Introduction to Psychodynamic Psychotherapy Technique

Second edition

Sarah Fels Usher

ROUTLEDGE

Introduction to Psychodynamic Psychotherapy Technique

Introduction to Psychodynamic Psychotherapy Technique is a revised edition of the popular technical guide to the conduct of psychodynamic psychotherapy written by Sarah Fels Usher, published in 1993. In her thoroughly updated book, the author takes the student from the very beginning through to the end of the processes involved in using psychodynamic psychotherapy as a method of understanding and treating patients.

Introduction to Psychodynamic Psychotherapy Technique offers explanations of how psychoanalytic/psychodynamic theory underwrites the technique, and demonstrates how the technique follows from the theory in a clear and accessible style. Each chapter is organized around the psychoanalytic concepts of transference and counter-transference, demonstrating how these concepts bring the work together. New material includes a chapter devoted to working with patients' defences, an in-depth look at the emotions on both sides during termination and a chapter on the experience of supervision, all accompanied by lively clinical examples.

The book is unique in that it is written from the point of view of the student, highlighting the difficulties they may encounter in practice and offering concrete suggestions for technique. *Introduction to Psychodynamic Psychotherapy Technique* will be of interest to psychoanalysts, psychotherapists, psychiatric residents, graduate psychotherapy students and social work students.

Sarah Fels Usher is a psychoanalyst and psychologist in private practice in Toronto. She is the past President of the Toronto Psychoanalytic Society, the Founding Director of the Fundamental Psychoanalytic Perspectives Program and a faculty member of the Toronto Institute of Psychoanalysis. Dr. Usher is also the book editor of the *Canadian Journal of Psychoanalysis* and the author of *What is This Thing Called Love? A Guide to Psychoanalytic Psychotherapy with Couples* (Routledge, 2008).

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For my students who have taught me what it is important to learn

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Preface

This book is addressed to all students and early practitioners of psychodynamically/psychoanalytically oriented psychotherapy, and is offered as a basic theoretical and technical guide to treatment.

When I wrote the first edition of *Introduction to Psychodynamic Psychotherapy Technique* more than 15 years ago, I had just been accepted into analytic training at the Toronto Institute of Psychoanalysis. My then publisher (International Universities Press) told me they were glad I had written the book before becoming an analyst, as they expected that a much wider range of readers would be able to understand it! Since then, there has been a gentle hue and cry for a revision, as the book is being used on several course curricula. I hope that it will still appeal to a variety of therapists and therapists-in-training wanting to learn about the psychodynamic/psychoanalytic approach—those starting out, and those who have been indoctrinated in other methods and are secretly interested in converting.

Rumours that long-term treatment is dead have been greatly exaggerated. The quick-fix therapies that became popular at the end of the last century, in part due to a need for speed and in part to restrictive insurance coverage, may be on the wane, as patients/clients want help that is longer lasting. A recent article by Shedler (2010), who conducted meta-analyses of treatment outcome studies of all forms of therapy, showed that the benefits of psychodynamic psychotherapy not only endure, but increase, with time.

Psychodynamic psychotherapy is based on psychoanalytic concepts and, to some extent, methods. Shedler cites several consistent characteristics that, together, distinguish it from other therapies:

- focus on affect and expression of emotion—the therapist helps the patient put feelings into words, including contradictory or troublesome feelings, which they may not have been aware of;
- identification of recurring themes and patterns—particularly patterns that are painful or self-defeating;
- understanding of the effect of past experience on present problems;
- focus on the therapy relationship—that is, the transference and countertransference.

Having critically surveyed the literature comparing various types of psychotherapy, Shedler concludes:

> [T]he available evidence indicates that effect sizes for psychodynamic therapies are as large as those reported for other treatments that have been actively promoted as "empirically supported" and "evidence based" . . . Finally, it indicates that the benefits of psychodynamic treatment are lasting and not just transitory and appear to extend well beyond symptom remission. For many people, psychodynamic therapy may foster inner resources and capacities that allow richer, freer, and more fulfilling lives.
> (Shedler, 2010, p. 107)

Having said that, however, I am aware that other forms of psychotherapy—such as cognitive behavioural therapy—are sometimes equally or more useful for certain patients and feel more comfortable for some therapists. But even for these therapies, which often utilize core features of psychodynamic treatment—usually unacknowledged—therapists need a grounding in psychodynamic theory and technique. In these situations, this knowledge can provide a valuable base in learning about, and understanding, the therapeutic relationship—whether or not they choose to share this knowledge with their patients during treatment. An either/or way of thinking, or a competitive approach as to which method is better, is a waste of time for everyone. I like to think of it this way: Having an understanding of psychodynamic concepts—such as transference and counter-transference—will never get you into trouble and will be a good base on which to build whatever theoretical approach you may decide eventually to adopt.

The focus of this book is on technique—a kind of "how to"—but the technique is, of course, underwritten with theory, which will be explained here. Hopefully the eager student will go on to read more of the psychodynamic/psychoanalytic literature to get a better idea of the "why."

It is generally accepted that both in psychoanalysis and psychodynamic psychotherapy, the relationship between the clinical data and theoretical propositions or concepts is extremely important and highly complex (Bibring, 1968). Such theoretical knowledge is an integral part of one's training as a therapist: It feeds that part of you that can intellectualize and hypothesize about what is going on with your patient during the session, and when you think about them afterwards. It is this knowledge of theory *and* technique that separates you from untrained "counsellors" of every sort, well-meaning friends and relatives—or your patient's lover. Your theoretical knowledge can sometimes be shared, in appropriate doses and at appropriate times, with your patient. There are many excellent books on psychoanalytic/psychodynamic theory, and so I will not review here what has been said elsewhere. I particularly recommend Sandler, Dare, and Holder (1973), Greenson (1967), and Chapters 1 and 2 of Gabbard (1990). Eagle (1984) offers an excellent

overview of developments in psychoanalytic theory, including object relations theory and self psychology, as do Greenberg and Mitchell (1983) in their book *Object Relations in Psychoanalytic Theory*. Of course, Freud himself is always a pleasure to read, particularly when he focuses on technique (see Bibliography). Keep in mind that he was writing 100 years ago. This is an invaluable way of starting to understand the thinking that spawned the theory that is still very much alive today.

As you can tell from this partial reading list, there are several perspectives within psychodynamic/psychoanalytic theory and treatment, and although some people are adamant that one size does not fit all, the different theoretical approaches are actually not that disparate. Classical psychoanalytic theory, advanced by Freud, was the beginning. Freud introduced us to the concept of the unconscious, explaining that an understanding of drives and defences, and conflicts and the resultant compromise formations (symptoms), will help us to understand the functioning of each individual. Object relations theorists followed, including Margaret Mahler and Melanie Klein, who worked with children, and Fairbairn, who first formulated the idea that our basic drive is to seek relationships with people, not the satisfaction of biological drives. This opened the way for self psychology and relational psychology, both focusing on the person in relation to others. (For a fuller description of these theories, see, for example, Bacal and Newman, 1990.) If the reader is interested in placing the development of psychoanalytic theories into an historical context, one has only to consult the chart, published as *One Hundred Years of Psychoanalysis: A timeline, 1900–2000* (Young-Bruehl and Dunbar, 2009).

Much of the contents of this book are taken from my experiences in supervising doctoral interns in psychology and students (professionals) of an advanced psychoanalytic psychotherapy program at the Toronto Psychoanalytic Society. A long time ago, when I was on staff at a teaching hospital in Toronto, I used to listen to every session of every supervisee on tape (remember tape recorders?). I would make notes on their interventions, and on the flow and climate of the sessions. Then the quivering supervisee would have the opportunity of hearing my impressions; we could discuss our ideas and hopefully some of the counter-transferential reasons for their comments. Of course, the main difficulty with this method—besides being incredibly cumbersome for both of us—was that the students' anxieties about my listening in sometimes overpowered any productive discussion of their work—as it would, even for a seasoned therapist. Aside from that, though, students maintained that they learned a lot about technique from the exercise of taping their sessions. They always asked important questions during our time together, which I took the liberty of recording, and which contribute to the contents in this book. A discussion of supervision and its possible effects on the student can be found in Chapter 8.

Throughout this book, I will refer to the objects of our therapeutic endeavours as *patients* rather than clients. This is only because I received my

training in a medical (hospital) setting, and the word comes more naturally to me. If the reader is happier with the word *clients*, then please substitute it as you go along. Supervisees are referred to as *students* at times; however, the word is meant to embrace all therapists who are interested in learning about this perspective on treatment.

What Ogden (2004) says about psychoanalysis can also be applied to psychoanalytic psychotherapy, when it goes deep enough: "Psychoanalysis is a lived emotional experience. As such, it cannot be translated, recorded, explained, understood or told in words. It is what it is" (p. 857). I will try to explain here what I can, and I hope that this provides a beginning for further understanding.

Acknowledgements

Between the first edition of this book and now, I received my psychoanalytic training at the Toronto Institute of Psychoanalysis, where my teachers and supervisors effected an invaluable change in my thinking and on my method of practice. The difference in the two editions—besides being a result of any updating in the theory and practice of psychodynamic psychotherapy—is accounted for by this training.

I would also like to thank my supervisees and my patients who, over the years, have taught me how to listen better and understand more deeply.

Of course, I want to thank my husband, Gary, whose patience endured throughout, and whose lowered expectations of me during the months of revision were much appreciated.

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Chapter 1

Understanding the language of psychodynamic psychotherapy

This chapter offers definitions for some of the most frequently used concepts in psychodynamic psychotherapy. Although they may not all be meaningful to you at this point, they are offered at the beginning in an attempt to make the rest of the book more accessible. They can easily be referred back to as needed.

Interwoven into some of the definitions are beginning suggestions for technique; that is, examples of working with the concept in the therapy situation. Sometimes definitions and technique are hard to separate when one tries to explain them. This is particularly true here in the sections on transference and defence.

Psychodynamic

The psychodynamic approach is based on the psychoanalytic thought and theory that began with the writings of Sigmund Freud. Freud got his data from listening to his patients, and used this clinical data to describe the study of neurosis, which was originally believed to be the study of neurotic conflict (Greenson, 1967). In essence, behaviour was viewed as a product of hypothetical mental forces, motives, or impulses and the psychological processes that regulate, inhibit, and channel them. The word *dynamic* implies movement; in psychodynamic therapy, it is taken as a given that there is a fluid movement of these forces—which are often in conflict with each other—and an ebbing and flowing of the strength of the defences that arise to modify them in relation to the outside world.

A summary of the characteristics of psychodynamic therapy is given in the Preface.

As the therapist listens, he or she begins to make connections between the patient's current thoughts and feelings and their past experiences—sometimes very early ones. Some of these experiences have been "forgotten" or repressed, and can only be seen in their current—often disguised or distorted—manifestations, for example, a phobia, or an unusual mannerism, or indeed, the patient's transference reactions, to be discussed later. It is from these

thoughts and feelings that we infer the underlying inner psychological processes.

In both the psychoanalytic and the psychodynamic approaches, the meaning of the patient's symptomatology (e.g., anxiety) is thought about in the context of an overall picture of the person as a dynamic, growing, feeling human being, with conflicts, fears, anxieties, and psychological defences. The patient's ability to form close relationships—both within the family and outside it—his or her character/ego strengths and weaknesses, preference for certain styles of coping, and how these factors shape character, are all part of, and useful in, a psychodynamic approach.

Psychologists who administer and interpret projective tests (e.g., the Rorschach) are accustomed to the detective work of discovering what makes a person tick. It may be helpful for therapists to read psychological reports that focus on unconscious dynamics, and then to watch for them in the therapy situation. Psychodynamic treatment is always informed by an understanding of the relationship the patient develops with the therapist (see the sections on Transference and Working Alliance). To greater or lesser degrees, this relationship becomes the fulcrum for the treatment; in this type of therapy, it should never be ignored.

History

The psychodynamic approach is essentially an historical approach to treatment, meaning that the therapist's comments—observations and interpretations—which help the patient understand their behaviour will, at least in part, be based on the therapist's knowledge of the patient's history (i.e., their early upbringing and family life). As Basch (1980) puts it:

> Throughout our lives we signal implicitly by behaviour, appearance, and attitudes, the hopes, the wishes, and the fears of childhood which we try explicitly to hide from ourselves and from others by assuming so-called adult roles. Our happiness depends to a great extent on how successfully we manage to blend those early needs with the expectations we and others have of us, as adults. A person who becomes a patient in psychotherapy is saying in effect that in some significant way he or she has failed to achieve this goal.
>
> (Basch, 1980, p. 30)

A thorough understanding of the patient's childhood, then, will help the therapist identify important themes in terms of relationships with significant others, attitudes towards school and work, philosophy of life, and so on. Having some knowledge of this is also invaluable in predicting what will happen in the therapy, in terms of the patient's motivation for the work, the resistances that may emerge, and of course in predicting some of the ways

the relationship with the therapist will be played out. Therefore, a more or less structured history (the newer you are at this, the more structured it should probably be) should be obtained as close as possible to the beginning of treatment. A suggested outline for the history taking is given in Chapter 3.

Empathy

> Two words, sympathy and empathy, are commonly used to describe three distinguishable things. These are: 1) an elementary, involuntary capacity which puts us in touch with the emotional state of another; 2) the use of "trial identification" to discover, consciously or unconsciously, the emotional state of another; 3) the affect of compassion.
>
> (Black, 2004, p. 579)

Black states that because these three usages have not been sorted out, and because the word *sympathy* has been disparaged in psychoanalysis and psychodynamic therapy, the term *empathy* has been overused. If a psychoanalyst uses the word sympathy inadvertently, he or she often corrects it and says "empathy" instead. Empathy is a word we use with pride. We feel that by empathy we make a trial identification with our patient, without losing our secure stance in ourselves, and as a result of this, we may make the assumption that our interpretations relate to our patient's internal state.

At the conclusion of his article, Black defines sympathy as: "the elemental and involuntary capacity that makes affect [emotional] attunement possible" (p. 592). It also makes possible "the more sophisticated operation of empathy, and the more developed and specific affect of compassion that is often, confusingly, also called sympathy" (p. 593).

The use of empathy is inherent to the conduct of all effective psychotherapy (including therapies that are not psychodynamically oriented). As stated above, it involves feeling the world from the *patient's* point of view, and not according to how the therapist thinks the patient should, or must, be feeling. The definition of empathy from the Oxford English Dictionary is: "the power of entering into the experience of or understanding objects or emotions outside ourselves." Freud (1921) considered empathy an essential part of treatment.

Carl Rogers (1951), in his landmark book, *Client-Centered Therapy*, talked about putting oneself in the client's shoes, and outlined ways of learning empathy—including paraphrasing what the client has said. This method can sometimes be carried too far by beginning therapists, as the patient perceives the greater emphasis to be on reflection and not enough on forward movement. More recently, the psychoanalyst Heinz Kohut (1977), in working with borderline and narcissistic personalities, formalized the concept, refocusing therapists' attention on the central importance of empathy:

> In psychoanalytic therapy empathy is used to describe an intrapsychic process in the therapist by which an understanding of the patient, particularly an emotional understanding, a capacity to feel what the other is feeling, is enhanced. Situated somewhere between listening and interpreting, empathy serves as a precondition for both.
>
> (Berger, 1987, p. 8)

The therapist, then, has to be able somehow to accurately attune to the affect of the patient's experience—to know what it must feel like *for the patient*—by just taking a sample of it. If a patient is sobbing, it doesn't help if the therapist is sobbing, too. But it would help if the therapist can feel the sadness enough to say: "This is a very sad moment/event/memory for you." Having said that, of course there are times when we are genuinely moved and that is fine, as long as it is infrequent; otherwise, the patient begins to feel that they must protect us from sad/scary/angry feelings, or take care of us when they do occur. As an example, I was seeing a 20-year-old woman whose family had to put down a beloved dog. I have heard about many deaths of loved ones over the years, but the death of George, a golden cockapoo, whose antics I had heard a lot about, and whose picture I had seen in various poses, made me incredibly sad. My patient's raw, undefended emotions around her dog's death really got to me and I teared up.

The ability to empathize depends partly on the capacity to identify with others. It is not necessarily a natural talent, although some people do seem to find it easier to accomplish than others. With practice it can be learned, and our capacity for empathy improves with the experience of seeing patients. Not only do patients teach us how to empathize with them, but also they show us the skill of putting ourselves in the background while still remaining exquisitely present.

If you are one of those therapists for whom empathy seems to come relatively easily, it is important to know the limits of your empathic ability and to be able to learn to use it as a therapeutic tool. This means being conscious enough of the process so that you can move in to what the patient is feeling and move out to your more objective knowledge and experience, as is most helpful. It also means being as aware as possible of your own emotional (counter-transference) reactions to your patient, particularly when you may be having difficulty in being empathic, or when you may be getting "too involved." More will be said about counter-transference later in this chapter and throughout the book.

If you are a therapist who has considerable difficulty empathizing, then it is important to search out the categories of patients you have difficulty with, either in your personal therapy or in supervision. For most therapists, or people who want to become therapists, this usually occurs in relation to specific types of patients, for example, narcissistic patients, or patients who do something that is against your values.

Sometimes a beginning therapist can go overboard in trying to reflect a feeling back to a patient in an effort to be *really* empathic. A new intern I was supervising was exploring her young patient's dilemmas about which courses to take for her new career, as she had decided to change plans rather late. The therapist said, in a pained tone of voice: "That must have torn you apart." Her patient said: "No, it actually didn't feel *that* bad." This attempt at empathy was really an empathic failure—because the therapist was not in tune with her patient. Usually people aren't "torn apart" by course decisions as they might be, say, by the break-up of a relationship or the death of a loved one. This therapist needed to learn how to use her own sense of what it might be like for the patient, and also whatever cues she was picking up from the patient, to make a more accurate empathic comment.

Empathic failure is the term used to describe a "miss," when the patient's feelings are not captured accurately. There can be degrees of empathic failure, from very slight to gross, and most therapists—no matter how experienced—have failures from time to time. When this happens, it may be noticeable from your patient's verbal reaction, from a facial expression, or from body language (e.g., the patient may shift away from you). Depending on the patient and the point that has been reached in the therapy, I find it is best to "admit" to these types of failures as soon as you notice them, and to ask the patient for a further clarification of what they meant. It is also important to ask about the patient's reaction to not being understood. Self psychology has taught us that acknowledging and repairing these kinds of failures usually makes the therapy relationship stronger, once it is back on track.

When a therapist has been able to give an accurate, empathic response, the patient will not only agree heartily, but will continue with the theme, sometimes using the therapist's words, giving more examples, and taking the exploration of the material deeper.

Transference

This term has been misused so often, in an almost clichéd manner, that it is important to try to get an understanding of it as early as possible. The concept was first introduced by Freud to describe a phenomenon that develops when a neurotic patient is undergoing psychoanalysis. When he first wrote about transference in the *Studies on Hysteria* (Breuer and Freud, 1893–1895), he referred to it as that part of the therapist–patient relationship where the patient makes a "false connection" onto the analyst. His (1905) broad definition, which is still useful today, reads:

> What are transferences? They are new editions or facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the

> physician . . . Some of these transferences have a content which differs from that of their model in no respect whatever except for the substitution. (Freud, 1905, p. 116)

Freud's advice about how to handle the transference was taken as gospel: 1) Make the transference conscious; 2) demonstrate to the patient that it is an obstacle to the treatment; and 3) attempt, with the patient's help, to trace its origin in the patient's history (Greenson, 1967).

Although Freud describes patients "falling in love" (in Freud's time, this always referred to a female patient with a male therapist), and although some patients do feel as though they are falling in love with their therapist or analyst, the concept of transference is usually used in a much broader sense. The term refers to both conscious and unconscious repetitions of early important relationships and can, and does, occur in any type of psychotherapy—regardless of whether it is recognized or labelled as such. In fact, transference is ubiquitous, and occurs in all of our relationships to some extent: in work, friendships, and most certainly in our choices in romantic relationships (Usher, 2008).

The technique of psychodynamically oriented psychotherapy, or psychoanalytic psychotherapy, then, puts the transference under a magnifying glass, where it can be more clearly seen, analyzed, and explained. In the therapy situation, the transference is understood as the *displacement* (or misplacement) onto the therapist of the patient's at least partly unconscious perceptions of important figures in their past, such as father or mother.

One of the tip-offs that your patient is in the throes of a transference reaction is that the reaction is usually inappropriate. It may be an overreaction to the situation or to you, an under-reaction, a bizarre reaction, or even a total lack of reaction when one would naturally expect one. Ambivalence is also a characteristic of transference reactions, where one aspect or dimension of the feeling (often the negative part) is unconscious (Greenson, 1967). A patient may experience in a therapy session only loving feelings and not angry ones, or vice versa, in an intense and unidimensional manner, even though both feelings are present intrapsychically. Tenacity is, perhaps unfortunately, another characteristic of a transference reaction; it many take many interventions by the therapist—and several observations by the patient—for the reaction to ease up.

