjoys music and with his wife he has now retired to Wales and lives out in the country where they are self sufficient to some extent. She describes her 62 year old mother, who is a retired teacher, as also inhibited. She says that her relationship with her mother is distant. ELIZABETH herself is the third of five siblings. Her eldest brother, [redacted] is 31 years of age and she says that he is "pretty strange". She describes him as being dull and wondered whether he was educationally subnormal. She has little contact with him but understands that he spends much of his time unemployed or at times works at jobs such as cleaning windows. The next in the family is [redacted]n who is 30 years of age and lives in London. [redacted] is single and has studied for much of her life to date. She initially took a history degree and since then has worked studying arts and crafts. According to ELIZABETH [redacted] "can't launch herself into real life". She sees [redacted] as being inhibited and eccentric. Although lives in London ELIZABETH has little contact with her. There are two younger brothers, [redacted]l is aged 27 and he works as an Engineer. She sees him as successful and "the most realistic of all of us". [redacted] is 26 and works as a Horticulturist. He lives with his girlfriend and she says he is easy going. She is in regular contact with him. She feels that all the members of her family have "a tenuous contact with reality". There is a family history of psychiatric disorder , in that her sister has been treated for depression and has attended for group therapy. Her brother Michael was seen by his local doctor for stress.

Cont.

Your ref .....
Our ref ID/SG .....

(ELIZABETH)Appendix 1
Notes on Psychotherapy Assessment

Of note in her personal history, ELIZABETH recalls in her early development that she was aware of her mother not being present as her mother was teaching. She recalls a feeling of abandonment in relation to this. She attended school until the age of 16 and said she was always " very competitive". and furthermore "I felt stress, I always felt I wasn't doing enough and I had sleepless nights even before the 11 plus". She remembers school as a time of exams and anxiety. She left after taking 'O' levels. She spent a year studying clothing design and then went on to do a general arts foundation course for a year. She spent a year doing a number of odd jobs which she did not enjoy and then went to Nottingham to study photography. She stayed there one term only and moved to London to study photography and filming. She took a three year course here and then was unemployed for the next year. She subsequently did a course in the Royal College of Art and has since done freelance work in filming for the past three years. She has attained some success in this field and has worked in Italy and Brazil as a Director in the last year. When senior jobs in film making are not available to her she works operating lighting and cameras. Her plans are to continue working as a film maker and writing scripts.

ELIZABETH'S first long term relationship was a three year relationship when she was 17 to 20. She said that she was very dependent in that relationship and eventually they drifted apart. After a few short relationships with boyfriends she met Martin when she was 23. He was one year her senior and he was also involved in the film business. She said that he is very work orientated and they had a poor relationship over the years but considerably worse over the last six months. ELIZABETH says that she feels that she has an inferior complex in relation to Martin and that as their relationship worsened she feels devastated and struggles to survive. She describes the film world and Martin's social life as a place with heavy emphasis on success and achieving and she describes her own unhappiness in this atmosphere. ELIZABETH lives alone and says she has been "reclusive" over the last year. Her boyfriend, ... , visits her about once per week.

Premorbidly, ELIZABETH says she never felt any confidence in herself and relied on others to give her this. She does not abuse drugs or alcohol.

On mental state examination ELIZABETH was bright and articulate. She is often dramatic in her presentation and it seems as though most of her life and experiences were described in a very polarised way - "the most wonderful or the worst". Her main dilemma at present is whether to abandon or be abandoned.

I discussed the possibility of brief therapy with ELIZABETH including the option of group work. She felt unable to commit herself to a group and we agreed on brief therapy. She has been put on the waiting list for brief therapy.

Senior Registrar - Department of Psychotherapy.

(MARY) Appendix 1
Notes on Psychotherapy Assessment

PSYCHOTHERAPY ASSESSMENT REPORT

PATIENT:

ASSESSOR: DR. K. (Therapist)

DATE:

LOCATION: CASSEL HOSPITAL

MARY is a 26 year old single woman who works as Senior Dietician at She was referred formally by her GP, Dr. because of multiple anxiety problems related to a family history of breast cancer and her current concern about the health of her Grandmother. Dr. : has known her socially for the past number of months and wrote a supporting letter to the referral. She filled her form A very comprehensively, having given it a lot of thought. Prior to my seeing her she had conveyed the message that she was very needy and anxious and needed to be seen as quickly as possible. I saw her a week earlier than I had originally planned.

When I collected her from the waiting room, she asked where the toilet was and kept me waiting for a couple of minutes. She wondered if I had read her form and then said she didn't know where to begin. She talked initially of her anxiety and her obsessions particularly around the house, fearing that the gas would be left on causing an explosion or the taps left on, causing flooding. She spoke of checking a lot on her decisions at work, particularly over the last 6 months. I commented that it appeared she felt something very destructive might happen if she didn't keep it under control. She responded saying she didn't think she would cause anything destructive but things passively happen to her. She spoke of feeling critisized by a colleague at work who had accused her of stepping out of her role and making a medical decision. She acknowledged that she feels very sensitive both how she feels herself and to what other people think of her. She spoke a bit of how successful she's been in her independent career. When I enquired for her to talk about her Mother, she became very tearful and said she can't talk of death or of the happy times - that it was too painful - 'did I mind if she didn't speak of this' - 'would it matter'? - 'would it affect the therapy'?.

I acknowledged it was difficult for her to share this pain and wondered about her other relationships. She spoke of her recent boyfriend with whom she broke up about two months ago. She had been in love with him but then found herself out of love. She didn't hate him and was quite emphatic that the break up was amicable, in fact he's staying at her house now still. She recalled a previous boyfriend whom she had known for 4 years, throughout the time her Mother died. He too was called John and it ended similarly, in harmony and without ill feeling. I wondered about her Father, another important man in her life. She was surprised at remembering his name was John. She wasn't sure but she thought he had bowed to pressure from his Mother not to marry when her Mother was pregnant with her. She felt he might be a weak man and had heard that he had since married and had a family of his own. She doesn't think much about him, she never tried to seek him out - her Mother might have been very hurt if she did this when she was alive and indeed her Grandmother might be hurt now, as Grandmother doesn't think very much of him. Her Grandmother she says is the only person she really talks to about the death of her Mother or about how she's feeling inside. I wondered if she'd been able to speak to others about coming here today. She said only Glen, her boss at work and one other close friend knew that she was coming. Glen and she are just good friends. She's surprised that she sees him as a good friend, as she

Cont/d .....

really has only been going out with him for two months. She wondered if it was OK to talk about as I knew him but had commented that she always trys to do things right. She dresses the right way and critisizes the way he dresses.

During the course of the session, she made a couple of slips of the tongue, which I pointed out to her and we reflected on. She said dependent instead of independent in relation to how she has felt throughout her life. She also said she wasn't sure whether she was interested rather than interesting. We discussed the option of brief focal therapy, group therapy or longer term private therapy. She ruled out group therapy, feeling she can only talk on an individual basis about herself. She felt she could not afford private therapy on her NHS salary and therefore wanted to opt for the 12 session individual option. I encouraged her not to rush, to think about what we had discussed today and that we could think about practical arrangements next time we met. She was very anxious to organise a time when she could come, perhaps after work or perhaps later in the day when she wouldn't be upset about having to go to work after being here. I acknowledged that she may fear things might get much worse if she is to get in touch with what's inside of her. She talked about her own role as therapist to her patients but felt I had been different today, in that I had given her space to say things and I commented 'not to say things' if she didn't want to.

Impression

MARY is a competent achiever who is pleasant and attractive and engaging. However, she can appear this way at tremendous inner cost to herself. She holds on to her painful emotions around loss and leavings, particularly of her Father, her Mother, the break-ups with her boyfriends - both called John and her current fears about her Grandmother's death. She has a very strong sense of right and wrong and judges herself, I feel, quite harshly in relation to her frightening, disturbing, hating feelings. I think brief focal psychotherapy with a focus of death and loss and the accompanying anger and hate, which of course would be linked to the endings of the focal therapy might be the best option for her. She may or may not wish to consider longer term psychotherapy after this. I will write to her GP after I have seen her next time on Thursday, at 8.30am.

Dr. K
Senior Registrar in Psychotherapy

SECOND ASSESSMENT SESSION

PATIENT: MARY

THERAPIST: DR. K.

LOCATION: CASSEL HOSPITAL

DATE OF ASSESSMENT:

MARY arrived six minutes late for her second meeting with me. As previously, she asked to use the toilet and kept me waiting before coming to the room. I wondered about her thoughts about and since our last meeting. She said she had let it sink in for a few days. In the meeting, we had talked a lot about her relationships and her Father - she didn't feel that these things are a problem. However, she felt a week, indeed it's over a week since she was here - this felt too long, so many thoughts were occurring to her. However, her problem is still the same. At work she is very afraid of making the Mother of a child even more anxious because of her own anxiety.

I wondered about her personal fear of making the Mother anxious. She talked particularly of her Grandmother, who she says is anxious about MARY living alone or going abroad - indeed, she plans to go to Finland and possibly Russia later this year but hasn't told Grandmother. Grandmother treats her as a child and thinks she is younger than she is. She wants MARY to get married and have children - perhaps she wants a grandchild. I commented that she has a grandchild. MARY stopped in her tracks thinking 'Oh no, I mean great grandchildren' - 'but she treats me like a daughter.' She didn't think her Grandmother wanted her Mother to marry but maybe she did, but since then she doesn't like her Father. However, Grandmother thought that MARY would marry John. MARY went on to talk about her first boyfriend, who was a much older man. She was a virgin at 17 and her Mother discussed with her whether she wanted him to stay in their house - Mother left the decision to MARY - 'That made sense,' MARY said. However, she stopped and asked me if it made sense to me. I commented she apparently had her doubts about it.

She said she wanted to know what I'm thinking, I say very little - I wondered what she was thinking or feeling. Usually she said, she listens to others - she doesn't talk like this outside of here. She wondered if I was fed-up of her talking about herself all the time - Glen she said, sits and listens for hours. I focussed with her on the options open to her and the choice she had to make today. She didn't feel she wanted to be in a group situation but didn't understand why. She felt longer term therapy to be a frightening idea, anyway, she wondered if she could afford it. She asked if the individual sessions would be with me and then opted for the 12 sessions. I explained the on-going research here - she would have no difficulty or problems being part of this. We next thought about times, I offered flexibly, three times - 4.30 pm Wednesday, 1.30pm Friday or 8.30 am Thursday. There were problems with each. She wondered if there were no other options. I suggested she think about these times and let me know as soon as possible. I told her of my holiday and wondered with her if she would prefer to start now or leave it till mid-August. She opted for now. She wondered what sessions would be like - she had found it difficult to intellectualise what I was saying about her Father. She didn't like my focus or didn't agree with these Freudian ideas of normal families or slips of the tongue. I commented on her wish perhaps to get away from feelings by intellectualising. I commented on something that I felt she may not understand or it may make some sense - I wondered about

Cont/d .....

CONT/D

her using the toilet before each meeting with me, as if getting rid of something before coming in here. She said she is not devoid of feelings and that she feels defensive here in relation to this - she felt she is talking, she just had the urge to go to the toilet, she was so rushed before coming here she hadn't had time. Recently she had cystitis and had to go very regularly but maybe there is a link, she'd never thought before of getting rid of feelings in this way. I suggested that one of the feelings she may have feelings about was my finishing on time and asked her if she knew her way out - she said yes and left looking a bit perplexed.

DR K
Senior Registrar in Psychotherapy

St Thomas Hospital
London SE1 7EH

Your ref
Our ref AR/SG/Z195335.

(STEVEN) Appendix 1
Notes on Psychotherapy Assessment

PSYCHOTHERAPY ASSESSMENT

Referred by Dr. A police officer on medical leave for the past six months. His problems go back to the past four years and, fairly explicitly, are related to the discovery at that time that his son had been involved, among many others, in a homosexual relationship with a school teacher. His son was then 14 and has always denied the fact but Steven actually called to the police station and saw the evidence there. He used his influence to prevent his son actually having to appear in court for the prosecution and then felt very betrayed when his son in fact appeared for the defence. The teacher in question was given a four year sentence, due to come out now. His son has been in some correspondence with the man since which also annoys him and upsets him. About the time this came on he was also seen for headaches and since that time he has been liable to quite unfamiliar outbursts of anger inappropriately both in his work as a policeman and also on other occasions. He even hauled somebody out of a car for a minor offence and wanted very much to beat them up and this is all something quite unlike his previous self. He is an only child, father was away during the war but he had a very good relationship with his parents who are now both alive and well and in their late seventies. Humble, working class family in Kent. He left after a period in the police cadets, did his National Service. Tried working in industry for a few months and then joined the police force where he has now completed thirty years. He has basically enjoyed the job. He has not sought promotion, likes working on the street. For quite a long time he was in the diplomatic protection corp. He said his attitude to homosexuality in general is not extreme at all and had his son as an adult chosen and announced the choice he would have found it more manageable. As it is it still brings him to the edge of tears in the room. His son was home at Christmas and it went off alright but no hint of discussion about this issue was possible. He is finding it quite hard to occupy himself, unable to think about the future and generally quite critical of himself. Over the same period he also had a brief affair in which he was sexually impotent. Sexual interest in the marriage had waned to almost nil over this time. His wife seems to accept this. He says the marriage is otherwise alright and reasonably supportive and that they are quite enjoying being at home without the children, their older daughter being now married and away. I did wonder whether there was not some strain there or dissatisfaction and he was talking about perhaps he could find some younger woman who would restore him his powers. He is clearly worried about the loss of sexual potency. He is sleeping alright and does not give the impression of a seriously depressed man but clearly this prolonged reaction to the news is abnormal. The only other clue I got was that clearly he is very protective of other people, i.e. keeping his son out of court and i.e. not telling his wife what had happened for a long time after he knew about it and maybe there is a certain amount of "I have to manage everything" in him.

Cont.

St Thomas Hospital
London SE1 7EH

Your ref
Our ref AR/SG/Z195335

Ext

(STEVEN) Appendix 1
Notes on Psychotherapy Assessment

Mr. Steven - cont.

I explained the nature of the therapy and put him down for 4 months of CAT.

P.s. He is available on and can come any time of day.

PSYCHOTHERAPY ASSESSMENT BY DR C

CAROL

CAROL is a 38 year old qualified solicitor who has been away from work for several years and is currently doing a course of employment training in order to restart. She was referred by her GP and suffers with life long problems which have recently been brought to the fore by difficulties with her family. She was married in 1979 and the year after gave birth to a severely handicapped child which has placed significant strains on her marital relationship. She has low self esteem and feels a failure although is more confident recently as some of the difficulties are being worked out.

Her husband is Dutch and after the marriage they went to Holland where they had their children. The oldest, (handicapped one) is 9 years old and her other two children, Sarah and Amy are six and a half and four. In [illegible] their marriage split up and Hilary returned to England with the children. Following some psychotherapy at a child guidance clinic in [illegible] she eventually went back to Holland where they had some marital counselling. Earlier this year she returned to this country because of her unhappiness in Holland and her husband is joining her in October this year to give the marriage another go. Currently [illegible], the 9 year old handicapped child, is with foster parents in Holland although it seems that she will need institutional care because of her severe physical disability and mental handicap - her mental age has been judged as 18 months.

One of the difficulties involved in her relationship with Katie was that she was born by emergency Caesarean section and under the general anaesthetic it took one and a half hours to get the baby out. It does seem that there was some genuine blame on the part of the hospital although there is no legal action involved.

CAROL 's father is 77 years old and lives in Putney and is still working as a solicitor. He is a very reserved man whom she cannot talk to but he has high standards and pushed his children very hard. Her mother is 67 years odl and lives with her father. She is described as domineering and picky. They are a Jewish family who are very close and CAROL sees her parents every weekend. Her sister, Jani[illegible] years old and works as an Editorial Assistant [illegible] She has been marreid but has been separated for the past 5 years "because her husband was impotent". CAROL 's husband, [illegible]e, is a 37 year old and works as a hotel cook. He is from a strong Catholic family but

is not practising himself.

CAROL was born in London with no birth problems and 6 weeks after her birth her mother went back to work [redacted], working for her father. CAROL felt that there was never really any space for the children and at the age of 4 was sent to a local private school. Her academic performance has been variable but she gained a place at grammar school and from then on did well academically. At 15 she had a period of anorexia nervosa which she managed to overcome in about a year though has continually had eating problems since that time. She gained 7 O'levels and 2 A'levels and started her law degree at Kingston Polytechnic. During her final examinations she panicked and took a year off from her course, eventually completing it at [redacted] Polytechnic in 1973. To her regret she became articled to her parents firm and admitted that this was an easy option. In 1978 she finished her examinations but never really worked as a solicitor, mainly doing odd jobs in shops and offices. She met her husband in London and they managed a restaurant in Carnaby Street for a short time before leaving for Holland. It is now 10 years since she worked.

Her eating problems involved bingeing and dieting with fluctuation of her weight. She tends to like sweet things such as biscuits, sweets and ice cream but does not vomit nor use laxatives or any other method to lose weight. Her husband does not seem to mind her behaviour and he is overweight and is a heavy smoker and drinker. Their sexual relationship is reasonable although she finds she cannot have an orgasm during sexual intercourse though does through masturbation.

At interview CAROL presented as a shy, overweight woman who generally had a low opinion of herself. She is intelligent and spoke frankly about her symptoms of depression, binge eating and occasional temper tantrums. She feels very guilty about her first child and seems to have some regrets about not taking legal action at the time. Her core state seems to be that of a child who was never cared for emotionally and this was brought to the fore by her own difficulties in caring for her first child. There is also some ambivalence towards her husband though I think this is basically a sound marriage.

I think she is a good candidate for CAT and I will put her on the waiting list. I will be sending her a psychotherapy file in the meantime.

DR.
Senior Registrar to Dr
Department of Psychotherapy

(ANDREW) Appendix 1
Notes on Psychotherapy Assessment

FIRST APPOINTMENT ASSESSMENT FOR PSYCHOTHERAPY

ANDREW DATE:

ANDREW came into the room after I had initial difficulty in pronoun his name. He told me how it should be pronounced and said that it would be better if he was named Mr. Smith and he sat down and talke very endearingly, with great sadness, about his current situation in terms of his two homosexual relationships. He told me about "his friend the priest" who he has had a relationship with for fourteen years but which is now on the rocks, and also about a man that he has fallen in love with who he wants to leave the priest for. After asking me whether our assessment would be confidential he began to tell me the names of the people involved, and told me then of the shame of meeting the second lover in some toilets when he had been able to enjoy sex, after not enjoying it for fourteen years with his previous boyfriend the priest. He told me of his recent move in the vicarage to upstairs, just a little away from the priest, and of his initial meeting with the priest, his exorcism, his christening and his confirmation. The priest is now saying apparently that there is a dark evil power in him and that somewhere ANDREW believes this. Also with his second relationship he has been told that he has instigated the falling in love process of the man who he is now in love with. He seemed quite relieved by telling me of these problems and then began to tell me of the home background which he hates. It is a working class background and he has always felt like he didn't belong and that he was perfor for his parents. He has always felt distant from his parents, alth he recognises that they love him very much. He recalled an inciden of his mother going away when he was nine and him being left to be bed with his father and he wonders whether any incest took place at this time fantasising that it would be more likely for him to appro his father than the other way round. He also talked of remembering a 'Lassie' film and wishing that he was the wounded Lassie that was being protected by the large man in a trilby hat. He remembers dreaming about this programme for days and weeks afterwards and fantasising about how wonderful it would be to be carried by this man. He then began to tell me about the discovery that his brother who is three years' older than him, is adopted and how he looked fo the adoption papers to prove this. At this point it seemed to me t he was describing his home as a prison in the very same way that he was describing the relationship with his friend the priest as imprisoning, and I put it to him whereupon he became very over-whelmed with emotion and unable to speak, breathing heavily and fas to a point where I became quite worried about him. He recovered an told me that this was the very same comparison that his friend the priest had drawn between him and his trying to replace him with the new lover. The end of the session involved me suggesting that he was feeling quite a lot of imprisonment and punishment inside himse and that it would seem significant that he could only enjoy good se when he was in a shameful environment, or at least when a relationsi began that way. It seemed very much like his relationship with the priest was giving him the outside punishment rather than him perceiving it from inside. I arranged to see him in three weeks' t and he then explored his difficulties over the forthcoming holiday the priestwhen he would be expected to share a cabin on a boat trip He said that he hoped he wouldn't rock the boat.

(ANDREW) Appendix 1
Notes on Psychotherapy Assessment

SECOND ASSESSMENT FOR PSYCHOTHERAPY

ANDREW DATE:

He walked in smiling rather superficially and sat down telling me immediately of his apprehension and the awful panic that he had been feeling off and on for the last three weeks since he saw me last. He told me he felt trapped and had been feeling very sad at times but denied categorically feeling suicidal. His work had not suffered too badly and he was still very much in love with his new boyfriend. He told me of the awful guilt again of feeling that he has let down his friend with whom he has had a relationship for eighteen years. I felt at this point that there was a feeling that he really wanted to be in therapy already with me and when I put it to him that I needed to remind him that this was an assessment for psychotherapy, there was a reaction of some dismay and I think a fair bit of anger, although he was not able to acknowledge this. He told me that he had been warned about his likely dependence on me by his new boyfriend and he wondered whether this is what he does with everyone. He told me of the importance he attributes to my suggesting that he is perhaps leaving home only now and he had been thinking very much that this was absolutely correct. I wondered, at this point,whether there was a need to idealise me as the "Lassie Man" or at least the "Lassie man's" good characteristics, and he thought that this was perhaps the case. He told me that it was all too easy to see the good "Lassie Man" but when it came down to it he had often felt that the "Lassie Man" would jump on his back.

In discussing options for psychotherapy, he was keen to tell me that he felt the time was ripe for him to have psychotherapy and he was very much in need of it. There was a push from him for me to make a decision about a future option for him and in throwing this responsibility back towards him, he decided that he would like to try a brief focal psychotherapy with the idea that things may well be stimulated such that he would like to continue with individual therapy sometime later. He told me that he was scared that he would not like what he found out about himself, but none the less felt that it was his best option at present.

Plan

I will put him on the waiting list for brief focal psychotherapy and a mutually agreed focus would be along the lines of his need for a father figure and this is seen quite clearly in his repetition of relationships in this pattern. This would lead onto a possible attempt to answer the question "does he really want to give up "? i.e. his marriage. He is aware that I am writing to the G.P. and also that there is a waiting list for brief focal psychotherapy.

/am

(ANDREW) Appendix 1
Notes on Psychotherapy Assessment

SECOND ASSESSMENT FOR PSYCHOTHERAPY

ANDREW DATE:

He walked in smiling rather superficially and sat down telling me immediately of his apprehension and the awful panic that he had been feeling off and on for the last three weeks since he saw me last. He told me he felt trapped and had been feeling very sad at times but denied categorically feeling suicidal. His work had not suffered too badly and he was still very much in love with his new boyfriend. He told me of the awful guilt again of feeling that he has let down his friend with whom he has had a relationship for eighteen years. I felt at this point that there was a feeling that he really wanted to be in therapy already with me and when I put it to him that I needed to remind him that this was an assessment for psychotherapy, there was a reaction of some dismay and I think a fair bit of anger, although he was not able to acknowledge this. He told me that he had been warned about his likely dependence on me by his new boyfriend and he wondered whether this is what he does with everyone. He told me of the importance he attributes to my suggesting that he is perhaps leaving home only now and he had been thinking very much that this was absolutely correct. I wondered, at this point,whether there was a need to idealise me as the "Lassie Man" or at least the "Lassie man's" good characteristics, and he thought that this was perhaps the case. He told me that it was all too easy to see the good "Lassie Man" but when it came down to it he had often felt that the "Lassie Man" would jump on his back.

In discussing options for psychotherapy, he was keen to tell me that he felt the time was ripe for him to have psychotherapy and he was very much in need of it. There was a push from him for me to make a decision about a future option for him and in throwing this responsibility back towards him, he decided that he would like to try a brief focal psychotherapy with the idea that things may well be stimulated such that he would like to continue with individual therapy sometime later. He told me that he was scared that he would not like what he found out about himself, but none the less felt that it was his best option at present.

Plan

I will put him on the waiting list for brief focal psychotherapy and a mutually agreed focus would be along the lines of his need for a father figure and this is seen quite clearly in his repetition of relationships in this pattern. This would lead onto a possible attempt to answer the question "does he really want to give up "? i.e. his marriage. He is aware that I am writing to the G.P. and also that there is a waiting list for brief focal psychotherapy.

/am

although he did not consider this to be the case and just said that older men interested him more than younger men. is in fact in his fifties. He also mentioned that in some ways it was like the Lassie film that he had once watched, in which Lassie was injured and picked up by a large man, and he had wished that he was Lassie being picked up by this large man and protected by him.

I pointed out that I was unclear as to what exactly it was that I could do to help him, but discussed the possibility that in fact instead of trying to get him back to , maybe it would be more appropriate to get him to come to terms with his lifestyle, which had in fact improved since returning to the old ways of his sexual practices. had also commented that the relationship at home was much more tolerable and they had both felt more comfortable about this.

I pointed out that obviously provided him with basic needs and companionship, but he also needed to satisfy his sexual side with something more exciting. He felt that this was a perceptive observation.

We ended the assessment by him saying that he had not talked to anyone for months about his sexual feelings and had felt better as a result.

Dr

My sort of person I'd like to be

Someone who is rarely, if ever, at the mercy of their mood. There are times when I feel like a blubbering child of four years old I can't face the world, the responsibility of forging a life myself — I crave affection, to have responsibility for myself taken out of my hands — I don't want to feel like this and if I must I want to be able to fight it, to deceive others, to appear always in control, able to be responsible for myself.

Sometimes I avoid social situations because I feel shy, withdrawn, lost for words — unconfident. Recently I have avoided going to two parties because it would have meant going alone and I felt unable to cope with the prospect of having to be gregarious and also of being a 'spare woman', an available woman. I wish that I were less intimidated by men and especially by potential sexual encounters with strangers — I just panic. I'm always too self conscious to dance (unless I'm very drunk or stoned). At parties I can neither relax or enjoy the sense of sexual frisson that prevails if one is an 'available woman'. I want adventure, I want affection, I want sex but the prospect of it terrifies me. I either avoid the situation completely or, when it happens, I back out of it. I am shy, stumbling, unconfident. I feel unattractive mostly. I wish I were more confident about myself, especially my appearance — I usually

feel ugly.

I used to be very confused about my gender. I say gender rather than sexuality — I wished I'd been born a boy. Now I don't but I'm still not comfortable with femininity.

It's important to me to be attractive to men, even ones I'm not interested in — I wish that I knew better how to manipulate them the way it seems to me that most women do. I wish I felt comfortable about femininity. If I wore a skirt and stockings I'd feel like I was in drag! or if I wore much make up.

I wish I didn't crave affection — I worry that because my need for physical affection (not necessarily sex) is so strong it makes me undiscerning ie; if I were desparate enough I'd take the first man who'd have me. Lately I have an image of myself as 'a sad case' — it's not a useful image I wish I didn't have it.

Sometimes I'm very negative — why wasn't I born beautiful etc?

I wish that I had great emotional strength — as a writer/filmmaker I'm always going to be somewhat socially detatched and yet loneliness tortures me when I can't endure it any longer I ring up people I know, I cry, I am weak I can't just deal with it myself.

Strong, self reliant, resiliant, enduring, constant

This relationship which is ending, has been ending for a year now, is like an achilles heel. I can't imagine life with him or without him. He is tall, when I cry my head rests on his chest, his arms fold around me, his hands hold my head, Stroke my hair, he handles me like a child, when I cry This makes me feel like a child — a small tragic child, a lump in my throat, tears of woe, a red puffy face, hair all over the place — he's like the parents I never had I had parents, have parents but they never handled me like that. It seems important to me to retain certain elements that I associate with childhood — naive logic, spontaneous instinctive response to things, instinctiveness is very important but there are some instinctive responses I want to control. I want to feel more adult, I especially don't feel adult with men.

Perhaps I don't feel confident about (i.e; can't conceive of) a life without this man because I lack confidence in myself, I feel he's the only person I can trust. I had a mental picture of how I felt about him — that he is a wedge that fills a space I used to have and now my whole weight bears down on the wedge to keep it there. He has seen (represented) a side of me I never wish to reveal to anyone else — reduced to the weak blubbering clinging child — completely without dignity — this somehow constitutes a very strong bond between us

I know I said in [illegible] film maker would go [illegible] the [illegible], he would be like Halliwell & Orton minus the wit and yet if he asked me to (which he never would) I don't know if I'd have the strength to decline — If I were pregnant by him I'm sure I'd have the baby, anyone elses I would abort

I wish I were less susceptible to flattery. I love to be the centre of attention and yet if I have to act or read aloud I'm crippled with self consciousness terrified of making a fool of myself, that's why I don't dance at parties — this kind of self consciousness is unbearable to me — I want to be gregarious, confident, to be able to relax and above all to be able to have a good time in company — I want to be able to cope with solitude but I don't want to be a solitary individual. I think it's mostly lack of confidence I swallow what witticisms I think of because I don't have the confidence to say them right — witticisms delivered badly are an embarrassment to all concerned — it's terrible when people launch into an anecdote and loose confidence half way ~~through~~. I want to be socially adept. I wish that I could be light hearted at will — I am rarely light hearted lately. I wish I could see the funny side of things. I wish that I were more assertive and less aggressive. I wish I could swim. why can't I? I am what I am — if I am different than

other women or people [illegible] I must [illegible] the [illegible] to my relationship. I don't know how to. I'm not [illegible]

I'm terrified of people I perceive to be 'losers' because I feel close to the edge myself.

I want always to have the courage to [illegible]

Either I want not to be the way I am or else I want to have the courage to be the way I am — alone. I want freedom but I don't want vertigo.

possibly I wouldn't feel this 'can't live with/without' way about him if I could organise a way of life for myself that made me happier.

I am wary of my tendency to put everything into literary terms since I started writing scripts, but here goes:

why do I need psychotherapy?

Because I have been trying alone to accommodate the break up of a relationship that feels like trying to sever one of my own limbs.

I'd like to be brave and uncomplaining. I can't write at the moment because I'm having an identity crisis. I don't know which me to write from. I can't find the one I like — the only one I trust to commit ideas to words.

Our File Ref ..... Your File Ref ..... DATE

DEAR ELIZABETH reformulation

You are , one of five children and as you said, your mother's attention was divided among you, but you feel not very evenly, for you do not remember her, being demonstrative towards you, witnessing her being physically demonstrative towards your younger brother. You felt apart from the rest of the family.

Your family had very strict rules, your mother played a passive role, didn't try personnally to reinforce these rules except that like the rest of you, she didn't hesitate to betrayed her children to her husband in respect of theses.

Your father was a disciplinarian, while the boys were caned, the girls had to undergo father's examination of their underwear. Wetting one's pants was followed by a very hard smack which left you breathless. You said, that you lived in fear of being caned, and remember waiting in anguish for your father to come back.

Faced with your father's abuse, you were either passive and betraying like your mother or adopting your father's rule. You lived in fear mixted with the pleasure of seing someone else punished rather than you.

What you are left with now is a blurry image of yourself, having extreme moods swinging between as you say, feeling like a "blubbening child of four years old, who can't face the world, the responsability of forging a life for yourself, wich reflects the lack of caring support you suffered in your childhood. Or you swing into the role of a charactere pretending to be in charge.

You have difficulty into identifying with your gender, for when faced in a situation where you have to be an adult woman you find yourself feeling like a humiliated child. Your sens of dignity was under constant attacked in the family morbid.

You are very critical of yourself and thus represent an internalisation of your father.Although disliked, this was firm ground, which your mother did not offer. You are trying to organise a firm ground for yourself now,in an attemp to make an adult self that is not passiv

This however is very defeating. You were a small fearfull child h who could not turn to the protection of a mother and cannot now rely on a warm internal mother, and you feel sad, abandonned and fragile. You also repeat the pattern of depraving yourself of good things.

The agenda for therapy will be to work on gender identity in opening a dialogue between, the critical fathe r, the fearfull ch child and the passive mother. Learning to operate emotionally at a ore adult level, with more realistic beliefs about yourself and the world, Learning to test these out.

J

(ELIZABETH) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

"goodbye letter"

Dear ELIZABETH

You first came feeling prisonner of your isolation,having gave up trying to breaki giving up, after several unsuccessful attemps to go out into a more active social life.The script described it well, the main caractere, being a woman, which spend day and night recluse in her room. She walks about naked,it is her way , naked and isolated, like others dress and go to work. Thats how you felt, that other people could see through you, while you had a blurry image of yourself. You suffered from extreme mood swings,between feeling like a "bubblening chid" and "coping with it al In an attempt to stand on firm ground we opened the dialogue between, the critical f father (abuse) the fearfull child and the passive mother. ~~Then the dialogue~~ You placed yourself in abusif situations, where as a women you remained passive, experiencing t the terror of being abandoned as a child. Then the dialogue went to a next stage between "adult ELIZABETH and "chid ELIZABAT, There you realised the split in you. A Adult fearing of being let down by child, and humiliated in social situations, child not trusting the adult to fulfilled those needs. While doing a creative imagination excersice, you measured the situatio which is; that your preoccupation is to go into the world whithout the child. The child is terrified to be abandonned.

It seemes to be an irreconciliable split between the tow. We looked at your views about both. yo8u see the adult as; independant, confident, successful, loved.

child as ; needs an enormous amount of love, unsecure, fearfull abandonned.

At the intellectual level you know that thoses labels don 't have to be split, but a attached to both.On a developmental level , it seems that unresolved childhood expe riences have stop you from going on to the next stage ,adolescence, thus hindering adulthood. This division is an artificial one , nobody goes, in a clear cut way from one to the other.

Now that you have had the courage to explore the childhood, the pain, that you ande stand your family dinamic,you no longer falls into a despair at weekends. You also recognise how the need to grow up quickly into a woman, without facing the dilemma of childhood, lead you to project the "father- lover " onto You choose to opt out of a relatioship, which is more depraving for you. That was a turning point.

(ELIZABETH) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

The gap between childhood and adulhood is being filled, you are entering into an adolescent phase. you have began to rewrite your script.It is going like this. This woman whom you call my your "alter ego" is now very much dressesup, we have been dressing her up , in those weeks spend toge her. She is going out, as an anarchist. You said " I won't tell you what she is going to do ". You are saying too, you won't be there to see it.

Adolescence is going back and forth rom home. for you, living on your own, a mixture of holding the loneliness, and going out to find a peer group. It is to assert one's newly found self, pushing things to the extreme in order to find out, how far you can go.

The aim of the therapy was, learning to operate emotianally at a more adult level, with more realisti c belief about yourself and the world. Learning to test these out. No doubt you are on the way to do it.

Take care,

St. Thomas' Hospital
London SE1 7EH
Telephone 01-928 9292

Your ref .....
Our ref .....

Ext .....

(ELIZABETH) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

Dear ELIZABETH

When asked to fill the psychotherapy file, you said, not to be able to do it, because of feeling that you could answer the questions in a way today and another tomorow. Not knowing which way to turn to, at the moment. You have the need of "directing" your life, which is not fulfilled also, you are looking at yourself through the eye of the camera. And being like an actor who is asked to perform without knowing the script. Where the director doesn't know the script either. Out of that, it appears that you focus dramatically on what others think of you. I can relate it to an innerrcritical parental voice. You are anxious as being a woman. Not feeling comfortable wearing women's clothes. Being very critical of yourself. Swinging between being isolated in your room, reading a lots of books that yo u have to read. Putting yourself under a strict discipline, or going out feeling vulnerable, an available, so much, that you could be anyone 's. This constant self examination, remind me of your father 's daily inspection of your underwears to see whether or not they were wet. You only weted your pants when la laughing yourself away at school. The spontaneous laughter was to be sanctionned. You also live in fear of loosing your dignity, this is what you call being ~~hidejac~~ by the blubbening clinging child. In between those two poles the competent adult g got lost. Betraying yourself. For in your family you had to betray in order to survive. Escaping this way the "commotion" by mean of what one of you will be caned — "commotion" which brought everyone in the garden to watch it, feel with a mixture of excitement and relief that it was not you. You lived in fear of that happening to you. Betraying you said, had become a reflexe, even at school when in fear of being punished, you betrayed your friends. I have been thinking about "betrayal" and which form it could take within our relatioship. My though are that you could betray yourself by , either turning me into a "critical father" or "a passive mother" like your mother was. I think that it is very important for you at the moment to ex

St. Thomas' Hospital
London SE1 7EH
Telephone 01-928 9292

Your ref .....
Our ref .....

(ELIZABETH) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

perince a "good enough" relationship with another woman. Without feeling that you m might become the desperate clinging child, like it happened during your previous cou counselling. Learning to say no to the blubbening child with learning altogether to take care of yourself.

You said "I don't want to be a sad case", no , but I see our work together as openin up exits, for the potentially happy woman in you to emerge. And we have to look at yo family background , where, betrayal, pleasure, punishment, was present as well as, the abuse. Where the qualities of the child, wich you describe, as, saine logic, spontenaous instinctive response to things couldn't find the space to develop. I know that i it is a deep, sad reget ,but not everything is lost, for theses qualities belong to the adult too.

The most difficult time of the week , is the week-end. Time, when you feel most isolate Thinking, that everyone else are busy, being and doing with others. That they are priviledged, and you are underpriviledged. I was thinking about, who was "priviledged" or "under priviledged" in your family? The brothers underpriviledged for being caned and you watching priviledged not to be. Or them who were the center of attention, despi te the punisment, and you underpriviledged to be just standing there as a spectator.

ich role to play, in the action.

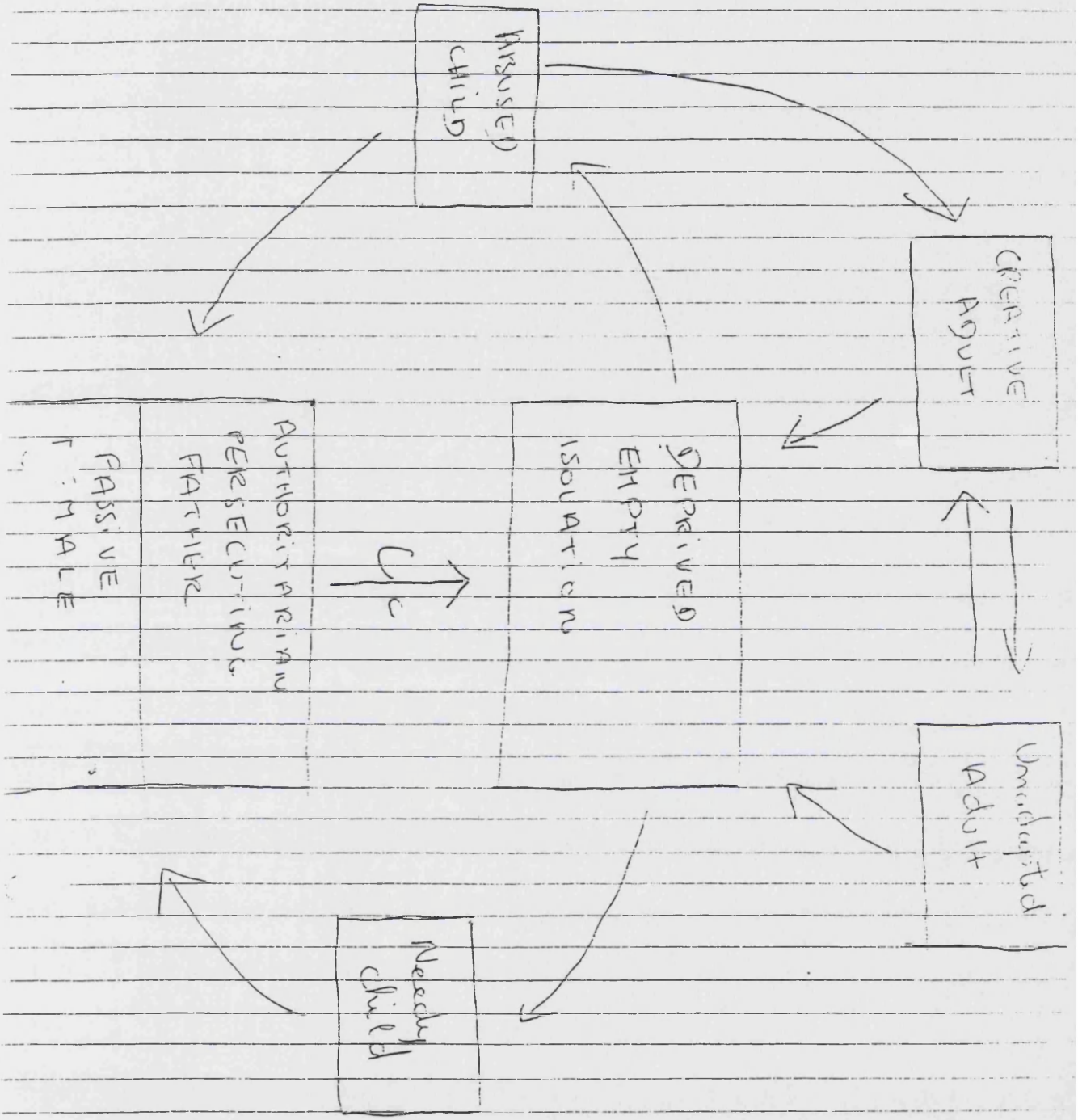
You said.

"I crave affection, to have reponsabilities for myself taken out of my hands, if I must ,I want to be able to fight it."

Rather, denying your needs, for dependancy, trying to disregard both your needs for independance without stifling the need to depend on an emotional support system.

" Fighting the need of being cared of is to deceive others, to appear always in control, being responsible."
sounds like "either I am in control, or face a terrible mess"

(ELIZABETH) Appendix 2
Additional Material Used in Cognitive Analytic Therapy



Goodbye letter (Therapists)

(STEVEN) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

Steven,

You came into therapy because of your fear of the violent, out of control aspects in yourself. Now that therapy has come to an end you seem to be afraid of the consequences of what you have discovered about yourself. You have had to face painful, unpleasant feelings and come to terms with your vulnerability. The issue for you has been one of control and what this means for you. There have been many times during our meetings when you have let yourself go and lost control. This has been very important as at those times you were fully in touch with your feelings. These were very intimate moments when you were able to share with another. You often chose to see those times as signs of weakness. However, I consider them as signs of strength. It seems to me that you have begun to learn to listen to yourself, to experience your feelings and to recognise and share your needs.

Early in therapy we established that you felt the need to stay in control of your feelings. In this way you used control as a defence against experiencing your true feelings. We found that for you this control was a relatively safe place in which you could function o.k. However, unknown and potentially threatening situations can never fully be kept at bay and the tremendous anxiety which they aroused was always there as a very real possibility. It feels very dangerous outside of the safe embrace of this type of control. This is the frightening feeling you have experienced as the end of therapy has been approaching.

During therapy you have come to realise that the time in control in which you have sought release

is ultimately unsatisfactory. Basically what it is is a desperate attempt to push bad, unwanted feelings away. In this sense it has never really been a control at all. This becomes clear when a threat arises and control is so easily lost either to aggressive impulses or escape into a nice fantasy of a distant island where all is wonderful. Control, in essence, has meant a clinging to the familiar and the safe. In therapy you were able to explore what was and was not safe. You took some risks and now you are aware of the possibility to find another kind of self-control. The difference is one of being in control of yourself by knowing yourself and experiencing your feelings as you appropriately feel them, rather than being controlled by the fear of them and what may happen if they are given expression. Before therapy, you found it difficult to explore the anxiety and vulnerability you feel. You now know that being in touch with your feelings does not necessarily mean that you are out of control in a self-destructive way. On the contrary, it is an essential recognition and acknowledgement of your own needs.

You have always seen yourself as a protector of others. Indeed the job you most enjoyed doing was the professional equivalent of this. You were respected in this work and you felt there was a place for you there. Losing this job was the beginning of a series of events which eventually led you to therapy. Finding and losing a place for yourself is of the greatest importance to you. When you lost the job in which you were respected, when you began to fear that you

drifting apart then you began to experience your deepest fears and you fell victim to your powerful rages against yourself and others. It was as if any loss of control, any show of vulnerability was so terrible that it had to be denied in case you lost your place and became nothing.

We were able to talk about this and perhaps this great fear stems from the time your father returned from the war and took his place beside your mother. In effect he displaced you and you must have felt anger, desperation and sadness about this. In a family situation where these things are not talked about openly a child will often control their feelings thinking they are inappropriate and bad. This leads to guilt and shame. I remember in our meetings how you would often feel ashamed of letting your feelings out. You said, "It is like the father in me will not let the little boy cry." During therapy you have been able to acknowledge that little boy who could not cry and you were able to find his voice. This was particularly so towards the end of therapy when you were able to express the sadness and fear about the ending.

Boats and cars have been powerful providers of metaphors in our meetings. We've often speculated about the best way to get to the treasure island. We've also discussed the merits of certain types of car. If the therapy was to be seen as a boat or a car which would provide the best means to get to the desired good place, what would it be? A Lamborghini or a Skoda, a power boat or a rowing boat. I would rather think of it as something in between. A Lamborghini

or a speedboat feels too flashy, too fast, too escapist and too superficially powerful. A Skoda or a leaky old rowing boat may eventually get there, but the journey might be lengthy and very difficult. It may well be that this is wh it will take to get there, but perhaps it's better to consid something more mundane. You need something reliable, whic may occasionally breakdown, but can be repaired. Something that you can feel comfortable with. But not too comfortab to lull you into a false sense of security. It needs to be something that you can handle without having to worry about the speed or the slowness and it needs to be capable of being understood. It also needs to be something which is cared for and nurtured by you and those closest to you. You're going to need some back-up.

To continue the transport metaphor I suppose therapy is like a map. It can show you where to go and it can point out the dangers and pitfalls but it is you who must make the journey. It has to be experien In this brief therapy you have gone some way to understanding why you are experiencing difficulties. You have been able to share some of your deepest feelings with me and you have faced the fear of them openly. There have been times when it has been very difficult and I acknowledge how hard it has been for you to stick with it. However, you have done so and now that you have begun the journey you must carry on. Things will never be the same as they once were. You've changed and you recognise this. There can be no turning away from awareness. You need to share this with those closest to you. There is so much to be said and it needs to be said. I wish you all the best.

I

THE PSYCHOTHERAPY FILE

An aid to understanding ourselves better.

We have all had just one life and what has happened to us, and the sense we made of this, colours the way we see ourselves and others. How we see things is for us, how things are, and how we go about our lives seems 'obvious and right'. Sometimes, however, our familiar ways of understanding and acting can be the source of our problems. In order to solve our difficulties we may need to learn to recognise how what we do makes things worse. We can then work out new ways of thinking and acting.

These pages are intended to suggest ways of thinking about what you do; recognising your particular patterns is the first step in learning to gain more control and happiness in your life.

Keeping a diary of your moods and behaviour.

Symptoms, bad moods, unwanted thoughts or behaviours that come and go can be better understood and controlled if you learn to notice when they happen and what starts them off.

If you have a particular symptom or problem of this sort, start keeping a diary. The diary should be focussed on a particular mood, symptom or behaviour, and should be kept every day if possible. Try to record this sequence:

1. How you were feeling about yourself and others and the world before the problem came on.
2. Any external event, or any thought or image in your mind that was going on when the trouble started, or what seemed to start it off.
3. Once the trouble started, what were the thoughts, images or feelings you experienced.

PSYCHOTHERAPY FILE

By noticing and writing down in this way what you do and think at these times, you will learn to recognise and eventually have more control over how you act and think at the time. It is often the case that bad feelings like resentment, depression or physical symptoms are the result of ways of thinking and acting that are unhelpful. Diary keeping in this way gives you the chance to learn better ways of dealing with things.

It is helpful to keep a daily record for 1-2 weeks, then to discuss what you have recorded with your therapist or counsellor.

PATTERNS THAT DO NOT WORK, BUT ARE HARD TO BREAK

There are certain ways of thinking and acting that do not achieve what we want, but which are hard to change. Read through the list that follows and mark how far you think they apply to you.

Applies strongly ++ Applies + Does not apply -

TRAPS

Traps are things we cannot escape from. Certain kinds of thinking and acting result in a 'vicious circle' when, however hard we try, things seem to get worse instead of better. Trying to deal with feeling bad about ourselves, we think and act in ways that tend to confirm our badness.

Aggression and assertion

People often get trapped in these ways because they mix up aggression and assertion. The fear of hurting others can make us keep our feelings inside, or put our own needs aside. This tends to allow other people to ignore or abuse us in various ways, which then leads to our feeling, or being, childishly angry. When we see ourselves behaving like this, it confirms our belief that we shouldn't be aggressive. Mostly, being assertive -asking for our rights- is perfectly acceptable. People who do not respect our rights as human beings must either be stood up to or avoided.

PSYCHOTHERAPY FILE

(STEVEN) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

Examples of Traps

	++	+	o
1. AVOIDANCE	X		
2. DEPRESSED THINKING			X
3. SOCIAL ISOLATION	X		
4. TRYING TO PLEASE		X	

1. AVOIDANCE

We feel ineffective and anxious about certain situations, such as crowded streets, open spaces, social gatherings. We try to go back into these situations, but feel even more anxiety. Avoiding them makes us feel better, so we stop trying. However, by constantly avoiding situations our lives are limited and we come to feel increasingly ineffective and anxious.

2. DEPRESSED THINKING

Feeling depressed, we are sure we will manage a task or social situation badly. Being depressed, we are probably not as effective as we can be, and the depression leads us to exaggerate how badly we handled things. This makes us feel more depressed about ourselves.

3. SOCIAL ISOLATION

Feeling under-confident about ourselves and anxious not to upset others, we worry that others will find us boring or stupid, so we don't look at people or respond to friendliness. People then see us as unfriendly, so we become more isolated from which we are convinced we are boring and stupid- and become more under-confident .

4. TRYING TO PLEASE

Feeling uncertain about ourselves and anxious not to upset others, we try to please people by doing what they seem to want. As a result (1) we end up being taken advantage of by others, which makes us angry, depressed or guilty, from which our uncertainty about ourselves is confirmed; or (2) sometimes we feel out of control because of the need to please, and start hiding away, putting things off, letting people down, which makes other people angry with us and increases our uncertainty.

PSYCHOTHERAPY FILE

DILEMMAS (False choices and narrow options)

We often act as we do, even when we are not completely happy with it, because the only other ways we can imagine, seem as bad or even worse. These false choices can be described as dilemmas, or either/or options. We often don't realise that we see things like this, but we act as if these were the only possible choices.

Do you act as if any of the following false choices rule your life? Recognising them is the first step to changing them.

Choices about yourself: I act as if:-	++	+	0
1.Either I keep feelings bottled up or I risk being rejected, hurting others, or making a mess.		X	
2.Either I feel I spoil myself and am greedy or I deny myself things and punish myself and feel miserable..			X
3.If I try to be perfect, I feel depressed and angry; If I don't try to be perfect, I feel guilty, angry and dis-satisfied.			X
4.If I must, then I won't (other people's wishes, or even my own, feel too demanding, so I constantly put things off, avoid them etc.).			
5.If other people aren't expecting me to do things, look after them etc., then I feel anxious; lonely and out of control.		X	
6.If I get what I want, I feel childish and guilty; if I don't get what I want, I feel angry and depressed.			X
7.Either I keep things (feelings, plans) in perfect order, or I fear a terrible mess.			X
Choices about how we relate to others			
Do you behave with others as if:			
1.If I care about somebody, then I have to give in to them.			X
2.If I care about somebody, then they have to give in to me.			X
3.If I depend on someone, then they have to do what I want.			X

4.If I depend on someone, then I have to give in to them.

5.Either I'm involved with someone and likely to get hurt, or I don't get involved and stay in charge, but remain lonely.

6.As a woman, I have to do what others want.

7.As a man, I can't have any feelings.

8.Either I stick up for myself and nobody likes me, or I give in and get put on by others and feel cross and hurt.

9.Either I'm a brute or a martyr (secretly blaming the other).

10.Either I look down on other people, or I feel they look down on me.

++	+	o
		X
		X
		X
	X	
X		

SNAGS

Snags are what is happening when we say "I want to have a better life, or I want to change my behaviour but.....". Sometimes this comes from how we or our families thought about us when we were young; such as 'she was always the good child', or 'in our family we never...'. Sometimes the snags come from the important people in our lives not wanting us to change, or not able to cope with what our changing means to them. Often the resistence is more indirect, as when a parent, husband or wife becomes ill or depressed when we begin to get better.

In other cases, we seem to 'arrange' to avoid pleasure or success, or if they come, we have to pay in some way, by depression, or by spoiling things. Often this is because, as children, we came to feel guilty if things went well for us, or felt that we were envied for good luck or success. Sometimes we have come to feel responsible, unreasonably, for things that went wrong in the family, although we may not be aware that this is so. It is helpful to learn to recognise how this sort of pattern is stopping you getting on with your life, for only then can you learn to accept your right to a better life and begin to claim it.

You may get quite depressed when you begin to realise how often you stop your life being happier and more fulfilled. It is important to remember that it's not being stupid or bad, but rather that:

PSYCHOTHERAPY FILE

a) We do these things because this is the way we learned to manage best when we were younger,

b) we don't have to keep on doing them now we are learning to recognise them,

c) by changing our behaviour, we can learn to control not only our own behaviour, but we also change the way other people behave to us,

d) although it may seem that others resist the changes we want for ourselves (for example, our parents, or our partners), we often under-estimate them; if we are firm about our right to change, those who care for us will usually accept the change.

o you recognise that you feel limited in your life:

for fear of the response of others,

b) by something inside yourself.

<u>Difficult and unstable states of mind.</u>

Indicate which, if any of the following apply to you:

	++	+	o
1.How I feel about myself and others can be unstable; I can switch from one state of mind to a completely different one.			X
2.Some states may be accompanied by intense, extreme and uncontrollable emotions.	X		
3.Others by emotional blankness, feeling unreal, or feeling muddled.			X
4.Some states are accompanied by feeling intensely guilty or angry with myself, wanting to hurt myself.			X
5.or by feeling that others can't be trusted, are going to let me down, or hurt me.			X
6.or by being unreasonably angry or hurtful to others.	X		
7.Sometimes the only way to cope with some confusing feelings is to blank them off and feel emotionally distant from others.	X		

Reformulation

St. Thomas' Hospital
London SE1 7EH
Telephone 01-928 9292

Ext .....

Your ref .....
Our ref IS/MW .....

(STEVEN) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

STEVEN,

You came into therapy because you were afraid of the violence and rage which can boil up from within yourself. You are used to being in control, and these feelings and their expression are frightening and dangerous.