For several years I saw in analysis a professional woman, Alice, in her thirties, who was very aggressive and argumentative, and who had difficulty forming relationships both socially and at work. Her main affect was hostility, both with me and in her life outside the analysis. After some time—and some interpretation of the hostility—Alice decided to try getting a cat, hoping she would be able to be kind to it and look after it. All at once, in one session, she turned around to me and asked: "Do you have a cat?" Perhaps because of my surprise at the direct question, or maybe because I was trying to function

as a model for identification, I answered: "Yes." Her next words were: "Really? I thought you were too nasty to have a cat." So, there you go: a mixture of transference (I hope)—her mother was mean and teased her a lot—and also an example of projective identification—where she put into me the bad feelings she had about herself.

A less primitive example can be seen in the case of Betty, a 42-year-old woman, who always came early for our appointments. She was annoyed if I did not come to call her in exactly on time—although she never acknowledged this. Then we changed our morning meeting, by mutual agreement, to a much earlier time and I arrived for our first session five minutes late. She spoke to me in an overly sweet, and definitely condescending, tone: "Would you prefer to meet at our former time instead?" Of course, I commented that she must be quite angry at me, which turned out to be the tip of a very productive iceberg. (I grant here that a therapist's being five minutes late is, in reality, something to be angry about; however, in this case, the feelings seemed unusually intense.) During the session, Betty recalled waiting in the family car as a young child, with her mother and sisters, excited about going out together, while her father—a tyrant who controlled the women and girls of the family with threats of physical violence—stormed around inside the house deciding whether and when to leave. She had spent a lot of time sitting in that car, in the driveway, waiting: frustrated but also frightened. In this way, then, Betty's intense anger at my lateness was fuelled by a displacement from past feelings about her father. In the session Betty, who had been her father's favourite, was finally able to explore her feelings of anger at him for his bullying behaviour. This was complicated by the fact that at the time she entered therapy, her father was suffering from Alzheimer's disease.

To somewhat over-simplify, we can talk about *positive* and *negative* transference. I call this over-simplifying, because we know that a part of the transference that is not being expressed may well be lurking behind what is expressed. The positive transference refers to those feelings of liking, respecting, being sexually attracted to, and even loving the therapist. In a rather interesting statement about how to handle an erotic transference, Freud (1915) wrote:

> It would be easy for me to lay stress on the universally accepted standards of morality and to insist that the analyst must never under any circumstances accept or return the tender feelings that are offered him: that, instead, he must consider that the time has come for him to put before the woman who is in love with him the demands of social morality and the necessity for renunciation, and to succeed in making her give up her desires, and, having surmounted the animal side of herself, go on with the work of analysis.
>
> (Freud, 1915, p. 163)

Unfortunately, he gives no concrete assistance at this point as to the technique for accomplishing this!

For beginning therapists, it is always best to start with a positive transference; that is, the patient consciously wants to be in therapy, seems to connect with you and to look forward to sessions, and that they try their best to do the work. This will minimize overt resistances such as absenteeism or continued lateness (see the section on Working Alliance).

Negative transference, as it has classically been defined, refers to feelings of aggression in the form of anger, dislike, hatred, or contempt for the therapist (Greenson, 1967). As was mentioned earlier, most transference reactions are actually a mixture of erotic feelings, love, anger, and aggression—because the nature of transference is usually ambivalence. It is, in fact, always interesting for the therapist to think about the opposite side of a reaction that is being expressed. In the example of Betty above, the ambivalence could readily be seen when the therapist explored her feelings about the original person—her father—as well as in the therapist's sense of how she was responding to the current situation—the therapy—which, in this case, was overall in a positive and appreciative manner.

Transference reactions are usually fluid throughout the therapy, and sometimes even within a session. It is a mistake to think that because you are a female therapist, for example, your patients' transferences to you will always be maternal, or that you will be seen as a sister or an aunt. The patient's initial response may be gender-linked; however, this will change if the qualities that the patient experiences in you are incompatible with their experience of the parent of that sex. Let us say that you are a female therapist seeing a patient whose father was experienced as empathic and whose mother seemed abusive and uncaring. In this case, it would be preferable for the initial transference to be a paternal one; if not, the therapy may start out with defensiveness and resistance. However because, as stated above, transferences can move around, the therapist can move from "father" to "mother," even during a session. In the case where the father was empathic and the mother not, for example, the therapist can be happily basking in the glow of a father transference, until he or she makes an error in attunement or empathic listening. At this point, he or she may become mother. As the therapist, you must be alert to these possibilities.

Using the same example, it could also happen that the negative (maternal) transference will emerge once the patient feels safer with the therapist. Positive transferences are usually manifested in the beginning, because for most people, they are less threatening and certainly more socially acceptable than negative ones. But keep in mind that if negative feelings are never expressed towards you throughout the therapy, this is not a good sign—even though it may feel great. It implies either that your patient is scared to express these kinds of feelings, or worse, that you are giving off signals that warn your patient that the expression of negative feelings towards you cannot be tolerated.

Baranger and Baranger (2008) have described the "as if" quality of the transference:

> The patient transfers onto the analyst[therapist], sometimes with great intensity, a number of internal . . . figures whose origin is in the patient's history. Transference fear and resentment reach their zenith; however the patient continues to come to sessions and goes on hoping to get help from the analyst . . . In other words, the patient feels and acts *as if* [italics in the original] it were a real situation . . . but keeps the therapeutic relationship uncontaminated by it. If this ambiguity is lost, the analyst is experienced like any other persecutor [lover, etc.].
>
> (2008, p. 799)

The patient's ability to continue coming during stormy times speaks to the quality of the working alliance, to be discussed later.

Sometimes when the transferences stirred up in the session are difficult, or even unbearable, for the patient, they may be re-transferred, as it were, to the patient's life outside the therapy. This is referred to as acting out (meaning outside the therapy office). An example of this might be a patient who, after a bad therapy session, displaces their rage for the therapist onto their partner instead—or even worse, their cat. Or, a patient who is in the throes of an erotic transference may come to their sessions describing a torrid love affair they have just started with someone who really appreciates them and understands their needs. An observation by the therapist that these feelings may stem from the therapy relationship–through either the deprivation of such opportunities, or the provision of temptations that can't be indulged—can help to bring the difficult emotions back into the sessions.

Students are often concerned that making observations to their patients based on transference manifestations may seem egotistical or narcissistic. For example, if a holiday break is approaching and the patient has a difficult history with loss and separation, the therapist might ask: "I wonder what feelings you're having about our not being able to meet for two weeks?" Or when a therapist senses that lateness, silence, or over-concern about appearance may be transference-based, he or she might ask: "Do you think you are having any feelings about *me* that are getting in the way here?"

Beginning therapists may cringe at the thought of putting themselves into the session in this central way. However, as will become clearer throughout this book, as a therapist—even though in many ways you are in the background—you will be important in your patient's life—whether you want to be or not. Since transference manifestations are not *usually* intended for the real person of the therapist, but are projections or displacements, comments or observations by a therapist who is not afraid to throw him- or herself into the mix as a projective object—or even as a real person—are invaluable in helping patients gain insight into their emotions and behaviour.

Most of the information on transference above is given from the older, classical perspective of *one-person* theory. That is, psychoanalytic theories were originally based on the premise that the patient brought their problems to the therapist, who remained, as much as possible, a blank screen, and who carried out the therapy—particularly in the case of psychoanalysis—based largely on what the patient projected onto him or her. More recently, there has been a shift in the basic principles of all the observing "sciences" to incorporate the knowledge that, as we observe, we influence what we are observing. In psychodynamic therapy, our process of observing, our asking questions, our empathy, and even our sitting quietly all influence the patient. After all, there are two human beings present, both products of their family histories, anxieties, preferences, and prejudices. Thus, we are involved in the result: the transference is composed of both the therapist and the patient, and this makes for a *two-person* theory. In the case of the therapist, it may be their counter-transference (to be discussed next)—sometimes unconscious—that influences the patient's transferences.

Proponents of the two-way theory include Owen Renik (1993), who coined the term "the irreducible subjectivity of the analyst," meaning that we can not get rid of our subjectivity in the session. Contemporary relational theorists, such as Lew Aron (1996), talk about the transference as co-created and mutually contributed to. Aron states that transference is not all misplacement from the past, because the patient picks up on the therapist's needs, expectations, and personality, and these may be interwoven into the resultant transference. Additional support for these theorists is seen in the example of a patient's having the experience of seeing more than one therapist; usually the transferences are quite different. Baranger and Baranger (2008), cited above, describe analytic-type therapy as a "bi-personal field" (p. 795).

The discussion continues to this day: What really is getting played out, or acted out, in the transference? Real memories of times with loving or abusive caretakers? Defensively revised editions of the past? Wishful images? Real reactions to the real person of the therapist? What do you think?

Counter-transference

The term counter-transference was first coined by Freud (1910) to describe the feelings generated in the analyst:

> We have become aware of the counter-transference which arises in him [the analyst] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it.
>
> (Freud, 2010, pp. 144–145)

In the beginning, feelings of counter-transference in the therapist/analyst were seen as an obstacle to the treatment—caused in the analyst by the

patient—and something the therapist must rid him- or herself of at once, usually by getting re-analyzed. Freud and his early followers felt that having a reaction to the patient spoke to blind spots—or unresolved conflicts. And if, God forbid, a therapist had a dream about a patient, they were considered almost too deranged for re-analysis; therefore, most early analysts—probably up until the 1960s—did not disclose such matters. But counter-transference has gone, historically, from inciting feelings of horror to welcoming the feelings, emotions, and reactions of the therapist as providing pure gold for the treatment.

It now seems to us mind-boggling that it took almost 50 years for therapists to recognize that counter-transference provides useful information about the patient, and about the process of the therapy, but it finally came in the form of an article by Paula Heimann (1950). She liberated the concept of counter-transference from its negative connotations, and extended it to include all the feelings the therapist experiences during the session—whether stirred up by the patient or not—and placed it in the centre of psychoanalytic therapy technique. It is this meaning of counter-transference that will be emphasized in this book. Heimann, and most writers after her, recommended that the therapist's feelings be sustained, not discharged.

Counter-transference reactions can begin even before a therapist has seen the patient—one can react to the referral source, to the patient's manner on the telephone or in email, or to the patient's coming late or cancelling their first appointment.

Of course, conscious reactions are usually easier for the therapist to handle, as he or she is aware of them. These reactions provide the sort of material we must always be on the lookout for: feeling sleepy, feeling excited, feeling anxious, feeing dumb, feeling brilliant, feeling envious with some patients, or feeling all of those with one patient. Or, it may be that we sense something is bothering us when we are with a certain patient, but find it hard to articulate.

One of my patients, Carol, whom I had seen briefly when she was in high school, had a psychotic depression while away during her first year of university. When she came home, she returned to therapy, and disclosed that her mother was a (secret) alcoholic and got very angry at her for seemingly no reason. This activated my "good-parent-to-the-rescue" counter-transference reaction, which was conscious—or at least most of it was—and I allowed some of it to fuel my desire to help her. Carol became knowledgeable about the medication she was required to take and then began to explore, tentatively and psychodynamically, the reasons for her being unable to cope away from home. Her mother's alcoholism, a secret she bore, was, it turned out, only one of many family secrets she had been carrying with her. Although it was hard not to beam as she started to do better and better, and particularly, as she became more and more psychologically minded (activating my "need-to-teach"), because I was conscious of it, I was able to keep most of it in check.

Carol asked if she could bring her mother to one session, and I agreed. During this session, I watched (again beaming) while Carol explained to her mother, in psychodynamic terms, what had gone wrong for her, and answered her mother's questions in a mature and genuinely caring manner. I said very little. She is now back at university here, but has chosen to live away from home—which has worked out well for the time being.

As was said in the section on transference, the therapist, having his or her own history, usually responds to charm and warmth in patients and feels uncomfortable in the face of overt hostility and aggression (Slavson, 1953). We cannot just hope that these responses won't be triggered by our patients, but only that we will become aware of their possible existence and, for the most part, work them through instead of acting them out.

Positive counter-transference feelings can arise in the therapist from a number of sources, including the patient's representing the therapist's own ego ideal, memories of individuals in the therapist's past, and other soft spots in the therapist, such as those I described above. When a patient works hard in therapy, and seems to be getting better, we feel good; when a patient persists in holding us in a negative transference, we usually feel worse. Negative counter-transference feelings can arise when the patient activates painful memories in the therapist (e.g., of the therapist's own parents or siblings), or even fear—in the case of an aggressive patient. Resistance to treatment, if it persists, can also evoke negative feelings in the therapist. Overly intrusive behaviour on the part of the patient—such as prying into the therapist's personal life, continual criticism of the therapist's manner, clothing, or office—all of these behaviours may stir up negative counter-transference feelings in some therapists. Others may find these behaviours fascinating.

As with transference, counter-transference can be seen as co-created—a product of the interaction of the two subjectivities of the individuals involved.

Of course, where counter-transference becomes a slippery slope is when these reactions remain, for the most part, unconscious. Then they are at risk of being acted out—either with the patient or behind the patient's back, so to speak. The best insurance against this is: 1) your own therapy or psychoanalysis, where you can discuss strong reactions and understand their source; 2) supervision, where you can report on the details of the session, and to some extent, the feelings and fantasies evoked in you (see Chapter 8); 3) talking with experienced colleagues, either in the forum of a study group, where patients are discussed, or in a private consultation.

For most therapists, especially those who want to pursue a psychodynamic or psychoanalytic approach in their work, personal psychotherapy or psychoanalysis is invaluable. This is the best way to learn about your own personality and in so doing, to understand why you are affected in certain ways in the intimate twosome that is psychotherapy. It also gives you insight into what it feels like to sit in the other chair (or lie on the couch): having a break for

your therapist's holidays, feeling upset or angry when leaving a session, and the importance of everything your therapist says. There is a noticeable increase in empathic attunement to, and understanding of, a patient for those therapists who have undergone their own treatment, as well as a growth in their therapeutic effectiveness.

Working alliance

The working alliance, or therapeutic alliance, essentially speaks to the element of partnership in the psychotherapy. Perhaps it is best summed up as: When the work gets tough, the tough *don't* get going. It describes the relatively non-neurotic, rational rapport the patient has with the therapist. I referred to it earlier in the section on transference—it is when the "as if" quality of the therapy is not lost. The working alliance is the manifestation of the patient's capacity to work purposefully in the treatment situation (Greenson, 1967).

Working alliance is distinct from transference and, at the best of times, coexists with the transference, so that it can be clearly identified even when the patient is in the throes of a transference reaction. For example, the patient might be responding to a comment by the therapist as a criticism, but may also be able to say: "I feel criticized by you now, but I know that you don't criticize me—it just feels like when my father used to criticize me." The patient's motivation to overcome problems, along with the sense of helplessness, and a conscious and rational willingness to cooperate, all form part of the working alliance. In psychoanalytic terminology, the actual alliance is seen as being formed between the patient's reasonable ego and the therapist's analyzing ego (Sterba, 1929).

Alice ("cat," see p. 6), who came from a very aggressive family and who had difficulty forming relationships with friends and at work, exhibited negative transference reactions through much of our work together. In one session, as we were discussing her problems with men— in a cautious manner (but not cautious enough)—she became enraged at me, screamed, "I hate you, you Bitch," and stormed out of the session. I was somewhat shaken by this outpouring of aggression directed at me, and wondered what would happen next. Would she telephone to cancel? Would she come late? Would she continue her harangue at me?

The next day she was back, at her appointed time, and although she thought *I* must now hate *her*, was ready to put on her metaphoric rubber boots and wade into the therapy again.

That's a working alliance.

Luborsky (in Claghorn, 1976) outlined two types of working alliance: 1) based on the patient's experiencing the therapist as supportive and helpful with him or her as the recipient; and 2) the alliance based on working together in a joint struggle, with shared responsibility. This alliance, then,

is a part of the "real" relationship, for the most part, and tends to develop as the therapy goes along in a silent, almost imperceptible manner. The formation of such an alliance takes different lengths of time for different patients, and may take 3–6 months to fully develop. Patients who never develop this kind of alliance, who react solely to the therapist in an instinctive, impulsive, intensely emotional and transferential manner at all times will be extremely difficult to treat in psychodynamic therapy.

The formation of a working alliance usually requires that the patient identify with the therapist as the professional helper, at least partially, so that they can think about issues in a similar way. However, some patients may use a strong identification with the therapist, and what knowledge they have of psychology, as a resistance (discussed in a later section) against dealing with more painful and embarrassing material.

Just because your patient nods and smiles frequently, agrees with everything you say, tells you how you have changed their life, and never gets annoyed at you does not mean you have established a working alliance. It may, in fact, be just the opposite. The patient whose main goal is to be a good patient, and to get you to like them, will find it hard to establish a true working alliance, because they fear their real selves will not be acceptable to you.

The therapist plays an important role in the patient's ability to form a working alliance. Winnicott (1958) first introduced the concept of the "holding environment," describing the environment the mother provides for the infant, within which he is contained and experienced. This term is an apt descriptor of the therapy situation: it is the therapist's job to provide for the patient an accepting and safe milieu so that he or she can, for the most part, relinquish the defences needed in the outside world. Greenson (1967) highlights some of the therapist's contribution to this as: their personality or presentation, the privacy of their office and waiting room, their timeliness, their capacity for listening and for empathy, their setting a regular time for the patient, among others. Having a regular weekly or twice weekly time helps the patient to organize their work and home life without having to miss a session, reduces the patient's anxiety, and speaks to a firm commitment on the part of the therapist.

The therapist needs to establish a frame for the therapy, and respect for the alliance, by setting boundaries. Although it is certainly not advisable to interrupt a patient in mid sentence, the therapist should try, as much as possible, to end the session at the planned time. Beginning therapists often feel they are giving their patients something "extra" by going overtime, but it is my experience that patients at best find this confusing in terms of what it means about the therapist's feelings for them, and at worst find it an inconvenience as it may make them late for the rest of their day. If you are late, then try to make up the time by inquiring respectfully whether the patient can stay an extra, for example, five minutes. Do not assume they are only too happy to be able to do this for you. If they cannot stay, then find

another session—preferably the next one—onto which to add the missed time. More will be said about ending sessions in the next chapter and throughout this book.

In order to maintain the frame, the therapist should not answer the telephone during a session unless it is absolutely necessary. If this is the situation, then warn your patient ahead of time that you are expecting an important call and will have to answer. Turning the ringer on your phone or cell phone off completely will screen out this unwanted distraction and helps your patient to see that the whole of your attention is focused on him or her—that this is their time.

Informing your patient of vacation plans well in advance demonstrates to the patient how important you feel this work is, and allows time to open up the possibility for talking about their reaction to being left. It signals an important event: one that may evoke anxiety, rage, envy—or even relief. It is often a time for the patient's tried and true defences to kick in—as it can repeat hurtful abandonment experiences from their past. Even if the break is short, it is important to notice, and even explore, your patient's reaction to it. Some years ago, I was seeing a young woman in analysis whose narcissistic mother gave her very little in the way of basic supplies. She was grateful for the analysis from the start, and became agitated whenever there was going to be a break. In her first year, I had assumed that Good Friday, a statutory holiday, was something everyone naturally expected but, as the week wound down and she became more agitated, I asked her what was happening. She said: "We're coming to a break." I asked: "Which break?" She answered: "Good Friday, of course." And then: "Unless you see patients that day."

This small example can teach us a great deal: Not only did this patient need and value her contact with the analyst, but we see evidence of the partly conscious wish that the therapist will be available for her always, or perhaps that the therapist will make an exception and see only her, or that she could be part of the therapist's "holiday life," or that the therapist will miss her, too. This latter wish was frustrated by my asking "which break." I mentioned also that this was her first year in treatment. In long-term therapy, we have the opportunity of noticing our patients' reactions to holiday breaks at different times during the therapy. For some patients, the first holiday does not evoke much feeling, as they are not completely attached to the therapy and want to believe they can easily do without it; for some, the first break can be catastrophic. As the therapy goes on, how a patient responds to our breaks usually changes, depending on where they are in working through their problems and in the depth of their transference feelings. If a patient has been talking about something they never dared share with anyone, the break will feel different than if they have just worked something through that has always bothered them. If a patient is angry at the therapist, obviously their reaction will be different from a patient who thinks he or she is in love with the therapist. Often a break will give us new information about understanding

the transference. In my experience, patients don't seem to react much if they are leaving us; only if we are leaving them.

Being aware of the above points is important in helping your patient to develop an enduring working alliance.

Defences

Fernando (2009) defines defence as "a psychical reaction or process that attempts to keep some mental content—a wish, feeling, judgment, etc.—from conscious awareness and/or behavioural expression" (p. 25). He illustrates the motivations and dynamics of many commonly used defences; for our purposes, we will examine those that you may be able to recognize early on in your work.

Resistance is a general term implying all those forces within your patient that *oppose* the procedures and processes of psychodynamic therapy (Greenson, 1967). Resistance will appear in greater or lesser amounts as the therapy moves along.

In the *Introductory Lectures* (1917), Freud states:

> [S]uch fine weather cannot last forever. One day it clouds over. Difficulties arise in the treatment; the patient declares that nothing more occurs to him. He gives the clearest impression of his interest being no longer in the work and of his cheerfully disregarding the instructions given to him to say everything that comes into his head . . . He is evidently occupied with something, but intends to keep it to himself.
>
> (Freud, 1917, p. 440)

Freud's explanation of this relates to the patient's transference, either positive or negative, that erupts periodically and gets in the way of the smooth progress of the therapy.

Castelnuovo-Tedesco (1991) has stated that fear of change is central to the whole analytically oriented therapeutic endeavour, and that what presents itself clinically as resistance might productively be looked at as an expression, and also as a consequence, of this fear.

Resistance can be seen as the outer level, as it were, of a defence. Fernando (2009) states that as the therapist interprets depth-wise from resistance to defence, and to the inner workings of the defence, it is not that we are moving from the concrete to the abstract, but rather along a chain of inferences, beginning with what is more readily observable (p. 291). Defences manifested and functioning as resistance include: repression, denial, intellectualization, reaction formation, undoing, and identification with the aggressor, to name a few. This is not a complete list, but some familiarity with these should help you to tune into the possibilities you may encounter when working more deeply with your patient. A brief definition of these more commonly used,

often unconscious, defences follows. Working with some of the more easily spotted defence manifestations is highlighted in Chapter 6.

Repression, one of the earliest defences to be identified, involves keeping ideas and feelings that are incompatible with the patient's view of themselves and their actions from entering consciousness—that is, keeping them unconscious. The patient has no access to these unwanted feelings until the therapist catches a glimpse of them and helps the patient, by gradual observation and interpretation, to make them conscious, at a pace that suits the patient.

Denial is another defence that is employed to keep things from awareness. It may be unconscious, but the material is usually closer to the surface than it is in repression, and therefore may be easier for both parties to spot. A male patient I had seen for some time had repeated serious problems with work. He told me often that in his current job he wasn't making the same mistakes as he had in other jobs, and that he felt that his boss really liked him. I was cautiously reassured, until he arrived at his last session before a break, and announced that he had been fired. His defence of denial was directed against the awareness of the reality of his inability to function at work. Using this defence kept this man's self-esteem intact and helped him not to fear, or anxiously anticipate, the eventual humiliation of losing another job. In this case, the defence was not at all adaptive.

Intellectualization is in evidence when the patient stays in his or her head, struggling to analyze or interpret what's happening, instead of feeling it. People who use their brains a lot in their work, such as academics, are more prone to using this defence. Also, if your patient has taken a course in introductory psychology, they may try to stay away from their painful feelings by using (often inappropriate) jargon.

Reaction formation means implying or stating the exact opposite of what one really feels; for example, some patients find themselves being overly friendly with people they don't like. Some patients speak in a soft and sweet voice when they are really enraged.

Undoing means just what it seems to mean. For example, "I hate your haircut—but I guess short haircuts are really in fashion for the summer." We try to take back a statement, or action, or even a thought that seems unacceptable, hoping the other person won't notice and the bad feeling that slipped out will be undone.

Identification with the aggressor comes about when a person identifies (shapes an aspect of themselves) with the person who has harmed them, as a way of feeling powerful. This defence can be used by patients who have been abused, and who then turn to abusing others—not necessarily in exactly the same manner.

As we come to know our patient, we will see that he or she favours certain defences, depending on their character makeup, and it is these defences that will be observable during times of resistance. For example, we expect the

patient who tends to use denial to be particularly cheerful when resisting an exploration in therapy: they had a happy childhood, their parents were marvellous human beings, etc. (No one believes this, not even the patient.) Someone who cannot express their anger directly and uses passive ways to communicate it might come consistently late to sessions, or sit in silence. Someone who has suffered severe trauma may have "forgotten" the details, in a kind of post-trauma amnesia (repression). Someone who is always praising a friend who does better than them may be hiding their envy and hatred with the opposite emotion (reaction formation). "The lady doth protest too much, methinks" (*Hamlet*).

These kinds of behaviours may occur quite naturally throughout the treatment; they are commented on when they are used as an attempt to obstruct the procedures and goals of the therapy. Resistance may be conscious and unconscious, and is usually expressed by emotions, attitudes, and behaviour, and sometimes by a contradiction in emotion versus behaviour. Sometimes transference—even though it is so important to the treatment—can be viewed as a resistance, particularly when it is intensely positive or negative, and won't budge.

Whenever a patient cancels an appointment, or misses a session, the therapist must consider the possibility of the patient's resistance, no matter how valid the excuse seems. Remembering that resistance may be unconscious, that is, that the patient is not aware of it, resistance must be suspected in all of the following examples of instances in which there are "legitimate" reasons for the patient's defensive behaviour: Patients who telephone at the last minute to say that they have been called to an important meeting; patients who take unplanned vacations; patients who continually get themselves into situations where their time is abused by friends or family members and who thereby come late for a session or miss it altogether. Silences, as mentioned earlier, where the patient has "nothing to say," may also signal a defensive process in action. Silences in therapy will be discussed further in Chapter 5.

Focusing on people outside the session that have little or nothing to do with your patient's life (e.g., describing the problems a friend is having with her boyfriend) may also constitute a resistance—unless, of course, the patient is using this indirect way to talk about him- or herself. This kind of flight from the work can often be handled by the therapist's saying, "I'm wondering why you're talking about this right now." This intervention interrupts the flow and prompts your patient to examine his or her own behaviour, and incidentally accomplishes the task of educating them about the way they typically avoid discussing painful material. Acting out outside the therapy (e.g., a love affair, or the precipitation of a crisis that derails the therapy) —as discussed in the section on transference—may indicate an avoidance of intense feelings towards the therapist. Of course, the patient's persistent complaint that there has been no change in those problem areas that brought

him or her into treatment may also signal unconscious resistance, and can be extremely frustrating for both the patient and the therapist.

Donald, who had been very interested in being in analysis, came for therapy after several broken relationships. He started a new relationship shortly after we began our work together. This one he thought had real potential: the new woman was a colleague and "spoke the same language"; particularly, she deeply understood his anxiety about the job. About six weeks into this relationship, she left him a voicemail asking him to attend an event at which her family members would be present. He did not answer that voicemail, or any subsequent voicemails from her. Claiming I had failed in my work with him, he stated that now he had lost the one relationship that could have had a future. When this type of event occurs, it is always helpful to ask ourselves, and indeed, our patient, what purpose not having a relationship serves for them. This provides a very different perspective for most people, as they are forced to think about the defensive—that is, protective—quality of their actions. In this case, after many sessions, we discovered that subtle messages his mother had given him implied he should not have a woman in his life other than her. This describes a very small part of this treatment; my point here is to indicate that if we think of a behaviour as defensive, we can then think about the motive behind the defence—that is, why our patient needs this protection.

Often our patient's affective involvement or lack thereof can be a tip-off to a defence in action. This is mainly when the patient is overly emotional about something under discussion; if there is little or no affect about a topic that has been seen as important; or if the emotion is contradictory or inappropriate to the content of what the patient is saying.

There are, then, at least three important questions to be considered in terms of psychotherapy technique, when we are helping our patients to become more conscious of their defensive manner in the treatment:

1 *Think about the preceding session*, and the content of the ongoing therapy. Is the present difficulty linked to a topic that was broached earlier? Did the patient end the session with a comment such as: "Next time I want to talk about sex." Did he or she disclose material that was painful or embarrassing, the pursuit of which in the following session might have been very difficult? Or, on reflection, do you think that you may not have reacted to what you heard as your patient had hoped, that is to say, was there an empathic failure or a disappointing response to particularly charged material?
2 *Think about the transference*, that is, your patient's reactions to you at this point in the treatment. For example, if your patient keeps coming late to sessions, are they reacting to you as if you are a figure from their past? Or are they trying to tell you that they have feelings about you which are too difficult to discuss? Whatever your gut sense is of the transference

at this time, it can be brought to light with the patient, once the observation that something is not quite right has been accepted?

3 *Think about the defensiveness in the context of the patient's outside life.* Does she or he tend to be resistant in other close relationships: Is it when they are feeling particularly close or warmly towards another? Or when they feel angry? Sexual?

Many beginning therapists feel uncomfortable with the encouragement given by their supervisors to comment on what seems like resistance, as they fear their patient will experience these sorts of comments or interpretations as judgmental or critical. However, the suggestion is not to pounce on the patient with an "Aha! Late again today, eh?" As with all well-timed observations made by a therapist that have been carefully thought through beforehand, interpretations of resistance will be of *help* to the patient, not only in becoming enlightened about their behaviour in psychotherapy, but in gaining insight into behaviour in other life situations as well.

It is a disservice not to inform your patient when behaviour seems to be resistant and getting in the way of the work.

Interpretation

This leads us into the topic of interpretation. We usually don't sit in silence while a patient is resisting treatment, or being defensive, or is in the throes of an intense transference reaction, without commenting on it—unless we feel the patient is too fragile at that moment to permit an observation. Interpretation is an intervention made by the therapist to help the patient clarify and understand the underlying causes of his or her behaviour, thoughts, or emotions. In psychoanalysis, interpretation is usually seen as the therapist's ultimate and decisive instrument or tool; every other utterance, for example, empathic reflection, prepares the patient for an interpretation, or amplifies an interpretation, i.e., hammers it home (this could be a little strong, and may bear some "undoing"). Giving interpretations as a main way of figuring things out distinguishes analysis and analytic psychotherapy from all other therapies.

To interpret in its purest sense means to make an unconscious phenomenon conscious. The interpretation can include the history and source of an event. By interpreting, we go beyond what is readily observable, usually assigning meaning and causality to a psychological phenomenon (Greenson, 1967). An interpretation often requires more than a single mention, and may have to be given several times during the course of treatment to be fully heard, accepted, and worked with by the patient (see above under "hammering home"). We are, overall, searching to make the interpretation felt by the patient as true and meaningful and, even more importantly, to be corrected if our hypotheses are inaccurate.

Laufer (1994), describes the process of formulating an interpretation as a move from truth to experience. The patient and the therapist may have different ways of defining what they are doing; for example, therapists talk:

> [of] "following the patient's anxiety," "addressing the experiential self," "working with the present unconscious," or "addressing the primitive anxieties of the patient"—but what all these appear to me to have in common is the search for a way that approaches the . . . truth through the patient's experience, because we see this as a way of making what we have to say accessible to the patient.
>
> (Laufer, 1994, p. 1093)

Freud first used the word interpretation in connection with the *Interpretation of Dreams* (1900). At this time, interpretation was seen as a one-way process, where the therapist made use of his or her knowledge to help a patient understand what was called the latent—or hidden—meaning of a dream. As was mentioned in the Introduction of this book, we now see interpretation as a two-way process. In terms of dreams, we ask patients for their associations to the dream content first, and then together we form what might seem to be a meaningful interpretation of a particular dream.

An interpretation usually has two dimensions: In the first dimension, the therapist may make an *observation* of something unusual or contradictory that the patient has just said, or of a discrepancy in the emotional state the patient is reporting and the way these emotions actually appear to the therapist. For example, the therapist might say: "You say you are angry, and yet you are smiling." Or of a behaviour, "Have you noticed that you've been coming late for the past couple of sessions?"

The second dimension might be the therapist's attempt to suggest, or hypothesize, a *cause* for the unusual statement, behaviour, or reaction by linking it with events in the patient's past, or with something currently happening in the treatment situation. It is offered with a combination of mirroring, empathic attunement, gentle confrontation, and an effort at reconstruction—attempting to tie the pieces of the patient's story together.

I always see an interpretation as a *hypothesis*, an informed guess, offered to the patient as a possible explanation of or formulation about a problematic feeling, thought, or action. I will often say, "This may not be exactly right . . ." Or, "This is only a hypothesis but . . ." Or, "The way it hits me is like this. Does it seem that way to you?" I want to invite my patient to participate, or to make modifications. An interpretation can be an unmasking, or deciphering, activity, proceeding from surface (what is known to the patient) to depth. It can be used to communicate the therapist's thoughts and formulations to the patient, as well as assigning meaning to the material, and bringing about insight that can lead to change.

It often happens that our patients are not as impressed with our brilliance as we are, and they do not readily accept our interpretations. (Luckily for us, this too can be interpreted: see resistance, referred to on p. 16.) In addition, lack of acceptance of an interpretation can mean: 1) the interpretation was inaccurate; 2) the therapist's timing was wrong; 3) the patient does not understand the language of the interpretation; 4) the patient is an oppositional person and may not accept any interpretation that comes from any therapist; 5) the patient is reacting to the interpretation as if it were a criticism; 6) the patient is in the throes of a transference reaction and actually hears the interpretation as if it were coming from someone else (e.g., mother, father).

None of the above is mutually exclusive. The trick is to discover step by step, and by testing out your hypothesis again at appropriate times, whether your interpretation was correct or partly correct, or whether you were off-track, and why. Part of this work is done mentally in your head, but a great portion of it can be done in alliance with your patient.

What do we interpret? In psychoanalytic therapy and psychoanalysis, we interpret first and foremost the transferences the patient appears to be having, and the defences the patient appears to use. Dreams, silences, behaviours, and even non-verbal cues can also lend themselves to interpretations. The timing of an interpretation—or almost any comment from a therapist—must be given at a moment when the patient is open to hearing it.

Gabbard (2010) states that as a general principle, the therapist should postpone the interpretation of transference until it is close to the patient's awareness. If the interpretation is premature, the patient may be unable to relate to it and may feel misunderstood. "One useful adage suggests that one should formulate the interpretation and think about it four times before verbalizing it" (p. 76).

The response you are looking for, when you offer a possible explanation/interpretation to your patient is: "Yes. That's it!" And when further examples of the same type of thoughts and emotions follow, then you know you are on the right track. We also hope that when we don't get it, we have a strong enough working alliance with our patient so they feel free to say, "No. That's not it at all." And then we both try again.

Working through

This concept is often misunderstood as it may be thought of as a one-shot experience that the patient has in either retelling, re-experiencing, or reconstructing a past trauma or other painful experience, and applying some logic to it. This, however, is only part of the picture, and this, indeed, is where therapeutic patience—and patient patience—becomes a necessity. Working through implies *repetition*—indeed, many repetitions of the process of the patient's understanding of or gaining insight into a particular problem. As Gabbard (1990) says: "Interpretations delivered by the . . . therapist rarely

result in 'Aha!' responses and dramatic cures. Typically they . . . require frequent repetition by the therapist in different contexts . . . until the insight has become fully integrated into the patient's conscious awareness" (p. 83). You and your patient may feel ecstatic when an important insight has been achieved between the two of you that makes the pieces of the puzzle come together in a way that allows for a fresh understanding of a major portion of your patient's difficulties. However, this insight may be "forgotten" by the next session, or it may have altered in the way your patient has thought about it in between, or in the way they have retold it to someone outside the session.

One principle you will learn over and over again, in the process of doing psychoanalytic psychotherapy, is the incredible difficulty that human beings have in changing any part of themselves, whether or not that change is seen by them as being for the better. Therefore, what often follows on the heels of insight is resistance. But, take heart: The other principle you will learn is that the issue, if it is important, will resurface—all you have to do is wait. Another opportunity will present itself where you can offer your patient the same interpretation or understanding, from a slightly different angle—and then you have *begun* the process of working through.

When the issue comes up for a third—or fourth—time, try to avoid sighing and thinking to yourself: "I thought we'd dealt with this already." What is important here is to understand the context in which the issue has arisen again: Is there new information? Has your patient felt you have not heard them clearly? Is your patient resisting taking in this particular insight, or does your patient experience this with every new idea? At any rate, you are being given the opportunity for another shot at it, and so your sensitivity to your patient's experience and your creativity are both being called into play here.

Successful working through implies that the patient has passed through their work on this problem, or as much as can be reasonably expected—considering the limitations of the patient and the environment—and that the understanding gained from this process has become an integrated part of your patient's way of thinking, so that the issue is no longer experienced in the same troublesome way. One test of whether a problem has been worked through is to ask yourself, if your patient were seeking therapy now, would this particular issue be articulated as a presenting complaint. If it seems appropriate, you can even ask your patient this question.

All of the above, although not complete, offers a beginning glossary of terms used in the field of psychodynamic psychotherapy, and hopefully will give the reader some grounding in order to understand, and benefit from, the chapters that follow here.

Chapter 2

Starting out

Whether this is your first patient ever, or you are meeting with a new patient, there is always some anxiety for both people anticipating this initial encounter. Amazingly enough, you will be able to start taking your countertansference temperature even before the meeting: What are your feelings about being in this particular setting, whether it is a hospital, a clinic, or private practice? How desperate were you for a therapy case, or are you already overwhelmed by the number of patients you are expected to see? What are your feelings about the person who referred the patient—is it a colleague, a supervisor you don't want to disappoint, or someone known for "good" or "bad" referrals? What have you heard about the patient already, and what is your reaction to what you have heard? This includes any demographic data plus the tone of voice of the person giving you this data. What are your feelings, fears, and hopes about the individual who will be supervising you on this case? Do you feel in competition with other therapists in your setting (e.g., who gets the "best" or "most difficult" patient)? How self-confident are you as a psychotherapist at this point?

As you can see, once you get a referral to see a patient in psychotherapy, many, many factors are already at play. It may seem overwhelming at first that all, or at least some, of the above may be influencing you even before you meet your patient. However, actually being aware of these possibilities can be of the utmost help. You may have the opportunity to discuss these elements in a supervision meeting, or with a colleague, prior to your first contact with your new patient, and then notice how, or whether, they continue to affect you as the therapy goes along.

The initial interview

When you greet your patient in the waiting room (hopefully you know which one he or she is); it is best to address the person quietly by name so that they feel expected and welcome. Next, introduce yourself, so that the patient is sure this is the right place and the right time. I usually shake hands at this point. Regarding the issue of using your first or last name, I like to leave this

up to the comfort of the patient as the therapy progresses. Their preference may be based on their age, a need for familiarity or a discomfort with familiarity, their feelings about coming for treatment, and so on. Therefore, in the initial introduction, I will use both my names (e.g., "Hello. I'm Sarah Usher"), thus giving them a chance to choose.

Personally, I am comfortable with either: If a patient calls me by my last name, this may serve to clarify the relationship and set limits, which I may be relieved to have as the therapy progresses. Many interns prefer their patients to address them by their first name, partly because it creates more of a sense of equality, and partly because they are not confident enough of their training or skills to put themselves forward as Mr. or Ms. Medical interns and residents in psychiatry more frequently use Dr. with their last name right from the start—in this case, it may serve as a protection against being seen as newly minted. Psychologists often happily switch to the use of Dr. once they obtain their doctorate degree.

When you are greeting your patient, some minimal social aspects should apply. Welcome them with a smile: you are glad to see them, and glad they have found the office, if this is their first time. After you have said hello, don't ask them how they are—as you may then be starting the session on the way to your office. When you do ask them how they are, you really mean you want to know, and so this is best done after you are both seated and you are ready to listen. Yet, don't be afraid to be friendly. For example, if a patient comments on the weather, you can certainly respond. If they ask how you are today, I always answer "Fine." Patients do not want to know that their therapist has just had a root canal. This will make them feel burdened. If you remain silent, and don't respond in a normally civilized manner, your patient will feel ignored, imagine you are a very cold person, or will probably feel that you already do not like them. The amount of small talk can usually be limited to the time it takes to walk from the waiting room until you are both inside the office.

Once in your office, indicate clearly where the patient is to sit. There is an old comedy routine where a therapist and patient come into an office in which there are four chairs. The therapist says nothing, but every time the patient moves towards one of the chairs, the therapist exclaims, "Aha!" The patient, finally feeling nothing they do is without meaning, decides to remain standing up.

It is best for psychotherapy purposes if your two chairs are placed across from each other at a conversational distance, a little farther apart than would be appropriate in a social situation. Some people prefer to have the chairs at a bit of an angle, so that they are not facing the patient directly. The therapist should not sit behind a desk—as this creates a significant barrier between themselves and their patient.

The goal of a first session is to attempt to make your patient as comfortable as possible so that they can talk about what they need to talk about. Your

job is to get as clear an understanding as possible about what is troubling them. As was mentioned earlier, counter-transference feelings may have already started to develop. Similarly, transference feelings and resistances on the part of your patient in their unconscious (and conscious) response to the therapy situation, and to you as a therapist, may have started developing well in advance of the patient's having made it to the waiting room. The feelings, fears, and hopes about being in therapy, about being referred to you, about the location of your office, hospital, or clinic, will all have been triggered.