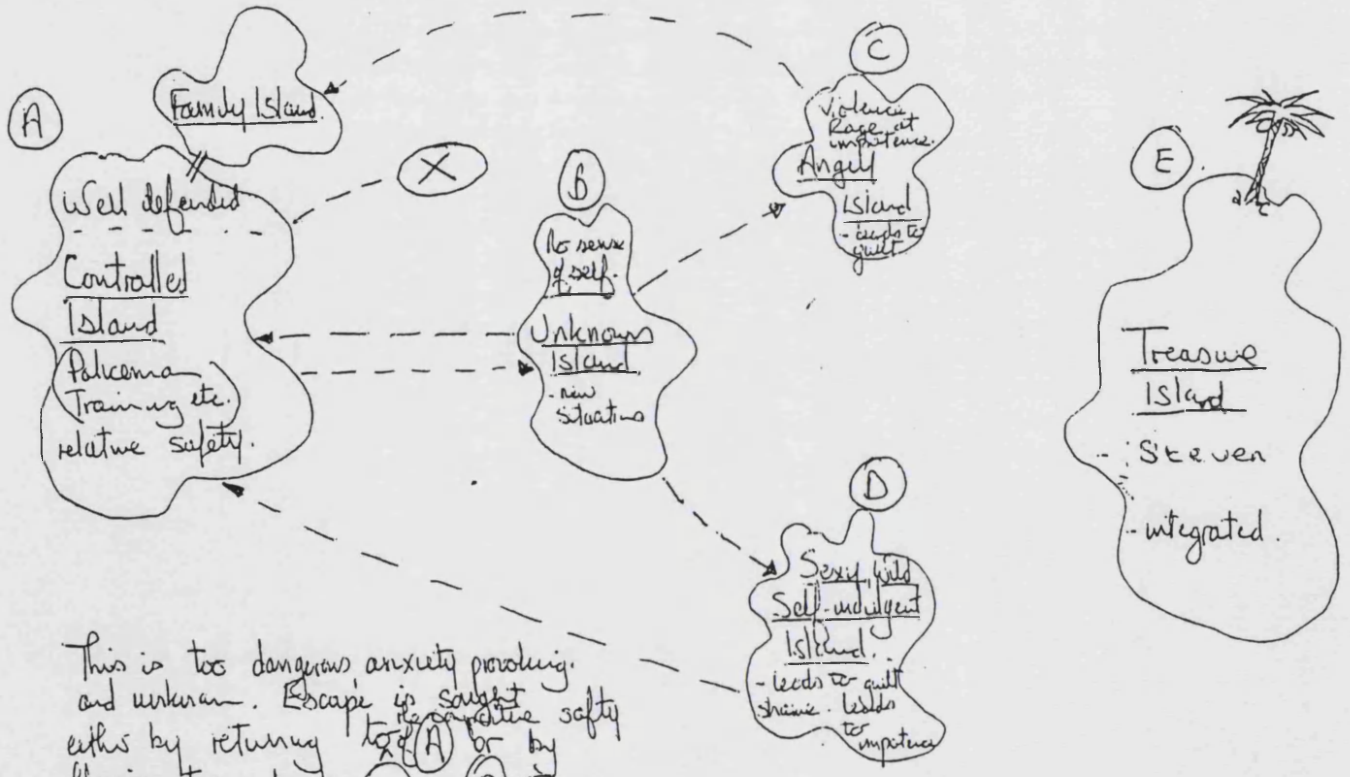
The past few years have seen significant changes in your own life and in the lives of those closest to you. You changed from one job, where you were valued and respected, to another, where you found it hard to find a place for yourself. You have also recently experienced great difficulty in your relationship with your son, and you feel that you and your wife have drifted further apart. These events appear to have cast you adrift from all that was safe, controlled and secure.

You have had to face the unknown. This seems to unleash powerful, unmanageable and out of control feelings which threaten your stability as a person. Your first response to this is to retreat into the relative safety of control once again. The angry rage provides a good reason for doing this. It seems to work as an early warning system when things are getting out of control, and it also appears to highlight the limited way in which new and potentially creative or exciting developments are kept under control. It feels as if the anger is a response to the restrictions you impose upon yourself when the pressure to be free of control comes up. Becoming more creative in self-expression is also very frightening. This demands, new, autonomous and independent responses to unknown situations and these are in opposition to controlled responses. They require being in touch with appropriate feelings; from vulnerability to strength; from pain to pleasure; and from anger to caring.

It seems that for most of your life you have been protected or have protected yourself from your true feelings. These feelings are beginning to come out. It is important that you allow yourself the space to feel them in all their aspects. This involves sharing them with others, as you have begun to do in therapy.

E
TREASURE
Island. (Integrated)
- Anger | Fear
- Success | Potency
- Pain | Loss
- Family | Work
- Good | Bad
- Dialogue | Sharing
C
FRUSTRATED | ANGRY
VIOLENT RAGE
Island
- Very Frightening
- out of Control.
A
- Fear, Pain, Anxiety,
Loss, Frustration, Impotence
Betrayal
UNKNOWN
Island (Unmanageable
Feelings)
- Creativity, Triumph,
Success, Power
Potency
D
SUCCESSFUL | Sexy
SELF-INDULGENT
PASSIONATE | WILD
Island.
- Very Frightening
- out of Control.
FAMILY
Island
PAIN
IN CONTROL
Island (Policeman | Training)
· Well-defended
· Relative Safety
· Restricted.
- Holding things in.
- Tight | Rejecting
- No dialogue
B

Happened – the Past.



This is too dangerous anxiety provoking and unknown. Escape is sought ~~to~~ relative safety either by returning to (A) or by fleeing to islands (C) & (D). Two rather extreme options, both of which result in guilt and shame and ultimately a return to safety of (A)

Goodbye Letter (Patient)

When I started therapy I hoped and expected that it would solve some of my problems. I was a policeman who had begun to lose control and had outbursts of anger and violence, and a person who's personal life was unhappy & difficult. However, I had a set of standards and values which had sustained me until that point, and in which I believed.

Now, at the end of therapy, I need to look at what I have gained from it.

It has enabled me to look at and realise the sadness that I feel at my sons homosexuality. Whether it will help in overcoming the barrier that I feel is between us, or helping re-establish a relationship with him, I don't know!

Since I started therapy I haven't become involved in any of the violent situations that I occasionally found myself in before, but I do suspect that the anger is still there and may only need the appropriate trigger to set it off.

I suppose that my personal life is marginally better, in that my relationship with my wife is now more comfortable that it was, and has therefore improved.

All in all, however, I feel that therapy has created more problems than it has solved. It hasn't offered any solutions, it has only asked questions. And it seems to me that everything that I do is questionable! The old standards and values that I had, and upon which I based many of the actions and decisions in my life, may no longer be valid, and I am left in a state of indecision & inaction.

My decision to leave the police force may be disastrous. I don't know what else I can do, or even if I want to do anything! But to do nothing is financially impossible.

"Rediscover your sex life", you advised! How? Where? With whom? And if with someone else, what about my wife?

In the past, my family and friends looked to me for advice and help, but I no longer feel able to give it and avoid trying to do so.

I feel less able to cope with my life now than before I started therapy, and I feel a sense of isolation. It could be that all of this is just a part of the changing circumstances of my life, but to use your islands analogy, I feel out there in mid-ocean that the boat is sinking and I've forgotten how to swim, and that survival is by no means a certainty!

Dear CAROL,

Coming to therapy means; coming to term with overeating, being less ner vous about achievement, getting more confident in yourself. I would like to rephrase it this way. Coming to term with overeating is an attempt to control the need for unconditional love, being less nervous is related to a chievements, and is a way of trying to do for yourself, rather than to please your parents, these being crucial factors in making you feel more confident. The need for unconditional love is there to try to fill the gap that the lack of love has left in you. It is like being deprived, you will never have enough, that it is difficult for you to feed on what is given t to you. As you said, there was never really any space for children in the family, we got attention when either doing well or failing to meet our par rents 's expectations. So now you focus on achievement, obedient to the parents 's wish, which keep you from the intense pain of feeling the early deprivation. And I know how difficult it can be, to feel the deprived child in you and at the same time learning how to stand on your feet, feeling reasonably good as an adult.

As far as being less nervous in relation to achievemebnt is concern, it is very difficult for you. In your family, doing well or failing meant a all world of difference, going from being loved or rejected. Up to now, you are so nervous when doing, that the anxiety makes you feel threatened, depriving you of your potential to achieve, thus rejecting the possibility of success., making you vulnerable to fail and being rejected by others.

You come to the point where the parent in you says "You should", the child says "I won't " entaqngled in the dilemma "If I must, then I won't " I would like to explore this either one or the other by looking at the way you defend yourself against the parents's control, and needing their approval at the same time.

(CAROL) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

In reation to the parents conditional controlling and the need to separate I see three main patterns.

Compliance, Needy, Rebellious.

Compliance, where you identify with the parents voice, critical. contemptuous of other's and your behavior, you call it the " Prison", this attitude rejects others and make them reject you so living you deprived of the stroking you need. Attitude maintained through obeying the ten golden rules. Being valued and accepted is a very important part of the adult well being. Failing to achieve, makes you feel guity, it is all your fault, because it is very difficult for you to accomodate both your parents failure to nurture you as a child and the need for their approval, the latest bringing you back to the primary need of complying to the parents in order t to be loved. Thus not having a voice of your own, perpetuating the deprivation.

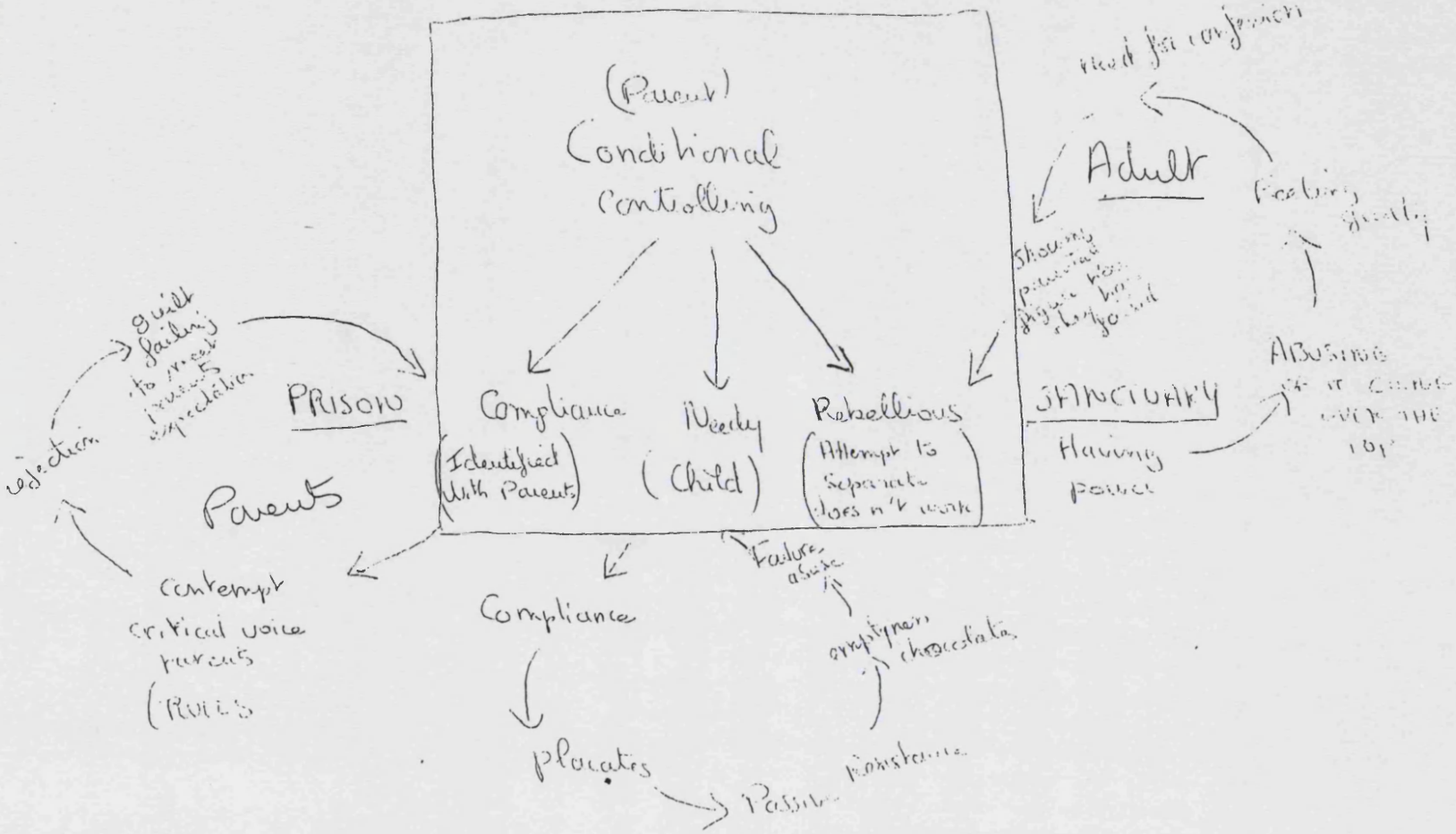
Rebellious is the Sanctuary, when you find yourself in a position of power feeling whithout restrictions, but whithout holding to.This is an attempt to separate from the parents, I am strong I don't need you, you tried to control me, but somewhere I can have everything I want. This formulate itself in your own parenthood at times. Displacing the anger you have for your parents onto the children. Which makes you feel guilty, like not capable of establishing your own boundaries, giving you the feeling of not being safe,seeking the security of the Prison, thus the need for confession, I will say sudo confession, for it is as this need to confess is fulfilling the purpose to call your mother and say, see how Ifail, how you fail to bring me up ,as an independant adult.

So going in to a to and fro from the prison to the sanctuary. The passage of adolescence into adulthood is made of a to and fro, going from having a fair amount of independance to needing at time parental support. but it also call for bearing the lack, which in time get filled up through experiecing the new adult. in your case the deprivation was such that the holding of the lack, is very hard, so you fill yourself up with chocolats, the parrents voice so strong that you hardly explore your potential as an adult.

(CAROL) Appendix 2
Additional Material Used in Cognitive Analytic Therapy

Our work together will be to work on tne dilemma "If Imust, then I won't To study the cycle of anxiety, which prevents you from exploring your a adult talents, to familiarise yourself with those three states, Compliance, Needy, Rebellious, hopefully to feel safe enough in our relationship to fee the anger directed at the parents,the emptiness of the adult, the depriva tion of the child.

J



Hold the inner tension, fight the urge of confessing emptying leaves with nothing to feed on.

John · Pre-therapy Interview

I think that should be it. Get it as close to -

OK then I'll sit near the microphone for you, shall I?

Thank you. 4th August. Could you tell me about your life?

Er, where would you like me to begin?

Anywhere.

Well I was er, I was born [redacted] in Bournemouth but then shortly we went to live in Kent, where my family basically live, in Dover but that was an area where people weren't allowed to live in the war years. I went to school there, to convent schools and then went to secondary school in Dover, in Dover Grammar School for Boys. Then I um, after leaving school I worked at the port for a little while. Then I went to a theological college in Wales but messed some papers up so I took a diploma in education instead at [redacted]

Mmhm.

[redacted] college of education. Which lasted three years. After that I worked for the British Railways Board with British Rail Hovercraft in Dover as a personnel officer doing induction teaching for new staff. That was for the regular staff and the 300 seasonal people we took in each year. Then um after that company passed out of the hands of British Railways I worked for another part of British Railways, Sealink, doing very similar work. And then at the same time I studied to be a priest for a

second time concurrent with my work.

Mmhm.

And so that was the position in 1987. Then since 1987 I've been a priest for a year in the parish of Addlestone, a few miles down the road. And the year before that I was sort of a half priest in the parish.

Mmm. What made you decide to become a priest?

Um I suppose its origins probably go back to my days in the Convent school where the normality of life was the cycle of mass and the church offices and things like that and the rest of life.

Yes. What about your social life and your relationships?

Um I've tended to have quite a lot of friends which naturally one makes at school and in the course of my employment and that I suppose is what I miss mostly now.

Mmm.

As a priest people think you're probably a bit strange (laughing) which might or might not be true, and also coming into a new area at the age of 43, that's not an age when one makes new friends as easily as one does in the working environment I had in my 20s and in school days.

Mmm. What about relationships with women or sexual partners or something like that?

I've never had any sexual partners with women. I've had sexual friendships with males from time to time.

Mmmhm, mmhm.

But not with any of my closest male friends because they've been heterosexual -

Sure.

And so it's a case of if people are heterosexual you have to respect the fact that that's what they are and build a friendship on the basis of something you have in common together.

It sounds to me ... a little bit lonely in some respects.

Yes a chunk of me could say that, yes, but another chunk of me would say that I made attempts to balance it. It could eas- one could easily have been run away with loneliness, yes, that's why I always tried to work in an environment that I enjoyed. I mean my work at the port was almost a hobby as well.

Yes.

And um so that in a sense counteracted it but it was always the disappointment that say if one had a close relationship with someone who was heterosexual then obviously you couldn't take that to, to an ultimate sexual relationship -

Sure.

But you have to make the best of things as they are.

Mmm. Could you tell me about your difficulties ... brought you into seeking therapy?

Uh yes it's really a set of physical symptoms. It was a set of physical symptoms initially. Just before I was ordained twice over I had an infection of the labyrinth and some of my friends at the port did at the same time because all our headphones were kept in the same box.

Mmm.

So that was definitely something physical.

Mmm.

Which applied to us all. We all got better from it but I found after that that if ever I was slightly nervous about something, either pleasurably or unpleasurably, either way round, I could lose my balance and in the worst circumstances fall to the grond. And I was always anxious that this shouldn't happen at a time when I was doing something public or in a public place. I suppose I first noticed this when I took church services in Addlestone.

Mmhm.

In my own parish church, it was a very old fashioned Catholic church with furniture etc. and so you were always standing at the pulpit or at a lectern but I found that whenever I was saying anything just from a book if I was slightly nervous the loss of balance would come over me and as there was nothing to hold on to

just for that few seconds to get the balance back I became increasingly nervous and that started making me feel ill as well. Now I didn't realise till a year later that that illness was in fact tachicardial. I put it down to drinking too much coffee because I did discover that when I stopped drinking coffee or tea it was not so bad. And um but by then I'd developed what I think I can only describe really as a phobia becuse of these unpleasant symptoms that had attached themselves whenever I was doing anything publicly -

Mmm, mmm.

So I wanted to withdraw from doing them, not that I disliked the things I was doing in myself but because I knew it was going to be unpleasant. A lot of people said "Oh you've got a case of depression" but it wasn't that because I would think depression is you really don't want to do something.

Mmm.

Um so I went to see my doctor, he gave me, this was my doctor in Dover because I kept with him, I'd never seen a doctor before so we just kept my Dover doctor on the books (laughing). He prescribed for me some beta blockers. They to some extent stopped the heart irregularities but the phobic condition had built up by then so that now we're at a stage of affairs that whenever I go out to do anything, whether it's pleasurable or unpleasurable, there's always an apprehensiveness that without the medication I take I think would possibly make it impossible.

But I don't put it to the test because I'm so busy that I don't like to have to back off.

Mmm, mmm.

How else, are there any other ways in which you've been trying to cope with these difficulties up till now? Any other way in which you have tried to do that?

Um -

You've told me about the doctor and the drugs.

Yes he, so there's, I've tried a few touches of behavioural therapy of my own. I thought that when this was at its real worst, which was last November, I felt that really I didn't want even to go the shops and I thought really you can't let this get a grip of you, so I started going, made sure I kept going to one or two small shops then I went to bigger shops for a little while -

Mm.

And I discovered in retrospect that whenever I've been going to London I've felt ill so I just said I'm going to London on the train for ten minutes. (Laughing) Then when the 10 minutes is up I'm coming back and then went there for 20 minutes and an hour and so London's fine now.

Mmm.

Because I always loved London and it was absolutely perplexing

that all this imagery that I had could now have this unpleasant gloss to it.

Mmm, mmm.

And that's helped a bit. The one thing that I just cannot under any circumstances bring under control, and this is I suppose the thing that worries me most, is that there are certain church services where you've just got to conduct free-standing such as the marriage service. You don't really want to put a barrier of a book stand between you and people at a marriage so that's one thing that's always on my mind, how am I going to get that shifted.

Mmm.

And the other thing is I dread the panic attacks that I was getting in November having an opportunity to come back this autumn.

Mm.

Because as the cycle of the year comes round I keep thinking gosh I was trapped in my own house which was something that wasn't natural to me and so the house took on a very strong sense of emptiness and I kept getting, the solar plexus region of my stomach became absolutely tense.

Mmm.

And it was that that the Larazapan -

Mmm. What did you think was happening to you initially?

(Laughing) I thought I was going mad at first because I'd always been so OK before. If -

I think I had read them completely wrongly. If I had know a year ago that I've got tachicardium, my heart was racing fast and all that that does -

Mmm.

I could have said ah, that's tachicardium but -

Mmm.

- all those feelings normally come about due to some mental distress -

Mmhm.

I mean it was exactly how I would feel if on the one hand someone had suddenly said to me "You've won a thousand pounds".

Mmm.

Or on the other hand if I'd looked round somewhere when I was in a hurry and found I'd lost my wallet, that sort of feeling would bring on that feeling around the heart.

Mmm. ....?

Pardon?

Painful as well or? Or just the palpitations?

It wasn't really painful that the dis, it was discomfortable, yes. It was, I was very nervous as I thought, I thought my head was telling me to be nervous and I couldn't find out why my head was telling me to be nervous so I thought I must be going mad, out of control or something.

How was the decision reached that you would get into therapy?

Um Dr. had always had a very high regard for therapies at Ham Common Hosptal, Cassell Hospital and thought it might be of assistance in this case.

Is he your GP?

He's my GP.

What was the diagnostic interview you had with Dr. Healey like? Was it what you expected? ....

Yes because I'd had some psychotherapy with um, with a priest psychotherapist in the diocese and I expected it to be of an exploratory nature and it was of an exploratory nature.

When did you have this previous psychotherapy?

That was er for about four weeks in October last year.

Mmhm. Do you wish that you had talked about anything other than what you talked about with Dr. H ?

I don't think so. The main obsession if you like is to be able

to be physically balanced again and to stop anxiety attacks.
Mmm. Do you feel you were understood?
Yes, I think, especially at the second interview, when he said, when he, it suddenly struck home home that he knew absolutely what was the case when he said all this random behaviour of your sympathetic nervous system is stopping you enjoying life.
Mmhm.
Now I've, I've never expressed it, I've not heard it expressed or expressed it myself so succinctly before.
Mmhm.
He'd actually got on target and it was from that point I felt we could get somewhere because if he was a psychotherapist he'd pinpointed exactly my feelings. He would have said "Well go away now, I can't help you -
Mmm, mmm.
If that was going to be the case.
Mmm. Now that you've got this far, what are your expectations of therapy?
I think it all depends to what extent I think that, I'm hoping quite strongly that the, that the therapy will help do away with the phobia, the panic attacks or give me some resource to go if I have a panic attack because it was the panicking and not knowing, having a clue what to do about that probably made me at my worst last October. But the grey area is this question of balance, because I'm not entirely sure that it's psy- entirely psychological.

Right. So you still wonder whether there might be something physiological ..

Yes. A sort of hang on from those two bad doses of loss of balance.

Right. Are there any external circumstances that you see helping or hindering your attempts to deal with your difficulties better in the future? In terms of your life.
The anxiety symptoms, you know that awful feeling in the solar plexus like a toothache -

Mmm.
Where you just don't know what to do because it's um, I can see that being helped in a number of ways. As you will have read perhaps from the reports I was working with an exceedingly difficult priest. He's now gone away and if his successor is reasonable (laughing) certainly the priest who has been standing in has been a very pleasant and ordinary man to work with and he's staying on as well, so there would be his company and er from what I've seen of the new parish priest it seems he's quite a pleasant person. Also another thing I think that will help and it gives me anxiety at the same time, is that in a year's time I'll be able to go back to my home area so that means that I can be surrounded with my home friends again and and my relatives can come and live with me, my father and my aunts, because you get big enough vicarages. But at the same time it makes me apprehensive to get rid of all this trouble so that I can go back to Kent because I don't know if the Archbishop will take me back to Canterbury automatically until I'm better.

Mmm, mmm.

Are there any external circumstances that you want to change right now?

I've never liked, I've never liked living in my house alone and er but I think that's likely to be balanced because I think my father is coming up to live at my house with my aunt because it's a big one because they're a bit crowded in with their own families at home. So whenever they're staying the symptoms are always, whenever there's people around me at home the symptoms are always much less. Yet the anticipation of them coming makes me worse for a while.
Mmm, mmm. Do you feel you can do anything about this right now? You know it's happening but is there anything else that you feel might be ... and that could actually influence at the moment?

No I don't.

It occurs to me when I was looking through that, you talked about the way that you grew up. What about brothers and sisters and your mother and you know, your family you grew up with?
Yes um it was so sort of ordinary it's hard to know what in particular about it except we all, we're children by adoption I expect you saw from the report so we're not genetically related.

How many of you are there?
Three of us, myself my sister and my brother. I've always been a lot closer to my sister than to my brother.

Mmm.
How old were you when you were adopted?

Um I was only um a few weeks old, my sister was a few weeks old. My brother was a little older, I think he was nearly a year before he was adopted. Mmm. OK well that's all I need to ask you at the moment.

(This was a first interview conducted with Reverend John in pre-therapy)

January 26th 1989

Post-therapy Interview with Rev. John

Right.

New machine?

Do you feel that your way of looking at life has changed as a result of therapy?

Not at all, no.

Could you expand a bit more about that?

Not really.

Do you feel it had any impact on you?

None at all. In fact I found it had a bit of a negative impact at first and then neutral impact.

Mmhm. Could you tell me a bit more about that?

Yes I think so. Um the thing that started this physical, the physical symptoms off originally seemed to be a number of stresses that all came at once. They have all slowly been removed one by one and are now quite a way in the distance and the therapy largely revives those and therefore it would make me feel uneasy for a day or so after the therapy reliving those things that were past.

Mmhm.

Then after a few sessions that past and when we reviewed or looked at anything it didn't hve, didn't have so much that effect but it didn't have any positive effect either of removing symptoms.

So you still have your symptoms?

Yes. One set, one set of symptoms have gone. That is the sort of pervasive anxiety that was there all the time, with or without medication, but with medication that remains exactly the same that pervasive anxiety isn't there all the time. But I still get the physical symptoms of unsteadiness and unbalance for most of the time.

Mmhm. I remember you had a lot of problems at work ... how is that at the moment? How is your work situation?

Er that has changed quite a lot. I said one of the difficulties at work was working with an extraordinarily difficult priest -

Mmm.

And the other one was that we didn't use the church furniture which, with that feeling of unsteadiness and unbalance, made the situation even worse. The new priest that has replaced my former boss is entirely different. He uses the church building as it was defined for so that means everything's done from reading desks or lecterns so if I feel the slightest bit dizzy I can hold on till it passes and then continue. And he himself is an exceedingly pleasant person and easy to get on with so as I say

that whole area has been wiped out. Except I wouldn't even, I don't even like to having stand at a reading desk and feel dizzy because you don't feel you're participating -

Mmm.

- entirely on what you want to do becauss of the thought of the others going through your head.

Mmm.

A bit like doing something with toothache I guess, by analogy.

Mmm, mmm.

So you feel it takes away, you can't concentrate on what you're doing ... symptoms?

Yes it spoils the concentration. I find I can help the concentration a considerable degree by going over what is to be done in the service several times beforehand so its in my memory and not in the written text so that helps me to enjoy it more but there's still the other there in the background.

Mmm. What about your leisure activities?

My leisure activities are mainly going out driving and studying the history of odd asepcts of London and London Transport history. That means I either go to locations and take photographs. I usually do a lot of background reading and then go and take photographs at locations. So that's really the main thing I do with what spare time I do get.

Mmm, mmm. This has been a long-standing interest of yours -

Yes it has.

And you've been continuing that throughout this time ..

Except that since I've been in [redacted] as opposed to where I used to live in Dover it's much easier for me now to go to London.

Mmm. How long have you lived in [redacted]

Three years. It's also helped to lift the agraphobia I was getting at the beginning as well.

Mmhm. What about your social life?

My soc- it's difficult when you're a priest to divide what is your professional life from your social life to a large extent. If I say, if I block off what is most distinctly part of my priestly work it's mainly being at home with my father and my two dogs. This is another element, my father has come to live with me mow and brought the other dog to live with us. I visit friends in Dover once a week where I used to work and that's about the sum of it.

Mmhm.

I've never had a high profile of social life any way so if really, this illness hasn't made any difference to it.

How do you see your relationships?

With?

All your relationships now.

Fine.

Could you expand on that a little bit? I mean we talked at some length abut your relationships when we met last time. Talked about the difficulties there were to actually form relationships.

Difficulties to form relationships.

I seem to remember you were saying something like that anyway.

I don't think so. I've never found it difficult to form relationships er in the settings where I work. If I wanted to form relationships but the propensity is not particularly - when I have a will to form relationships it's quite easy but I haven't really got a great propensity for a great deal of relationships.

Your main relationship I think ... with your father?

Yes I guess so really. My father and my aunt who comes up and stays with us.

Mmm.

How are those relationships now?

If there's such a word as normal I would say normal.

Mmm. You were also talking abut difficulties in forming sexual relationships. I remember that.

Maybe I've never made too much of an effort (laughing) so -

Mmm.