Here is an example of one patient's feelings about the location of the therapist's office—a hospital to which he was coming for outpatient treatment—and the way in which these perceptions affected the course of treatment.

Edward, a 39-year-old businessman, who was seen in therapy by a student I supervised, came because of severe marital stress and interpersonal difficulties with co-workers. He was an extremely anxious, defensive, rigid, somewhat narcissistic type of individual, who was not psychologically minded and was unable to expound clearly on his need for psychotherapy. During the first interview, Edward mentioned that his late father, with whom he had developed a very close relationship only as an adult, had been treated at this hospital.

As he spoke about his father, the therapist could hear strong, unresolved loving and caring emotions for his father that Edward had never been able to express, and which he even now only alluded to vaguely. His deceased father's severe depression had been treated on the in-patient psychiatric unit of our hospital. Edward stated that his father's care had "saved his life" during that time. He also mentioned that his father had become "friends" with one of the psychiatrists on staff.

In the beginning of the first session, then, it became evident that Edward's coming to this hospital for treatment was of great significance, as he identified it with his deceased father, and also that there may have been an unstated expectation that he, too, would become "friends" with his therapist. Unfortunately, probably in part because of the frustration of this unstated goal, and probably because of his personality makeup, this patient, who continued in treatment for over two years, never quite succeeded in making a warm attachment to his male therapist. Although the observation that his therapist may be frustrating his hope for a friendship was offered to him on several occasions, Edward was not inclined to hear it. He did, however, arrive early for his sessions, and his symptoms improved. The therapy had given him the opportunity to act out the identification with his father, whom he missed so much, in coming to this particular hospital for help. His therapist's ability to listen empathically helped him to express and deal with this significant loss.

In the initial interview, sometimes a patient will begin speaking first, but usually it is up to the therapist to get the ball rolling. What you want to find out is why this patient came for treatment—and there are many ways

to ask without putting your patient on the defensive. You may have already noticed that your patient has reacted to something in the hallway or your office, that your patient is extremely anxious, or that they are holding back tears. These cues will help you in deciding how to begin. I have had first interviews with patients who began to cry as soon as they sat in the chair. Just knowing they were in a safe place, and that someone was finally there to listen to them, gave them such a sense of relief that emotions that had been stored up for a long time came spilling out. One of my patients got into a minor car accident on her way to her first session—and came late because of it. She was highly anxious backing out of her driveway and hit another car. Another actually knocked on my door while I was ending with the patient before her, and said: "I need to come in."

For the above two patients, there weren't a lot of opening lines needed. However, for most patients: "Tell me why you wanted to come and talk to someone," "Tell me what's happening with you" are reasonable ways to indicate that you *want* to know and are ready to listen. Asking, "Why did you come here?" make make the patient feel uncomfortable. They may think, "Maybe this therapist thinks I shouldn't be here," or "Maybe I won't be able to express what's bothering me in the right way."

If you have done your part well, what you will hear next is the *chief complaint* or *presenting problem*. These labels come from medical practice, and are extremely helpful in organizing both the patient's material and your own thinking. For example, in the case of Betty, the 42-year-old woman mentioned in Chapter 1, who became intensely angry when I was five minutes late, the presenting problem, or chief complaint, was a morbid fear of her boss that made it impossible for her to work effectively. (Of course, as the therapy progressed, we were able to see the link between her autocratic boss and her storming father.)

Most of the first session, and if appropriate, some of the second session should be spent on exploring the chief complaint. It is important to know for *how long* the patient has been suffering with this problem; *when* it first started; and the *circumstances* under which it began—if these points seem relevant. Why the person has come for help *at this time* is also important. In the previous example, Betty had been feeling so much anxiety that she had actually been unable to go to work for several weeks. Her friends had encouraged her to seek therapy. It is also important to know, at some point, whether your patient has ever been in therapy before and if so, for how long, if it was helpful, and how it ended.

The early sessions with your new patient have to be balanced between your attention to your patient's needs—to express the nature and details of what is causing them distress, which are first and foremost, of course, and your own needs—to find out relevant information in order to gain a full understanding of their situation and to make an appropriate decision about treatment.

So much depends on your ability to listen empathically—that is, to hear the presenting problems and their history from the patient's point of view. Beginning therapists are often surprised at how difficult it is to *listen* to a patient. Listening, after all, is not a skill we are taught in school—even, or perhaps particularly, in graduate school. We're supposed to know how to listen automatically, provided one doesn't have a hearing problem. In every situation, there are many factors that interfere with hearing what another person is saying. These factors can be magnified in the therapy situation. Therapists can feel bombarded by a patient's presentation: how they look, the number of issues brought up, the intensity of the patient's emotions, the way the patient responds to you—trusting or not—and, of course, if a therapist is in supervision (discussed in Chapter 8) wondering what the supervisor will say about the initial meeting.

All of your own reactions (i.e., counter-transference) will influence how you listen. Feeling sorry for your patient, for example, will interfere with your ability to listen to them in the early sessions. Also, although you may enjoy intellectualizing or theorizing about your patient's dynamics, indulging in this exercise prematurely will certainly get in the way of your hearing everything your patient has to say.

Therapists who have some familiarity with music may find listening to a patient easier than those who don't, because they have been taught to listen to the rhythm and flow of sounds. A therapist must listen both to the words and the music; that is, hear the content of what the patient is saying and hear the underlying emotion (or affect)—as well as what the patient is not saying. Listening in therapy is by no means a passive endeavour. You will be surprised at how much energy good listening takes and at how hard you are working in a session when you are "just listening." Does your patient seem involved with what he or she is telling you, or detached from it? When your patient is describing certain people or events in their life, are there changes in affect? And if there is no observable affect, then why not? Your patient can be included in these observations when it seems appropriate.

Other important information that can be obtained in the initial sessions would include: Does your patient require structure, or balk at it? Do they seem to establish a dependent relationship with you too quickly (e.g., implying that you will solve all their problems; or that they need to come as often as possible)? Most patients want their therapists to like and accept them. Is this the case with your patient, and how is this demonstrated? How does your patient respond when you speak: Ignore you? Or soak up every precious word?

It is often interesting in the early sessions to try out a possible observation, or preliminary interpretation, based on the information your patient has given you so far, to begin to get a feel for their psychological-mindedness. For example, in the case of our friend Alice ("cat," see p. 6), I asked in the first interview whether she thought her experience in her family was at all related to the problems she was having with friends and colleagues now.

If she had said, "No," this could have indicated either a lack of psychological thinking or a resistance to anything you ask. If she had said, "Yes," too quickly, then I might wonder whether she is too eager for any input, or too ready to agree with everything I say. So what, you may ask, can the poor patient say that is right? If your patient reflects on what you have said, considers the possibilities, and only then agrees or disagrees, then this is a positive sign. If Alice had taken what I asked further, for example, by saying, "I guess so. My sister, in particular, hated me and I hated her," this might have indicated a readiness to think psychologically, and to begin to make connections.

If your new patient presents with symptoms of *depression*—that is, fatigue, lack of energy, not caring about life—then the following questions could be asked to determine the extent of the depression:

1 Are you having problems with sleep? If so, do you have trouble falling asleep; are you waking during the night; do you wake up very early in the morning? When you awaken, are you aware of what thoughts you are having? Or, are you sleeping more than usual?
2 How is your appetite? Does it seem normal for you? Have you gained or lost weight recently? If so, how much?
3 Do you find you are crying more than usual? Does this seem related to anything in particular, or does it just happen?
4 Do you feel worse at any particular time of the day? For example, early morning? mid afternoon?
5 Do you find yourself lost in gloomy thoughts about yourself or about the world situation?
6 Have you felt so bad that you have thought of ending it all—killing yourself?

These questions are asking about vegetative, that is, biological, signs of depression, as well as suicide potential. If strong vegetative signs are reported, then you should consider having your patient assessed for the possibility of antidepressant medication.

If your patient expresses suicidal thoughts, then you need to explore these quite thoroughly to try to determine the probability of their making a suicide attempt. Some questions that may be helpful in determining the extent to which these thoughts not only preoccupy your patient but may lead to action, are: How often do you think about suicide? How long have you been thinking this way? Have you thought about how you might actually carry it out? If your patient seems to have a fairly clear idea of how they might go about killing themselves, then you must ask: Do you have access to pills? A gun? Their answers to these questions will help you to determine how much danger your patient may be in.

Another important determinant of suicidal potential is whether your patient has ever made a suicide attempt in the past, and under what circumstances. If they have, this makes them a more serious risk.

If you are concerned about suicide at this particular moment, then you have a responsibility to help that person protect themselves. The therapist can ask "Would you like to come into the hospital for a while?" Most patients who are feeling this bad will agree, relieved that someone has finally heard how much pain they are in, and is going to help them. Then, it is your job to know which Emergency Room is closest to your office, and to make a phone call to them before sending your patient over. If you are in supervision, then you should definitely consult with your supervisor. If the situation seems immediate, you can ask your patient to wait in the waiting room, while you seek out the assistance of your supervisor, or a more experienced colleague.

To return to the more usual flow of the early sessions, since the therapeutic relationship is going to be different from any other relationship the patient has had, it is often helpful to use the initial session as an opportunity to begin to *educate* your patient about the process of psychotherapy. I like to tell them that they can say anything they want in therapy, and that I like to hear what is at the top of their mind, even if it seems unimportant to them. I also give them a general idea as to what they can expect from me. For example, by stopping the small talk once entering the office, I indicate that we will not be spending time on this in our session. I try to give them information on how often we will meet and how long the sessions will last as early as possible in the beginning sessions. By inquiring about how my patient felt coming here, I indicate that it is important for us to know and understand their feelings about being in therapy. By showing an interest in their close relationships, or in a dream—if one is mentioned, and in all their emotions and concerns, I indicate what we will focus on in our work together. Asking the question: "Anything else?" after a patient has described a problem shows that you are ready to hear everything. I also like to give them the opportunity to voice any questions they have for me.

The way you *end* the first session is extremely important. Again, this will be different from how most people behave in social situations; therefore, your patient will probably have no idea as to how the ending will come about. It is important to remember that at this point, you are setting a precedent for the future. Whether or not you have finished finding out as completely as you wanted to about your patient's presenting problems, if the time is up: *end on time*. This does not, of course, mean cutting your patient off in midsentence, but it means being aware of the clock and winding down as close to the specified time limit as possible. As was mentioned earlier, you are not doing your patient a favour by going into overtime. The reliable structure of the therapy situation provides a welcome relief for most patients, even those who seem to want to drag it out. Consistency in ending cuts down on attempts at manipulation, guilt feelings, feelings of favouritism or rejection, and the stress for both parties of having time intruded upon. Be gentle but firm; for example, "Our time is up for today. Let's continue with this next

time." Or, "I can tell this is important for you, but unfortunately we have to stop now." Standing up helps to convey the message that the session is over.

One of my patients who had some difficulty with ending sessions early on, took advantage of a recent Christmas to buy me a huge hourglass as a gift. Unfortunately, the thing went for a full 60 minutes, and my sessions with individuals are only 50 minutes. Maybe there was a not-so-unconscious message there. In any case, it provided great amusement for both of us as we watched the sand going down, and she commented, "Oh my goodness. Our time is almost up!"

There is no need to chat to your patient on the way out of the session, or to walk him or her to the elevator, unless they are infirm and unable to get there alone. Again, this is different from a social situation. Your patient probably needs some space to think about what has just transpired, without your undoing it by being "nice." More will be said about ending sessions in Chapter 6.

Regarding the *taking of notes* during a session, I find it quite helpful to take notes during those beginning sessions when I am getting factual information; for example, during the first and history-taking sessions. Not taking notes at this time may lead to the therapist's being distracted by the effort of trying to remember details to the extent that their ability to listen is compromised. For psychodynamic therapy, taking notes once the therapy has actually begun is usually not recommended, as note-taking when you are facing someone can be distracting to both the therapist and the patient. I generally let my patient know that I will be taking notes for the first few sessions, implying that this will not be the norm throughout.

It probably should be mentioned here that the therapist should allow time after every session for the writing of *progress notes*. These notes consist of a one- or two-paragraph summary of the session, written in the patient's chart or file, signed by you, and co-signed by your supervisor, if you have one, and if this is necessary.

Although we seem to be getting a sense of a patient in the initial session, often patients can present quite differently when we see them the second or third time. This may be due to their having been extremely anxious in the first session, or even to something new and important having happened between sessions. It is never wise to make formulations based on one, or even two, sessions; the therapist can look forward to a few surprises in subsequent meetings.

Before moving on to taking a history in the second or third sessions, you should first attempt to discover how your patient reacted to the first encounter with you. For example, you can ask: "How did you feel after our meeting last time?" "Did you have any further thoughts about what we talked about?" Questions such as these will educate your patient in terms of what is interesting to talk about in here. What happens to your patient between

sessions provides a wealth of valuable material, and is an important indicator of their suitability for psychodynamic psychotherapy. Some patients "forget" what was said by the time they get to the elevator and don't give it another thought until you ask about it. Other patients may have talked to friends or partners about it; one or two may have had a dream about, or related to, the therapy. Some may have found themselves more emotional at home or at work. All this information will help you to begin to understand your patient's motivation for treatment, and their ability to stay with it.

We are now on our way to hearing about our patient's background.

Chapter 3

History taking and formulation

Most psychodynamic/psychoanalytic therapists find it important to know about their patient's early life as soon as possible in the therapy. As you can tell from the examples given previously, parts of the patient's background are always present in the descriptions. Of course if the patient is in a crisis, the background information has to wait; but in these cases, I always feel I am flying blind. Knowing about your patient's early life and relationships will help you to understand their symptoms, their choice of defences, the way they present in the therapy, and to a great extent how they will react to the therapy. Transference issues become somewhat predictable, (see the section on Transference, Chapter 1); for example, if a patient has had extreme difficulty with a parent or sibling, we expect to see that recur in some form in their relationship with the therapist. Therefore, it is important to get as clear a history as you can, while not dragging it out too long so as to interfere with addressing the reasons the patient has come.

Most patients are quite sensitive to *transitions* in therapy, and so you should try to make these transitions as smooth as possible. Telling your patient what you are planning to do is a simple way of effecting this, and it works every time. Comments such as, "Now I'd like to ask you some questions about your family background, if that is all right," or, "I'd like to ask about your early family life so that I can get caught up with you and get to know you better," will help your patient to understand and be prepared for what is about to take place. If your patient seems reluctant, for example, "I don't like talking about my family," or, "I'm afraid I don't have a very good memory for those sorts of things," this is usually a defensive expression of embarrassment or other bad feeling. You may choose to ask a little more about this; try to reassure them, and then try introducing questions in a gentle manner. If this doesn't work, then you can proceed with what your patient says, and keep an ear tuned to background material. Most patients will simply nod in agreement when asked about history taking, and try to answer as best they can. Again, this part of getting to know your patient requires that you take notes, as there will probably be too many details to remember without being distracted from listening.

It should be noted here that there are many experienced psychotherapists, particularly psychoanalysts, who prefer not to take a formal or structured history, but to allow the material to emerge from the patient in the order in which it occurs to them. This is an acceptable way of proceeding after a therapist has taken many histories, has a clear idea of what information is needed to determine appropriate treatment, and has the luxury of time, as one would in a longer-term treatment. However, for the beginning or intermediate practitioner, a good history is invaluable to get a sense of your patient's experience in life so far. Besides, even with a structured history taking, an example of which is given below, there is still material that won't get asked about, and that will emerge slowly throughout the therapy. So, it is important to be aware that you will not know everything about your patient's past just because you have taken a history, and that you need to still be on the lookout for experiences and people that were not described in this part of the process.

The *history taking* usually starts with gathering information about your patient's parents. The following questions about parents assume a heterosexual parental couple. If that is not the case for your patient, that is, if he or she has same-sex parents, then obviously the questions need to be altered to make sense in this situation. You can start with: "Tell me about your parents," and take your cues from your patient about how their parents are referred to. Also, if there are not two parents in your patient's family, then you need to adjust your questions for this.

Following is a suggested general outline for taking a very comprehensive history. You probably will not want to use every question: they are given here to demonstrate some of the issues you might need to keep in mind. Start with either father or mother, or other caretaking adult—even with older patients—and move on from there to the questions you feel will be most important.

History-taking outline

Parents

1 Is your father (or mother) still alive? How old is he/she? Is he/she in good health?
2 If a parent has *died*, then ask: How old were they when they died? How old were you? Can you remember your reaction? How long did you feel that way?

The answers to these beginning questions give us an idea of the patient's environment, whether they are under stress because of a parent's illness, and how they dealt—or didn't deal—with loss, if a parent has died.

3 What kind of person is/was your father/mother? Can you describe him/her to me?
4 Was he/she an outgoing person, or a quiet person?

These questions can give you an indication of how parents were experienced by the patient, which parent is easier to describe or talk about, and whether emotions are triggered during these descriptions.

5 Did you feel close to your father/mother when you were growing up?
6 Did you ever do activities with him/her—just the two of you?
7 Did you ever confide in him/her about your worries regarding school or your friends?

Here we can get an idea of our patient's early object relations, whether they could trust either parent, and which parent they felt closest to. The answers will provide clues as to how transferences to the therapist will be played out.

8 Do you have early memories that involve him/her that you could tell me about?

If your patient has no early memories, it is interesting to speculate about why: was there an early trauma? Is the patient embarrassed to say what their memories are? Or are they not interested in knowing about early memories?

9 What is your relationship with him/her like now?
10 How often do you see or speak to him/her?
11 What is it like for you when you are together now?

This gives the therapist an indication of whether or not separation and other issues with the parents have been resolved.

12 Tell me a little about your parents' marriage as you saw it. Would you say they had a happy marriage?
13 Did they fight often? Did you ever see them fight?
14 Did you ever see them express affection for each other?
15 Who seemed to make more of the decisions in the marriage?

The answers to these questions give us our patient's child's-eye-view of the parents' relationship, and possibly some information re: our patient's difficulty or lack thereof with their own relationships.

Siblings

1 How many brothers and sisters do you have?
2 Where are you in the lineup?
3 Who is the oldest sibling? Is he/she married? Children? What does he/she do for a job? What is he/she like as a person? What was your relationship like when you were growing up? What is it like now?

These questions can be asked about each sibling. Here we get a further picture of the family environment, our patient's early object relations, tendencies to bully or be bullied, competitive strivings, and the resolution of early conflicts.

One can also ask: Were there any *other relatives* who were very close to you—an uncle or a grandparent? Was there anyone else who lived in your home?

School

You can transition away from the family by saying: "Now I'd like to ask you some questions about your school life." This can be omitted for older patients.

1 Did you like elementary school? High school?
2 What subjects did you do well in at school? Did you participate in extra-curricular activities?
3 Did you have many friends at school? Any of them close? Did you have one close friend for any period of time?
4 How far did you go in school?

Leaving home (if age appropriate)

1 Can you tell me what that was like for you?
2 How did your parents react to it?
3 Where did you go to live at that time?
4 In what circumstances are you living now? How long has that been? Do you like it?

Working life

It is also helpful to know about your patient's *working life*, if they are employed.

Relationships

After this, another transition statement will be helpful. "Now I'd like to ask a little about your *relationships* with men/women."

For heterosexual patients

1 Tell me about your boyfriends/girlfriends.
2 Can you tell me about your first boyfriend/girlfriend? How long did that relationship last? Was that a sexual relationship? How did it end?
3 Are you currently involved with anyone?

These questions can be asked about all long-term relationships (six months or more) and will give you an idea of your patient's current object relations.

Can your patient form a sustained relationship with a member of the opposite sex? Do they have extreme difficulty in talking about these matters? Do they always end the relationship, or is it more equal? Do they seem to choose partners who make them feel good about themselves?

For homosexual patients

1 If it has already been made clear that they are homosexual, you can ask: When did you first know that you were homosexual? How did you react to this discovery? What about your family—do they know?
2 How has it been for you in terms of finding relationships?
3 Can you describe your latest long-term (six months or more) relationship? How did it end?
4 Are you currently involved with anyone?

Again, we are interested in the development of adult object relationships, whether your patient ends relationships or his/her partner does, and whether a sustained long-term relationship is possible for them.

Psychiatric history

1 Can you tell me if you have ever seen a psychiatrist, psychologist, or social worker before?
2 How long ago did you see this person? For how long did you see them, and how frequently?
3 Why did you stop seeing that therapist?
4 Did you consider seeing them again this time?
5 Have you ever been on medication for emotional problems? Are you at present?
6 Have you ever been in hospital for emotional problems? Or has anyone in your family?

Additionally, if it seems appropriate, the therapist can ask:

7 Do you have any serious *medical* problems?
8 How about your use of *alcohol*? *Drugs*? Have you overused either of these in the past?

If your patient is still awake and talking to you after this exhaustive history taking, you can give it one more shot by asking: Is there anything I haven't asked you that you think I should know?

If your patient has presented with symptoms of depression, then if you haven't asked the types of questions suggested in Chapter 2, it is appropriate to ask them during the history taking.

History-taking summary

Mental status is often part of the very early, history-taking interviews, particularly for residents in psychiatry. This involves getting a sense of your patient's mental competency—from whether or not there are gross memory problems or a psychotic process in evidence, to the patient's intellectual ability and potential for psychological-mindedness. There are standard questions that can be asked to determine memory problems; for example, asking your patient to repeat series of numbers of incremental length, or asking your patient to try to remember four objects at the beginning of the interview and testing them during the interview and at the end to see how many they can remember. In terms of the presence of psychosis, this is usually much easier to spot as a patient will give themselves away if they are having hallucinations, delusions, or paranoid thinking during the interview. Otherwise, if you are not sure, you can ask directly about their experience. I won't go into these matters more deeply here, as we are mainly concerned with patients who will be in psychodynamic psychotherapy, and so these concerns and questions will only be useful to rule out patients who are inappropriate for this type of treatment.

In terms of assessing intellectual ability, usually some sense of this can be obtained from conversing with the patient and from a knowledge of their educational pursuits. Psychologists and psychology interns who have done a lot of intelligence testing may be able to get a feel for someone's intellectual functioning more easily than therapists who have not had this experience. It is helpful to have some idea of the range of your patient's intellectual ability, as potential for psychological-mindedness involves, in part, a certain kind of intelligence, having an initially positive response to the treatment situation, and having an interest in reflecting on and understanding one's life problems—rather than hoping to get advice on what to *do* about them.

Gathering all of the information, or whatever part seems needed and appropriate, may well take more than one session. Although you do not want to dominate sessions with your agenda, it is usually important to take a fairly complete history. You will be happy you did later in the therapy when your patient refers to various family members and you understand to whom they are referring. If your patient comes to a planned history-taking session in a crisis, then of course, you must attend to that and put your questions aside. It is always a good rule, anyway, if the history takes more than one session, to check in with your patient as to how things are going for them right now, and if it is all right to continue with a few more questions. If it is in your patient's best interests to move away from history taking, try to come back to it as soon as you can.

Actually, asking questions about your patient's early life is not as much of a burden to them as it may seem; it often serves to communicate that you are interested in all the details of their life, past and present, and that you care enough about what they have experienced so far to take the time to ask about it.

Flagging the transference in the history

Many of my supervisees will be sure that the above heading contains a typo, and that what I meant was *flogging* the transference, since they sometimes feel I pound away at them about transference issues. However, what I mean by flagging is putting up a mental flag—a flag such as you might see on a golf course—so that the particular statement, or emotion, is marked for future reference. As was referred to earlier, during the process of answering questions in the history-taking sessions, your new patient will unknowingly be revealing possible future transference reactions that will arise during the therapy. The questions about father(s) or mother(s) give an indication of whether they were experienced as supportive or critical. Since the psychotherapist is often seen as a parental figure, it is crucial to get an understanding of your patient's perception of each parent. You may be able to get a sense of which parent you are representing in the beginning; ideally, it is the "good" parent, or the one your patient feels closest to, as it is generally easier to start this type of psychotherapy with a positive transference. However, this may not turn out to be the case, and it will change over the course of the therapy. If you are familiar with this part of your patient's history, you will be able to identify these transferences and to help your patient to see and understand them as well. As touched on earlier, if a parent has died, your patient's answers to your questions will give you an indication of whether they have been able to let go, or may now be searching for a replacement, and how your patient deals with loss and separation. This has indications for your own separations—vacations and eventual termination.

Be alert to the possibility of a sibling transference as well, particularly if your patient is close to you in age.

For example, to go back to Alice from Chapter 1 ("cat," see p. 6): when she came for treatment, she complained that she had very low self-esteem, that everyone in her family criticized or teased her, and that she could not have a stable career. She had several relationships with men where she felt taken advantage of. During the history-taking session she described a relationship with her older sister, whom she thought of as perfect, and hated. Her sister had planned her own career, and was engaged to a man with whom she seemed to be madly in love. During family gatherings, and indeed at almost every opportunity, her sister (a physician) would tell her what she should be doing with her life and berate her for being unable to enjoy her career choice or to have a steady boyfriend.

I saw Alice when I was somewhat younger, but it didn't take age appropriateness to elicit a predictable sister transference. After hearing the history, it was evident that this relationship from youth—with its combination of teasing and underlying seduction—was of utmost importance in influencing Alice's adult life. A great deal of time in the beginning of our work was spent in helping Alice to observe when she felt she was being judged by me. As she began to identify this more and more as a transference reaction,

Alice was able to disclose more unflattering parts of herself and to begin to understand their origin. A huge accomplishment in this treatment was Alice's new ability to stand up to her sister, and as time went on, to claim her as a friend—although she never trusted her completely.

Hearing your patient's early view of their parents' marriage will give you a sense of how they see relationships in general, as was mentioned above, and usually relationships with the opposite sex. Unresolved oedipal issues, which will emerge in the transference, can often be spotted first in the description of the parents' marriage. For example, "My father never seemed to talk much to my mother; in fact, he shared more with me—we thought more alike," if spoken by a female patient may herald seductive behaviour with a male therapist and competitive behaviour with a female therapist. In general, your patient's point of view of adult loving and caring, borne from these early perceptions, is bound to reappear in their perception of the therapist–patient relationship.

How your patient accomplished—or failed at—the developmental task of leaving home may speak to dependency issues in relation to the therapist, as well as possibly underlying some of your patient's presenting problems, namely, anxiety, phobias, or guilt feelings that may inhibit progress. Does your patient have to get angry in order to effect a separation? Clues about this will be forthcoming in terms of the separations experienced in the course of therapy.

Formulation

The word *formulation*, as in "What is your formulation about this patient?" often strikes terror into the hearts of beginning therapists, and sometimes into the hearts of more experienced therapists as well—as they feel they should be able to have a succinct formulation of the person they are treating as early as possible. Because of this, thinking through a formulation is often an exercise people try to avoid.

However, as anyone who has been forced to do it will testify, it is an extremely helpful process for the therapist to undertake, as it focuses you on your own thinking about the dynamics of your patient, and is imperative in terms of making treatment decisions. It will increase your confidence in your work, your power of predictability (i.e., cut down somewhat on the surprises in store for subsequent sessions), and, most importantly, give you a deeper understanding of how and why your patient got to the situation they are in, and how their personality style was formed. First formulations are usually attempted after the family history has been completed.

Basically, a formulation is a hypothesis: a hypothetical explanation of the factors that have contributed to the precipitation, development, and maintenance of your patient's problems. It should also include your patient's strengths and vulnerabilities, as well as what you have been able to observe so far about their defence mechanisms. Formulations are not essays and are not *carved in stone*. Because you may have written what you thought was a

brilliant analysis of your patient after seeing him or her three times, you do not have to—nor should you—adhere rigidly to the same perceptions of your patient's dynamics through the ensuing months or years of psychotherapeutic treatment. In most instances, you will not be put on trial to defend your initial impressions. The above is said to reduce formulation phobia, often occurring in beginning therapists.

Since formulations are basically hypotheses—well thought out hypotheses—they will sum up the impression you have gained of your patient thus far. They involve, among other observations:

1 a clear statement of the presenting problem, or chief complaint;
2 a summary of the history of the problem(s);
3 a hunch about why your patient is suffering from this complaint at this time (predisposing factors);
4 a description of the defence mechanisms you have spotted in your patient so far (e.g., denial);
5 an estimate of their intellectual and psychological capabilities; and
6 an estimate of this patient's suitability for psychodynamic psychotherapeutic treatment (see Chapter 4 for elaboration).

If appropriate, your formulation could also include a statement about how the complaint relates to your patient's family background, and a suggestion about what additional complaints could arise for this person. You should also include any comments you can make at this point about expected transferences or resistances—remember these can certainly change, even in the very next session—and some reasons for your choosing this type of treatment, preferably as related to your patient's needs, in addition to your own biases about working in this way.

Psychiatric residents and sometimes other interns are required to postulate a diagnosis utilizing the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association. Because specific training in the use of the DSM for making formal diagnosis is a standard part of clinical psychiatric training and is taught in every setting, and because it is not a part of the training of most other clinicians, it will not be discussed further here. If you are expected to add a "guess" about your patient's DSM diagnosis at this point, then it must be included in your formulation.

If you have listened to your patient carefully, then you should be getting an understanding of why your patient came for help, and a good grasp of the climate in which they spent their early life. You may also have been able to flag several possibilities of what might be enacted in the transference-countertransference. With all this under your therapeutic belt, the formulation will almost write itself. Here are some examples.

Betty, a 42-year-old single woman (described in Chapter 1, who had an authoritarian father), came to treatment complaining of feeling so much

anxiety that she had been unable to go to work for the past two weeks, as she felt frightened of her boss. She had been noticing her anxiety build over the three years she had been in this job, but stated that "sometimes things go very smoothly." Shortly before she became unable to work, Betty found out from her mother that her father had been diagnosed with Altzheimer's disease. This, plus an extra heavy load at work, seemed to be a precipitating factor for the current crisis. Betty seems to use intellectualization and obsessive compulsive defences to try to deal with her anxiety. She reports that she is extremely orderly at home and at work, and fears that people don't like her because of this. Her family was strict and the expression of emotions was not encouraged. Father is described as a tyrant, and mother as depressive and "weak." The combination of a bullying "authority" and a "weak" mother may lead to conflicted transference reactions with a female therapist. Betty is an intelligent woman, having obtained an MBA degree, and probably could allow herself to ease up on her defensive posture in order to think psychodynamically, and to be able to use the therapy effectively.

In the above example, it was discovered much later in the therapy that Betty had been the victim of sexual abuse as a child by an uncle who stayed with the family for several months. However, since this information—and its possible effects—were not known at the time of writing the formulation, they obviously could not be included in it.

Alice, described above, presented with the complaint of low self-esteem and troubled relationships, mainly at work, where she fought with her colleagues and the support staff, and felt that everyone disliked her. She had spent about two years in each job she had; however, this difficulty had begun in university when she had her first experience of others being "smarter" than her. To protect herself from experiencing feelings of inferiority, Alice developed an aggressive way of being, which is consistent with how she was treated in her family, particularly by her sister whom she saw as the favoured child. Despite her tendency towards aggressive behaviour, acting out, and the use of projective identification, Alice is an extremely bright woman and is learning quickly about self-reflection; therefore, I think she will do well in psychodynamic therapy. She is also highly motivated to change her current situation as she is in a significant amount of pain. Her sister seems to have had an enormous effect on her self-image, and on her view of her sexuality; therefore, she will probably appear in some way in the transference.

Again, in the case of Alice, there was a great deal of information that was not known at the time of first formulation.

The above examples are concise; formulations can certainly be longer, but there is no need to reiterate in the formulation everything that has been said in the history taking.

Before getting into the actual course of therapy, it might be helpful to highlight some of the preferred features of patients selected for psychodynamic/psychoanalytic therapy.

Chapter 4

Selecting appropriate patients

As discussed in the section on formulation in the last chapter, one of the factors we need to think about is a recommendation for treatment. Since we are concerned with psychodynamic therapy, let's have a look at those patient characteristics that give us the most optimism about recommending psychodynamic or psychoanalytically oriented treatment. As discussed in the two preceding chapters, a considerable amount of information about your new patient can be obtained in the early meetings, and it is from this information that you—in discussion with your supervisor, if you have one—have to make a decision about the most propitious treatment for him or her.

Bear in mind that, as mentioned earlier, your own reactions (countertransference) to the new patient, both conscious and unconscious, will already be kicking in, and that these reactions may influence decisions about treatment (e.g., "She's so cute, I'm sure I can help her," "Wow. He's into film. I've always wanted to be in film," "Does she ever wash her hair?" etc., etc.). Our first responses, in fact, sometimes linger for a long time. Thus, a feeling that you don't like the person when you first meet them should be taken into account when considering more intensive psychotherapy with them. If, in discussion with your supervisor, your own therapist, or a colleague you can get an understanding of your reaction, this will obviously be extremely helpful to both you and the patient in making the best decision for them. Also, considerations about the possibility of intense transference reactions—as far as they can be predicted from the initial interview and history taking (see previous chapter)—will provide important information in terms of choice of treatment.

Psychodynamic psychotherapy, first and foremost, requires that a person be able to tolerate a somewhat *unstructured* therapy situation and also have a tolerance for *ambiguity*. Unstructured therapy means the issue to be discussed in each session is whatever is top of mind for the patient, and therefore is raised by the patient. And there are no requirements to continue with this issue in the next session. Just remember: Patients Rule. Therefore, the therapist, although offering guidance, observations, and interpretations at appropriate moments in the session, generally follows where the patient leads. In essence,

this means that the therapist does not use a lot of questioning (after the history taking) except to follow up on and clarify what the patient is saying, does not suggest homework assignments, or set goals with the patient in a formalized manner; in other words, the therapist does not deliberately impose a structure on the sessions.

Since responses from the therapist are kept to a relative minimum (that is, relative to the therapist's role in other forms of therapy, such as cognitive–behavioural therapy, but not as minimal as in psychoanalysis), the patient must have some ability to be self-sustaining and not require constant input and approval from you as the therapist. These comments are necessarily unspecific, as it is difficult to state how large a dose of this or that particular intervention is warranted with any one patient. It is probably helpful just to think of psychodynamic therapy as leaning in a direction *away* from providing structure for the patient.

Good signs

If your patient is able to tolerate the moments in your initial time together when you are not asking a question or taking the lead in some way, this is a good indicator of their being able to tolerate less structure. Typical of these moments would be occasions of silence, or times when you have put out a feeler—about something emotional they have described or a dream they have started to talk about—and they are able to discuss it without needing your input or an immediate resolution.

Another factor we always try to assess in the opening sessions is the person's level of *psychological-mindedness*. This term has been mentioned earlier and means exactly what it seems to mean: that is, that the patient can hypothesize about his or her own life, and show an interest in gaining an understanding of it, again without needing quick solutions. It also means that the person themselves has an interest in their family history and its impact, and a generally positive attitude about being in therapy. Patients who have never been in treatment before naturally differ from those are familiar with psychological terms and psychological ways of thinking. However, it is not the person's ability to offer a polished presentation of psychological theories that is important—in fact, this kind of response usually gets subsumed under the heading of using intellectualization as a defence—but rather the ability to philosophize, to entertain new thoughts about, and new perspectives on, themselves, to allow for the importance of their past in determining their present, and to demonstrate an open-mindedness about exploring life in a new way.

Actually, it is hard for me not to list a sense of humour as being the first good sign for this type of work. Here, I don't mean necessarily laughing at your jokes (although that's certainly important), but having a way of smiling at themselves, and of occasionally being able to view their life from a

humourous perspective (e.g., the patient described in Chapter 2 who brought me an hourglass as a gift). This implies a capacity to step back a little, and observe.

In addition, I would like to offer the following more specific criteria to keep as *part* of your armamentarium when thinking about suitability for psychodynamic treatment. These criteria are not to be regarded as carved in stone; however, the more of these characteristics your new patient has, the more likely it is that they will be a good candidate for psychodynamic psychotherapy:

1 The person should *not* show signs of psychotic symptomatology (i.e., delusions, hallucinations, paranoid ideation). Paranoid thinking may sometimes be tricky to spot, as it is not always blatantly obvious, and can range from, "Wherever I go, people are talking about me," to, "Everyone at work hates me, and that's been the issue every time I get a new job." In the latter example, if enough positive signs are present—in this case, the person is able to get a job—and if the patient can see that this may not always be the case, or that there is something wrong with their thinking, then we can proceed with psychodynamic treatment, with caution.
2 The patient should be at least average intellectually, as estimated by their level of education, their occupational level, their interests, and their general knowledge.
3 The person's general level of functioning should be taken into account; that is, how are they coping in spite of their symptomatology, and will they be able to "wait" for the effects of a psychodynamically oriented treatment.
4 The person should be interested in treatment and, at least consciously, express a willingness to cooperate with it.
5 Past relationships should include at least one positive close and caring attachment (e.g., mother, father, grandparent, close relative). This speaks to their ability to recognize a trusting relationship.
6 It is helpful if the person has shown some capacity to form a close relationship in the present; for example, a friendship (quality of their object relations).
7 The patient should have some degree of awareness of their affect or feeling states during the initial interviews and be able to acknowledge and discuss them to some extent.
8 The patient should show some ability to delay impulses and to postpone immediate gratification, that is, to discuss, rather than act. This can be discovered in questioning how the person has handled other crises in the past, and what thoughts they have had so far about dealing with their current situation. In the example I gave in Chapter 2 of the woman who knocked on my door while I was ending with another patient, we would certainly proceed with caution.

9 If your patient has memories, dreams, and fantasies relatively available for discussion, this is always a nice bonus—provided they are not too readily available, as in: too much information too soon. If the session is dominated by what would be termed primary process material—that is, raw and from the unconscious—then the person's control over the expression of this type of material, and their judgment, is too compromised to allow them to benefit from this form of therapy. They may need to be closed up (defences shored up in a structured therapy) rather than opened up.
10 If the person has had previous treatment, it is better prognostically if they feel the earlier treatment helped them. This implies that they can benefit from therapy, that they have a positive outlook towards it, and that they are not going from therapist to therapist acting out the disappointments they may have experienced in their earlier life.
11 The person should not now be involved in substance abuse, or illegal behaviour. Substance abuse may mean your patient arrives at sessions drunk or stoned, which makes it impossible to work with them. Illegal behaviour means you may be caught in an ethical dilemma, while treating them.

From reviewing these points, you can see how important the history taking is in terms of predicting success in the therapy.

Frederick, a 29-year-old law student, was referred to me by his maternal aunt, a social worker. He complained of having trouble controlling angry outbursts, and also that he was too critical when with possible girlfriends. No physical violence was involved. An only child, Frederick stated that he had been angry for most of his life, but was uncertain why. In the history-taking session, he described his mother as a depressive, clinging woman, who made him feel guilty about growing up. He had spent a lot of his childhood worrying that his mother might die, as she often said to him, "You'll be sorry when I'm dead." In fact, his mother had been treated with medication for depression on and off during his youth and, when he became an adolescent, she was diagnosed with a benign brain tumour. The aunt who referred Frederick for treatment had observed his mother's dependence on him, and feared for his future.

Federick remembered a warm and friendly relationship with his father, whom he felt approved of him and loved him. His father had often implied that the two of them had to watch over the mother and not cause her too much trouble, as she could easily become ill. Unfortunately, when Frederick was 20 years old, his father died from a heart attack while skiing, and he was left alone with his mother.

In this example, all the above information was obtained from the patient in the first two sessions. His complaint of angry outbursts caused me to proceed with initial caution. I asked several questions to assess his impulse control.

He answered in what seemed like an open manner, and volunteered more information in both sessions. He was intelligent and able to articulate his concerns. He did not directly blame his mother, but took responsibility for his anger; still, he was able to see that his relationship with his mother might have some bearing on the problem. He had had a close and trusting relationship with his father—and, presumably, someone who was concerned about his future, in the person of his aunt. Finally, he did not expect a "quick cure." I therefore was interested in seeing him in psychoanalytically oriented psychotherapy.

Bad signs

As has already been mentioned, the possibility of a successful outcome if your patient is having psychotic symptoms, or is abusing substances, is minimal. If you could not tell from the first few interviews whether they can tolerate an unstructured therapy, or whether they have the potential for psychotic thinking, then it might be a good idea to refer the person for psychological testing, particularly projective testing. If you yourself are a psychology intern or psychologist, it is not a good idea to test your own patient. This complicates the relationship by introducing a new dimension that may well prove to be aversive to them, or may feel too intrusive at this point in your relationship. Also, whatever transference they have made to you thus far will influence their responses to the testing. Therefore, after discussion with your patient, a referral to a colleague is in order. It should be understood that the consulting psychologist will discuss the results of the testing with you, in addition to giving your patient feedback.

If your patient does not appear to fulfill a majority of the criteria listed above under Good signs, chances are you will have difficulty carrying out psychodynamic treatment, at least at the start. Sometimes after several months of the benefit of a structured and supportive therapy, patients can become more able to tolerate less structure, and also to become more psychologically minded. Often interns are in a hurry to get started with a case and may be lax in applying the criteria for selecting an appropriate patient. However, in the interests of your patient's well-being—and in terms of your avoiding narcissistic injury when your patient terminates prematurely—it is best to get over your "white- knight—I can-treat-anyone" complex and to bear in mind the guidelines given above.