I, um, I suppose the value of the relationship and the inconvenience in forming a relationship that's not necessarily widely accepted in all circles outweighs the other.

Mmm. It doesn't cause me any worry though.

Mmm. What about your sexuality? Whta do you do with that then?

Well live more or less on the lines of a monastic priest, celibately, which I don't find difficult.

Mmm.

How are you coping with your difficulties now? You said a little bit about the furniture, that you'd found practical ways of dealing with that. How are you coping with them apart from that?

Um by chance I happened to be at home one morning when there was a television programme on that identified um a condition called organic brain dysfunction which sounds terrible. I don't know if you ever heard of it all. Where reflexes aren't quite right and that. And so I wrote to the Rainbow Foundation, which is one of the bodies concerned with this, and I believe there's another one in this area, and much of the physical symptoms so matched up to that that I'm exploring that further.

Mmhm.

And another thing related to this that was discovered by accident I, after waiting a year for an appointment I went to see um - oh what do you call such a man - man who looks after bones?

Osteopath.

Orthopaedic an ordinary orthopaedic surgeon at St. Peter's Hospital because my left foot turned inwards slightly.

Mmhm.

And he found that the muscles in my legs go into spasms and then become normal and I said to him "If I was, when I'm standing up, if I feel unsteady and shaky, can that be the result of such spasms?"

Mmhm.

And he said yes so that seems to be accounting for part of these symptoms. So what he's intending to do is to retake the set of X-rays and examine all the same muscular movements he made that he said were tight and going in and out of spasm under an anaesthetic to see what that does.

Mmhm.

What that tells him I don't know.

Mmm.

Have you done anything else? Are you thinking of any other ways of coping?

Um one - people who hve had anxiety states have told me that they've found that um various exercises help you know like tensing and flexing of the muscular system and I find that that has no effect whatsoever.

Mmm.

Which may relate to the way the muscle sytem is behaving anyway.

Mmm.

That may have formed a clue when I found out the other day that exercises, breathng from the abdomen are supposed to , to help and I've not found that to be the case. Supposed to stop hyperventilation. So whether I'm creating another anxiety and hoping it will work and therefore that's blocking the way and entertain that as a possibility.

Mmm. Anything else you want to say about the coping?

No I don't think so. I think we've more or less covered that.

OK well let's go back and talk a little bit more about your therapy and your therapist.

Right.

In general, how did you feel about your therapy?

I felt that at the back of it all there's a physical condition and therefore the psychotherapy wasn't going to help. We talked about - when I said that it all began with a physical condition

in the middle ear and then whenever there was any stress of any sort that would cause the symptoms of dizziness and then that took on a life of its own later. With all the stress that was going on it produced tachicardia and at the- by the time I go to the therapist all those things that had brought it on, things that an earlier stage might have been things within a psychotherapist's realm to help, were all out of the way. So there was I left with these physical symptoms that had become more reflex actions than the product of anything that was disturbing me at the time.

Mmhm. How did you feel about your therapist?

I felt that he was puzzled as well about it.

What happened in the sessions?

Well I, when I first arrived I said "Well, what do we do in these sessions?". He said "It's up to you". I said "Well all I know about psychotherapy is what came from the Cassell Hospital that its a talking therapy intended to produce cure or reduction of symptoms and so all we really did was a mapwork of my life. We looked at the previous stresses that had occurred and as I said reviving them did more harm than good I think at the time. And that's all we really did, week after week. At several stages I asked if he could identify for me um what exactly it was I was suffering from but he said that he couldn't so if he couldn't he couldn't and that's that. It's just that I'm the sort of person that if I can put a label to something it helps.

OK. In general how did you feel during the sessions?

It was difficult to know always how to respond to the therapist because he was a very, a very solemn person by nature and I always find it difficult to know how to respond to solemn people. Because if you're cheerful with them it sometimes unnerves them and if you're over-solemn to them back on the grounds that you think that's how they are and that's how you should be with them, they might think you're being unduly unpleasant even, towards them. So it's difficult to know how to balance one's conversation with Dr. H

Mmmhm. OK. Did you feel you were able to talk fairly freely, or were you interrupted or stopped or was there - how did you feel you were able to talk about yourself in the sessions?

Perfectly freely. I'm not a person who would really talk a lot in the ordinary way or indeed a person who needs to talk so having not really had the need to talk I found the first three or four sessions diffiuclt to, no the first couple of sessions difficult to talk sort of for an hour or - what was it for an hour or so - yes an hour but after that it became habit and was OK. But very neutral thing, I couldn't think how in any way it was helping me or was going to eventually help me as the course proceeded.

Did you ever feel your therapist was uncomfortable or?

I don't think he, I didn't detect him feeling uncomfortable at all I don't think.

What sort of relationship would you say you had with Dr K.....

Er it was very much two professionl people talking with one another.

Mmm. Was your therapy what you had expected?

Well I had to say at the outset that I hadn't a clue. It was just that Dr. K said that this may - that if we couldn't get at the symptoms themselves and stop them there might be something in psychotherapy that would make symptom management easier.

Mmhm. Were there unexpected things, did unexpected things happen during your therapy?

No but I got um, I got the complete, I got a complete impression er that Dr. K is heavily into the Freudian school of psychology and was looking for sexual answers possibly that just weren't there.

Mmmhm. Were there things you wished you had been able to explore but couldn't for some reason?

Not really because there were the physical symptoms that were the cause of all the distress and there seemed no way within psychotherapy of getting at them.

Was there anything that annoyed or frustrated you?

Frutrasted me, yes. After the fourth session I wrote to Dr.

K and said it would be best to call off any further sessions because I couldn't see that this was getting anywhere. But then he wrote to me and said er "Please come along because I think we can" so I thought pehaps he knew of some change of direction in the therapy but we really continued on our previous pattern.

Mmhm. So you felt, it sounds like you were a bit disappointed in some ways?

Yes I, because it seemed to me that the symptom, the only way that a psychology approach could get at my symptom would be more by being in contact with behaviourist therapy, you know, slowly doing the things that were causing the distress and melting them that way, as I've found to some extent such practising myself had. But um whenever I mentioned, when I said things like um "Would behavioural therapy help?" to Dr. H he said um "I don't know". And I would have thought, it seemed that, it did seem that he was absolutely tied to psychotherapy as an avenue of psychology and wasn't prepared to give any hints or clues as to whether other lines of psychological help might be helpful or otherwise. So that was a frustration.

Yes. Did you feel you were understood?

Yes I think I was perfectly understood.

In very general terms, how would you describe the quality of your life now?

If those symptoms were not there, if the symptoms of unblance weren't there it would be perfect, quite happy.

How do you see your future?

I've a very nice offer of the future. I've been offered the post of Assistant Parish Priest back in my own town of Dover. It's nice to picture that, perfect back in my own environment yet knowing that the physical symptoms could occur - the hyperventilation and the unbalancedness - makes you know that you can be about to be doing something or doing something you're really enjoying and that leads you to a fear because it can go right down to the road almost stopping you.

Mmm.

But those two thngs lifted and I've been fine.

Is there anything else you would like to say about the experience of being in psychotherapy?

I don't think I could have, I would have been as, I was able to be frank with er totally frank in every aspect of my conversation with Dr. K because it was a strange area, he was a strange person, so the anonymity of it all made it very acceptable. Less anonymity and I couldn't have responded so loosely.

Mmhm. OK fine well thank you very much.

Right.

Pre-Therapy Interview -

Could you tell me about your life?

What, from babyhood do you mean? Or do you mean recently or-

Wherever you would feel you would want to start.

Er, OK. Well I was born just before the war in a North Country town, steelworks and my father was er a bank manager, come from Leeds, both my parents come from [illegible] Yorkshire. Brought up with two brothers during the War. I was the eldest. I was quite a bright boy in my primary school and er got a scholarship to a very good school [illegible] er which was a Benevolent Foundation which meant my father could give me a good education although he didn't have to pay very muc and indeed my brother followed me there. And er I did well academically at school and I was er quite good at cricket. I was captain of the school team and um I was Head Boy of my house and that sort of thing and Deputy Head Boy of the School. I was guided into studying classics, Greek and Latin, not that I chose it, it was chosen for me, although I was actually qyite good at Pure Mathematics.

Chosen by whom?

Well by the Masters. I mean I was simply told you are going to be a Classical Sixth Former and not scientific or whatever it was. And I did, you know I got 100% at O Level in my Mathematics which had an intellectual appeal for me as Mathematics does for some people because of the sort of purity of the concepts. And

er I went to, I got a Scholarship in Classics and a State Scholarship to [redacted], which was what I suppose the Masters in charge intended I should be in terms of the sort of academic factory. I went into the [redacted], which I enjoyed and I've kept a long association with the [redacted] because I learned Russian there and I stayed on the Reserve for a long time as a Russian interpreter and I run a society to keep the friendship together of the Russian interpreters I met. I went to [redacted], where I was Editor of the University newspaper. I did Philosophy in my last year, which wasn't long enough really and er I got into the BBC as a general trainee, which was a highly competitve entry and er I got sort of promoted fairly fast, fairly quickly and then got rather stuck. [redacted] ever since [redacted] television programme. I was [redacted] well-known commentator on [redacted] for quite a long time. In 1970 I got married. I've always lived in West London um we er found we couldn't have children. We've adopted two who are now, the boy's 11 the girl is 9.

Was that sad, difficult for you not to have children?

Well er sad, yes, anyone likes to er perpetuate his own blood. Um but um you know in the whole of life one has to accept the cards one was dealt and play the best hand. In this case we tried very hard with the Children's Society and that closed down and we thought that was it and then all of a sudden we got a contact with the Catholic agency which out of the blue provided us with

our first child within 24 hours which was a hell of a shock and the girl shortly afterwards so we've been very happy and really very fortunate. We know many people who can't have children who don't have adopted children at all and in fact one, although I'm telling you this for history purposes one tends to forget they're adopted.

Yes, yes.

It makes no difference to the relationship between us. I have to sort of occasionally remind myself that er I have a duty to remind the children that they are, that they have other parents somethwere. I suppose they'll have the right to er, well they will have the right to discover all that at 18 when the papers which are lodged iwth the Solicitors will be free to them.

What age did you adopt them?

They were both small babies, six weeks. We had to go through the Court. We had a Guardian ad Litem who is really a Social Worker appointed by a County Court and they come and inspect you and discover whether you're drunkards or whether you fight with each other and have proper outside toilets and all that sort of thing and er a report is given to the Judge and also there is a period during which the natural mother can change her mind which occasionally happens but fortunately not in our case and er it wasn't a very pleasant period. It was kind of being on trial because adopted parents have to be more perfect parents than natural parents sometimes who don't particularly want to have children or children come along by accident so you have to

prove yourself. Anyway I've had a very happy home life and um recently what has thrown me has been a violent and unforeseen upset in my work life where I had a certain sort of esteem and status among colleagues and Members of Parliament and you know the sort of people I mvoe in. I and four others were suddenly sort of hurtled out of our posts under duress - no reason was given - and forced to hbe attached to other programmes which we didn't particularly want. And that had quite an emotional effect and er I mean it still hasn't finished because although I'm employed by the BBC I don't have a job really. I'm, kind of floating around just doing odd jobs and there's an anxiety - I'm 52 - about what I do next or what I do seriously. I mean I'm in the process of applying for a number of posts now, one of which I hope I shall get but er there's that sort of nagging uncertainty all the time which gives one a sort of perpetual anxiety which makes er you know, unless you keep busy if you fight it and start reflecting and I get depressed. I mean inevitably, because I don't think I'm doing a proper job and I, I've explained all this to the doctor at the ... but er I'm used to what you might call a high profile, mixing with Ministers and appearing on radio and television and all of a sudden it's like a sort of chopper coming down.

Mmm.

They originally wanted me to go and teach er or train an ethnic minority reporters' course but a) I didn't want to go into training because I thought that was a ghetto from which people

never return, um and b) there was a contradiction, if they said well you're not good enough to be a reporter any longer but we want you to be the model to tell other people how to do it then ther seems to be considerable contradiction. So er I hussled a bit and took lots of people out to lunch and tried to find a better slot and I found a better slot which at least I'm with a programme where I'm um continuing to broadcast and continuing to do politics and do a lot of political related jobs like um writing and preparing and voicing political obituaries on a lot of politicians [illegible] of the latest [illegible] elections [illegible] I'm about to cover the [illegible] by-election and I'm getting on the air a lot um but I don't think my future can lie as a broadcaster, which is what I like and know and love because the people in charge don't want me there for unstated reasons. I think just for the reason of ageism really, they just want younger people. So I'm having to try and find employment really as a Manager and my problem is that I've got no experience of management. As a correspondent I've lived by my wits. I've never even had a secretary, I've been a broadcaster. So it's been a considerable upset and that has er to my surprise I mean I controlled my anger but felt bitter and frustrated and generally upset but trying not to let it spill out into daily life although my wife says I was er fairly unpleasant to live with, and I found it had a physical consequence which were these curious things which I've never experienced before because I've always been very fit. I called it a stress attack, some people call it a panic attack, I don't know what it is but I mean when I first had it I thought it was a heart attack because it was in the middle of the

rush hour driving home and I suddenly got these pains and shortage of breaths and you know tingling in the fingers and legs and funny sort of tightness across the chest and I was extremely alarmed. It took about three or four hours to recover. Fortunately it was near a hospital and I drove straight into the Outpatients and after taking two weeks off I, obviously I consulted a doctor and the doctor at the West Middlesex was very sympathetic and I discovered in fact that these are more common than I'd thought they were and there's a name to them and um I discovered the phrase hyper-ventilation and all the sort of things which are commonplace to doctors but not to me having really never been in hospital in my life. And I thought that really that was just a one off and then subsequently er I had two separate attacks, one in Scotland on holiay. I took the family skiing and I got very angry with a hotel, which was completley incompetent and cold. Er and I found I got angry and then all of a sudden I got one of these attacks again, again out of the blue?

Did you actually get angry or did you just feel anger and not let it-

Well both, I mean we arrived in the hotel where we'd stayed before and the roof was leaking and the radiators were cold and there was no fire in the bar and the staff were miserable and the food was horrible and I mean they were just absolutely useless and er I was furious. And I moved out next morning but the particular evening when this happened I mean I just suddenly had to go and lie down for three hours. And I went to see the local

doctor in n Scotland and told him what I had previously been prescribed and he prescribed the same thing and I've learned a bit of technique for breathing, either into one's hand or into a bag to increase carbon dioxide which I mean I don't understand the physics of it but it seemed to work. And then I had another once, I went on a management course in February and we did some outdoor exercises which were sort of leadership, outward bound kind of things and um we did one exercise on a very, very cold day which was in a blizzard which involved crossing a gorge with ropes and there was a lot of sort of tension of stress and anxiety about whether we'd get across or not and also people were extremely cold as well and there was a sort of pressure on everybody. I mean we didn't actually achieve it but anyway I quite enjoyed the process because my particular role in the exercise had come out well and then in the um sort of truck going back where in fact we were snowed in and couldn't get back to our base and had to stay somewhere else for the night all of a sudden these symptoms reappeared and it was slightly embarrassing sitting in the back of a truck and sort of you know breathing like a grampus and going white in the face and trembling and so on and of course nobody else understood what was going on and I had to be taken to hospital in Derbyshire. And again it took about two hours to recover. Curiously there the doctor was rather angry with me because she said why didn't you use the techniques which you've been taught and why have you bothered me and that sort of thing, I mean very aggressive, which surprised me. And I suppose because I hadn't realised the seriousness of the onset or I hadn't really appreciated the point at which I should start

using the breathing techniques. So at leat I now know to start it at an early stage but I am now concerned that if I have any management job I won't be able to cope with any stress at all because of the unrpedictability of the emergence of these symptoms which er I've just no idea, you know, whether they're going to happen in the next five minutes or tomorrow or whatever it is. I've learnt not to be alarmed by them but they do knock me over for two or three hours and if anybody else is in the vicinity they get extremely upset and worried about me. At he moment I'm takimg a pill called Motival which is a part calmer down part anti-depressant, I don't know, I don't feel depressed but I feel tense and it does seem to have some effect. I mean on the whole I take them on days when I think I'm going to be under stress and I don't take them at weekends when I think I'm not becaue I don't like being drug-dependent at all. And obviously these physical attacks are connected in some way with my emotional state and er in talking to Dr Bowen the emotional state may well be connected with you know the whole of my emotional development during my life which, I mean I don't fully understand that relationship but I'm willing to give it a go and see where we get to.

Mm. Would you now tell me a bit about your relationships. I mean you mentioned your marriage in passing and, your marriage and other relationships in your life. What have they been like?

Well I think I've had er - well I find the questions very open-ended but er I had I hope very good relationships with my parents, who I am very fond of. My mother is stillalive, I see

her a lot, we're quite a close family. We see my two brothers, we move around, I'm going off this weekend to my brother-in-law's, I see my wife's brother and sister and their families, we are very much a family that mixes withn the family. I've got two brothers er who are very different but whom I like um as well as being brother to and we see each other and occasionally go on holiday at Easter and Whit and so on to each other's houses. Er I have a happy marriage ...stay married to the same woman for as long as I'm alive and all that.

Could you tell me a bit more but it, I mean a marriage is a very rich experience -

Well I think you'll have to be more specific about what you want to know about it.

Well I mean, you must have had your ups and downs one way or the other, agreements, disagreements. Do you enjoy ... and general ideas like that.

Well I think we both have the same sense of humour, we're both interested in the same sort of thing, we both work for the BBC. Rosemary works part time, I work full time. Um I think occasionally we get short-tempered but um we don't hit each other and usually finish up in the same bed at the end of the day.

What about your sex life?

Well I don't regard that as any problem. I mean it's very difficult to know what the norm is, I've always been faithfull and er my wife has and I don't think it's a matter which er, I

don't know, you'd have to ask her. I mean I'm perfectly satisfied with it. I hope she is. ... the sort of thing one talks about it a great deal. I suppose you could describe it as intermittent. Er, it's not a matter of um, well sex life is a matter of affection as well as um sex and I think there's quite a lot of affection.

increasing on you?

Yes, well my wife says that I was much more irritable and difficult to speak to and snappy and I have a tendency to be short-tempered. I mean I think she's very understanding. I think she makes allowances for the fact that I'm under a strain which she understands and she herself is a Personnel Officer having to deal with people herself who have various personal difficulties. I mean she's a lot more understanding of me than I am of her. I think I'm more uptight emotionally, she's more extravert, she's more gregarious, she is more sort of party-going than I am. I mean I'm happy with friends but I don't awfully like going to parties and dances and having to make social chit chat with strangers but that's just the sort of person I am. And I'm not one for pretending what I'm not. I mean if she says you know there's a barn dance at the school I say well I'm not ging you know because I just don't like them and I'm not happy in that sort of social milieu.

Mmm. Do you have other close friends other than family in your life?

Yes I have a number. Actually one of my best friends ... from school is a psychiatrist. Head of a psychiatric hospital in Oxford whom I've known since the age of 11 and I've a very good freind who's a solicitor. I've got a lot of very good acquaintances rather than friends who I play cricket with on Sundays. I've got good friends fromt the Navy who I see. I organise various social functions like dinners and parties and things to see them. Very much sort of men's men if you know what I mean. People I've been in institutions with like the Navy, the University and I've been Chairman of a lot of things. Until recently when I was in the Commons

[illegible] Club to um entertain various sort of bigwigs to give speeches. I mean I'm quite used to standing up and making speeches and things like that. And er so I've got a wide range of what you might call acquaintances and of course one has colleagues at work but I mean I distinguish between them and friends, that is people with whom one can speak intimately about one's various friends, various problems. I've got one or two from work whom I've worked with a long time who I like and trust er you know with some of whom I've shared the sort of experiences I've been through recently. I mean one of the interesting things to me is that er having ventured to tell them. because one is careful about talking about this sort of thing to people because anything associated with

psychiatry or mental health people sort of have funny notions about, but at least two colleagues have told me that they have suffered precisely the same symptoms from, in one case stress resulting from a marriage which was breaking up where the guy sort of fell down and had a blackout and scarpered off to hospital, and other case of a leading correspondent in television who he had exactly the same thing and taken three weeks off but again he kept his secret and didn't volunteer it until I volunteered that I myself had had this sort of curious thing. And then all of a sudden you find that there are a lot of colleagues sharing the same kind of stresses, because my job was very stressful er and I was very much subject to events. I would get rung up in the middle of the night by a newsroom and had to go out at all times, jump onto aeroplanes and was constantly meeting deadlines and having to make you know such and such a news bulletin or such and such a programme. But I mean that became part of one's life and er it was something you accepted and certainly I was able to cope with. Now I'm unsure whether I can cope with it because I won't say I am fearful but I am sort of slightly apprehensive that all of a sudden something will snap.

Well you've told me a bit about your difficulties. Would you now tell me a bit about how up till now you've tried to cope with these? Have you done anything in particular?

Well one of the, I mean obviously I've talked to my doctor at some length, who is a man I like and trust. Er and on the whole I've taken these Motival pills and I take a thing called Poseidon, which does precisely what it is intended to do which is

give me sort of slightly deeper sleep at night. I find if I don't take them I do sort of toss and turn and have rather shallow sleep and dreams and anxiety dreams and things like that although I could't tell you any details because I don't write them down but er they do have that effect. How I coped with it? Well I've taken life slightly easier. I mean I've been very much er um a diligent worker all through my life. I've sort of taken work seriously because I've been interested in politics but now I say well what the hell, I've given them a hell of a lot of my life and um been treated with rank ingratitude so I don't see why I should sweat. So I mean that's one aspect of how I've reacted and I've er worked less hard and in many cases, I mean a lot of people only work a three or four day week. In some cases I've taken a fifth day off, that's one thing. Um I wish I could say, I mean it would be an obvious thing to say that I've tried to void situations which entail stress but I haven't. I mean I've just gone on doing the sort of work that I do but it happens that because I've been taken out of the front line so to speak and I'm more in the tail and in the trenches that I don't do the same sort of jobs with the same sort of stresses. I haven't been in the sort of situation where I've felt that a sort of stress attach was coming on because they are by their nature unpredictable so I haven't taken any precautionary things like if I was in the sort of situation where I felt one coming on where I sort of pulled out of what I was doing. Well I can't say that because that hasn't arisen. Er in each subsequent case, in the past two cases they've taken me completely by surprise.

When the third one happened I was on this course. I mean I seriously wondered whether I should go on with this management course I was on and I came back to London from the Midlands where I was and again I consulted my doctor and took his advice as to whether I should pull out. I mean I wanted very much to continue this management course because it was a sort of scalp to put on my belt and was a good qualification when applying for further jobs when they would say well, what experience have you got at management, and I would say well I've completed a course at Cranfield School of Management. So you know I've taken medical advice all along but I haven't deliberately avoided stressful situations. I think the truth is that because I've been pulled out I've just not had to face as many stressful situations.

Yes. How was the decision made that you should come into therapy?

Um, well through my doctor really. From the first time he prescribed these pills er there was a gap of about 6 months, and then when I came off this course to see him in February/March um I said I was sort of distressed that it had re-emerged and he said well it may be connected your kind of er I don't know what the word is - it was clear that they were psychosomatic and er came from something deeper than something just physical and he said how would you like to um go to the Cassel Hospital, which I'd never heard of, which um tries to treat problem without drugs and I said um yes fair enough because I recognise that is the nature of the problem. It is something deep within me and within my makeup and in the way I've been brought up and in my general

emotional attitude towards life er that something has broken. Something has snapped, the body has said um you know I can't cope with that level of whatever the word is, angst, emotion, stress, I don't now how to describe it. Um and then when I went to er see Dr. Bowen for an initial chat she took some history but then offered me a series of options. One was group therapy, one was a series of 12 um psychiatric sessions with her on the National Health Service, the third was a long term thing and a fourth was um something I don't again know quite what words to use, a sort of logical treatment which is something to do with breathing exercises with a man called Nixon is he called?

[illegible]. And I went away and thought about it and I obviously discused it with my psychiatrist friend to try and understand all the implications and he really confirmed my initial inclination that, and this is what I told Dr Bowen, that I thought the first most important thing was the psychological thing that I should go to [illegible] (incidentally I haven't heard from them) er and try and learn um psychologically is the word I suppose, how to cope with any attacks. And because I don't know anything about it I don't know whether it's breathing or whether it's more disciplines or techniques or techniques, but anyway that I learn techniques so that if it reoccurs I've been trained to handle it rather than just blowing into a paper bag. So that was the first thing and the second thing was I though well, I'll do a series of 12 sessions with her.

So you will be going to the as well?

I hope so but she said she would write to them but I mean there has just been complete silence ... um I'm about to have a series of sessions and see if the focus, is her word, the focus would be to try and understand whether or what it is in me that gives rise to it. If she, either because of her perception of me after talking to me for a long time or through me coming to understand through talking about it, er about my own background, inhibitions; relationships, whatever. I mean I'm going into it completely in the dark. I've never been through this sort of thing before and I've just no idea whether it will be successful or a waste of time or whatever.

Was the diagnostic interview you had with Dr I. what you expected?

Um, well I didn't know what to expect. Er so I didn't go with any expectations. I felt er she got quite deep into things which um you know were quite hard to say and which roused emotions within me as I said them and she got in there pretty early er I thought it was going to be a preliminary interview but she went straight for the jugular pretty quick (laughing). Um but I didn't mind that, I mean I recognise that some things are going to be very painful. Um but I mean I think that is part of the process of learning.

Mmm. Since the interview do you wish you had talked about any other things as well as what you talked about?

No, er I put myself in her hands. She's a professional, she knows what she's doing.

Did you feel understood?

Yes, I felt that she was a very good listener because I mean very often I'm answering questions and I don't have the first idea of why she's asking them and sometimes I'm interested to say well why do you ask that? But on the whole I think if she knows what she's doing and she's obviously done it with a lot of other people, then er I simply try to be as truthful as I can in the hope that she can sort of perceive things which I can't.

Mmm, Mmm. Now that you have got this far, what are your expectations of therapy?

I don't have any, I don't have any. I am hopeful I have hopes but not expectations, put in that way.

Mmm what are the hopes?

Well I hope that um it gives me a greater understanding of myself and it allows me to be um less anxious and that it avoids the outbreaks of these sort of panic stress attacks or whatever it is I get because to tell you the truth I don't really understand whey they happen or when they're going to happen. Um -

Are there any external circumstances that you see as helping or hindering your attempts to deal with your difficulties better in the future?

I don't understand the question.

Do you see that any of your external circumstances -

What does that mean?

You know your job, your marriage, your wife situation, your financial situation, it could be anything. Anything in your life apart from your attempts to deal with them could somehow influence in a good way or in a bad way.

No I don't think so, I don't think so. I mean I'm starting actually next Tuesday, I mean it's hard to make time, as a matter of fact I'm due to see her at 9.20 next Tuesday and I'm supposed to be covering a by-election. I mean I have to ask myself can I duck out of my work and not tell my bosses that I'm seeing a psychiatrist at the hospital, which is a thing I'm not going to tell them, or do I cover the by-election? Well I'm actually going to go and see her and cover up.

Sure.

That's an external circumstance. But I think it's important that I do see her and do go through. So I have to, well not tell lies, but I have to dissimulate.

So your job is really something that's hindering your attempts to deal with it in this way -

Well because I lead an unpredictable life as all reporters do. you never know what you're going to do, where you're going to be sent. Er I could be abroad you know. As it happens I've spent three days in South London on one report and I've come back and I find that they're expecting me to spend Monday, Tuesday,

Wednesday in ... l in South London. Well, I mean that is an inhibition but I don't, I mean my wife is supportive and frankly I don't tell anyone else that I'm going.

Are there, I mean you already mentioned that you feel unhappy about your work situation - but apart from that or you know, including that, are there any other expternal circumstances that you would want to change?

Well, it's the word external that I -

External, I think when we talk about external we mean the internal one is our inner life, external is the things out in the world which, you know, your job, your relationships -

Yes, well no, no. I mean what would make me happy is that if I hve a proper job to do for which I'm recognised as in post on the staff and doing it and let me get on with it, that's what's going to make me happy.

feel you can do anything else, anything about this job situation that you would want to change?