Here is an example where the treatment decision was difficult. Georgie, a 31-year-old engineer, came to see me complaining that she was completely isolated from her colleagues, had no friends, and had never had a boyfriend. These social difficulties had been characteristic of her for as long as she could remember. She stated that no one had ever liked her, from primary school onwards. Her coming for treatment at this time was precipitated by an incident at work where someone she had thought was going to be her friend,

at last, had started actively avoiding her. Georgie's early life was extremely deprived, both emotionally and financially. Her parents, who were immigrants to this country, did not allow her to express herself at home and felt that she should not associate with other children at school for fear she would lose her attachment to her own background. The children at school soon began to tease, and even physically abuse, her for being different.

Georgie's father was physically abusive to her for no apparent reason. Her mother, who remained distant from her throughout her growing up, blamed her whenever anything went wrong in the household in an attempt to deflect the father's anger onto the patient. She was not allowed more than two toys at home, her parents' rationale being that, since she was an only child, she might become spoiled.

During the initial sessions, Georgie was cooperative, but remained fairly flat in her affect, except for the occasional laugh, expressed when describing very sad and painful past events. Although she knew her problems with other people arose from her abusive treatment by her parents, some of her thoughts about how others felt about her definitely had a paranoid flavour.

Again, all of the above information emerged during the first two interviews. Georgie was clearly intelligent and wanted to cooperate with whatever treatment was proposed. She showed some intellectual understanding of her current difficulties. Yet, I was cautious about the possibility of pursing a psychodynamic approach with her. Since her past relationships had been so impoverished, and there was really no one she had felt close to, I was not certain that she could form an alliance in the therapy, or that when the going got tough, she could still believe that this was a relationship she could trust.

I also felt that her lack of awareness of her own feelings was evidence of brittle defences, and I was concerned that she might decompensate should her defences be challenged. In terms of the possible transference, I kept in mind that since there was no precedent of a relationship with a positive, caring parental figure, the chances were that the more intense the transference became, the more rage, humiliation, and pain would be mobilized, and probably displaced onto me (!). This would make it more and more difficult for Georgie to tolerate remaining in therapy, and certainly for me to maintain a neutral, accepting stance. I decided that she would do best with a structured approach, at least for the first several months, with fairly active involvement on the part of the therapist, not in terms of deciding on agendas for her, but in being genuinely responsive to her and in role modelling a positive, relatively non-threatening relationship.

Transitions

Once a decision has been made about using a psychodynamic approach in the therapy, I often give the patient some indication of how to proceed. For example, I might say, "From now on, I'm going to stop taking notes, and I'd

like you to talk about whatever comes into your mind during our sessions." It is usually not helpful to give more specific instructions, such as "I'll be interested to hear all about your dreams," as this will bias your patient towards either bringing in material they know you want to hear, or not bringing in such material in order to resist the treatment or "rebel" against you. The process of starting and continuing the psychotherapy is elaborated in the next chapter.

If, during the treatment, I decide that a *change* in my approach would be helpful, then I explain clearly to my patient what the change will be and as much about the reasons for it as I think would be helpful to them. If I thought that a highly structured, behavioural approach might work for treating a specific phobia, for example, I would explain how this type of therapy could help us.

Having said that sometimes a patient can move from a structured and supportive psychotherapeutic treatment to a psychodynamic approach, I would also like to mention that there are patients who look great on all the points listed above under Good signs, but turn out not to be what they seemed, as you get more into the therapy. This may happen, for example, with people who have a borderline personality disorder, who may be fairly high functioning, but whose potential for negative transference and rage make doing this kind of work with them extremely difficult and sometimes impossible . It can also happen that a "star" patient who encounters an extreme crisis after starting therapy—such as a death or divorce—decompensates in a way that was not predicted, and therefore needs a different kind of therapy.

This situation often feels like a major disappointment for interns and their supervisors (who may be counting therapy hours for a requirement) and also for more experienced clinicians, who feel the patient has let them down. In these instances, if working psychodynamically is first and foremost, then it is better to select another patient for this type of therapy, and to continue seeing the first patient, if you are so inclined, in a structured and supportive therapy. Remember, both transference and counter-transference issues will still arise in supportive therapy, and can be thought about and discussed with appropriate others; and psychodynamic formulations can also be made. There are always opportunities for learning, as no matter what kind of therapy you select, the same patient–therapist issues will arise, whether or not you choose to bring them to light with your patient. As long as you are aware of your patient's limitations, and of which defences they need to survive emotionally, you can even try out an interpretation or two, provided you are not wedded to it and can let the interpretation drop if it is not picked up by your patient.

Any therapy situation with any patient can be a fruitful and exciting learning experience, as we shall see in the next chapter.

Chapter 5

The ongoing therapy

After the introductory work, there is another *transition*: from the relative structure of the beginning and history-taking questions to the patient's talking about whatever comes to their mind. This may be a difficult transition for your patient because the structure you imposed earlier often feels safe; that is, answering questions may seem easier than generating one's own material, at least at first. Therefore, it is important to tell the patient what is happening: for example, "I've got enough of this kind of information for now, so next time, let's just talk about whatever you want to talk about," or, "I'm going to put away my notes right now, and for the rest of the time, I'd like you to talk about whatever comes to your mind."

There may be a natural silence as your patient makes the mental shift and tries to adapt. If a patient is really struggling (e.g., "I don't know what to say"), you can comment empathically that this is difficult; or you can ask why it is so difficult, depending on the patient. Talking about the transition usually helps it to occur without either one of you having to work at it. In some cases, this might be an appropriate opportunity to educate your patient about what goes on in therapy (i.e., that he or she will talk and you will listen and you will both try to get an understanding of their problems). One can always say, several times if necessary: "This is *your* time." This may be a difficult concept for your patient to grasp, as they may feel, on some level, that they are here for you—to perform and be a good patient—associating therapy with school or family situations.

If the difficulty in getting started persists, you can search your mental transference file for the flags you put up during the history taking, thinking about what transference issues might already be in play that may be inhibiting your patient. Focus particularly on what you have heard in your patient's descriptions of their mother and father. If the description of authority figures is quite aversive—angry or frightening—then you might try reassuring your patient: for example, "I know this feels weird, and maybe like I'm expecting something particular from you, but just tell me what you're thinking, ok?" *No* transference observations or interpretations (e.g., "I wonder if you're experiencing me as you did your mother") are appropriate at this early point.

If the early parental relationships seem benign enough, then there is no need to pursue this at this time, just keep it in mind.

Still stuck? Then ask: "How did you feel after you left here last time?" Or "How did you feel coming in today?" Or "What thoughts did you have sitting in the waiting room?" Again—*do not ask* at this early time: "How did you feel talking to me?" This is too threatening in the early stages of therapy, when your patient doesn't really know what is expected, and probably will still be behaving as if they are in a social situation. If you ask prematurely, your patient will probably answer politely that everything about you and about talking to you is just fine, and since you won't be able to explore it further, you will unwittingly be reinforcing this kind of response to transferentially loaded questions.

As was mentioned in Chapter 2, *listening empathically* to your patient may not be as easy as it sounds. Freud described the listening posture of the psychoanalyst as evenly suspended, evenly hovering, free-floating attention (Freud, 1912b). Empathic listening is especially important in the beginning of therapy, to get a good understanding of your patient, so that you can give them a clear indication that you grasp the meaning of what they are saying. Remember that you are trying to facilitate the formation of a warm working alliance, as well as your patient's experience of being deeply understood. Once this is underway—after some hard work by both the patient and the therapist—then it is much easier to proceed with forward-moving observations or interpretations.

What happens now can be amazing! Your patient starts to adjust to your permission to say anything that is on their mind, and to the feeling of being held in a safe place, where someone is genuinely interested in what they have to say. For some people, putting their toes in the water first and then slowly going deeper feels better than diving in with an explosion of affect or a cathartic telling of painful events. Some patients feel quite guarded at first; some—especially those who have had prior experience of any kind of empathic relationship—sense right away that the therapist is on their side and that they now have support. These latter patients may feel incredibly relieved, and may show this by crying or becoming emotional in some other way.

In describing the flow of the therapy in this chapter, we will be referring to the concepts that have been introduced in the previous chapters—expanded here, with fuller examples. So, check back to the definitions if you don't feel familiar enough with any concept.

Two briefer-than-usual therapies

Some years ago, I was referred two young female patients for psychotherapy who were students at the same private high school, where the suicide of one of the students, a 17-year-old in her final year, had occurred. Although these referrals were close in time, the two patients were not friends, and so I agreed

to see both. Despite the patients' only being a year apart and both coming for the same presenting reason—their parents' concern about how they were reacting to the suicide—they reacted in very different ways to the experience of being in treatment.

Hannah, a good friend of the student who had died, was also in her final year of high school, and was having considerable difficulty continuing with her studies. Her parents had been separated for about two years; she lived alone with her mother in a condo, fairly far from the school. Her relationship with her mother was described as "quite close." Hannah was able to share with her mother a lot of her feelings about her social problems at school, and also about the suicide. When she told her mother that she was spending a fair amount of her studying time "talking" to her dead friend, her mother thought she should get help. After only one or two missed appointments, Hannah settled into the therapy, and seemed relieved to have someone outside of school or home to talk to. Even though Hannah already felt different from the other students because she lived in a condo and her parents were separated, she did not seem to mind this additional "difference" of having to see a psychologist. The probability of her developing an alliance with me seemed high at the beginning, as her close and rewarding relationship with her mother may have predisposed her to the expectation of having another positive relationship with an older woman.

As Hannah started to be able to express her deep feelings of grief over the loss of her good friend, she slowly began to see how the emotions she was having were similar to her feelings of loss when her father left the home. She missed his presence a great deal, and had never mourned this loss because she felt this would upset her mother. As this link was made, Hannah began to talk more and more about her father, and her early memories of times with him. She relaxed a little more at school, and she set up a meeting with the guidance counsellor to draw up a reasonable program of study. She allowed herself to reconnect with her father in a different way than she had when she was younger. She also allowed herself to maintain a close connection with her deceased friend's family, particularly her friend's mother and sister, whom she had feared losing as well (as she had feared losing her aunt and uncles in her father's family). All of these gains, and Hannah's willingness to continue exploring and understanding in the therapy, were evidence of a productive alliance. After a brief six months of treatment, Hannah told me that she had been accepted to the university of her choice, and that she wanted to study—you guessed it—psychology. She promised to send me a card from school.

Ingrid, who was seen for approximately the same length of time as Hannah in treatment, never quite developed a working alliance. Ingrid was 16 years of age, and was also a friend of the suicide victim, although not as close as Hannah had been. Ingrid was the youngest in a family of three siblings, and the only child left living at home with her mother and stepfather. Her older brother had left home for university, and her older sister—who had been in

psychiatric hospital on several occasions—was travelling to various cities, unable to settle. Ingrid seemed most attached to this sister and felt that she was exactly like her under the front she chose to show to the world; that is, possibly psychotic. She drove herself hard to keep up with expectations in this private school, and also as a defence against letting her "psychotic" side show. Her only recreation was an involvement in acting in school plays, which was structured enough, and fit with her desire to hide her real self from others.

In the therapy, Ingrid talked a lot about her older sister's problems, and seemed more concerned with these than with her own. This defence of guarding herself from disclosing her own terrifying issues—mainly her bad feelings about herself and the fear that she was exactly like her sister—seemed impenetrable during this time. As she could not trust that the therapy environment was a safe place to look at these fears, Ingrid ended treatment prematurely, telephoning to say she did not want to continue.

Thinking and feeling: A delicate balance

In terms of how you are going to process your patient's material, if you keep an eye on yourself while you are working, you should be able to notice what ways of listening help *you* to understand exactly what your patient is saying, and what techniques help to protect you from getting swallowed up in the intensity of your patient's emotions. Some beginning therapists find that seeing the patient and their problems as a puzzle to be solved is helpful to them. This is basically a (productive, we hope) use of intellectualization. As discussed in Chapter 1, it is imperative that some form of cognitive/intellectual activity be going on in your mind interlaced with the affective, empathic endeavour. I find that thinking theoretically—in particular, psychodynamically—in an ongoing way throughout a session helps me to pull out of the emotional quagmire, at least for some moments at a time, and to indulge my fascination for figuring out why my patient is experiencing these feelings, how they connect to his/her past or to their current situation, and of course, to their transference to me.

There are times when you are thinking less and feeling more with your patient. If you stay completely in your head and don't let yourself experience the emotions—particularly your patient's rage or sadness—you may be unable to be empathic. Of course, if you stay completely on a feeling level, then you won't be able to help your patient understand their emotions in the context of their history and personality dynamics, and you will be offering them approximately what a good friend might offer. It is definitely *a delicate balance.*

When Hannah, described above, broke down sobbing heavily over the loss of her friend during one of our sessions, I had already learned something about her past and current life situation. Even though I was intellectually aware that the intensity of these emotions was fuelled, at least in part, by her feelings of loss—and of being lost—when her father left, as well as by her recent

disclosure of feelings of guilt over not being a good enough friend to the suicide victim, I stayed with her on that feeling level for a significant period of time. I was trying to empathize with the extent of the pain she was experiencing, and to allow her the time and space to feel it. I offered her an intellectual understanding of the combination of emotions only after I was certain she had enough time—certainly more than one session—to express her feelings.

The requirement here is that the therapist be able to walk and chew gum at the same time: that is, to empathize with the patient while thinking. Then comes the decision about which type of intervention will be most helpful for the patient, and at what point. The process for the therapist sometimes feels like a movement "up" and "down": up to a cognitive level and down to an emotional level, at different points during a session, usually not staying in one particular place for the entire time. However, if your patient has just suffered the loss of someone close, or has been involved in a traumatic situation or a crisis, then all bets are off, and we remain on a feeling/empathic level for as long as the patient requires (while still thinking, of course).

This delicate balance between emotions and cognition required of the psychodynamic therapist gets easier with the experience of working with a variety of patients, learning how to formulate hypotheses, and getting to know how certain issues affect you as a therapist, as well as what type of patients you find it easier to empathize with and which ones seem more difficult (that is, understanding your counter-transference reactions). Most beginning therapists find it surprising to discover how strenuous it is to spend an hour (or 50 minutes) with a patient in psychotherapy. Taking into account the cognitive work that has to go on behind the scenes, that is, remembering the characters in your patient's past and present life, keeping several hypotheses afloat at the same time and selecting one that you offer at an appropriate moment—this kind of thinking takes energy. Of course, empathizing takes a lot of energy, too.

If you offer what seems to you to be a stellar observation/explanation/interpretation to your patient and they reject it the first time, do not discard it. Your job now is to think about which mental file it should go into: Should it be tried again at a later time in its original state? (see under "hammering home," referred to on p. 20). Should it be modified in some way and maybe tried again sooner in its revised edition? Often when your patient rejects a hypothesis, it not just rejected out of hand. Usually there is a statement such as: "No, that's not it, because I never had that experience with my mother." In this way, your patient offers a helpful hint about revising your hypothesis. Should you discard your interpretation, seeing it as inaccurate after listening to your patient? If you decide not to discard it, then you can keep your theory stored away, and you will still have it floating in your mind for what might be a more opportune time. Staying loose mentally should produce the most therapeutic results. You may need to keep several hypotheses on your mental

screen at once, moving back and forth with some ease, kind of like intellectual rocking.

Greenson's (1967) description of his mental processes in an instance when he had difficulty understanding one of his patients follows. If you keep in mind that Greenson was Marilyn Monroe's analyst, you might find the paragraph more interesting. (Of course, we don't know which of his patients he is referring to here):

> At this point I change the way I am listening to her. I shift from listening from the outside to listening from the inside. I have to let a part of me become the patient, and I have to go through her experiences as if I were the patient and to introspect what is going on in me as they occur. What I am trying to describe are the processes that occur when one empathizes with a patient. I let myself experience the different events the patient has described and I also let myself experience the analytic hour, her associations and her affects as she seems to have gone through them in the hour. I go back over the patient's utterances and transform her words into pictures and feelings in accordance with her personality. I let myself associate to these pictures with *her* life experiences, *her* memories, *her* fantasies. As I have worked with this patient over the years I have built up a working model of the patient consisting of her physical appearance, her behaviour, her ways of moving, her desires, feelings, defences, values, attitudes, etc. It is this working model of the patient that I shift into the foreground as I try to capture what she was experiencing. The rest of me is deemphasized and isolated for the time being.
>
> (Greenson, 1967, pp. 367–368)

The judicious use of interpretation

Jeff, a 39-year-old single businessman, complained to me of problems in his relationships with women. He had been intimately involved with several women in the past few years, all of whom reportedly had wanted to marry him, but to none of whom he could make a commitment. Some of his relationships were with friends of his former girlfriends, which had complicated things further. At the time of entering treatment, he was involved with a 28-year-old woman who had never had a long-term relationship. When he had again come up against his old pattern of wanting to leave, she had suggested he get professional help.

In the first session, Jeff seemed anxious to impress me with his business successes, and seemed reluctant to talk about the more personal areas of his life. He did manage to tell me, however, that his mother, a domineering woman, did not think of him as having made it, because he had never completed university. He ended by assuring me that he wanted to work on his commitment problems, in particular in relation to the woman he was now seeing.

Jeff arrived at our second session, one week later, with a big smile on his face, and announced that he was engaged! He had thought about our talk, and apparently had decided there was no reason to delay any longer. So he had bought his female friend—now a zealous believer in the power of psychotherapy—a large diamond ring.

So, now what? I was at a decision point. Restraining myself from shouting, "Congratulations! We did it!" I asked Jeff to describe his thoughts and feelings leading up to the engagement. While listening, I thought about the engagement as a possible form of acting out. Maybe the first session had been so anxiety-provoking that he had needed to call up this characteristic defensive form of behaviour. I thought about the content of the session: he had talked mostly about his work, a little about his relationship problems, and he had mentioned his mother. Then I thought about his possibly fearing that the therapy might lead to his finding out information about himself that he had been fending off, and that, this time, he was really on the hook. Of course coming weekly for therapy implied a commitment—as it happened, in this case, to a woman—too. Then I thought about the transference. I knew nothing yet about his father, but I did know that he felt he could never meet his mother's expectations—not having the right "equipment" (a university degree). Possibly I was already being perceived by him as this critical mother. I remembered his smile and excitement as he told me the news—maybe an indication that he thought he had done something right, and that I would be pleased.

Even though I know the reader must by this time be worried about our patient, Jeff, with all this "thinking" going on, I have to admit that I took another moment to marvel at the ingeniousness of what he had done. His unconscious use of the defence of acting out had achieved the following: solved his commitment problems with his girlfriend; given him the opportunity to once more demonstrate his success in making money, by buying a large diamond ring; pleased a critical mother who probably thought he couldn't do it; saved himself from the commitment of psychotherapy, as he was now cured; and saved himself from the anxiety and dread of learning more about himself, which he seemed to expect would only shine a light on his failings—this, in part, because of the early maternal transference.

By now thinking that there was, in our poor patient, a fascinating combination of factors, I had to decide what to do. I decided to file all these thoughts for later, and not to interpret his behaviour as acting out at this time for the following reasons: 1) I did not know Jeff well enough to know whether any of my hypotheses might be helpful; 2) it was so early in the treatment that we had not had a chance to develop a working alliance. I did not know how he would react to hearing my thoughts and feared I might lose him; 3) an interpretation might prematurely curtail his own further exploration of his thoughts and feelings about the engagement and whatever insights might be forthcoming from this; 4) I wanted him to learn that

insights in therapy will be gained by the slow and thoughtful work of a partnership, not by my giving him quick explanations of his behaviour.

The only reasons I could think of for pointing out the acting were: 1) to save Jeff and his fiancée some embarrassment by their possibly calling off the engagement before any further announcements; or 2) to show my patient how smart I was to have spotted this (rather obvious) piece of defensive behaviour. Tempting as the latter reason was, I decided against it.

Finally, coming back to our patient: I encouraged Jeff to spend this second session telling me his conscious thoughts about being engaged. Near the end of the session, he spontaneously began to talk about his mother and his ambivalence about telephoning her with the news.

Jeff returned, responding to the genuine invitation to say what he thought, and for the next few sessions, I tried to get to know him better. I spent as much time as he could tolerate on a feeling level, helping him to help me get a sense of his emotions and, in the process, legitimizing them. After about six months of therapy, he asked me what I thought about his engagement. This was a signal that he was ready to explore the issue himself, and so we talked about this for the next several weeks. By the time my suggestion about his possible acting out was offered, I knew a great deal more about his relationship with his mother, and about his defensive style, and I was better able to predict the effect that this interpretation might have on him. For his part, Jeff was becoming more and more aware of the intensity of his feelings of failure regarding his lifelong attempts to please his mother. He was also able to begin to accept that he might be fearing he had not pleased me.

Jeff stayed in treatment for two years, deciding that he would remain engaged but postpone the wedding. He was able to work on his rage at his mother, and also to become conscious of his need to defend against an identification with an "inadequate" father which had led to an exaggeration of his assertiveness at work. He changed jobs to one with slightly less pressure and status, but that he enjoyed more, and after two years, he felt ready to take the plunge into marriage.

Most of the time, it is hard to discuss the process of psychodynamic psychotherapy without talking about *interpretation*. In psychoanalysis, you can't have one without the other: interpretation is the major component of the therapist's armamentarium. By offering an interpretation to your patient, you are offering him or her a dynamic understanding of their troublesome thoughts, feelings, dreams, or behaviours. You help your patient to put these into a context—the context of their life so far, as well as their personality dynamics (as described in Chapter 1).

In the example of Jeff, above, we can see that an interpretation is most successful if a working alliance exists between the patient and the therapist, if it has been thoroughly thought through by the therapist, and if it is correctly timed—being given when the patient is readiest to hear it. As was stated earlier, interpretations often have to be given more than once to be able to be heard and reflected on by the patient.

Sometimes when an interpretation is fully heard, this can change the flow of the therapy. The patient becomes aware of how they have been thinking and of what they have been doing for a very long time.

It is helpful to keep in mind that many patients will experience interpretations as criticism, especially in the beginning of treatment. Most of us grew up with parents who gave us at least some criticism, rather than nonjudgmental observations. (This may be changing a little as parents learn more about encouraging their children.) Your patient, then, has to begin to see your hypotheses (interpretations) as helpful observations, while you are tuned in to them. They will usually learn that they can do this type of thinking on their own, whether it is to facilitate the therapy or to understand a maladaptive behaviour pattern they always disliked in themselves.

An interpretation may also be used to help a patient to see how they are resisting the treatment. The concept of *resistance* is explained in Chapter 1. When we are interpreting (giving an understanding of) a possible resistance, we are often pointing out our patient's (usually) unconscious motivation to obstruct the therapy, and inviting our patient to reflect on why they may be doing this at this time. The hope is that this type of intervention will not only give the patient valuable insight into their actions, but will also assist him or her to move along in the treatment. In the case of Jeff, above, who became engaged to his girlfriend rather prematurely, this acting out could have been interpreted as a resistance to the therapy; however, this type of intervention would no doubt have been experienced as criticism, especially taking into account Jeff's past experience.

When the silence is deafening

Silences during therapy are sometimes resistances, and sometimes just pauses. They may be particularly difficult for interns to manage, as they occur in a manner that is rarely allowed to blossom in social situations. In psychoanalysis, when the patient is lying on the couch and not looking directly at the therapist, silences are much easier to handle, and sometimes go on for relatively long periods of time. When you and your patient are face to face, however, a silence can feel stressful, or even embarrassing. Some patients feel that it is their "fault," and that they should try to think of something quickly to break the silence. This often reflects their experience in social situations. Some patients actually feel quite comfortable and safe when there is a silence, appreciating the space to think their own thoughts.

Silences in psychotherapy always provide grist for the mill—sometimes, but not always, for the mill of resistance. Before trying to understand your patient's silences—or, perhaps more realistically, after your first experience of prolonged silence in a session—it will be important to get an understanding of your own reaction to silences, both in everyday situations and in psychotherapy, so that you will be able to predict what effect your patient's

silence may have on you. This can be done in supervision, in your personal therapy, or with colleagues. How do you feel during a silence? How much silence can you tolerate comfortably? What about silence bothers you?

Beginning therapists often have trouble tolerating long silences, that is, a silence of more than two or three minutes. Some therapists may feel threatened, as if the patient doesn't like them or want to talk to them, and therefore that this is proof they are terrible therapists. Needing reassurance that this isn't so, they may feel the need to rush in and discover what the patient is thinking. Some therapists experience the feeling of being excluded during silences, which may relate to previous experiences in family or social situations. Some patients never allow silence; others may tend to stop talking periodically. One of my supervisees, who had a patient of the latter type, thought I was being unnecessarily hard on her and her patient by asking her to wait a little longer during periods of silence. She defended herself by saying it was cruel to let her patient "sit there and stew." This was a therapist who herself found silences unbearable.

When a patient is silent, it may indicate that a censoring process is operating, which may be conscious or unconscious. If this is the case, then possible reasons may be: what the patient has just been talking about may have triggered another thought, but not a thought that is easy to share. They may actually be aware of the thought, or experience/memory, that came to mind, but may not dare say it out loud. Or they may only be aware of thinking about "nothing," having a "blank mind," and may not be conscious of what is being censored or repressed. Often I find in these situations that the patient will look away, or look down, quite deliberately, while they are thinking the unsaid thought. Then, when they have finished this thinking, they will look directly at you again, signalling their readiness for contact. Until this occurs, it is best not to interrupt. You may never know about whatever conscious or unconscious thoughts are floating around in your patient's mind during silences if you break a silence with your own agenda, or with a specific thing you imagine is troubling your patient. Sometimes your patient may become silent at certain regular points in the session; for example, right at the beginning or near the end. Then it is interesting to understand together what it is about beginnings or endings that causes this.

If a silence goes on for an inordinate length of time, and in your clinical judgment is unproductive, you may have to ask a question. It is important not to be critical about silences, or to make an intervention that causes your patient to feel that silences cannot be tolerated during treatment. Comments such as, "I'm wondering what you're thinking about right now," or, "Can you tell me how you're feeling right now," or, "Are you having any thoughts you could try to share with me," all focus on the *patient's* experience and allow for the possibility that you can be surprised at hearing what your patient has been thinking about. Once your patient volunteers all or part of the information, it is usually interesting to explore what it was about that particular thought, feeling, or topic that made them go silent.

Some patients are never silent. One of my patients has a habit of saying, "I guess you're going to give me a speeding ticket today," indicating that she has a lot to say and wants to tell me as much as she can. And there are some, who if not prompted, could be silent through most of the session. In terms of the former, the volume of speech and lack of reflection may constitute a resistance to exploring more deeply, and should be commented on by the therapist at the appropriate time. In the latter situation, where patients seem more comfortable in total silence, this may indicate a fear of the therapy or the therapist, feelings of unacceptable rage at having to be in therapy, or in some cases, a social style that indicates severe shyness with others. This is all grist for the therapy mill.

Free association

There are certain, often exciting, moments in the course of psychodynamic/psychoanalytic therapy when we are privy to illuminating glimpses into our patient's unconscious. This is not to say that these moments don't occur in other forms of treatment, but they are seldom noticed or remarked upon. For the psychodynamic therapist, anything from the unconscious is golden. Patients in this type of therapy, because they are encouraged to say whatever is on their mind and are not given a particular structure, will often *free associate*, whether or not they are lying on a couch. Free association occurs when a patient describes the exact thought that came to mind at a specific moment in association with another thought or event—without censorship (e.g., "My mother was always so critical of me. By the way, did you know the colour of your office is awful. It makes everyone look yellow"). Their spontaneity and the tone of their voice tip off the therapist to the genuineness of the free association. Often the thought appears to be a non sequitur, particularly to the patient, but the reason for its coming to mind soon becomes clear, and it offers a great deal of valuable information to both parties. The thought may be introduced as, "I don't know why I'm thinking about this, but . . .," or, "It seems ridiculous but this thought just came into my mind," or, "This doesn't relate to anything but . . . ."

One of my patients, a 45-year-old social worker who was moving towards the termination of her analysis, had for several weeks been experiencing an unusual amount of anxiety that she could not readily identify. She started one session in silence and when I said, "Umm?" she began humming a tune. (Granted this is a lot easier to do when lying on the couch.) As she hummed it louder, we both recognized it as the Beatles' song *She's Leaving Home*. This song, as she understood it, speaks sadly from the perspective of the parents of a young woman leaving home. From this association, she was able to elaborate on her fear that I did not really want her to end, and would miss her too much, as she thought her mother had missed her. Her mother had become seriously ill when the patient had married and moved to a different

city, and she had never recovered. We could say, in other words, that she killed her mother by leaving her. This patient needed to know that I would survive her going, and that I would still be there for her in the future (at least as far as I knew) should she want to return. This "new" material, that is, that part of her transference to me that concerned what she imagined she would do to me by leaving, emerged as a result of her free association.

Working with dreams

Dreams are, of course, another window into your patient's unconscious that can provide valuable material, and possibly insight, of which he or she may have been previously unaware. It is well over 100 years since Freud published what he regarded as his best work, *The Interpretation of Dreams* (1900), yet we still employ many of his original ideas. In the early days, the technique of psychoanalysis was almost synonymous with that of dream interpretation, and patients who insisted on dwelling on other matters were seen as resistant to the analysis. In the first chapter of *The Interpretation of Dreams*, Freud quotes a beautiful description of dreaming written in 1875 by the German author, Hildebrandt:

> There are few of us who could not affirm, from our own experience, that there emerges from time to time in the creations and fabrics of the genius of dreams a depth and intimacy of emotion, a tenderness of feeling, a clarity of vision, a subtlety of observation, and a brilliance of wit such as we should never claim to have at our permanent command in our waking lives. There lies in dreams a marvelous poetry, an apt allegory, an incomparable humour, a rare irony. A dream looks upon the world in a light of strange idealism and often enhances the effects of what it sees by its deep understanding of their essential nature. It pictures earthly beauty to our eyes in a truly heavenly splendour and clothes dignity with the highest majesty, it shows us our everyday fears in the ghastliest shape and turns our amusement into jokes of indescribable pungency. And sometimes, when we are awake and still under the full impact of an experience like one of these, we cannot but feel that never in our lives has the real world offered us its equal.
>
> (cited in Freud, 1900, pp. 62–63)

Dreams, which are with us from infancy to death, are still seen to be of tremendous importance in psychoanalytic therapy. Even more contemporary data on the neurophysiology of dreaming has found that Freud was basically correct in his approach; namely, that dreams have a meaning and that this meaning can be understood. Medical science has found that there is a surprising regularity to dreaming in all of us, as we move through the four stages of sleep. Most of us have three to five dreams per night. Dreams occur

during REM (rapid eye movement) sleep, where we spend—if we're lucky –about two hours each night. And dreams last longer as the night goes on, so that our last dream is our longest and usually the easiest to remember (Frayn, 2005).

Patients in forms of therapy other than psychoanalytically oriented therapy or psychoanalysis still dream of course, but even though they may mention their dream, usually these dreams do not become a focus of the work. If they are given attention at all, the dreams of these patients may be handled in a very different manner.

Frayn (2005) states:

> There are so many types of dreams that it is hard to classify them satisfactorily . . . whether the dream is a "good" (pleasurable) or "bad" (unpleasurable) dream seems to be a basic way to categorize [them]. If dreams were meant to help avoid painful affects, there should not be so many unpleasant dreams or nightmares, but we see that bad dreams make up about 10 per cent of normal dreams in normal subjects. The role of the emotions experienced in the dream, as well as in the telling of it, is paramount and may be more important than the dream narrative itself.
>
> (Frayn, 2005, p. 132)

As productions of our patients, dreams are precious material and should be treated with care. When your patient begins to tell you a dream, it is important to listen to all the details carefully and not to interrupt. Because of the nature of dream material, patients will often be embarrassed by the content of a dream, or the lack of a coherent story. It is important to encourage your patient to tell whatever they remember—even if it is just a small piece of the dream—and to disregard logic.

Dreams may describe in different ways how worried your patient is about an issue, how stuck they feel in the treatment, or how much progress has been made—sometimes before that progress has even been consolidated in the person's life. In fact, many dreams that are brought into treatment are used as forms of communication by the patient, and it is often productive to think about what your patient may be trying to tell you by bringing in this dream at this time. Some patients can only talk about certain parts of their life, for example, sexual activities or fantasies—or indeed transference feelings—by couching them in the more acceptable manner of their having appeared in a dream. For some patients, the dream is a gift to their therapist. They are saying, "See how much I believe in our work together and, in particular, your orientation to it—I have brought you a marvelous dream."

Freud understood dreams as wish-fulfillments, mainly from early childhood. He wrote that the interpretation of dreams is the "royal road" to a knowledge of the unconscious activities of the mind. The technique of free association (described above) which Freud devised was also used in relation to dreaming

to provide us with insights into the meaning of the dream for the dreamer. Today we would recognize that dreams may depict other internal messages besides unconscious childhood wishes. They also represent fears, anxiety (Freud actually wrote about "exam anxiety" dreams 100 years ago, you will be reassured to know), conflicts, and in the case of traumatized patients, recurrent efforts to master traumatic experiences (Gabbard, 2010).

Although contemporary analytic practitioners have modified some of the early theories, most analysts and analytic therapists still use the basic concepts passed down from the master himself. First, Freud referred to the surface content of the dream as the *manifest content*. The manifest dream is the "story" or fragment of the dream that people remember and can tell others. He called the underlying motivation for the dream, and the symbolic meaning of the dream, the *latent content*.

Freud also identified several "laws" that the dreamer may use to construct the dream, that is, that latent (unconscious) thoughts of a dream get transformed into manifest (conscious) thoughts through various mechanisms (Gabbard, 2010). One such mechanism is *condensation*—which combines or condenses more than one wish, feeling, or impulse into one dream image. For example, one individual seen in a dream may have the characteristics (hair colour, size) of some other individual known to the dreamer. In the dream, these two individuals are combined to form one person. Another is *displacement* —where, for example, the intensity that is associated with one person (e.g., mother) may be diverted to another, stand-in, person who is less emotionally charged (e.g., a friend) to become more acceptable to the dreamer telling the story as in: "I dreamt I ran over my friend Judy in the car—I'm not sure why I dreamt that. I actually like Judy." *Symbolic representation* speaks to the dreamer's use of symbols to represent intense feelings; the popular example of a dream of trains going in and out of tunnels representing sexual intercourse comes to mind. These three mechanisms are used in our more primitive attempts at disguise. Another mechanism, *secondary revision*, is described as more sophisticated, and involves an effort by the dreamer to edit out the irrational and bizarre components of the dream before waking, so that it forms a rational story. In fact, we never hear the dream without some revision, because the minute the patient starts to describe the dream, they are revising it; writing it down may involve even more revision. However, the essential components are usually still discernible.

While we are listening to a dream described to us by our patient, we can think about the possibility of any of the above mechanisms being used. Like with defence mechanisms, certain patients may have a tendency to use certain dream construction mechanisms repeatedly. Some dream mechanisms can be seen as analogous in function to defence mechanisms.

Although they are aware of these dream laws, or tricks of the unconscious, self psychologists think that sometimes a cigar is just a cigar: that a dream may mean just what it is saying. They refer to these dreams as "state dreams,"

dreamt to describe, or communicate, how a person is feeling at this particular time.

To return to the man who smoked the cigars, another concept he described in relation to almost every dream is what he called the *day residue*, which refers to the triggering factor from the patient's waking life—usually found in the preceding day—that precipitates the dream or starts the story. In the following dream, the day residue was a long telephone conversation my patient had with a friend the evening before, which she had great trouble ending:

> *She was with her longtime friend and was trying to tell this woman that she was wrong about something. The friend kept smiling. Finally, my patient started shouting, and then pinched and pulled the friend's cheek really hard. The friend kept smiling through it.*

The manifest dream, which in this case was itself filled with affect, was the story of how this young woman felt about her powerlessness with a friend who was always right about everything, and who had the annoying habit of starting a new, "important" topic as my patient was trying to end a conversation.

To move from the manifest to the latent content, I asked my patient what she thought about the dream, and encouraged her to talk about associations to specific parts of the dream that seemed out of character, or unusually compelling. Often the patient themselves will be mystified over one part of the dream that does not seem to fit.

In the above case, my patient first talked about her friend's know-it-all attitude. She moved on to notice that her deceased mother had always smiled, or even laughed, when the patient was angry, and didn't seem to be affected by it. In the past, she had sometimes had a vague feeling that this friend reminded her of her mother—about whom she had very few positive memories—and how this contributed to her ambivalence about the friendship. This led her slowly to an awareness, on an even deeper level, of her need to keep her mother alive in her current life—an awareness that genuinely surprised her. Her conscious wish had been to bury her mother as quickly as possible after her death. We then began to explore her inability to let go of a negative person in her life.

The latent content of the dream then, what we think of as the unconscious being expressed through the royal road, can be arrived at by the patient's free associating to the different elements of the dream. The dream should be respected as our patient's unique creation, which probably has some meaning to them that we cannot fathom. Therefore, *their* associations are what counts. The dreamer is the author, the artist—we are the observers. A therapist's laying on an "interpretation" of a dream shortly after hearing it at best sounds like crystal-ball gazing and at worst stops the patient from any exploration of the

dream, if they are so inclined; in addition, of course, it sets up incorrect expectations of the psychodynamic therapist.

When I was an intern, my patient, a 27-year-old woman, presented me with a dream quite early in the treatment. In the dream:

> *She was in my office, seated at a table, eating vegetable soup. The soup was filled with all kinds of hearty chunky pieces of green vegetables. She was eating rather slowly until I came and sat down beside her, at which point she began spooning the soup into her mouth as quickly as she could. The dream ended with her being unable to finish the soup.*

The manifest content of the dream seemed quite clear to me, and despite the ending, my immediate association to it was that this patient was already experiencing me as a wonderfully nurturing person, giving her the most nutritious of food, and that her increased speed in eating when I came along showed her eagerness to cooperate in the treatment with me. Fortunately, I was able to keep my newly acquired expertise to myself and to allow my patient to reveal as much of the latent content as she could through her own associations.

For her, the dream called up an image of her very domineering aunt, a woman who told everyone in the family—particularly her mother—what to do in every situation. As a young child, this patient's only rebellion against her mother was not eating, and it so troubled her mother that she asked the aunt for advice. Her aunt took this opportunity to be at my patient's house when she arrived home from school for lunch, "to get me to eat." Apparently, this aunt would sit beside my patient at the table, exhorting her to "chew, chew; swallow!" with every bite which, of course, had been a rather terrible experience.

These observations opened up the possibility of a transference interpretation of the dream—my patient's possible fear of me, and/or her anxiety that I would move her along faster than she wished to go. Transference manifestations in dreams will be discussed in the next section.

Dreams can serve a defensive function, for example, as a resistance to the treatment. Having a dream and not remembering it, for example, "I had a dream last night that was pretty heavy, and I think you were in it, but I can't remember it," may be frustrating for the therapist. In this case, identifying it—at least to yourself—as resistance can help you to look at the therapy as a whole and try to understand with your patient what is making them put the brakes on at this time. Some patients bring in a flood of dreams, one more colourful than the next. Although this may seem fascinating and as though you have a "star" patient at first, if there are too many dreams, you have to consider that the dreams are functioning as a possible resistance and are helping your patient to avoid more painful, difficult topics. If you suspect this may be happening, you can ask your patient directly about it; for example,

"Have you noticed that you have been bringing in a lot of dreams lately? I wonder what's going on?" Or, you can think back to those sessions preceding the flood of dreams, and inquire more about what was being talked about at that time.

Before leaving this discussion of dreams, we should note that not every dream needs to be completely understood or even closely examined. It may be that some dreams seem more significant for your patient, or appear at a particular turning point in the therapy; other dreams may seem more "ordinary" or may lead to dead-ends when explored in a meticulous manner. Sometimes these latter types of dreams—while not seeming important at the time—will be recalled by the patient in a later session, and may be able to be better understood in retrospect. Recurring dreams are usually anxiety dreams. These dreams can often be understood successfully as time goes on. As in all parts of the therapy, working with patients in uncovering the possible underlying meaning of their dreams must be done with empathy and sensitivity.

Moving along

As the therapy progresses, new issues that were not brought out in the initial sessions will undoubtedly arise. In the case of a patient presenting with memory problems, for example, it was discovered several months into treatment that she had been sexually molested by her father. When new material does emerge, it can be carefully explored with the patient, and often the reasons for its not having emerged sooner can be explored as well. In the above example, this patient's father was the only one in the family who had shown her any love and acceptance, and so it was extremely difficult for her to "remember" the sexual activity earlier in the therapy. She was afraid that allowing herself to know about this would affect both her own feelings for, and her therapist's impression of, this father, whom she had so desperately needed in childhood and felt loyal to.

Another phenomenon that may occur as the therapy progresses is that you will hear the same material from the history or earlier sessions, but now it sounds different, taking on a deeper meaning once you know your patient. For example, in the case of Jeff, the man with "premature engagement disorder" described on p. 56, as he told me more about his critical mother and inadequate father—already described in the history—over and over again in different contexts in our sessions, the information had a different effect on me, almost as if it were now about the Jeff I knew and cared about. This usually ensures that the details of your patient's life stay in your mind. It always amazes me how I can remember my patients' friends and family members—and even their dreams—when I can't remember what I had for breakfast that day.

Flagging and dealing with the transference in the ongoing therapy

Re-reading the section on Transference in Chapter 1 will be helpful before continuing.