Well I've done as much as I can. I mean I've seen a lot of people, I've consulted practically everybody I know who's fairly senior, I've had a sort of programme of going round and seeing all sorts of heads of this and that and training and ... Medical Adviser and anyone who is recommended to me I'll go and see and have a conversation or take them to lunch. I mean I've explored every possible avenue but in the end, because everything

is by competition, er you just have to apply, get put on a short list, go for an interview and you may or may not get it. I mean there's a job at the moment that I very much want and that I've applied for and I've made a lot of efforts to er get considered and to get a job, which is to produce the [illegible] programme on Radio 4 but er there will be five other people at the interview board and I will be very upset if I don't get it. Er I just hope that you know my qualifications are recognised but it's depressing because you think well I've got a black mark against me with someone because I wouldn't have been pitched out of my previous job and you never know what sort of whispering goes on between people at a very senior level. Um, and also I don't have any qualifications as a producer so I'm actually asking to be Producer of a very senior job without ever having been a Producer. So you know I'm tryng very hard and I'm looking every week for jobs and I'm applying where I can but er I don't think there's anything more that I can do.

Is there anything else that you think that you could be doing at this point in time to improve the quality of your life overall?

I can't think of anything off the top. I'd like a lot more time at home to sort out ...my, I mean I'm a great reader and writer and um I need about a fortnight to get myself sorted out here because I've been involved in doing too many other things. I just need more time.

Would it be possible for you to get that time?

Well no, because I've only got three weeks holiday left this

year and they're all taking the children abroad.

Mmm. So giving yourself time is not a possibility?

No, I mean in a family it's selfish. I mean children are very demanding of time and they, they deserve it. But you know, I can't just er take time off from work for purely selfish reasons and ignore my family and children.

Mmm.

Well I mean I could do but it would be extremely selfish. I certainly need at least and as you see I've got a large garden which needs a lot of er attention and I'm the only person who does anything about it and that's sort of constantly getting behind. You know lawns have to be mowed and hedges have to be cut and I don't employ a gardener.

Mmm.

I mean I've got a lot of things happening -

Anything else that you feel that you might be ble to do?

Well I suppose if I had the money I'd employ a gardener. That would take quite a lot of weight off my shoulders. I mean I'm very keen on gardening but er gardens are expensive. I mean I'm just going to employ a man to do maintenance round the house and that's costing £1,500 which I don't have.

Mmm.

Er and that's coming out not of earnings but of savings. I've

got a child going away to school in the autumn and God knows how much she's going to cost every term. I mean I don't have any money. I mean I never have any money except what I earn. And when I've earned fairly good money but I've spent exactly what I earn so -

So is there anything else you feel you might be able to do?

Um, not really. I mean you know I suppose I could give myself more time if I gave up doing things, if I gave up playing cricket. Um, if I employed a gardener but then you know I would just be more or less giving up the things I'm interested in and which bring me into contact with other people. I wish I had a quieter life. Er I feel under pressure sometimes - just too many damn things to do and not enough time to do it. But if you work in er the sphere I do you're under constant pressure to be kind of aware of world events and read all the papers and watch all the television programmes and be very much up to date with current affairs and that takes quite a lot of time as well. I mean I work for a programme which is all about the latest developments in China and Poland and Africa and Westminster and Strasbourg and so on and I'm supposed to be something of an expert on European politics and I go to Strasbourg every three months. So er there's a lot of reading to do. But I mean that's how I have achieved whatever eminence I have, by being extremely well-informed on these sort of things. And I am an expert on European politics because I've been covering them for 20 years. And in fact um three weeks ago I wote to my boss at the BBC and said I hope to goodness you're going to actually use me during

the campaign because it would be a criminal waste if you know all these sort of teenage people who we seem to be employing are all doing the job instead of me with my experience in it and I'm glad to say there was a positive reaction so now I'm extremely busy. But I mean I'm happy to be busy because I am using all the accumulated knowledge and experience but again that doesn't give me much free time.

I mean for instance on Monday, not only have I got to get down to [illegible]hall and go all round this extremely complicated [illegible]y-election but I've then got to come into the programme in the evening and then start writing links for another thing we're doing on Monday which is interviewing people in Scotland and Northern Ireland and Wales about the local situations there and linking that, so that goes out Monday and then I go back [illegible] on Tuesday, having dodged out of it to go to the Cassell Hospital but pretend that I'm on the beat, and then put together a programme for Wednesday so that is, I wouldn't say that is absolutely typical, it's slightly overstressed but er I do find things get a bit much sometimes.

Sure. Is there anything else you ... done?

I mean I think that's really up to you. I mean I've talked as freely as I can, I mean er it depends upon the breadth of the remit that you have.

That's fine at the moment. OK?

OK?

Thank you.

really, ... him.

feel that er -

Well no, I wouldn't hang in out of politeness to you. But I mean I think one's got to give the process its time. So I just feel, I feel an urge to do what's needed. On the other hand I am willing, you know, I must admit that er I fail ... to see, to understand what's going on. (Laughing)

You are saying I think you're finding it quite a difficult experience, particulary there are lots of things that are encroachng on it, I mean paticularly ... outside but I think that here there are things that are encroaching on the space that you could have to look at ... not inside, and that's difficult to give more expression but I think -

Well I think it's because I'm not used to er talking about what I feel very much. So it's a slightly hard process for me.

Yes, OK....

Bye-bye.

Good,thanks, bye.

- ___ - Post-Therapy Interview

18th November 1989

So whatever you really want to start telling me about your experience.

Yes.

Do you feel that your way of looking at life has changed as a result of your psychotherapy with Dr. [redacted] ?

Uh, no.

Um, did you expect it to change somehow?

I didn't know. I mean I was er, I had no experience of it and I er went in hoping it was going to help me but I wasn't quite sure what was going to happen and er um I think I said something like "I had sort of er hope but no expectations, in oher words I was looking for ways of helping me but I wasn't sure what psychotherapy could contribute.

Yes. Did you feel anything changed?

Um, no. Not really.

OK.

How do you see your relationships?

With whom?

Anybody, everybody at the moment.

Quite good actually, quite good. Er I feel er much more sort of relaxed and I don't have that kind of gnawing sense of physical anxiety inside me which was um you know a knot, which I could sort of feel like a pain. That's gone but I mean I - who can tell whether that's because I've rationalised things, because I've had psychotherapy or because it's simply gone away? I mean I think a lot of it is related to my work situation and I've had a very unstressful work situation for the last six months because er I've been in charge of my own work, I've been pacing myself, I've been doing fairly quiet research, I haven't had deadlines or programmes um in fact I've been producing a result a week which has involved writing and research, sound archives um and my relationship has just been with one man who I like who has been producing my talks. In fact I've been doing obituaries and er so er I think that because I am less irritable because anxiety causes irritation in me I think er inevitably my general relationships have improved but I cannot honestly attribute that to er the psychotherapy sessions.

Mmhm. What about er your relationships at home, with your wife and -

Very good, very good, in fact I think they've probably improved. Um um recently they've sort of marginally deteriorated but that's because she's been tired and overworking and it's been on her side and also we've had problems with our daughter who is er is in a sort of tamtrummy stage and my wife gets rather sort of dedspairing about all the sort of screams and shouts and won'ts and shan'ts and won't eat this and don't like that and -

Mmm.

She feels a failure because she thinks the relationship has broken down but of course inevitably that er spills off into her relationship with me and she sort of gets very dispirited and tired but that's er a sort of internal family thing which really has got nothing to do, I mean I'm not saying it's got nothing to do with me (laughing), it's got nothing to do with my state of mind, that's caused by other things. But I mean I think this is a passing, a passing thing. I don't think it's relevant to what we're talking about.

We often feel it can be quite relevant - all, all areas in your life can be affected so that's why it's quite useful to understand everything -

Well I mean I'm very sympathetic to her problems. I mean I'm not, I'm trying to avoid aggravating them. I'm trying to sort of cushion her through it.

Mmm.

Because I feel in fairly sort of calm state.

Mmhm. Right. How's your sex life? Now I think you mentioned it in earlier -

Well it's sort of intermittent. I mean there's nothing wrong with it. It's got more infrequent but I think it's been in a sense as much for the reasons I've just explained on her side as on mine. I mean you know earlier in the year it was because I was

a bit tired or irritated or prickly and I think it's now because you know she's sort of emotionally exhausted by fighting with her daughter.

Mmm.

And also she does quite a stressful job.

Mmm.

But um I mean I don't think either of us see it as a measure, I mean we don't measure whether our marriage is successful or happy by the frequency of sex. I mean I think that we've been married so long we've sort of settled down and it's just sort of part of it er when we feel like it but not a, not a thing either of us feels that if we don't have it we're failing.

How's your relationship with your children then I mean if you, these new developments?

Well my son has gone away to school. Um where he's actually not very happy and I'm missing him um but we talk on the phone a bit. My relationship with my daughter is all right but she is difficult. As a matter of fact I seem to be able to get on with her slightly better than my wife at the moment.

Mmm.

Um but then because I don't have the daily interface because I'm away at work wihich my wife has. So I'm able to act as a sort of er more of a friend to her and I try to be more kind of rational. I've also much stronger, I have much stronger discipline er -

Has this always been the case?

Um. Has it always been the case? I don't think so. I think it's arisen in the last er year or so because um suddenly at the age of nine she has become very er kind of overtly emotional about getting her way and stamping her feet and screaming and shouting if her will is thwarted and so on. Which I don't quite understand why but I assume it's a sort of phase in development. Um but on the whole I have a good and warm and friendly relationship ...

Mhm. But you now see your wife as having some sort of a worrying time -

Yes she is a bit. Not as serious as mine was but I think she's very concerned about it.

Mmm. What are you able to do to help her?

Well er -

Or is it something you feel that she needs to sort out?

She needs support and er comfort and so on but it's er but as I see it the problem is basically her relationship with... She has to work out and basically they have to work it out between them.

of take her out of the firing line by taking her swimming and trying to get her to help me but again the sort of things I do like sort of gardening and picture framing and things she can't really contribute very much. .. games ...

Mmm. Well you, we talked a lot about your difficulties before you went in to therapy. How are you now coping with your difficulties?

Well um the answer is I don't really have to cope with them because they aren't difficulties any more. I went into, well I sort of tried therapy because I thought it might help sort of not in curing but in understanding and handling a) the sort of um unexplained anxiety states that suddenly came and b) it might help me kind of understand and cope with any resurgence of these sort of panic hyperventillation attacks, of which I had three. But er a) I haven't had a recurrence of the attacks and b) the anxieties have gone away so the question doesn't arise because I don't have to cope with them but frankly what I think I'm learning from the Psychology Department at Charing Cross is going to be far more relevant to do with self-discipline, breath control, muscle relaxation because that strikes me as directly relevant er you know if one of them occurs or looks like occuring then I know from them precisely what to do whereas I don't think psychotherapy actually offers any answers to that.

How did you feel about your therapy?

Well, er it's er difficult to say. I mean I went through with it. I was hoping, I was sort of disappointed that nothing seemed to be happening but I didn't chuck it in because I thought there might be some cumulative benefit if I sort of stayed the course. I thought er you know really the doctor I was with was very sympathetic and professional. Er I mean I said to her at the

end, I feel a sort of slight sense of disappointment I haven't been a kind of (laughing) a better pupil. Hold on a moment -

(Sneeze?!)

Um so what was I saying, yes well I was saying that er at some point she said well you know, this is not for my benefit and I realised that and er you know I thought well the value, for a time I thought that the value might be in simply making me talk about feelings which I didn't normally express and that was a good thing for me because I'm not a great er expresser of feelings. But I also did feel that I was slightly disappointing her, if I'm slightly sort of repeating what I'm saying, er you know because er she's obviously profesional therapist and she's obviously had a lot of patients and she obviously thinks its a valuable thing otherwise shewouldn't be doing it and I wasn't really proving a success. (Laughing) and in a sense I wanted to be a success because I wanted it to be useful to me but also you know er something that um worked for her. And I took a, I wrote a few things down whilst I was doing it which are sort of abbrevations about the process. I mean I did feel, I wrote 'floating about' I did feel we were kind of meandering in an out of things and there didn't seem to be a sort of fixed structure and there were these great long silences where really one could sort of take off in any direction one wanted. And I'm er a journalist and a fairly rational person and I'm used to a structure and I like to understand what I'm doing and where I'm going and I felt this was er you know rather like a man at sea being blown around by tides and er that there was a sort of

aimless quality about it. I felt strongly and I told her that I wasn't getting much guidance or feedback about what I was saying. I mean I wanted to know whether er what I was saying was sort of relevant and I wanted to know er whether as a result of what I was saying she could provide me with insights that should be helpful. But I mean she gave me absolutely none and when they were, each session ended she just sort of said "Well that's the end of it, er goodbye" which I found rather annoying. Um you know I wanted er she's a professional therapist and I wanted more feedback from her. You know even to sort of how I'm doing or whether the session was useful; all that sort of thing. Perhaps I've got the wrong perception of it. And I wrote "Where is it going?" I mean I couldn't, this was in sort of middle sessions, I didn't, perhaps this is another way of saying there was a formlessness or lack of structure about it, but I didn't sort of see a direction. I also wrote "Is the process the therapy?" in other words er does the therapy not consist in her observations to me about er my state of mind but did it really consist simply in the fact of me talking about myself and my relationships and my work and all that sort of stuff? I concluded that was probably the answer. "Will there be conclusions?" I wrote. I was hoping there might be conclusions. I didn't think there were very many. I mean I think there was a quite useful analogy presented that you know I had a happy family life and that er I was used to er, both in the family now and the family I grew up in, a fairly warm and lovig relationship

I've been rather conservative in not

moving around in jobs, I haven't zig-zagged from firm to firm like a lot of people do and gone up a sort of career ladder by jumping around and being promoted but I've stuck with the BBC which er you know I've always had sort of fairly high ideals and principles about and thought it served a public service duty, and there was a matter of pride in working for it because I felt it was part of the nation and the community, and it had a, a valuable moral role so to speak in enlightening and educating and so on. And by being er sort of untimely ripped from my post, so to speak, I was er it was like um being kicked out of a family. Er and there was certain value in that as an analogy but I mean I knew that I'd suffered a great blow to my pride and didn't really need an analogy. Um and I knew that I felt er sort of upset and humiliated and that sort of thing. And of course the intensity with which I felt it was partially explained by the context, by the er the way perhaps I'd got over-used to being in the sort of womb or the bosom of TV, And perhaps assumed too much. I hadn't come to terms with the new er sort of market forces spirit that was pervading now you have to justify your position and that people don't value kind of experience or moral values any more, it's just what you're worth to them and er you know, I hadn't come to terms with that. Anyway er what else did I write? "Do I learn by talking and getting new perceptions?" was something I wrote down. Perhps that's another way of saying what I said earlier. That I was wondering as things went along whether I was in te process of self-education by expressing thoughts that I hadn't previously verablised I was actually teaching myself about myself. nd I think there mig t

- Initial Interview -

Would you tell me about your life?

I wouldn't know where to begin. It would be sort of parents and we're all quite close in age but very different um. I'm afraid I don't really know what to tell you. I'm a free lance film maker, I'm 30 and I don't see people in my family very much, none of us are very close and I think that probably having a religious upbringing probably sort of created great rifts in the family. I mean is there anything specific that you want to know?

Um, what about your working life please?

It's highly irregular in as much as I'm a free-lance film maker which means that I don't always do the same job. Sometimes I direct, sometimes I do camera work and lighting and it's quite difficult to get work so I don't work all that often and what I'm really trying to do is write and direct.

What kind of films?

Narrative film. Eventually I'd like to make feature films but one has to start with shorts so in the meantime I'm just waiting to hear about a short script that I've written to see if I'll get funding this year. So, you know, I suppose that's partly why I want to have therapy is that the whole nature

of my work is so personal and so unstable that I think one does, you know I don't think I'm a particularly weak person, I think one needs to be incredibly strong to cope with a life like that because there isn't anything regular about my life. You know I don't have a regular relationship, I don't live with anyone so I don't even keep regular hours. I can sort of stay up all night and walk round in smll circles in my flat if I want to. It's kind of sometimes you know, sometimes it's very easy to feel out of control.

... particular relationship, boyfriend or?

Well there has been one for about the last five years and that sort of more or less ended. I mean @we're very, well we don't see each other nearly as much as we did and the whole thing is very open ended now, um I suppose that's another reason why I wanted to do therapy because for a long time I mean for four years we were together fairly solidly. He's another film maker and this created huge problems for me. It seemed to be a terrible paradox that I was only attracted to people and still am, that somehow I feel inferior to, that I can sort of respect because I think they're so wonderful but then that creates huge inferiority complexes in me and I haven't really started writing until we moved apart and I sort of feel now that I am more myself. You know I used to think that because I didn't want to make films like him that mine were inferior but now I know they're not, they're just different. Well, they may still be inferior (laughing) but they're also different.

What was the ..., why did you interpret like that?

Well I think, um, I mean I think that women generally

who make films tend to make much more emotional and personal films and men tend to be either locked into genres and are making films as commercial enterprises or else um their approach is somehow more intellectual and less emotional which is certainly his approach and I used to worry terribly that I was stupid, I suppose, that I wasn't intellectual. And also you know that I wasn't tackling social issues. I think you know once you reach a certain age you feel as if, if you're going to live an indulgent life, which I think being a film maker is, that somehow you should do something useful in your films, that you should provide things for people to watch which will encourage them more, will somehow make them feel more optimistic about being alive and ...

Was there anything else about your boyfriend that made you feel inferior? Apart from this ...?

Well actually, yes. I mean just he fact that @he was a man. I certainly don't suffer from that as much as I did but all the time when I was a child I had, I have, one sister and three brothers and I always wished as a child that I'd been born a boy and I distinctly remember asking my *mother when I was very small if she'd had the choice would she have been a man or a woman and she said a woman and I was absolutely horrified. I couldn't understand this at all, how anyone could actually choose... Because it just seemed to me that life is geared up for men and not really for women.

What about the nature of your relationship otherwise?

Um, I suppose you mean with my boyfriend, as was ... Um because I never did feel terribly close to my * **parents or anybody else in my family really then I would really kind of

fling myself into relationships and I remember at the time when we began to sort of move apart which I suppose was kind of mutual but @ he actually initiated it largely because he was interested in somebody else at the time, um, I really felt at the time that it was kind of like I felt as if I had lost my whole family, I felt like an orphan. Yes I think that is probably the best way to describe it. I felt orphaned and I realized then that you know that I just felt that probably I wasn't capable of sustaining an adult relationship. I realized retrospectively because I felt orphaned I realized that ours wasn't a sort of match of equals, I felt like a child. I don't think it's a particularly healthy indication if you split with someone to feel like that as if you've been abandoned because then you're sort of foisting all the responsibility for yourself on to somebody else, which I think I did.

What about the sexual side of your relationship?

Mmm... Sort of very hit and miss. It always is. Umm, I suppose that's another reason why it was quite difficult for me to split up and also why I think it was also partly why I felt orphaned was that I'd never had satisfactory sexual relationships with anyone until him so that was quite, I mean it wasn't satisfactory probably 70% of the time even with him but it was sufficiently often to make it you know difficult for me to give it up. So I sort of felt, I don't know, that was one of the most difficult things for me to give up that physical contact that was, I think that's principally why it made me feel orphaned. Sort of suddenly being denied that physical affection. And also I think, I don't know, that's being going on now for

over a year and sort of steadily drifting further and further apart. It never seems to be sort of finally concluded. I suppose it will be finally concluded when one of us meets somebody else but even so I think he's probably changed quite a lot and so have I just this last year and it's certainly become easier for me to think seriously about films. It always seemed to me the priority that the relationship was the most important thing in my life and then whatever my occupation was was a sort of secondary thing. I just never took myself seriously as a film-maker and now that's definitely reversed. Um, partly I suppose for cynical reasons. I've just come to the conclusion that although my career is relatively unstable there is something more consistent about me and what I do than any realtionship that I might enter into so I now, you know, don't sacrifice things connected with work for anything else, which I suppose is the conclusion that most pepople come to a long time before I did. Um, I can't remember what I was going to say...

What about other relationships?

I'm pretty reclusive. Most other people that I know are film-makers, which means that you know, unless you want to talk shop all the time I don't really see people all that often. I now have a sort of weekly routine which I've had for months and months and months where I either work, you know if I have a job then I do that, but that's not very often so I'm either reading or writing during the day and then in the evenings three times a week I do aerobics and once a week I go to a script-writing group which has been quite useful because it's a sort of forum to air your ideas and to read your stuff and see whetehr people fall asleep or not. Um, and that just leaves Friday evenings or

weekends in which I socialise or else I don't, sort of 50:50.

Do you have any close friends, really?

Um ... No. I mean I've got friends I've known for quite a long time but I've never had close friends really. I suppose that's another reason, my closest friends have always been the people that I've had relationships with, which is another reason why my kind of drifting away from the last relationship is lasting so long because we were quite close.

How could you generally describe your dificulties that you want help with?

Um, I think I'd like things to be more evened out a bit. I tend to fluctuate between ridiculous kind of euphoria and black despair and it doesn't panic me as much as it used to because it's a pattern I've become familiar with. I know when I'm in despair that it will end but I don't seem to be able to actually control it myself. I don't seem to be able to make it end. All I can do is just kind of wait for it, wait for the cloud to lift. I'd like to be able to have some sort of control, I even think that what I what I wanted was to still have the euphoric bit and to go without the black despair but in fact I think the euphoric bits are equally unhealthy. It usually happens if I'm writing a script. I become so sort of excited about the idea that I almost feel sick and it actually makes it quite hard for me to write. I don't seem to be able to approach writing in a sort of conscious, logical way. I can only do it as a sort of catharsis, almost like being sick, and although it's sort of exhiliarating it's exhausting and I become you know,

nocturnal and it's all I think about and all I .. you know I just become obsessive.

How did you try to cope with these dificulties up 'til now?

Alone. Um I left college about 2 1/2, 3 years ago and when I was at college I used to go once a week for something which was called counselling which wasn't exactly psychotherapy. Marginally to try to cope with, it rreally was, that was when my inferiority complex was at its worst because I was at college with this man every day. And I would feel sort of humiliated every day I went into college.

(Coughing) Shall I make the tea? (Break)

.. they were touring South America in my last job for a documentary and it was a real experience, I mean it was a wonderful experience. It wasn't so wonderful being with them, that only lasted for about ten days but after everybody else went back to England I just stayed on in Brazil for another three weeks on my own and so now I think even in my blackest despair there's always Brazil. I mean it's just so wonderful to know it's there, you know that it is wonderful but I kind of ... certain things from that experience. I began the script before I went there and I didn't touch it at all when I was there. I just sort of existed, I didn't read or write anything. When I came back I wanted to use it soemhow, there were just various little things, that title and the boy, his name is Bernard, and I've decided you know that he comes from Manchester and the lead singer in the order is called Bernard and I imagined you know that the way that he would dress would be quite similar.

So really in a way you have been trying to deal with the break-up in your relationship by writing this film script?

Yes, um, well I mean principally I've been trying to write a film script. You know I can't make a film until I've got a script but yes it's sort of a bit, you know I wish that I could adopt a more objective way of writing scripts and possibly I could if I did it more but at the moment it seems that I can only really do it or feel any conviction about what I'm writing if there's something very pressing going on that I have to deal with and then it all just comes out. I think that probably does produce the best writing. I think it's probably the same for everyone, that things don't really ring true unless the writer knows what they're talking about.

Tell me, how did you reach the position of coming for therapy?

Well as I say, when I had been at the Royal College I had gone once a week for a period of about two years for counselling which wasn't very satisfactory. I was aware of the fact that somehow it kind of tided me over because the woman that I used to go and see was sort of quite maternal and basically you know she just used to sort of say "there, there, it's alright". And I sort of thought this isn't very constructive in the long run but you know since I'm a desperate person it'll do for the time being. Um, and then when I stopped it, I mean it could have gone on endlessly. I think she was sort of quite disppointed that I decided to stop but I just said that well two years hasn't really produced any significant results. I'm beginning to feel

like an invalid and I don't want to go on with this indefinitely plus the fact that it's a luxury I can't afford. So I stopped it and then came the break up and I thought I suppose I'd kind of realised, even when I was seeing her that the things that made me feel better were all things like you know, having a film on television and not kind of wingeing to somebody but was actually you know participating in the world and so then when this break up started I thought you know therapy is not the answer. I really did not know how to live. I was kind of desperate at the time. I couldn't stand being alone, I cried all the time but I just thought you know that if I could just go through that then I could go through anything and I thought the answer is to get work and to form new relationships, blah, blah, blah the answer is not

therapy to just winge, which is not very constructive. So I decided not to and so you know for a whole year I just coped and I had a fairly good directing job which was traumatic but good, made me feel real. And then in the end, I think it was just before I went away to Brazil, before I knew I was going I just reached a kind of crisis. I thought this is ridiculous you know, me just being all sort of stiff upper lip and I can cope with this on my own, I just can't. I was just sort of really deeply unhappy and so I went to see my doctor and said could I be referred for psychotherapy. And then I went off to Brazil when I was on the waiting list and I came back feeling great, you know thinking well maybe I don't need to do this and I had a meeting with somebody at St. Thomas's and I just told her that. And we agreed that I was still very much in the afterglow of having been travelling in South America and it seemed to me a good thing

to do something just like 16 weeks. I didn't want the feeling of somehow becoming an invalid and therapy becoming a once a week thing for the rest of my life for an indefinite period. And she said do you feel you could commit your self for 16 weeks? I just thought this time I know better than to sit there and whinge and although it's an indulgence it's one which most people don't get and it's probably quite interesting.

What was your G.P.'s attitude when you asked for psychotherapy?

Um, very sympathetic. I mean I was visibly pretty miserable, um, he didn't realy kind of, he didn't question it really. He said that it would be quite a long time before I would actually be able to begin and that he would be quite happy to see me from time to time, you know if I felt that I needed to talk to someone, which I haven't but he was very nice. He was sort of quite paternal I suppose.

_____ Post-Therapy Interview

Right, how do you feel now in comparison to the way you did before your therapy started?

Um, ... it sort of varies. Sometimes I feel exactly the same, um, but I suppose I feel that way less often that I did. Um,

Do you feel that your way of looking at your life has changed as a result of therapy?

Um, slightly but not radically. I think that I still have or you know that when I become depressed I still have ... negative attitudes to life. Um, I am now much more able I think to identify how that came about um, and I suppose I blame myself less for it. Um, it's hard to say I mean I think you know for a while I was feeling very much better and um I seemed be be coping much more with things and ... when I became depressed didn't panic me much as it used to because I was rather more in control of it and understood the ... of it better but recently actual events in my life have become more difficult than they ever have been during the time that I've been doing therapy and I'm finding that very difficult to deal with.

And what are they then?

Um, well I work in films which is you know probably about the most insecure ... and one of the reasons that I started therapy is that I'd been in a relationship for about 4, 5 years with someone else who is also a film-maker who sort of I always felt very eclipsed by his being um very much and ... I'm still

struggling very hard um both for a living and doing what I want to do um which is to light and direct. Um I have problems getting director's work because what I've done so far is not ... commercial that's difficult and um I usually have problems with writing my own work largely through lack of confidence ... difficult, um and he recently has really sort of leapt forward in terms of ... at work and money, you know and um I always have compared myself which is ridiculous um you know it's probably easier for men anway to get work ... and um ... confident but um

Do you feel that the therapy in any helped you to deal with this latest crisis?

Um, I don't think, I think that my, I mean I think that this latest crisis or everything that's happened in connection with this man um has really just sort of brought to the surface quite fundamental problems that I've had , ... my upbringing .. my father and um I don't think you can sort out that kind of thing all at once. Um for a while you know I was, I was feeling sort of much better. I don't know, I mean you know I can sort of identify my feelings like, I really know now that isolation is so bad for me and I am isolated so often and I am now trying to do something about it. I'm trying to find ... who are all isolated as well or who I feel secure with. So it's somewhere that we can go every day ...

So what about the rest of your social life? I understand it's a change and that's one thing that you've done since therapy. What

about your social life - how's that now?

It's virtually non-existent.

It's the same as it was prior to going to therapy is it?

Yes, um you know I just, it's quite strange really. I mean I don't really understand it myself but I get very fed up of being on my own but I very often feel sort of quite lost in company. I'm aware that I'm very detached from it so even when I'm with someone ... sitting across the table from me um, I often don't

time, I think when I get home I'm going to regret this. You know, I'm going to regret that I didn't make more of the company

think there must be a reason for it, there must be a reason why I need to isolate myself in this way and that maybe it's not such a bad thing, and there are other times when ... its very damaging.

What about your work ... now?

Um well financially I'm still kind of keeping my head above water just about um I don't know, I mean recently I really have felt very, very bad. Um, and it's not something I can control. I have nightmares I wake up very eraly every morning in an absolute state of panic and it takes me a long time to sort of calm down. Um, I know a lot of it has to do with the prospect of another day alone so to speak and ... but um -

Are there any other things you might imagine that you could do in order to alleviate your isolation, workwise and socially?

Um, no I mean I'm sort of very, very shy. I mean I know, I don't sort of despair completely because I'm not always like this. I have been, you know, quite a social sort of creature um in the past and I dare say I will be again but at the moment I, you know maybe it's just sort of part of the process of trying to um come to terms with my own identity that um, I don't know ... not feeling very sociable. I mean I have a friend who's also ... therapy and sometimes we don't get on at all really because our problems are too similar and we're bad for each other and then other times it's very good you know because we do understand each other and um I don't know I suppose at the moment I'm just going, finding it easier for me to get on with other people who've got problems. I just find it a great strain trying to sort of ... um

quite incredible I sort of I don't feel confident, I don't seem to have a sense of humour at all, um and I just don't feel like

very difficult and other times I just well that's how I feel and you know, that's OK. But um I just sort of feel as if I have to get to the bottom of something quite bleak and um -

What might that be?

Um, it has something to do with my parents um, the fundamental, last night actually I telephoned my father because I've written to them about three times in the last week and explained that I just didn't feel that I could come to see them because um they had such a sort of fundamentally transcendent attitude to life that was very religious ... higher things and I've written and

said you know this is no great comfort to me because all I have is the here and now. Um and what I feel, I feel most of the time emotionally about five years old and I've never had, I don't think my parents have ever been physically demonstrative or particularly supportive in the sense that they've been quite judgemental, particularly my father, and quite negative about things you know that I've wanted to do and um and the break-up of that relationship with ... has sort of brought all that forward, you know it's all in my mind now. Because I became very dependent on him for demonstrative affection and -

Mmm, your boyfriend?

Yes. And any kind of support that I could get and um I just know that you know that need is still very, very great and I don't quite know how I can overcome it. I'm not in a position emotionally or psychologically to enter any kind of relationship with anyone. I don't want ... happy again and I'm not kind of self-sufficient enough.

Do you feel that you should be self-sufficent in order to enter a relationship?

Certainly to a much greater degree than I am, yes, otherwise you are sort of very, very demanding, which is what I have been.

You don't envisage that somebody could actually respond to your demands?

No I don't. Um and somehow I kind of feel if somebody did then it would become grotesque. That my demands would become greater

and greater and greater and they would be more and more indulgent you know, I couldn't see it sort of keeping under control somehow. So, but I spoke to my father last night in sheer desperation because I just felt so um alone and unable to cope without you know some kind of support um and he was just you know, he was so incredibly formal. I'd forgotten how formal he was, he language is incredibly formal. I said well why didn't you write back to any of my letters and he said well, you know, you expressed a great difference of opinion ... liberties, believe what you will and I just thought you know that was an end to the matter and he said that um that you know it was a shame that I had chosen to believe something which was completely wrong and for which I would ultimately suffer i.e. ... go to hell ... And um I also told him that I was going to buy a computer because I want to use it for word processing to write scripts and it's quite a big thing for me because I'll have to spend, I had some savings, I've inherited some money from my uncle who is his brother, and um I'd decided to spend that money on a computer and to me it's sort of like making a a kind of commitment to writing because it is the only money that I had, the only money I had saved. And um it was so disappointing that he was so discouraging and he said well you won't have any kind of emergency money ... are you sure it's a good thing. And somehow it seemed to me that his attitude was always for the sake of doing less whereas I think well if I get this thing and I write scripts and I start making films um you know I can easily get some more money kind of thing. I mean nothing ventured, nothing gained and um it's just so

disappointing that he has always been so sort of mildly discouraging and generally negative.

Mmm.

And I suppose I just feel very desperate about that. I mean I established a long time ago that I had always, or for as long as I could remember it, emtionally I felt like an orphan and um during therapy Josie suggested thta I should try to establish a greater rapport with my parents and I suppose that's what I've been tryng to do. But I can't see it happening. My father is completely dogmatic. It gets to the point where I think he gets quite angry you know that I don't believe in God because he knows he's right and um he had an appalling relationship with his own father and I don't think he's capable of being demonstrative and supportive. I presume he loved me in his own way but it's not a way that I understand. It didn't seem much use to me so now just kind of wondering how I'm going to get by without.

How is your relationship with your ex-boyfriend now?
How do you see that as a relationship now?

I really you know, I, I've sort of realised that you know it had to end because I was so sort of emotionally dependent and um probably the kind of difficulties .. outweigh the nice things so you know ... surprised um, but I had, it was you know, I could understand that my problems created difficulties but I had always hoped that there were enough um valuable things about me that he would at least want to remain freindly with me and I don't know

whether he does or not. He doesn't, we don't see each other. Um I've written to him sometimes and sometimes he's written back but his letters are always very sort of cool and dispassionate um an they always seem to me as if he's slightly annoyed with me for being so me.

So ....?

Yes. Well no, not really. More like my mother actually. I think my mohter had a very sort pull yourself together kind of. More like that.

But in a way you still seem very uncomfortable with your moods. You see them as overwhelming and suffocating rather than ...

Yes. Well I don't, well yes because they're so intense at the moment.

Is it possible they are intense because there is no place to discharge them in?

Yes I think it probably is but somehow I'm feeling as if I'm not in a position to kind of relate to people um until they have been um you know satisfied in some way and I had hoped that that might happen with my parents but ...you know I really do feel as if I'm trouble, you know I really wouldn't encourage anybody at all and I'm still very much um affected by ... you know I still feel deeply inferior to him even now I worry about what he would think about things that I do or things that I write. It's becaue you know... proving myself ... and that's just lack of confidence.

Do you have any kind of sex life at the moment?

No. No it's funny I remember how I was before I started the relationship with him and um I wasn't having any kind of sex life then but actually started to um, I had some kind of like nervous skin thing for about six months before that happened and you know I was just generally in a kind of similar while not as bad as the state I feel in now but you know um I didn't sort of feel as if I was quite ... I mean I'd been in a kind sexual relationship not quite ... it's very very important and I remember how when that relationship started um or even just the friendship that preceded it my skin just cleared up an I stopped sort of worrying about little things you know I used to be less obsessive, less preoccupied and all sorts of things. Because I think when you're not in a relationship, particularly when you're spending a lot of time alone, it's almost impossible to maintain a sort of rational perspective on things.

Yes. How are you now coping with the difficulties. Could you get any kind of, describe any ways in which you try to cope with them?

(Laughing) Well recently I haven't been coping that well. I've just been sort of generally in a state of despair wondering how much more I can stand um it never occurs to me to commit suicide or anything like that simply because I'd be too afraid and I think fundamentally I am always hopeful and so I just sort of think God, you know, how long must I, it's just a matter of sort of tolerating it which seems to be a terrible waste of one's life

and a waste of one's youth. Um, ... um I started painting ... which is quite nice because I was just sort of becoming very kind of frustrated at the kind of problems that I was having with Martin and um at not getting money to make films um and it seemed important to me to ... some energies and I haven't really, I haven't painted for years because um I'm not technically any good at it but I just decided it didn't matter. So that's been quite satisfying. It's quite absorbing. Um, unless I'm feeling really bad I tend not to um look to other people. Um whereas I think you know if I felt sort of low I would ring someone up and kind of pour it out which really didn't make me feel any better. Now I tend to just try and cope with it on my own um which is almost like a sort of retreat into childhood, the ... It's very strange ... seeing friends and having company um I just often feel when I'm with people that somehow I'm not being really being myself and that I'm only being myself when I'm on my own. But I just am on my own too much ...

How did you feel about your therapy and your therapist?

Um, I'm really glad that I did it and in fact um I ... probably continue to do it um I was kind of after four months I suggested - well there was a time when the end of the four months was coming up that um I began to worry about the prospect of it ending and me being sort of left to cope on my own and um Josie actually said well if you want to do a few extra sessions or if you want to think about ... on a long term basis and um I kind of thought about it and in the end I decided that what I would like to do would be to continue to see her once a month for a few months and

um then I saw her last um aobut two or three weeks ago, two weeks ago and um since then I have felt pretty dreadful and um I got in touch with her and said you know I can't, once a month is just sort of not enough. I mean I think it probably would be if um my relationships with other people were better but um and that was partly what worried me I thought well I oughtn't to keep seeing her because as long as I've got her I'm not going to do anything about um sorting out relationships with other people. I'm just going to transfer whatever needs I have to somebody um you ... professional capacity but um I actually think that um my needs are so great that they would be far too strenuous for friends. You know there is a lot of stuff that we talked about ...

How did you feel about your therapist?

I liked her a lot. Um I'm really glad I'm seeing a woman and um I don't know, I mean yes it was quite reassuring that she had had psychological problems.

Mary - Pre-therapy Interview -

I'm just going to ask you a few questions about yourself then, about what happened when you went for your initial assessment. Um could you first just tell me about your life?

... how difficult it is ..

Right. It's a bit of a general question at the moment. I can't just tell you about my life, be more specific than that.

Sure. Well I mean if you were to think about it, how would you begin to approach that, if you made an attempt to answer it?

Um I thought you were going to ask me more general or specific questions about something, not to talk about myself particularly. You want me to talk about -

Just about yourself. Just tell me about yourself first so we get some feel about who you are. I mean you've obviously been assessed at the ... and you've been through this.

Ja.

That um I will ask you these questions and I will ask a kind of similar questions after your therapy to see how, what's happened and how you look at it ...

Oh right. Um well I'm, I'm a dietician at . Hospital. That's my job, that's one way of defining my life but just at the moment I'm suffering from anxiety problems in certain areas of my life and that's why I've been referred to the Cassel. ... I was

having slight problems with my life at the moment with being over-anxious about things.

Mmhm. What about if you were to talk about your childhood. What would strike you about your childhood, for instance?

Well lots, lots of things. Um sorry I find it quite difficult to suddenly be asked to talk about my life and my childhood. There's lots of things about my childhood that -
Mmhm.

- strike me. I mean I was an only child brought up by a single parent. Er my mother died a few years ago. Those were important issues in my childhood.

OK. Mmm. Er what about your working life?

That's OK. I mean my working life's fine. Um I enjoy what I do, I work quite a lot with a different range of patients. It's quite a demanding job but again that's one of the areas that's been putting some strain on me recently it's been the responsibility I've been taking for certain areas at work. It's been quite stressful.

Mmhm.

But no I mean the work's fine. I enjoy that very much.

What about your social life?

That's good as well. Um I've got quite a few friends locally, long-standing friends. Um I've just split up from my boyfriend

after two years back in um end of April we split. That was my decision and I feel that's you know, that's for the best. And my social life didn't suffer greatly since then. Um I'm quite happy with my social life.

So how long was the relationship?

Two years.

Mmhm.

What about sex?

What about?

What about your sex life? I guess er just split up with your boyfriend, what was it like beforehand?

Oh that was difficult. There were a few problems there. I think that that was ... I mean our relationship was basically wrong really. I didn't feel too happy about it.

Mmm. OK. I would like to ask you a little more about your relationships, the nature of your relationships a little bit more. If you could tell me a bit more in depth about the kinds of relationships that you had or have or tend to form?

Do you mean with members of the opposite sex or generally?

Well, generally.

Um I did form quite close friendships really. I've got quite a few close friends in the sense that I feel quite close to them

but probably don't talk about a lot of things to them that really affect me. Um I've had a few long standing relationships with boyfriends, this is about my third long-standing relationship over the last eight years, maybe. They've all been quite happy relationships I think except that the last one just didn't work out at the end really. The one before that didn't work out at the end but that was a ... relationship. We were quite close. Certainly friends, I mean I've stayed friends as well with the last two men I've had relationships with as well.

What about working relationships?

That's good. I get on well with people I work with, yes. Um I've worked with quite a few of the doctors here as well and on the whole the working relationships are good. There is one consultant that I don't get on very well with though but um I'm managing to cope with that all right.

What about, could you tell me a bit about the difficulties that led you to coming to therapy?

Right well, and I'm surfe they're connected to, partly to problems that you kow I have had over the last few years, family circumstances and things but it's really the last six months that um I've just been, um I've been feeling much more anxious than usual about things like my work and my house and that sort of thing. And my grandmother's health, that was the ... I was getting really worried about her all the time, irrationally so, I felt. I mean that was the reasons that made me, made me want to have therapy, was that it was just becoming difficult to manage,

to cope with those sorts of worries.

Mmm. How was the decision reached that you were coming to therapy?

First of all I discussed it with a friend, who's a um psychiatrist, well a registrar in psychiatry. We discussed it and he felt it would be appropriate. I then talked to my GP and he felt it would be appropriate too. And I was quite motivated myself to do that.

Mmm. When you talked about it with your GP what was his attitude?

He was very receptive to it. I mean first of all I think he tried to look for a physical cause why I was feeling anxious. He gave me a thyroid test and things like this. But we talked a bit more bout the nature of what I was feeling and he knew my history anyway. And I told him that I'd discussed it with a friend who is a psychiatrist and he thought that that was quite reasonable he was very willing to refer me.

Mmhm. Was the diagnostic interview you had with Dr. [redacted] what you expected?

No. No, not at all. I don't mean ... what I expected. I tried not to have any preconceived ideas about it. Um but I find it very difficult to talk about something to somebody I don't know. It's like talking to you now, it's a bit difficult to come out with questions like "Tell me about your life" or things like that. It's very difficult to answer if you don't know somebody you can't do it. Well I can't do it. And I found it difficult

with Dr. K at first to um to actually start talking about things with him. Um it was a strange sort of relationship, not one that I've had with anybody else in the sense of talking to somebody you don't know. But I expected in a way to be told more, to be given more feedback as to what was the problem and what I could do meanwhile to try and help the symptoms. But it was quite useful to talk about things.

Um do you wish you had talked about other things at the interview than you did? Or other things as well?

Yes. I think so. I think we concentrated on things in some places that I didn't feel were that much worrying me. Like for example we did concentrate a lot, just like you've been asking me, a lot about relationships. Now I don't feel that I'm unduly worried about my relationships. They don't seem to be the issue. I'm talking about my relationships with men actually. Or even relationships with friends. They're not really something that particularly worries me, that I'm aware of anyway. And um that was one area that we concentrated on a lot. I found it very difficult to talk to him about, in that initial interview about my mother's death. And I couldn't talk about really. I mean I think obviously we need to talk about it but maybe the first session, the first one I met him was inappropriate to talk really.

Mmm. But you wish you had talked about - what else?

Um well I wish in a way I'd got more sort of feedback from him.

He doesn't ... to say very much in return. He suggested a few ideas which did make sense to me and seemed with explanations. But maybe if we'd talked more about my father it would have been useful. And my relationships with my grandmother, we didn't really talk about that. Also we didn't really talk about the nature of my anxieties, even though I had written that all down in our initial form for him. We didn't discuss that much.

Nature of what, sorry?

The anxiety that I had been feeling.

Mmm. And we didn't talk about that hardly at all.

When you say the nature of the anxiety, what do you mean?

I mean we didn't discuss what situations provoked that, or how I coped with it or how I could cope.

OK.

Do you feel you were understood?

Mmm. Maybe to some extent there was some ... in some of the things that he said that I felt were insight into me. Um but some of the things not, no. Sort of, I remember he did say a comment about me being angry about my relationship or angry with my last boyfriend, I must have felt very angry. And I certainly didn't feel that angry. And there are just a few sort of instances of things he said that I didn't think I felt emotions that I didn't really relate to in feeling.

Mmhm.

There were a couple of things like that.

Now that you've got this far, what are your expectations of therapy?

Well I expect really to be made to feel, to be a bit better or to be able to feel a bit better.

Mmm.

About in terms of anxiety and things like that. But also I think it would make me feel better to talk about things that I find trouble talking about. I'm sure we'll get on to that and talk about that during the course of therapy as well. And there are quite a few things that I feel I need to talk about more, that I haven't done so yet.

What are they?

Things like my mother's death that I found that I couldn't talk with anyone about.

... feel it's important now to actually begin to -

Mmm. I feel that I now know him better or know that I'm used to the situation it will be easier to talk about it but trying to talk about it straight off at the first interview to me didn't feel right.

Mmm. Are there any external circumstances that you see as helping or hindering your attempts to deal with your dificulties

better in the future?

External circumstances. You mean beyond my, my control?

Er in terms of you know like, like generally in terms of the way your life ... in terms of work, or housing or ... or I don't know it could be anything like that... practical perhaps.

Money and housing and jobs and things like that are OK. The only thing I can think of is that you know if something does happen to my grandmother that's going to affect me quite a lot I think.

Mmm.

That's going to affect my ability to cope.

Yes.

I'm obviously quite, very worried about her.

Mmm.

So if she does actually become ill or die then it would be difficult -

She really is the only kind of -

Yeh. Well no there are two. There's my uncle as well but she's my main, my main family member, yeh.

Are there external circumstances that you would want to change?

No.

Are there any options available to you in your life at the moment

that you could actually, that might, that you might choose, something that you might consider doing differently or, are there, how do you see the options ahead of you right now?

Mmm well I don't want to make any moves, changes at the moment to my life at the moment. And I'm quite conscious of that but I'm not, well I've had quite a few changes along the way in terms of jobs really. I mean I've progressed to where I am now quite quickly, by changing jobs quite quickly and maybe I wasn't quite ready for the job when I first started it. I wasn't quite experienced enough for it. So I have found it quite sort of stressful in a way coming through my jobs ...I'm quite happy to stay where I am in my job for a while. I'm quite keen on my job. Um housing. I've got a house that I'm very fond of so I don't particularly want to move. I mean the only area of my life I see changing I suppose is again you know back to my relationships. I should think that I'll experience a few more different relationships over the next few months, few years. And that will be a major change in my life. Or maybe I'll meet the person that you know I'm going to have a more serious relationship with?

Would you want to?

Yes. I don't feel that I'm too young at the moment. Um I think it would take a long time before I would feel ready to commit myself. Yes but that would be ... related to, yes.

OK. Fine. That's all for now.

Right.

Mary - Post-Therapy Interview

Do you feel that your way of looking at your life has changed as a result of therapy?

Mmm, yes. Not as much as I thought it would but it has to some extent, yes.

How?

I think I think back about the way I react to certain things and also I look back over things that have happened in my past a bit more than I ever did. ... a way of thinking about your life, yes, I also talk a lot more about the way things that have happened in the past have affected me.

What kinds of things?

Well mainly my mother's death really and how much that affected me. And I've certainly never discussed that with my friends before. So I do discuss it with people a bit more now. Um the members of my family -

Mmhm.

I think I'm aware a bit more of how much stress that put on me and I'm slightly more aware of certain ways that I, I interract with other people in working situations and that sort of thing.

Mmm. In, what about in social situations and sort of in closer relationships. Would that be true too?

Social situations weren't one of my worries. I mean I didn't have a problem I didn't feel with the social situation. But I think that one of the ways that I have changed in social situations is that I talk about myself a lot more and relate to people. I mean people have said to me since that I've started to come, talk about things that they would never discuss with me more than I used to, certainly than I used to. But actual social situations themselves weren't really a problem before.

I can't remember whether you had a boyfriend or not or whether -

Um before I started my therapy I'd just finished with my boyfriend after two and a half years and ... am having a relationship now but its quite a recent relationship and I think I probably think a bit more about my behaviour in a relationship or certainly share more about me than I used to.

Mmhm.

But I mean it's too - I mean I'm not having a close relationship particularly at the moment so -

Mmhm. In general how do you see your relationships now?

Well they're different relationships than before, well certainly my, that sort of rela- my freindship relationships I think would be ... see them a lot differently.

Mmm. I think you mentioned a relationship with your grandmother, was it?

Yes that's right. That relationship. That mmm, I'm maybe not as

much concerned about her. I mean that was one of my main problems was that I thought I was far too anxious about her well-being, her health. Um that particular relationship maybe is slightly, slightly better, slightly less anxious about her but still there is that problem there that I am still quite anxious about her.

Mmhm.

But some things in the therapy have helped, helped me to deal with that, yeh.

Mmhm.

Some of the things that we discussed, my ways of seeing her and my ways of seing her, how she sees me have changed slightly.

Could you be more specific?

Um without going into sort of precise details of what discussed

causing her harm and that's slightly better but that's still present ... Certainly not recovered from that yet.

Yes. What about your, your attitude towards sexuality? I remember we talked about that a little bit in the first meeting we had.

Yes. I can't remember what, what we said or what I said.

But how do you feel about it now?

Um it's still not something that I would discuss probably with

you and sort of my sexuality I find difficult to discuss with somebody I don't know but um no, it's not, certainly is not a problem with my sexuality with this new partner anyway at all. So no, I don't think that's a problem.

Yes I remember you telling me about having some kind of, some kind of difficulties in the past of some kind.

Mmm. The previous boyfriend, the one that I'd split with before, there were difficulties in all sorts of areas of our relationsip really. I mean I don't know whether that as a cause or a result but I'm not having any problems at the moment really.

If you think back on the difficulties that you brought to therapy -

Mmm.

How are you now coping with these difficulties as opposed to before?

I think I try and relax. One of the things that I really notice is how, how stressed I was by things, the pressures of work. Um I stil find some problems, well a lot of problems coping with the pressures of work but I try and make myself relax and also I try and talk to my colleagues a lot more about what I'm doing so that they're being supportive. And as far as my grandmother is concerned - worries about her and her health - I try and relax about that and try not to get too uptight about ... her.

Mmm., You say try. Does that mean that you are actually making a conscious effort or it actually does not feel as stressful?

No I have to make a conscious effort still.

Right. Right let's talk a little but about your therapy and your therapist now. How did you feel about your therapy and your therapist?

I was, I was a bit disappointed that I mean it seemed to go so quickly, the therapy. I didn't feel it was long enough and I wanted quite srongly to continue and I wanted if not to continue with ... to continue somewhere else. So I felt quite unhappy about that at the end. Um I'm , I found Dr., I'm sure Dr. ... was a good therapist and I did you know enjoy having - certain aspects of the various situations - I certainly felt ... interested in the therapy. I'm sure if you... listened to the tapes from the sessions - do you get access to those?

I will yes.

Because um I used to be quite angry about lots of things ... the sessions finishing on time. I always felt I wanted to go on longer. And also this course of the sessions finishing after I think it was 12 sessions. I mean I felt I wanted to go on a bit longer. So I was a bit disappointed, I didn't feel that I'd changed as I was going through the therapy sessions particularly. I didn't feel I was getting any better and during the middle of the sessions I think I was the worst, I felt the worst about things that I've ever felt really.

Mmm.

And I kept feeling I want to be here, I want more help and more guidance and more treatment.

Mmm. How did you feel about Dr. K , your therapist?

I found it a very difficult relationship - I'd never had a relationship like that with anybody before in that he, obviously it was one way completely. And he would I mean there was no sort of interraction there about - if I ever asked him what he thought he wouldn't say or anything like that. It was like an unusual relationship for me. Or I said to him you know I want some guidance or some help and he would never, I found that very frustrating. So I felt quite angry and frustrated by him but um I felt that he, he cared what happened to me. I felt that he was interested in what happened to me. And I thought he was very strong as well in that he wouldn't bow down to any sort of pressure from me in trying to change appointment times or trying to get him to refer me on and he seemed to be like completely single minded about what he wanted. So that I had to trust him in what he was doing.

Mmm. What happened in the sessions?

We just talked about, usually I mean I'd start talking about my symptoms and how they were affecting my life, how they had affected me in the past week and then we'd talk about something that had come out of that and he'd say well do you, have you thought about it this way? And he didn't put, didn't give me any sort of interpretations as to what he thought was going on. Um but he would say have you thought about it like this? Or do you

think it could be like this? Um and we discussed that for a while and I'd -

Mmm. go on.

Usually I'd be quite defensive and I'd say no I don't agree, it's not like that at all. I mean I changed slightly. Along the way I started to think more about things maybe they could be like. You know I was a bit more open minded about that.

Mmhm. Were you able to talk or did you feel you were stopped or interrupted or prevented from talking or did you feel free to talk?

Oh no. Quite free to talk and sometimes there'd be awkward silences really because I couldn't think of anything to say.

Did you ever feel that your therapist was uncomfortable?

No.

Or that you had to worry about the way he felt?

No.

Is there anything else that you would like to say about that experience of being with Dr. Healey during those 12 sessions that could be of importance in terms of your experience of it?

Mmm I think before you start the therapy you need to have more of an idea what to expect from it because it took me at least half the sessions before I could really realise what was going to go

on, that he wasn't going to tell me the answers to all these problems and I think you need a bit more guidance about the outcome - what you realisticaly expect and -

What did you expect?

Well I expected to be better really by the end of it. I expected not to feel like that, I expected to have some technique for every time I felt panicky or anxious about my patients or about my family to be able to cope with or or just really not to feel those anxieties, irrational anxieties, that was what was worrying me. Worried about patients who really couldn't get that ill and I expected to be better and I'm certainly not better.

Mmm. So you feel in some ways you're not better although we talked about, hou said earlier on that you actually look at things differently.

I do, yes, but I still get the same symptoms.

Mmm. mmm.

Um maybe I can have a bit more insight into it but my symptoms haven't gone.

Mmhm. Were there developments or patterns in the therapy that you had not expected?

Um well the whole thing wasn't how I'd expected it really. It was all completely alien to me really. Um I found it difficult.

Which bit was most difficult?

Um I think there were lots of painful bits like talking about my mother's death was really painful and talking about how I felt about my grandmother and her living or dying was really painful. Those things were difficult. The other bits that were difficult was that if I'd had a particulalry bad week, having really bad anxieties would be actually telling him about what I'd felt, what I'd been worried about, what I'd thought would happen to the patients and that sort of thing. That would be really difficult.

Mmm. So in some .. you had not expected it to be quite so painful?

No I expected it to be painful but -

Mmm.

But ... difficult part. I think I almost expected it to be more painful.

Mmhm. Were there things that you wish you had been able to explore but couldn't? Areas ..

Seemed to touch on a lot of things like um how I actually felt on the day that my mother died and things like that and what about my father and my relationships. Loads of things like that that we touched upon and discussed and it started to make me think about them um but we didn't really have time to discuss them for very long. There seemed to be a lot of different threads that weren't, weren't linking up really.

Mmm. Mmm. Anything else that you can think of that you wanted to talk about?

There was nothing that I wanted to talk about that I didn't ever mention or we didn't ever discuss.

I mean you mentioned some of these things that you found frustrating but could you say again in brief what was frustrating or annoying about the therapy?

The time, I mean the fact that it had to finish exactly at 20 past and also the fact that it had to finish exactly after 12 sessions. I mean I had to miss a session because my grandmother - I had to go to Cornwall - and there was no chance to make up that session. I felt that that was really inflexible actually. Just because I mean I work in a slightly more flexible way with patients. If they can't make an appointment I'll try and rearrange it for them. I just thought it was, you know I did get quite angry about the inflexibility of things there. Um and also the fact that it was so short, the therapy and also the fact that Dr. Healey wouldn't refer me to see anybody else to continue with it I felt quite angry about really.

Do you feel you were understood?

Um I think he empathised with me or - yeh I think that's probably there but um he certainly didn't let me know that he understood. I mean maybe but I didn't get any feedback from that he did understand.

Mmm. In very general terms how would you describe the quality of

your life now?

Mmm. Oh dear, yeh. Mmm I don't know, I think maybe less unhappy than I was but um I am still quite worried that this anxiety is going to stay with me long term so probably quite depressed about that. Quality of life - I don't know. I don't think it's changed dramatically.

Mmm. How do you feel about the future?

Mmm. Have to be optimistic I suppose (laughing). Um -

Sorry? Have to be optimistic about it. Um I'm concerned that the future is that I am going to suffer from this problem into the future, yes. Um but I'm optimistic that perhaps I can, can get over it. Maybe it is a short term thing. I don't know. I don't feel, I don't feel too bad about the future. I'm not too worried about it.

Steven - Pre-Therapy - 24th February

Would you tell me about your life?

About my life? Where do I begin? Um I'm a policeman, have been a policeman for the past 30 years. I suppose really that sums up the major part of my life since it's what I've been doing. Married, two children. Is that my life or is that me? I don't know, I'm not sure how to define the question. But no, I'm a police offer and have been a police officer for the past 30 years and enjoyed it for the most part until fairly recently. That's all really. I've always been fairly happy with life, enjoyed it, not much to say about it really.

What about your social life?

That's not too bad. It's like everything else, it has its ups and downs. I'm not, I guess by nature a very social person. I believe something ... by and large but I have a social life. I belong to a number of clubs and .. other people to talk to and chat to and have a couple of drinks with and so yes I'm a reasonable social I would guess.

Well could you tell me a little bit more in depth about your relationships?

Um, do you mean family relationships or relationships outside?

All kinds of relationships.

I would guess that I don't have any strong relationships apart from with my wife and family. I have no relationships outside the family environment. Um one or two friends, possibly one close friend. The closest friend I had died ... years ago I guess. We were neighbours, he was reared in the same sort of area, as families we did things together and so on but he died I guess about 5 years ago ...

Was that .... relationship between you and him or was it you and your wife and him and his wife?

Yes it was that sort of relationship, a family, two families rather, and indeed our children, which coincidentally were the same age. But I would say that he and I were fairly close in that we exchanged confidences and we discussed things together that probably I would be reluctant to discuss with other people now I have nobody like that apart from his wife..... but I can't think of anybody else that I enjoy that same friendship and personal closeness with if you like, but we had a lot in common it's one of those things, but there is nobody else really that I can think of that I am that close to.....

Were you very sad when he dies?

Yes

What about the relationship with your wife could you describe that a little bit?

We've been married some 27, 28 years. We've had our problems my wife and I over the years but of late things seem to have been much better we are a lot closer now than we were say 10 years ago. We had to get married my wife was pregnant when we got married. She is also Norwegian and that led to one or two I would say cultural problems really and I would guess 11 years of our marriage were unhappy but ... children... we stayed together and now I think it's quite good it's quite a good relationship

You mean the strain of the children ....

No many of the problems we had were financial problems and her aspirations shall we say were considerably higher than mine and that led to stress - her belief that I was under performing shall we say in the job that my ambitions.... this led to all sorts of strains - her mother in particular was a very how shall we say socially aware person-

You mean snobbish?

Yes. Yes their standard of living out there it has to be said is much higher than ours here and the fact that she had two brothers and sister who live in very expensive detached houses in a nice part of North Norway compared to our little suburban semi as I said led to all sorts of problems, plus of course the children and the stress involved and plus the fact that I .... away....to make money and as I said this led to financial problems but I think now financially we are reasonably well off we enjoy a

certain.... company her aspirations have I guess changed over the years.....

What about your sexual life over the years?

It's of late - not - I don't know we are talking about a difficult area for me anyway

It's all right I understand

My wife was the first person that I knew sexually and apart from one minor incident three or four years ago has been my only sexual partner. I wouldn't say in truth by my definition anyway my sex life had been totally satisfactory. In truth I don't know how she feels about it because she won't talk about it. She finds sex a matter that is done and not discussed or talked about. In fact one of the problems I guess is the inability on her part to discuss any problems that we may have, she is possibly a little repressed.... I feel that she's maybe a bit repressed but I don't know. I have no criteria on which to base my sexual behaviour upon like other people. I think that there may be more to it than we have together but I have no real way of telling that it had to be said, so yes of late I guess my own sexual, I've not been as interested in the past two or three years as maybe I was before, I suspect that she is but because of my lack of interest she doesn't make an issue of it. Again it's not something that she will talk about, that we can talk about easily together so maybe this is the problem here I don't really know.

That leads us to our next question can you tell me about your difficulties in general terms which led you to seek psychotherapy?

Well in general terms I felt that I had a problems with work. The job gets very stressful at times and I have always been a fairly placid and mild sort of individual, not given to temper or even to getting too excited, always been fairly quiet and relaxed but of late I have tended to over-react to situations and become rather violent and at first I didn't think much of this ... just the work environment .. getting to the situations when violence occurs and becomes in a way part of your life but when it started to occur ... and we had an incident with my son where I over-reacted quite badly and my wife and daughter, who were aware of what happened ... that I was not reacting in a manner which was normal and my wife expressed herself so strongly that she felt that I ought to seek some sort of advice about the situation - um why it would and was affecting our relationship. I tended with her - I've never struck her, I've ... violent ... very very angry and abusive and so on ... and so it was and is affecting my relationships with people I care about and so she suggested that I ought to talk to my doctor about it, which is what I did and he felt that I was suffering from an anxiety state. I had an incident at work where I reacted quite strongly and quite violently and assaulted somebody. This happened twice, the first time I - other people saw it ... the second I was on my own in the police station and someone came in and I was frightened by my own reaction and of course you can't as a policeman go around

hitting people willy-nilly because they say things that you don't like. So quite obviously ... um a problem, the whole situation was getting out of hand. And so as I said I saw my doctor and he said ... go back to work for a while and take some time off and see what happens. He offered tranquillisers and so on, which I rejected because I don't really feel that that's the answer to the problem. ... of course I see people getting involved with this tranquilliser thing and I feel that it's something that I have to resolve in some other way. So any way the situation with my job is that when I'm off work for any length of time we have, the police force have a chief medical officer and .... off work for 6 or 8 weeks ... called up to see him to find out what he problem is ... what is to be done. And so I went to see him and he suggested that I see which is in fact what happened. I saw and things went on from there.

So these are the ways - are there any other ways in which you have tried to cope with your difficulties up till now?

No, no not really. It's just something that I feel I have to - well for a while you don't identify that you have difficulties. I mean now in retrospect I can see looking back over a period of time um but no, I used to drink heavily, possibly at one time but that ... um and I still drink ...I don't drink until I'm drunk anymore. I sleep better when I've had a Scotch or brandy so in a way maybe that was a reaction to it but no, there's no other way that I sought to resolve the problem. I don't know of any other way to resolve the problem in truth. I don't even know, deep down, what the problem is.

Mmm. So it was a doctor's decision that you should seek therapy?

Yes.

What was the doctor's, the chief medical officer's attitude when you came with these kinds of problems?

Um, I suspect he'd met the same kinds of problems before. Um, it's impartial. I mean bearing in mind that the chief medical officer sees ... attends at Scotland Yard must see ... dozen people a day and stress, if indeed my problem is stress, and I suspect it is um is a fairly common thing in the police force. ... all the time in a stressful situation er and so I suspect it was nothing new to him. He was fairly open-minded about it and said you appear to have a problem, you should see Pritchard, he's an expert and take his advice and indeed that's what I've done. I've been back to see him since and he's suggested or ... maybe I ought to consider leaving the police force as an option. It's not something that I'd considered up until then .... my wife live ...

It sounds quite drastic to leave your job?

Um yes, maybe it is but I'm able to leave my job with a pension now. I've been a policeman for just over 30 years. Um I'm 50 now, I can stay on until I'm 55, which is the age that .... Yes it may sound drastic but at the same time I have to think about it some time in the next 5 years and time is ... when it has got

to be a factor. Um I've been off since August, I haven't been to work since August and I don't know how I will react when I go back. Most police officers retire round about 30 or so ... about 30 years' service, which is the stage that I've reached. And I think when he suggested that it's not suggesting something extraordinary or anything, he was suggesting that it might be appropriate to me if I'm having these sort of problems and particularly if these sort of problems are of a work situation rather than a home situation but the stress, anxiety or whatever is induced by work I suppose then it would be reasonable to change the job. I mean it seems logical to me ... reasonable option.

Yes, mhm. I want you to now think back about your interview with Dr [redacted] ...

Yes.

Was the interview what you had expected?

I didn'tO have and don't have any expectations about it. What I know of psychotherapy is the sort of nonsense that one sees on TV and reads about. So by and large I have a fairly open mind about it or I haven't had a preconception of what was involved. I'm not altogether sure but if it offers any solution ...so I didn't have any preconceived notions about Dr. [redacted]. He was just somebody that I went to see because I was advised to go and see him. He was a very sort of sympathetic individual who said he felt that I may need or that psychotherapy may be beneficial to

me and that I ought to consider it and I said Yes, OK.

Mmm. Looking back on the interview, do you wish that you had talked about other things, other things than you did at the interview?

I think, I think no. I think all the things that I mentioned were, were relevant to the problem.

Do you feel you left anything out of any significance?

No, there's nothing I can think of ...

Did you feel you were understood?

Yes, yes. I felt that he, that I explained my situation to him that he followed what I was saying. He made one or two comments which I didn't agree with but I felt by and large that ....

OK. Now that you've got this far, what are your expectations of therapy?

I don't know but I would guess that I'm going to sit down with somebody like yourself and talk about what ails me really and I don't know more about it than that. I have assumed that therapy is a matter of talking out a situation and I don't know whether that is correct or not. That's as much as I understand about it and I don't really believe that there are any solutions really that you can't think. It's a matter of trying to resolve the

problems by discussing them, talking about them. And that's what I understand by therapy.

You don't have any ideas as to where you would want to be at the end of therapy?

At the end of therapy I would want to be a sort of reasonably balanced, I hesitate to use the word sane but um sort of normal human being with no sort of hang-ups, or at least I've got hang-ups but at least to know they are there and to be able to cope with them. Um the problem it seems to me is that I don't know how to cope with me, if you like and the situation. I don't know how to control myself from time to time and I would hope at the end of therapy to have that control, if you like. And although I may be upset or whatever at least then I'm able to um ... in some way and not react in the way that I do. And so yes, I mean, yes, that's how I feel that I would regain if you like, some degree of self control ...

Mmm, mmm. Are there any external circumstances that you see as either helping or hindering your attempts to deal with your difficulties ...

External factors? Um yes. I think anyway. You see I, it's difficult for me to know how some factors in my life are causing problems. Whether they are just there all the time or whether they are some of the things that are affecting me. I do have problems at work. Um with the actual job itself and the way I react to it, ... the police force now, the things that I learned

to do and the standards which I was taught as a young police officer no longer seem to apply and I have a problem relating to the police force as it is now and the way that I have been acting as a police officer for the past year. There are problems within my family and my son which are distressing.

Yes.

Er but whether that has any bearing on the way that I have behaved in the violent situations I don't know.

Mmm. Have you seen that these factors are perhaps things that affect your -

They are, yes they are all factors which it seems to me which are potentially relevant to the situation. Um they are the only ones which at this stage anyway I can see having a bearing on them. There may be other ones but they are the only ones at the moment which would seem to me to ....

Mmm. Are there circumstances that you would want to change in this -

Again I don't really know how to, what you mean by the question.

Yes I mean it's a bit repeating it but given the two circumstances, would you actually want to change, would you actually somehow want to do something about them? You mentioned that you were considering perhaps leaving the police force?

There's nothing you can do to make your relationship better or the situation better with your son?

No, I want to make the situation better but we don't communicate too well. I would like to change that but I don't know how to. No, I don't know how to.

Mmm, OK.

- Post Therapy Interview with Steven

Now I'm on a two hour meter or ... can we?

I would imagine we would be finished before then. Um, well thanks for coming, thank you very much for helping me. How are you feeling now?

OK, OK.

Do you think the way you're looking at yur life has changed as a result of therapy?

Yes.

How?

Difficult to evaluate and to express um, I'm probably more relaxed about some things. I'm easier about some things than I was before um, easier in some situations. Um, I suppose I look at things differently now from what I did ...

What do you mean, like for instance what?

Well I suppose some relationships, some personal relationships and um, in some instances the way that I approach people and deal with situations.

You talked about your difficult relationship with your son.

Yes.

Has that changed?

Not markedly, no. I don't think that is something which is you

can actually change very much in the short term. ... a long-term situation .. find some common ground if you like.

Mmm. Can you see that happening?

No. I mean there is an immediate problem in that my son is up in Middlesborough at College and I'm down here so there is no communication between us at all.

Yes, yes.

on a personal basis I don't really see that there can be. I'm not a great person for sitting down and writing letters and expressing myself that way and during the course of therapy I tried to do that.

Mmm.

aside ... and try and .. now rather than what's gone before

...at other relationships do you feel have changed or what do you

a difficult one.

Yes, yes, that too has changed. I think we're far more relaxed and more comfortable with each other. There's still problems there, I wouldn't deny that but um I suppose in some ways I'm more ... in attitude now than I did before. My expectations are possibly ... I don't know, but as I said, but certainly we're more confident in each other's company than we were before. So you know, it has changed...

How about sex?

That's hardly changed at all. My sex life is virtually nil. Um that was to me one of the problems and still is one of the problems. And I don't really know how to resolve that within the marriage. The only, you know from my point of view it leaves me in a position where I want to look outside of marriage but I feel that there's a sort of certain betrayal involved in that sort of situation.

Mmm.

That hasn't changed very much. I mean that was how I felt about that before and that's one of the ... I really haven't resolved. I mean I'm doing something which ... and I haven't.

Yes, yes. What options do you see in terms of the future. I mean we talked about the way you see the future with you and your son that you might work on that. What about you and your wife?

I don't, to be honest I don't, in terms of the sexual relationship I don't think there's very much there to work on. in truth. Um, I think if we both sat down and analysed it and talked about there is a sort of certain sort of sexual boredom there for want of a better expression. Um I'm aware of it and I'm sure that she's not really interested for that reason. If you take the sort of sex part of the relationship and put that aside then that seems to be a much easier option then we can communicate like two people who have lived together for the past 27 years. We have different concept of what we want to do and

where we want to go but I'm happy with those and I think she is becoming so as well and in a way it's, it's I suppose and .. relationship. I'm working, she is thinking about going back to work again and doing her own thing. And she's away on holiday this week. ... that's something which she probably wouldn't have done a couple of years ago.

Mmm. I see.

has changed from that point of view. ... and pursue her own interests.

Right. Is this something which you explicitly worked out between you or has it just as it were emerged?

No it's sort of evolved, I suppose. She's encouraged that the situations come up where I've said ... You know it's something that I suppose evolved ... We have never, ever sat down and talked about our relationship. My wife is very uncommunicative. And I find that she can ... talk about sexual aspects ...

Yes.

And it's very difficult to get her to talk about anything.

Mmm.

talking about it. We discussed Terry ... and the thought of that terrifies her. To expose herself and express herself is terrifying to her. I'm sure some of that applies to our relationship too.

Yes.

That she's not happy about talking about her feelings. They're deeply personal to her. And so as I said it's a matter of the relationship changing without talking about it.

I see that ... you weren't very comfortable talking about your relationship either before?

No, I'm still not, but now I make, on occasion anyway I try to make a conscious effort to but I have to say that one of the things that came up in therapy was the fact that I do tend to keep things to myself and that hasn't changed. There have been instances where I have been on the verge of talking about it to somebody else, but it's I mentioned to somebody that I've been .. but I couldn't explain why, I couldn't sort of. I don't know, a block. a barrier that makes it very difficult to express and talk about myself ... and that is still very, very difficult.

Yes, yes. Are there any other things that you see differently. You said you had a different view of your relationships and those were the two I remembered. Are there any others?

Yes. The main reason that I came into therapy was because I tended to lose my temper, get very violent. And indeed some of the people that I worked with an mixed with socially, they tended to upset me and get me very wound up and very angry and I tried not to let that happen ay more and I think I'm succeeding, I think I'm succeeding. It doesn't take into account the situation that I can see happening where it starts to become heated and

emotional then one can I suppose withdraw from it, take two steps back and think about it and about me in relation to what's happened. Um, and so I think my attitude's changed from that point of view. Before I would just be involved in it, I would start shouting and ...

Mmm. So now you step back?

I try to. Not always successfully, I might add but there is a consciousness about it that wasn't there before if you like and you can I suppose in a way analyse what's happening in a situation, what's happening to yourself and as I said try and control it whereas before there was no control there at all.

When you say control, is it a conscious effort or is it, do you feel it?

No, it seems to me anyway, that there's a sort of impersonal aspect to it that wasn't there before. It's difficult to explain but there were some sort of relationships that I had, I suppose social working relationships that I had with people who I didn't like, who I don't like very much, whose attitude I found overbearing and patronizing and so on and that used to grate, used to make me very angry. And now I can identify with it and say well OK this is the way they are. You know, they're not going to change and they're still going to ... but I can because I can see what's happened there and not let it get to me.

Yes, yes.

So I suppose in a way it's a realisation in me about them, what about them affects me, you know ... explaining this properly but there is something about consciousness of what's happening.

Yes. Now .. very important point about the way you're coping with the difficulties you had before. Could you think of other things

you deal with relationships and to deal with this ...

Yes, I mean predominantly they were to do with violence because it was affecting my job and I don't do that job any more ... I can't comment on how ... out of the Police Force.

So you made that a definite decision. I know that was something

Yes I did. So now I'm in strange territory in a way. I'm meeting people and having to cope with these situations which is a little bit unsettling at times and I don't know how that's going to go.

What are you doing?

Well I'm doing several things. Mostly at this given moment in time I'm trying to sell double glazing. I'm trying to sell replacement windows. That's not what I want to do I might add but one has to ... finances and say well this may not be what I want to make a career of but at least it's going to pay the bills in the short term. The other thing that I favour is the installation of burglar alarms and security and so on which I know a great deal about and what I would like to get into is

photography which is something I did over the years, a lecture once a week, talked about it ...

Mmm. Mmm. .. this option your mind you couldn't before. I know you're considering whether you should stay on in the Police Force but -

Um, only in the very vaguest sort of terms. I had felt before I came to the therapy I realised that I'd been 30 years in the Police Force and that some time or other I was going to have to make a break ... what I do when I go and that is still the problem now that I've gone. You know, I'm just exploring avenues really. I hadn't consciously thought about, never ever consciously thought about doing what I'm doing now which is trying to sell replacement windows. I mean that, that was -

You were thinking of retirement?

I, well I've reached 30 years service and 30 years is retirement age. I could go on and do another five years and indeed in some ways I wanted to go on and do another five years both from a financial point of view and because I thought that if I did that

get enought money together to say OK that's life and give it up and ... work. Um it was becoming increasingly apparent that I wasn't going to be able to do that in the state of mind I was in at that time. I was really involved in the situation ... and um, that's a very dangerous situation for a Police Officer to be in.

Mmm, mmm.

something and I came to therapy hoping that I could resolve that.

Mmm.

slight shift of attitude since I've been here.

Yes.

And I decided it would probably be best ... is to leave and look for something else, which is what I've been doing.

Yes. I think ... and the way that you're saying that now it feels a more positive decision to leave rather than an admission of failure. Would that be fair?

Um, I'm not sure about the admission of failure really. It certainly was a positive decision and I -

I just remember the way you were when we first met. ... to leave, it's something you have to do.

Yes, I mean I felt that I was going to, yes, and possibly ... involved in the actual decision itself. I mean the major factor in the decision was first of all that I felt that I should be doing something different, something more positive than just hanging on for the sake of ... The other problem was and is I suppose that I wasn't convinced that I had solved this violence problem.

Mmm.

Um, and I could see no future in the Police Force with that, with

the potential part of my sort of make-up, you know. So when I sort of sat down and talked about it it seemed logical to leave the Police Force. That would no longer be a problem in trying to move towards something different. And I suppose in a way it seemed to be the ... to do. Before I suppose I was so sort of emotionally involved in the Police Force and what I'd been doing that I was reluctant perhaps to cut off.

Yes. How did you feel about the therapy generally?

How did I feel about it? That's, that's difficult. I, in a way sort of enjoyed it.

Mmhm.

Um, it was new to me.

Mhm.

It was quite painful but I suspect in a way sort of cathartic for some of the things I'd hardly ever talked about were a sort of relief to talk about. And so I'm not sure that 'enjoy' is the right word.

Mmm.

I can't think of the right word but I felt it was a positive thing .. I'd feel that perhaps it could have gone on longer. I'm not sure that by the end of, whatever it was, three months, that we'd resolved some of the problems that were still there, that are still there.

Sure.

But it gave me a new perspective certainly.

How do you feel about Mr [redacted] ...

How do I feel about him?

Mmm.

Um, like a friend I suppose really. Um, yes, yes a friend, I mean initially he was just ... that I was talking to.

Mmm.

Um, but I suppose yes I mean if I'd met him on the way here .. you know ... you I felt that there was, certainly on my part anyway, a degree of friendlship ivolved in the relationship and I suspect that to him I'm just another patient, one of many, but to me there's quite a good feeling about it.

Mmm.

What happened in the sessions?
What happened? We talked about me, I cried a little bit sometimes, um and exposed some of my, I don't know, weaknesses you might ... strengths, and we talked about me ...

How did you feel?

Um, it varied from time to time. Sometimes I felt just as I am now, sitting here and chatting and at other times I felt very very sad. Um, never angry, which ... surprise, think that ... but no,

I feel sad and vulnerable.

Mmm.

Were you able to talk or were you stopped or disturbed in any way or did you feel free to talk?

No, no I felt free to talk. I felt that that's why I was there and so yes, I talked. Sometimes it took a bit of digging or probing on his part to get what ... I felt that .. matter of relationship really, ... but no, I felt it was a positive thing.

Mmm. Did you ever feel he was uncomfortable?

No, I never got that impression anway.

Never felt that he was vulnerable and you had to kind of worry aobut his state of mind?

No.

Um, was the therapy work what you had expected?

I had no expectations really. Um one has a vague idea of, one sees films and so on about therapy and there wre occasions when it was, I expected to be asked questions, for there to be a constant dialogue back and forward ... in fact very often there wasn't. There were sort of silences and I suspect, and I know that the silences were as much to evoke response from me as a question.

Mm.

That was unexpected in some ways. I was unaware I suppose of the actual techniques involved in that sort of situation but no, there was nothing there that surprised me.

Nothing that you had not expected?

No, no.

Were there things that you wish you had been able to explore but couldn't?

Yes, I suppose there were. Um it seemed that some of the things that we talked about, we talked about various different ... we covered in great depth, um sexual habits being one -

Yes.

Um, Yes, but there were one or two ... that I wanted to ... but I can't think of specific things about what they were now. After a while the sessions all blend together ... but there were, I know I sort of walked away from and gave some thought to and felt we should have talked about them more. But again, there is I suppose ... the time factor involved. ... really the amount of time necessarily ..

Yes. Um, I mean you mention sexuality as one of the issues you wish you had been able to explore more. Were there other specific issues that came to your mind that you wish ... greater detail?

Yes. Yes there are. Or were. Um, it's a matter of my ability to relate to other people. It's my social problem that I've had,

have over the years that I feel ... prevented me in ... much greater depth.

Yes.

Um, It's difficult to be more speficic about but I have a problem on social occasions ... people ... causes me concern, causes my wife concern ... it's something I would really like to explore and come up with some answers about.

Yes, yes.

Anything else that ... you wish you had been able to explore more fully?

Nothing that comes to mind off the top of my head. ... will probably walk away ... the car for half an hour and think Oh, dear ...

Was there anything that annoyed or frustrated you?

No, I don't think so. Um, no I can't think of any occasion when

Do you think you were understood?

Most of the time, yes. Thre were one or two occasions when I felt that there were aspects of me that were not totally understood and ... that one or two instances in the whole ...

What were they about, do you remember?

One of them related to and touched on it several times, ... my parents and childhood and so on. There are aspects of that which,

perhaps I misunderstood, um but maybe ... I don't know.

To do with your childhood?

Yes, um, parental influences and so on. I mean we talked about the fact that my father was away during the War.

Yes. ... I suppose I was ... a female dominated situation .. and that meant my father came home I felt threatened and ... and I have doubts about that. I'm not sure whether that's true. I have some reservations about the way that was explained to me.

It was explained in terms of ... could you tell me please how it was explained, what do you disagree with?

Well you see I'm not altogether sure that I do disagree with it because it's very diffiuclt to dredge up memories from that far back.

Sure, just impressionistically.

Yes, but the way that Mr. A ... explained it was that there was a sort of feeling of childhood, father comes home from the War and child feeling threatened and so on - and my base was taken over and having to respond in a certain manner or a certain way and that this had affected me now, you know that this conditions the way that I behave, think and act and so on now.

Yes.

And I'm not sure if it's true. I don't know but I'm not sure. I'm unconvinced it's true. Um, but there didn't seem to be

enough time to raise any doubts or questions or to go into that. I talked and he put up a sort of theory, this may be the reason

changed, we were talking about something else. He said, I don't think that I would agree ... with that, with that assessment.

Mmm. Was there something else where you thought you weren't quite understood?

There were other things that we didn't go into very much. Getting back to sexuality for instance that that's not so much a matter of understanding but not having enough time maybe to explore it and to talk about it and to get into it very deeply. I mean there are some aspects of it which ...

Are you suggesting perhaps that he didn't understand how important that aspect was for you?

Possibly, possibly. But again you see given, in a way I can understand because there were more, there were more - I suppose it's to do, I feel it to do with priorities really and the priorities I had when I went into therapy were the violence and depression and that you know and I feel that the therapy um coped with that up to a certain point but there are other aspects of me if you like that it never got into. But again I do appreciate that there's a time span ... and you can't expect within 16 weeks to encompass the whole of one's personality problems.

If you were to start all over again what would the focus be in your mind?

I suppose um, it ... get back to our relationship with other people again, the difficulty I have in relating to large groups of people and ... myself into the difficulty I have um, with women for instance in relation to being able to communicate and so on. I suppose in some ways I had a repressed childhood, that's the way it seems to me. I have this problem in being able to communicate effectively on the personal level.

Mmm.

outside it does and you sit me down in a sort of social situation with an attractive woman I am tongue tied and at a loss - and it's all part of this sexuality thing I would guess but it does cause me concern and if you put me now in the company of 20 total strangers I would be lost. I wouldn't know who to talk to, how to cope with that sort of situation. It's, I don't know it's an aspect of me that is negative and if I went back into therapy I would desparately try and find out what it really ...

Yes, mmm.

In very general terms, how would you describe the ... of your life now?

Um, well it's better. But not noticeably so. In my relationships within my own family are better but I wouldn't say that the quality of my life improved dramatically since therapy.

How do you feel bout the future?

That alternates between optimism and depression. Um, it's difficult to evaluate, I really can't. I'd like to be able to

optimistically say that ... but at the same time there are considerable worries about finance, about what I'm going to do with myself and so on. And yes, it's um, there is a sort of freedom if you like which I suppose ... doing what I've done I can see a freedom out there for me to explore but at the same time it's full of darkness and worry ... make enough money to pay my ...

How do you see your options open to you now?

how I feel now ... but no, I mean at the moment and generally speaking I feel there's an opportunity I ought to be trying to grasp but it's a little bit slippery and I ...

Sure.

But yes, there are within the sort of family context there are sort of things that hold me back. Things, possibly the things that one would really wish to do but by and large I'm my own person ...

Mmm.

It's an opportunity ...

Mmm.

Fine that's all. Thank you very much.

Steven appeared much more relaxed on this occasion in comparison wiht the first occasion, when he was struggling with tears all the time.

Initial Pre-Therapy Interview Conducted With

S

Tell me about your life.

Well I've had quite a difficult life I suppose. Um the major event I think in my life was that um when my +husband and I got married I got pregnant very quickly and I was very pleased and so was my husband. I was 29 then and it came as a great shock to us when #she was born severely spastic. We went through a very traumatic time and I think that it reinforced for me a lot of feelings of failure that I'd had all during my life. This was the sort of culmination that yet again we'd had a terrible failure and it took me a long time and I'm probably still not over it, to come to terms with it.

How old is she?

#She is now 9 years old.

Mmm. What about the rest of your life. I mean that's a life event but what about the rest of your life, other events?

Um, um you want from the very beginning or just -

Whatever you want to tell me.

Um the thing that I think has had a very important influence on my life is the fact that *my mother um is somebody who is very career orientated. From a very small age, about 6 weeks old my *mother went back to work. She had also a lot of family commitments. Her mother was on her own and she was often sick when I was small so my *mother was with us very, very little and um I realised (this is not the first psychotherapy that I'd had) that this led probably to some sort of feelings of guilt that I had and that there was something wrong with me and that my *mother didn't want me or my <sister either. I've got a <sister also who is two years older than I am and she also has very strong feelings of um insecurity, low self-esteem. I think that all during all our lives my parents, both my parents for one reason and another, but I think that perhaps our Jewish background is instrumental in that, have wanted my sister and I to be tremendous achievers and I always felt, although I probably succeeded reasonably well, but whatever I did wasn't enough, that I needed to do better than I had done and that I was always failing at what I did, that I was no good at anything.

Mmm. What did you do, workwise?

Er well when I was 19 I never really questioned it, I think, my **father was a solicitor and my *mother was helping him in the business, my <sister rejected that and did an English degree and I never really questioned it. I'd worked, well played, with my

parents in their office from very small and I always wanted to do legal work. I did a law degree and I really enjoyed it. Um I didn't get into university. I got into polytechnic and I stayed at home for the first two years. The first year I did very well. The second year um the .... I suppose I should have mentioned that from about 15 onwards I've had an eating problem, a serious eating problem. Um at that time I had anorexia. It was never properly treated. My *mother absolutely shied away from any idea of sending me for any sort of psychiatric help. She felt that it was, I think, some sort of failure on her part to bring us up properly and she didn't want any sort of criticism so she wouldn't let me go for any therapy and I was too young to sort of insist on it or to realise the importance. She tried to sort of cure me herself and the result was that I just became addicted to food and I've had this problem really since I was 15 of either over-eating, bingeing, not actually or anything like that but over-eating at various periods or dieting and I never have got a normal eating pattern at all.

Mmm. Were you working before you had the children - you're not working now?

Um I haven't been working but I'm now going to go back to work. Um I er did do very, I did get my law degree and I qualified as a solicitor but I found that well, I did my articles with my parents, although my *mother, I must be honest, advised against it, but um I found it was too difficult perhaps for me to really try very very hard, it was very difficult to get articles and so the opportunity to be articled to my father was just too easy an

option for me and I took that. And yet the experience that I had was very limited and I didn't have a lot of confidence in myself. I did get one job um as a solicitor but it didn't really work out and then I um in this time had met my +husband and he had, we'd acquired a business and I went to help him and then I fell pregnant and that was the beginning of sort of a very, very difficult time for us.

How many children have you got?

We've now got three children um after the #eldest one, that's Katie who was born spastic, was about a year old my +husband had an opportunity to return to the Netherlands where he comes from and we grabbed it with open, well you know we really wanted that a lot. And on my part it was make a new beginning, make a new start, be successful in life, which I felt we hadn't been up until that time, and so we went there and unfortunately of course you take yourself with you and your problems. It doesn't really change anything and during - #my little girl then was taken into what they have there is a rehabilitation hospital and we then said that we wanted to try for more children. And they said that we'd have to have tests to see what had caused her to be so severely handicapped. And then they did tests on her and it reinforced what we had always believed, although in England there was a sort of cover up about it, that it had probably, well that it was due to the hospital.

It was a birth trauma?

Yes, yes it was a birth defect. #She um, she was blue when she was born. She was without oxygen for quite a few minutes. Um anyway so we could have another child. There was absolutely no reason why we shouldn't have any other children. Um it did create a lot of problems for us when I was pregnant the second time because of the way that the first disaster had happened I didn't really believe that the ##second one was going to be normal and I was absolutely terrified all through the pregnancy with whatever I did. If I just put my you know, put my foot outside the door that I would do something and damage the baby. So it was a very, very difficult time for my husband.

For you it sounds?

Yes. After ##she was born, the second child, although we had very, very good help in Holland (she was born in Amsterdam in fact) the paediatrician convinced me, he said that she was quite OK, but he said to me, which was very um clever of him, that I wouldn't believe it until it came to a certain time that she was quite normal and that was partly because with the #first one it was told to us in such a terrible, terrible way that um I, I just didn't believe what my eyes told me because she seemed to be doing similar things to what the first baby had done but in fact it was quite normal. But they told us in a very, in a terrible way in England, to sort of try and make it, to lessen the blow, sort of prepare you by telling you some of sort of sounds, which in fact all babies did but to sort of soften so it wouldn't come as a tremendous shock that she was you know like, well as bad as it could be really and that there wasn't very much hope for it.

So that was very difficult. And the second one, I think she must have been about two or three before I really truly believed that. And um it was difficult also living in a foreign country where I didn't speak the language very well, I couldn't communicate very well and my feelings that I'd had all through my life of insecurity, of people not liking me, these were really reinforced in Holland a lot and I felt very isolated and er we had also moved out of Amsterdam, where my husband's family came from, to live in a small village and that, everything, that made things very, very difficult. And I was very unhappy. And then it was, then the hospital where the #eldest little girl was told us that they couldn't help her anymore and we had to make a decision what to do with her and I had been to visit her with my mother-in-=law and I just, I couldn't bear to put her into one of these homes, it was just so awful and my mother-in-law felt the same way. It was just horrible. So we decided we would have her at home with us. And um then I realised that we were just making too much of ##the second one. She was just made to feel too special, whereas in fact she was just a normal child and it was tremendously harmful for her and she would never lead a normal life. So I discussed it with my husband and as usual, he usually if I want enough he will give into me if he things it will make me happy, so we agreed we'd try for a third child and we did. But hat meant that we couldn't keep Katie at home with us. It was just too difficult. So we tried something that had been suggested to us earlier, which was to find foster parents for her, people who wanted to look after a handicapped child, and we found such people. We had the third child but in fact the foster parents couldn't look after her so then we had to actually make a

decision to put her into a home, which is what happened. And it's a very small home, #she is very happy there so I do feel a lot better about her.

This was already back in England?

No, #she's in a home in the Netherlands.

Right.

Anyway after the ###third little girl was born +my husband and I - we have always had our ups and downs, we come from very different backgrounds and I tend to doubt his feelings, I don't really believe the he, he truly cares for me, I think, deep down inside myself, although I know it's not true but consciously I don't feel it. And um anyway we had a lot of rows, a lot of problems because of the same sort of things that happened with the second child happened in a smaller way with the third child. I got very depressed as well and I just, I couldn't take the shouting anymore that was going on between us and I began to think it was very harmful for the ##second child so I decided to leave my husband with the two children. So we came to England but things were very, very difficult here for me. Um I had to live with my parents. We didn't get on very well. They made me feel obviously like a small child again and I just felt terrible. And in the end +my husband came over on a visit and we had a talk about things and we decided to have another go. And then in '86 ... then we were reconciled, and we went back. I went back and I tried very hard to make a go of it there but I just

couldn't and always the idea was in my head we'll do better in England, we'll be happier in England, I can get a job there. Um and so in the end we had an opportunity to get this flat and my husband agreed that we should come back to live here although it meant that we would have to be apart for a short period of time. So we came over in the January, myself and the two children, he stayed in Holland to pay off our debts and then he has just joined us in September. And that's it really.

What's your relationship like now with your husband?

+Well it's up and down. It's a difficult relationship I think. We do still have a lot of arguments. He's a person who does live a lot on his nerves. He gets very er easily loses his temper um he's had also I think a very difficult childhood and he doesn't really want to talk about it, he doesn't want to analyse his feelings that he had when he was a child. He doesn't really want to understand. he wants to just live now. And I'm just not like that. If something is going wrong I want to understand why it's going wrong, what's led him - if he loses his temper I don't want to think this is just because he's a horrible person, I want to think well there's a reason why he's going to shout at me or shout at the children or something, there's some ... and he absolutely hates that. He doesn't - we have a lot arguments about his work. he doesn't want to talk about his work. As far as he is concerned, when he leaves his work that's it, he doesn't want to go into any details. I'm used to being very, very open about things and discussing things in detail and that - he just doesn't like that at all so that leads to rows. But the basic

relationship that we have is that we do care about one another, we love one another. I think that he's a very good father to his children. He's firm with them but he's not, I mean he's not cruel in any way to them. He really cares a lot about them and as far as the eldest little girl is concerned he has always been very caring. He's never been unkind, sometimes I think husbands are unkind to their wives when they have handicapped children and blame them for it. He never has ever has done that to me. And we have stuck together through all the problems that we've had. I think it puts a terrible pressure on any marriage to have a #child as severely handicapped as that. I mean you just lose your faith and especially when you know that it's absolutely not your fault. That is a very difficult thing.

How is your sex life?

Um well I think when +we first were together our sex life was really very bad. When we first were married I think there was a period of time apart from when we conceived our little girl when we didn't sleep together at all and I felt very shy about things. Over the years because he's very understanding and he knows how I feel I still have somewhat of a reluctance, once we start and I make up my mind that we're going to do it I, I enjoy it although um I don't actually get to an orgasm but I'm getting now up to a period of time and he knows how to arouse me that I'm getting much more satisfied and happy. And I think he, he generally seems to be satisfied. I just think that he would rather have it much more frequently. I mean we tend to do it about once a week and he would probably like to do it sort of, he would probably

like to do it every day. And sometimes I feel that I have to do it. I feel there's pressure on me that I must do it.

Mmm. What about your relationship with your parents?

Well that is a bone of contention between me and my +husband. That he thinks I'm far too um influenced by my *mother still and he doesn't like that. That whatever she says that it guides me or tells me what to do, that I make up my opinions from what she says and that he doesn't like that because he says that I must make up my own opinions and stand on my own two feet. And that I would rather listen to her than I would rather listen to what he has to say. ... sort of problems. **My father is rather a nonentity in this respect. He is a person who sits back. He is not a very um forceful figure and if he had anything to say about anything he would always do it through my mother. We haven't, we've got a very difficult relationship. I don't understand at all what sort of person he is, what makes him tick. When I was a small child I don't think that I felt that he truly loved me and for him everything is measured in terms I think of success, how well you've done. I mean particularly academically. That was for him the most important thing. That was the way he would show that he cared about us that he was proud of us because we had achieved this or that but not because he cared about us just because of the people that we were.

But with your mother - you see a lot of her?

Well when we were in Holland, no, obviously. But now, yes. My

husband is, I think in his way he is trying to lessen it.

Yes.

Um I just speak to *her most days on the phone and I see her - well I haven't seen - when my husband wasn't here then we saw her every weekend more or less. Now it's much less, I mean I haven't seen her for about a month I think.

But you feel fairly close to her?

Er sometimes I do. Sometimes I get very angry with *her and I still feel very resentful about the past.

What about friends?

I've always found it very difficult to make relationships with people. Um but I have got one or two very close friends. I've got one &friend who I've known for about nearly 20 years, yes. We were originally girlfriend and boyfriend. He's a very, very close friend of mine. I feel completely at my ease with him. I can say anything to him, he can say anything to me. We are just, we are very, very close friends and we have a lot of feelings of affection, friendship towards one another.

But tell me something about your difficulties already. How would you say, what was it that prompted you to seek therapy? What difficulties in particular?

I just generally am not satisfied and think that there is still a tremendous room for me to improve myself and I suppose also that I've never come to terms with my eating problem yet. I must try and sort it out.

How have you tried to cope with these problems, all the problems you have told me about, up till now?

Well the emotional problems that I had, um, feelings of insecurity and so on er as I say they came to a real peak at about er just after my youngest little girl was born and I went in Holland at that time to get some sort of therapy because I don't believe in taking tablets or anything like that and I thought it was better to get some sort of help. I was going to see a therapist and then e came to England. Then I was very, very depressed and I was getting very irritable with the children and the baby clinic the paediatrician noticed it and she told me that I must go for some sort of therapy because it would have a very harmful influence on the children. So I went for psychotherapy at that time, which was at a child guidance clinic in Roehampton. And she was very, very good and I think I did come to understand my childhood a lot better. But the eating problems remained and when I went back to Holland it just sort of reverted and the feelings of confidence that I had they sort of gradually seeped away. When I was in Holland I again sought therapy but I don't think that it was psychotherapy. I think it was just some sort of guidance, something like marriage guidance therapy. I didn't find it terribly helpful. It was only once a month for about an hour and um it was, the approach was

completely different. In England when I used to talk to her about things, there were a lot of things that I wanted to get off my chest and each time I would come out and I would feel that I really let a burden, let a burden go. But in Holland I never felt that. We discussed some of the problems. Sometimes he gave me advice but he didn't really want to say anything. Their approach was not at all to analyse your childhood, it was just to try and confront your problems as they were now. And then when I came back to England I again thought that I still had, I still hadn't come to terms with the problems and that i should go further, so that's why I sought some more help. And so I was under a lot of pressure when I came back and I found on some occasions that I absolutely er if the pressure was very great on me then I would just get very angry with my children and once or twice I really hit them and I felt absolutely terrible about it.

Mmm. When you talk about pressure, what do you mean?

Um, too many things to do, um that I've got, that I had the children to look after, that I was um, decided that I wanted to go back to work, that I was doing a course, that I wanted the ch- that I felt torn between um doing what I thought was fair for my children and I wasn't going to sort of short-change them as I felt that I had been when I went out to work and also the desire to not be at home at all day and get bored and frustrated and do something with my life and I just felt sort of torn the two ways. So that was the pressure really.

Mmm. When you made the decision to go back into therapy, was the

doctor involved, your GP?

I was, no I went to see her and I told her about my #eldest little girl and I said that I still had problems with it and she said first of all that I should come and visit her a few times and we would discuss it and she would decide what would be appropriate and then after a few times she said I could still continue to visit her or I could go for psychotherapy so I said that I would like to go for psychotherapy and she then referred me to St. Thomas's.

Mmhm. When you got to St. Thomas's and you got your diagnostic interview, was it what you expected?

No it wasn't at all what I expected. It was very different from anything that I had come across before. I felt that the um consultant, he was much more um critical than I had been used to being. I felt that -

You saw Dr.

No Dr. J I saw. Um I felt um I started crying which I have never never, well I have done it but not in that way because I felt so guilty inside myself. He made me feel as though he had sort of ripped me open and then when I came out then it was quite a long time before um they told me that I was going to be able to start therapy so you were just sort of left dangling there.

Do you wish that you had talked about other things than you did

on hindsight at the finish of the interview?

Er no I don't think so, no.

Do you feel you were understood?

Some of the things he said I think were truthful, other things I think probably I didn't agree with what he said.

Now that you have got this far, what are your expectations of therapy?

Um I just hope that I will be able to have a better feeling about myself, that I'll feel stronger after the therapy, that I can cope with things better, that I don't rush off to the nearest supermarket and get a packet of biscuits or a bar of chocolate or something.

Are there any external circumstances that you see helping or hindering your attempts to deal with your difficulties better in the future?

I'm not quite sure what that question means. I think one of the problems that I'll always have is the fact that um I've made the decision to come back to England. My #little girl remains there and that will always be a source of depression. This week in fact they phoned us and told us that she had been very ill, that she had pneumonia and she had some sort of bedsores and had been taken to hospital and I felt very, very guilty and very depressed

about it because I couldn't go to see her. I knew that she would be terrified on her own and yet I had made the decision to come back for selfish reasons and so I did, I think that will always be very difficult for me now.

yes. Are there any external circumstances that you would want to change? You'd like to live in an ideal situation. I think that I would like to be in a position where we never had any financial problems, where um everything was, you knew that whatever you had done for your children was right but obviously that can't be so.

Do you feel you will be able to do something about these changes you would want?

I hope so. I think if I've got a - if I feel stronger in myself and am able to hold down a job um that should help us to improve our standard of living and that will help the children as well. The price that has to be paid for that is that unfortunately I won't be able to spend as much time as I would like to and the conditions in this country of childcare are very, very poor for mothers and that does make - it's so difficult to know what's the right thing to do to look after them properly.

Yes. What options do you see are open to you right now?

I'm not sure what you mean about that question.

Well options, I mean obviously you see the option that you feel you can go to work and you can go into therapy.

Mmhm.

I mean is the option still of for instance going back to Holland one or you know in terms of what sort of you know how much you feel you can control what's going on in your life.

Oh I see.

Would you change, do you consider leaving your husband again? I mean what, where do you, what options do you feel are open right now? For emotional and practical reasons?

Well the practical options, I don't think I've got a great deal of options at the moment. It's not open for us to go back to Holland. It's not open to me not to go to work because we definitely need the money. I think it's not open to me now to leave my +husband. I wouldn't put my children through that again. And anyway I wouldn't want to because no matter the problems that we have I'd rather be with my husband than I would be away from him. Um I think I haven't got very many options. I have got an option to go to therapy or not, yes. Um it's also up to me to a great extent to see whether that therapy works or not because I'm the person involved but more than that I can't - no, not many options.

Ok. Yes that's all.

Pre-Therapy Interview with ANDREW

I think I mentioned on the telephone, I think it would probably be actually easier if you were actually sitting there rather than er (but of course that's impossible) than having this machine. And then there's the confidentiality of it, this is such a terribly personal and er Dr.. Gavland doesn't take any notes, it's all in his head and er what happens to the tapes at the end of the session?

What happens to the tapes at the end of the session? They will be transcribed. All names, everything, will obviously be removed. And what we are trying to look at, it isn't at you as an individual case, we really look more at given a particular problem, how do you kind of deal with it, you or how does one deal with it, how do people begin to think of their life when they are in therapy in some ways. You know it's just to examine that process.

Mmm. But if you are already a psychoanalyst and you have presumably done your study into it, why is it necessary then to do this?

Well I guess because in brief psychotherapy we can capture some of the things that and then we can kind of carry on developing the techniques must be as it were catch the essence of it. We know things happen but we are not always quite sure why.

Mmm or how.

So in a way it's an attempt to try and capture something.

In other words to go a little bit beyond -

Mmm that's right.

Your studying, your psychotherapy.

Mmm that's right. But you are obviously free not to be part of it it's you know, you don't have to.

I'm split, you know I'm not quite sure how to -

Well I'll tell you what, if I go through these questions and then you can choose obviously - I mean unfortunately if you do want to be part of it I would need to have you know your sessions taped.

Yes of course.

Would need to have that sort of accurate record of what goes on.

Yes.

First of all I would like you to tell me about your life.

Well, I mean t his is - I find that rather difficult as I'm doing that with Dr G. and why is it necessary for me to go into detail on that.

Well I guess because basically if you tell me something today and then I come back when you have finished your therapy so we can see if you look at it differently.

Well we'd be here for the next you know half an hour or hour or so.

Say something.

Would you repeat the question.

Tell me about your life.

Um I am going through it. full stop.

What does that mean?

I'm just getting on with it as best as I can at the moment. I'm not particularly happy um I'm not particularly fulfilled um but I'm, I think I'm at last beginning to learn and understand a little more about how to deal with life, how to deal with living and how to deal with yourself really. And not relying on other people to do it for you.

Mmm.

I think. It's a very difficult question (laughing).

What about your working life? What do you do?

I'm a musician. A free-lance cellist. Um it's very um precarious, I'm never quite sure when work is coming in. It never rains but pours is a marvellous cliche - you're worrying that nothing is coming in and suddenly lots of things come in. So it has a big effect on one's general wellbeing, sometimes it's going well and sometimes it's going badly. Up and down, up and down and I think that reflects on the way you deal with the rest of your life.

Mmm. What about your social life?

Um I'm a little bit of a loner, I don't have a great social life, not really.

Mmm.

I tend to have to work in the evenings so when everybody's working I'm at home and when I'm working people are at home. So it is rather difficult.

What about relationships in terms of kind of closer relationships or intimate relationships?

(Laughs) Um difficult.

Well if to say it's difficult in terms of intimate relationships I would like to know a little bit more about your relationships

in general, about he nature of them, all types of relationships. Do you have a family a ... or any -

Yes I have a family. I'm a little bit confused as to what this is, what's going on here because I'm on a course of psychotherapy with Dr. G. and I'm suddenly thrown into a situation where I'm starting to have to answer questions, detailed questions, but I don't understand to what end.

Well like I was saying, it merely - I will ask you the same questions at the end of it and that will give us some idea about whether you actually look at life differently. I mean often people before they go into therapy they say "Oh everything is miserable, my marriage is rotten, my life is awful and then afterwards when you ask exactly the same question they come up with a completely different way of looking at things. And saying "Well, I didn't realise it then but this is actually what is going on. And actually looking at it like this I realised I had all these options". So things, the way you think about things change and this is only to get us a kind of base line record of the way you look at life and so on at the moment.

Well as far as the therapy is concerned I am thoroughly enjoying it.

Mmm.

I find it very stimulating. I've had three sessions now, three formal sessions um and I am enjoying it very much. I think it's

a great opportunity to talk to someone who is uninvolved in my life. he's got my trust now and this is where the threat of the tape machine has slightly interrupted the flow but I think I probably would get used to that. But I've gone away from what you asked me...

No I was just saying could you tell me about your relationships.

Um I said they were difficult and er - um (long pause) No.

OK um could you tell me about the difficulties that brought you into therapy?

Er I didn't have any difficulties in going into therapy. Someone -

No but there must have been reasons for -

There was a reason. I was very emotionally upset almost a year ago now um and someone suggested that I should seek a psychoanalyst or see a psychoanalyst or psychotherapist. Um I laughed - utterly absurd - no I can sort my problems out myself but I ended up going to my doctor because I was so upset. I suggested that I would like to see a psychotherapist and she put the wheels in motion. But I had to tell her why first of all, she didn't just immediately send me. Um she wanted to know the details because she would have to write a report, which she obviously did, to the Cassell Hospital and then I went last June, I saw a doctor there and then I waited for maybe 5 months before

I went back to see Dr. GP Which was very good actually because it gave a period of time to come back to earth a little bit and to be a little bit more balanced and I think I see the benefit now of the psychotherapy at this stage rather than if I had started immediately in the summer time I think I would have been, I don't think it would have very beneficial at all, whereas now as I say I'm relatively stable emotionally and I can see (cliche) I can see the wood for the trees, I can be responsive and receptive to anything that goes on it in conversation.

Before you sought therapy, how did you try to deal with these difficulties?

Black and white.

What does that mean?

Well it's either one thing or the other. You either do this or that, there's no sort of middle. But I didn't want to do that, I wanted to pursue what I was doing and er I did and er I don't regret it at all. It caused an awful lot of upset but I'm glad I did. And link that up with psychotherapy, why I did it, I think it's very beneficial and I think that's why I'm enjoying the sessions so much.

When you first went to your Doctor to seek psychotherapy, what was her or his attitude to your requesting something like psychotherapy?

She was um, I don't think she was particularly surprised. As I said earlier on she wanted to know why um I thought psychotherapy would be able to help and consequently she asked me to explain the situation and I told her and she readily wrote a report and sent it off to the Cassell.

If you think back on when you first time you saw, whom did you see at the Cassell in June?

Um Dr. [redacted].

Dr. [redacted]. If you think back on that interview, you remember it at all, was it what you had expected?

Well I had two interviews with her. I didn't expect anything really, I didn't expect a magic formula and I didn't know what to expect. I just went. I mean it was not clutching at straws but it was um I felt that I did need someone totally independent. Not a friend, not a doctor, or I wanted somebody who was so um divorced from all of my life and of course someone who was a specialist in psychoanalysis otherwise I wouldn't have gone. I mean I could have relied upon drugs to get me through the bad time but I didn't. My doctor prescribed tranquilisers and anti-depressants but I didn't want them. I didn't take them because I thought that was running away from and masking the problems.

When you went for these two interviews, did you feel relatively able to or free to talk about everything you wanted?

Yes.

And the same with Dr. S[illegible]?

Yes, yes.

Were there things that you wished you had been able to bring into the interview but couldn't?

No.

Do you feel you were understood?

Yes.

Now you've got this far, what are your expectations of therapy?

I don't have um expectations that my therapist will produce a magic formula. I am the only person who can make myself happy. I realise that. My hopes in psychotherapy are that the therapist will be able to sift through a lot of jumbled up wires, perhaps sort them out a little bit and present them to me and say well look, this is what I perceive as your problems, if there are any problems.

Are there any external circumstances in your life at present that are helping or hindering your attempts to deal with your difficulties better in the future?

No not really.

Are there any external circumstances you would want to change in your life?

Um no because I don't think that that's necessarily the answer. I think the answer is now whether you live in a different place, whether you have more money, whether you have this or that, I those are, I begin to see that those are irrelevant and that the famous cliche that the grass is always greener is so true.

But generally do you think that there are options open to you in your life at the moment?

Well of course. There are options but whether I have got the courage or the sense to do those things is a different thing. I mean one's always got options.

Sure but that's the whole point. That's the point I'm trying to get to. Are there options you would feel you have the courage to take at the moment?

No (laughs).

OK.

Appendix 4
Before/Psychotherapy Interview Schedule
and after

INTERVIEW SCHEDULE FOR INTERVIEW TO BE CONDUCTED BEFORE THERAPY COMMENCES

Interview to be initiated by silence after saying hello to allow the patient space to bring in anything he/she might want to at this point in time. In addition the following areas are to be explored as follows:

1. Tell me about your life?

2. From material arising from the above further questions relating to the Self. If not voluntered prompt about working life , social and married life if applicable.

3. Tell me about your relationships. (This area to be explored in some deapth to include as many relationships as possible, primary relationships as well as more peripheral ones and if nothing is voluntered about sex, the topic will be introduced to test out how the subject will respond.)

4. Tell me about your difficulties? How have you tried coped with them up till now? (Paying particular attention to absences, gaps, avoidance and what kind of language and expessions are used).

5. Explore how decision to come into therapy was reached. Was the doctor involved, how was s/he treated by referrer, what was the doctors attitude etc.

6. Was the diagnostic interview what you expected?

7. Do you wish you had talked about other things?

8. Do you feel you were understood?

9. Now that you have got this far what are your expectations of therapy?

10. Are there any external circumstances that you see as helping or hindering your attempts to deal with your difficulties better in the future?

11. Are there external circumstances that you would want to change? If so do you feel you will be able to do something about these.
(Or other relevant question aimed at exploring if the patient feels that he has options available to him, that is how widely he/she is exploring at this point in time).

Appendix 4
Before Psychotherapy Interview Schedule

APPENDIX 2

INTERVIEW SCHEDULE FOR INTERVIEW TO BE CONDUCTED AFTER ENDING OF THERAPY

The interview is aiming to establish how the patient sees his situation now as opposed to prior to getting into therapy. And attempting to explore his/her new old coping mechanisms.

The interview will be initiated by hello followed by silence to allow the patient to take the initiative if he/she so desires.
The following areas will be explores in the following fashion if they do not arise without prompting.

1. Do you feel that your way of looking at your life has changed as a result of therapy? If so how? (It may be useful to remind the patient of what he said in the first interview and ask if his/hers views have changed. For instance, This is what you said in our first interview, how do you see it now).

2. Further questions relating to the self rising out of the answers to the above question. Also included will be questions about work, leisure and social life.

3. How do you now see your relationships? This question will be related to the material collected at the beginning of therapy, the significant. Others mentioned at the first interview will be discussed, sexuality will be discussed if the subject does not bring it up himself (this fact in itself will be noted).

4. How are you now coping with your difficulties? (Further questions in this area will be asked if either the process or content of the answers suggests gaps.)

5. How did you feel about you therapy/therapist. What happened in the sessions? In general how did you feel during the session(s)? Were you able to talk or were you stopped etc. Did you ever feel that your therapist was uncomfortable or that you had to take care of him/her at any time during your therapy? If you did have these feelings what did you do with them? In general, how did you feel during the session(s)? The idea is to explore both the experience of having been in therapy and the relationship with the therapist (the transference).

6. Was your therapy what you had expected. In what ways? Were there developments/patterns that you had not expected.

7. Were there things you wish you had been able to explore but couldn't. Was there anything that annoyed or frustrated you? (Attempt to explore disconfirmed expectations).

8. Do you feel you were understood?

9. In very general terms how would you now describe the quality of your life now?

10. How do you feel about the future?