Even while the therapeutic relationship is in an embryonic state, there will already be issues regarding your patient's experience of the therapy, and their experience of you, which will continue as threads throughout the treatment. As was described in Chapter 1, these kinds of themes can be displacements of the patient's experiences of significant others from their past onto you, and sometimes onto the therapy situation as a whole. Through these early themes, the therapist gets a sense of what the patient is doing mentally with this novel process of psychotherapy, how they are categorizing or labelling it, and how they are reacting to it. Patients will use situations as well as individuals from their past in their attempt to adapt—using a kind of template from their early experience.

Discovering the projections and displacements that will inevitably emerge is an ongoing task for the therapist; once you become aware of them, you can flag them for yourself and make a judgment about whether and when to help your patient become aware of them, by offering an observation or an interpretation.

It is impossible to overestimate the impact of the personal figure of the therapist on the patient—even when they are lying down and can't see you! Everything that you do and say takes on the utmost importance for them —it's like the volume is really turned up. Although a transference is developing, your patient will be extremely sensitive to any real clues about your personality. Comments that your patients make about you are grist for the transference mill, whether they seem to be projections or not. It is always interesting to flag these and if they are not explored right away, to see how they change as the therapy progresses. As has been mentioned earlier, the most probable transferences to emerge in the early stages of treatment, and sometimes continuing throughout, are parental. By the middle of treatment, sometimes sibling or other transferences (grandparents, teachers) may be manifested.

There are several ways of identifying transference reactions. including those mentioned in Chapter 1. Your patient may have an excessively strong reaction to something you have said or an event (such as a brief vacation), or possibly an under-reaction. There is a change in behaviour not usual for your patient—they come late or come early, talk less or more, behave in a seductive or flirtatious manner, or dress up—or dress down—for the session. They may express a greater than usual interest in your life outside the office; bring a gift at an unusual time; seem intent on pleasing you by repeating how much you are helping them; react strongly to seeing other patients coming into your office, or leaving; or hang around in the hallway or the office building for an unnecessarily long period of time after the session.

The therapist's response to these indications of transference feelings is critical. What is of utmost importance to remember is that you are dealing with a transference reaction, and although it may have been triggered by something about you consciously or unconsciously, it still undoubtedly relates to your patient's history and experience. Therefore, there is no need to blush when your patient says you are beautiful/handsome, or to ask your partner for a divorce when your patient reveals they are falling in love with you. As exhilarating as an idealizing transference feels, as demoralizing as a devaluing transference feels, and as uncomfortable as an erotic transference feels, try to keep in mind that these feelings are being displaced from people in your patient's past onto you, and are almost always able to be understood—by both parties eventually—in this light. As long as you stay with your patient, always listening, and trying to grasp the world from their point of view, you will be able, piece by piece, to unravel the meaning of the various transference reactions that will emerge during the course of the therapy.

It should be borne in mind, however, that there is no transference reaction—no matter how fantastic—without at least a germ of truth, just as there is no realistic relationship (particularly our romantic relationships) without some trace of a transference fantasy.

Displacements from the past can be triggered by elements in the present therapist–patient relationship—even in the more primitive forms of transference. We could say that there are two levels of transference operating simultaneously: the part of the therapist–patient relationship that is "real," and precipitates the arousal of feelings from the past, and the transference reaction that represents the displacement of these impressions.

Sometimes it is difficult for the therapist to know on which level to start working with the patient, and so it may be helpful to envision it as a two-step process—keeping in mind everything you know about transference in general, about this patient in particular, and your own hunch about what is going on. The first step is to talk about those parts of the present-day therapist–patient relationship that appear to be contributing to your patient's current feelings. For example, you might say, "It seems that you're feeling angry at me right now." If this observation is made in a nonthreatening way, and if it is, in fact, the case, then your patient can hear it and agree with it. It is interesting that we use the emotion of anger so often in these examples. Why do you think that is?

Let us say that the patient felt angry because they thought the last session ended too abruptly. The session may have, in reality, ended too soon for the patient, and the therapist for some reason—either feeling rushed or possibly uncomfortable with having to end the session—may have, in reality, ended it more abruptly than usual. Here we can see a possible contribution by both parties. After the patient's feelings about how the session ended have been explored, then any familiar feelings the patient had when this occurred—any memories—can be brought out. For example, the patient might say that they

often felt cut short by their father in the past when trying to talk about something important. The link can then be made with the therapist, as in: "When you felt I ended (or, indeed, 'when I ended') last week's session too abruptly, it reminded you of the feeling you used to get when your father cut you off." In this way the patient can see that: 1) they are "allowed" to be angry at the therapist—in fact, it leads to productive results; 2) the therapist and the therapeutic situation survive the anger; 3) the therapist can be, at times, the object of displacement and that some of their feelings are not intended for the therapist personally—which enhances the "as if" quality of the transference, described in Chapter 1; and 4) the therapy can stimulate significant feelings from the past that need consideration.

Sometimes a patient may put you on the spot by inquiring about your personal life in what feels like an intrusive manner. We all have our limits in terms of how much intrusion we can tolerate—which is usually related to our own family backgrounds. If we're really on the ball, we can usually avoid these uncomfortable situations by answering the question with another question. For example, if your patient asks directly, "What part of the city do you live in?" you can ask, "What part of the city do you imagine I live in," or, "I'm wondering why you're asking this at this particular time." The rationale for handling it this way—and it is true, actually—is that you keep focused on the patient and their projections, not on your life. After all, you really are interested in why they ask; their answer can lead to a disclosure of transference fantasies.

(i) Transference elements in gifts

If a patient brings a gift, this may be difficult for beginning therapists to handle. Classical psychoanalysis used to dictate that no gift ever be accepted, and that the meaning of every gift must be interpreted. To send the consciously well-intentioned patient back home with their gift seems rather harsh, and probably no one, or almost no one, would do that today. I mentioned in Chapter 1 that one of my patients brought me the gift of a large hourglass, and this caused us both great amusement. I have received other appropriate gifts, or at least what I think of as appropriate—chocolates at Christmas, someone's baking that they have been talking about for me to try. Once, at termination, I received a brass statue of two parents and two children from a patient who, although married and the mother of two, had had great difficulty in manoeuvring her own parents out of her new family, and in coming to realize that the boundaries of this new family were the most important. That gift, given many years ago, still sits on top of my filing cabinet. Were those gifts for me? Or for me as transference object?

What is important with gifts, as with everything else, is the transference component, the motivation for the gift, the patient's fantasies about it—choosing it, imagining how you would react receiving it, etc. We must always

be aware that the gift may not be what it seems on the surface. My patient who brought the hourglass certainly had issues with the ending of our sessions. Some patients bring a gift when they are "in love," some when they are trying to be special to the therapist, above all others, and some—you guessed it—when they are angry as a way of appeasing, or even protecting, the therapist, even though the therapist may be unaware of their anger. Some patients bring a gift before they are about to ask a favour of the therapist. A gift can sometimes be a resistance, a trade-off (e.g., "I'll give you this gift if you promise not to pursue talking about my mother's death"). In case you're not entirely satisfied with the above, you could also consider what gifts mean to your patient: Who in the patient's life gave them gifts, and for what purpose; to whom did they give gifts?

After you do what is socially correct by thanking the patient for the gift, then you should ask, if it is not already obvious, "Tell me about this gift," or, "What were you thinking about when you decided to give me this gift?" Even if it is an "appropriate" gift-giving time, such as Christmas, there is usually a story about the particular gift and, as long as the discussion is conducted in an accepting and non-judgmental manner, your patient will appreciate the chance to tell it.

If the gift is not given in the last session, it can provide a perfect opportunity for exploring transference reactions. What your patient chose for you, and how they imagined you would react are good starting points. Again, as mentioned earlier, their relation to gifts and the giving of gifts usually yields information on their family traditions and the effect of these on them. Of course, the meaning of the gift—to both of you, if this seems appropriate—can be continued to be talked about in subsequent sessions. One of the issues that may arise here, especially if you are too grateful for the gift, is that your patient will bring more gifts, or bring gifts annually—even though they may no longer feel like doing so. As we know, because the transference is different at different points in the treatment, our patients will hopefully not stay in the same state of mind. Therefore, it is important to accept the gift graciously, while indicating that this is a special, and generous, gesture, that need not be repeated.

(ii) Transference elements in dreams

We discussed earlier psychoanalytic/psychodynamic ways of working with dreams. As mentioned, dreams very often have a transference meaning. A middle-aged professional woman I was seeing in psychoanalysis had difficulty tolerating not knowing much about me. About two years into the treatment, as we began to talk about her marriage to an introverted, isolative husband, she revealed that their sex life together was practically non-existent. One day she brought in the following dream: *I was in a building and there was a woman wearing a short jacket like I saw you wearing* (this had been about six months

previous when she had met me by accident in an office building). *She was wearing the jacket, but on the bottom she had a bikini. Her legs were the legs of those dogs with the short fur, like dachshunds, but with layer upon layer of wrinkles.*[dream].

After I stopped marvelling at the image, I asked about her associations. She said she had been trying to figure out what my husband did for a living: "I envy what you have, even though I don't know what you have." The image called to both our minds a very ambivalent view of my sexuality—to say the least: both her hope that I was sexually attractive/active and her wish that I, too, was not. This ambivalence was characteristic of a feeling she had about an older sister, who taunted her with her ability to have boyfriends, while my patient was more interested in her books. But it also had something to do with me, and with her hopes for the analysis. "Show me how to be a sexy woman," she might have said. But then she was not quite sure whether I could do it, or if I was even sexy myself.

Even though dreams in which you star in an undisguised role may seem quite obvious, what lurks behind their manifest content can be fascinating. In fact, you may actually be a proxy for someone else, someone the patient wishes had been more like you, or that you were more like.

Again, patients can use their dreams to communicate feelings to the therapist that they may have been unable to talk about directly, and these feelings often pertain in some way to fantasies about the therapist or the therapy situation. Not all dreams have transference components, but if you keep a close watch, you may find clues hidden in ingenious ways.

(iii) Transference issues in separations

Another important window into conscious and transference feelings is the trigger of a separation or a vacation, even if these have been planned well in advance. Unless you have had the experience of being in psychotherapy or psychoanalysis yourself, you will probably underestimate the effect of separations on your patient. There can be difficulties with a long weekend—even when it is a predictable statutory holiday, and even when the patient themselves is going away—especially if the holiday falls on a Monday or a Friday. It gets much more difficult, of course, if the separation is because of a holiday that you are taking, while your patient is staying behind. Separations may be experienced as a form of abandonment, and how your patient deals with separation from you gives important information about their reaction to loss.

This does not mean, of course, that you should never take a holiday. Like other events that may occur outside the frame of the therapy, reactions to holidays provide good grist for the therapy mill. I have supervised interns who thought they should see their patients on Christmas Day or other holidays. As discussed in the section on the working alliance in Chapter 1, it is important that you are serious about your commitment to the work;

however, not taking any holiday time, or coming to the office on a statutory holiday, may give the message that either you feel your patient is in such bad shape that they can't make it through without you—or, indeed, that you are in such need of your patient that you can't make it through without them! The patient may imagine you will miss them, that you are attracted to them, that they are more fun for you to be with than your family or friends—all of which are dangerous messages to give, and at the very least, constitute poor role-modelling regarding the taking of holidays.

The therapist can communicate commitment to the session times by warning the patient as far in advance of an upcoming break as is reasonable. The amount of time given may vary slightly from patient to patient, some of whom have shown that they need a great deal of time to discuss a break. Keep in mind, however, that because breaks are often painful, no matter how much or how little notice is given, patients often "forget" the upcoming break. Sometimes this can be colluded with by the therapist who is feeling guilty about taking the break. It is awful for both parties if the patient shows up to a locked door on the first day of your break. Therefore, I usually give at least one month's notice of an upcoming two- or three-week holiday, and then I remind the patient during the last session—often by asking how they are feeling about the upcoming break, and thereby killing two birds with one stone, so to speak.

Some patients like to have the opportunity to schedule their own holidays at the same time as yours, so that they will not miss sessions; in psychoanalysis, this is the norm. It follows, then, that these patients need as much warning as possible because their own family and work life will be affected by your plans for vacation time.

If you see that a statutory holiday will fall on a session day, then about one month in advance you should offer your patient an alternate time, if this is possible. This informs your patient that: 1) you are looking out for breaks in the treatment; 2) you respect the commitment and don't want to miss a session if possible; 3) you respect their schedule outside of the therapy, and therefore and want to give them notice to find another suitable time.

As we have said, vacations and breaks usually trigger themes of loss for the patient. Often there are feelings of our old friend, anger, at your leaving, even though your patient knows rationally that everyone deserves a holiday. There may be the feeling of: "How can you leave me, especially right now?" It often seems to the patient that the break is happening at a particularly inopportune time in their life—a time when they will be needing you more than ever. Sometimes this is based on reality, as at Christmas when they have to see their families, or at a time when they are going through a divorce, or the loss of a loved one. Sometimes, however, the therapist's leaving precipitates such a feeling of panic that it feels like there will be a crisis. And sometimes, a patient may act out and precipitate a crisis right before you leave, in an attempt to keep you from going.

When working with your patient's feelings about the break, you need to be aware of your own feelings about leaving them, so that you are better equipped to discuss their feelings. Often patients won't talk about how a break in the treatment makes them feel voluntarily, and so you have to ask. Therefore, once you have announced your intention to take a break, you can say: "How do you feel about our missing two (or more) sessions?" The response you get will only be your patient's first reaction. As you go along in the ensuing sessions, keep in mind that the break is coming and that at least part of how your patient behaves, the material they bring, the dreams they have, may be related to the imminent separation. Therefore, the question about how your patient is feeling about the break should come up again. This may seem like overdoing it, but in fact, it gives your patient the opportunity to tell you more about their feelings, after having thought about it.

Certain transference reactions may be predictable from your patient's history. Also, where you are—transferentially—in your work together will give you information about what to expect. For example, if there is currently a parental transference, your leaving may trigger sad early experiences of an absent parent, a sick or depressed parent, the death of a parent, or a parent who was never there when needed. If your patient has had a particularly intrusive, or nagging, parent, they may greet the news of your holiday with relief. Feelings of being excluded—since, presumably, you are going away without them—may be triggered in patients whose parents always seemed to have fun, leaving them out. If there is currently an erotic transference, your patient may have fantasies of being the one to go away with you, and may feel intense jealousy towards your partner, or whomever they imagine will be with you. If there is a sibling transference, your patient may feel envious that you can take a summer/winter vacation (as in: Mom always loved you best), that you have more money, or that you can leave your job (them!) more easily than they can.

All of this, as you can see, is very rich material—and it would be missed if you never took a vacation. When these feelings are evoked and accepted in a safe, non-judgmental environment, and explored and understood, you and your patient will learn a great deal about how they are perceiving you at this time, and how they react to separation and loss. If your patient is curious about your holiday, do not be afraid to ask: "Where do you imagine I'm going?" "Who do you imagine I'm going away with?" "How do you think you'll feel on the day(s) of our missed session(s)?" "What would help you get through this time?"

As Basch (1980) pointed out, the question of whether to tell your patient where you are going cannot be answered with a formula. If you believe that the anxiety of not knowing your whereabouts will serve as a productive and creative stimulus for your patient, it wouldn't be helpful to short-circuit that possibility by giving them the factual information. Basch reminds us that there may be situations where it would be a depreciation of your patient's

capacity for independence to tell them where you will be. For those of us who thought the film *What About Bob?* was a horror movie, giving any hint of where you will be is unacceptable. However, for patients in extreme crisis, knowing your general whereabouts may have a calming and settling influence, helping them to understand that you are not totally unavailable to them, and that you plan to return to them and to the therapy. Also, providing your patient with the name and contact information of a back-up therapist you trust can be extremely helpful, even though most patients never use the information.

If the treatment progresses long enough, you will notice that your patient has different reactions at different times to your breaks. Just because you may tell your patient where you will be one time does mean that they will need—or even want—to know the next time. Noticing the changes with your patient will give you both an indication of your patient's progress. Of course, the ultimate separation is termination, which will be discussed in Chapter 7.

(iv) Meeting your patient outside the office

Another possible trigger of a transference (and counter-transference!) reaction is if a patient happens to see you outside of your office. It is possible that your patient might at some time see you interacting with others in the hallway while waiting for them, or after seeing them. How you interact with people other than them is always very important to them. If they happen to observe you interact with another patient, this may call up feelings of sibling rivalry —for example, that patient is probably more interesting or more likeable than they are. If you are talking to a colleague, perhaps even sharing a joke, and your patient is coming towards your office, a more sensitive or paranoid patient may be convinced that you are describing their case to this colleague, in particular how silly or difficult they are. Sometimes your patient may feel wistful that this is a part of you they never see, and may notice that you seem more energetic in that conversation than when you are passively listening to them. Your patient may then feel envious and have fantasies of wanting to be your colleague. Asking your patient how they felt when they came upon you this way will yield more of the aforementioned grist for the mill.

There are times, too, when the contrast of your behaviour as experienced by your patient outside the session seems grating or unpleasant to them. I once met a patient on the elevator, and I asked someone else to push the floor number. When I asked my patient in the session how she felt about our meeting, she said that I had been "too aggressive." I found this quite surprising.

Meeting patients outside the office building, in your regular day-to-day life, can also stimulate transference feelings for the patient—and oh-my-god-that's-my-patient feelings in the therapist. Some therapists prefer not to acknowledge their patient in these circumstances, rationalizing their own wish

not to be seen by reassuring themselves that it would be embarrassing to the patient to be acknowledged on the street. This is rude. If you meet your patient in a restaurant, or at the movies, the best thing to do is say "hello," and smile. Most patients do not want more than an acknowledgment at these times, and the feeling that you are glad to see them—not that you wish to avoid them. They don't want to introduce you to whoever they are with, or to be introduced to whoever you are with.

In some situations it is harder to remain gracious than in others, however. A few years ago I met a patient in the locker room of a club where I worked out, which was located close to my office. I was completely naked, trying to grab my towel as fast as I could, and she was dressed—a rather tricky turn of events. I was able to greet her very briefly, though I certainly was not at ease. When I asked in our next session how she felt about seeing me there, she said she thought it was "neat," because she was always "baring her soul to me," implying that in that situation, I had been baring my body to her. It also emerged that she had been unable to think about me as having an existence outside of my office until that time. We understood this latter as a defence against the feelings of closeness and dependency she was experiencing. As mentioned above, if you do not ask your patient how they felt seeing you outside the session, they may not volunteer it, thinking that it's not part of therapy, or that it would be embarrassing to both of you, and the opportunity will be lost.

In general, then, all kinds of wonderful and unpredictable things happen in the middle phase of therapy. There will be new challenges that could not have been predicted from the beginning and history-taking sessions, even by an experienced psychotherapist. There will be totally novel material, there will be transference themes, and there will be resistances to the treatment—sometimes manifested in ingenious ways. You will be challenged as a therapist and as a human being, in the maturity of your knowledge and judgment, and your patience and basic ability to care. In terms of your counter-transference, at times it will be extremely difficult to listen to your patient in an empathic way, and at times it will be difficult to withhold your own comments and interpretations, waiting for the right time to speak. There will be times when it will be difficult to understand your own emotions in the session and, once understanding them, to keep them accessible enough to help you understand your patient, but contained enough so that they do not interfere with or inhibit your patient's full expression of their emotions. More will be said about the management and use of your counter-transference in the next chapter, and again in Chapter 8.

The task of doing psychotherapy is formidable, but also incredibly exciting and rewarding.

Chapter 6

Stick-handling defensive patients

In Chapter 1, several conscious and unconscious psychological defence mechanisms were defined and described. This chapter offers a lighter, perhaps more practical, look at working with the manifestations of these often provocative behaviours.

Although there are always challenging patients for every level of therapeutic experience, there are particular challenges that beginning therapists face with certain patients that can be tricky to manage. The following are not DSM diagnoses; they usually signal types of defences—or a defensive style—that some people employ, particularly when they are in anxiety-provoking situations (e.g., psychotherapy). Some of these are listed below for your reading pleasure; undoubtedly with experience, you will soon be able to add to the list.

The "bright" patient

This patient has fortified him- or herself before coming for therapy by reading several books on psychological theory (usually more than you have read) and begins early in treatment, often in the first session, to ask about your theoretical orientation in a very challenging manner. Beginning therapists falter here (experienced ones often do, too). If the truth be known, student therapists have not—nor should they yet have—a firm theoretical orientation. Beginning therapists are learning about the various ways of doing psychotherapy; more experienced therapists often adjust the way they work according to what they perceive the patient needs.

Although this question can be examined in more depth later in your work together, this is probably not the time to say: "I wonder why you're asking me this now?" For your patient, the question may possibly be a way of defending against their fear of having to be "weak" or "emotional," if that is what they imagine being in psychotherapy will demand of them. Or it may be a concern that you will soon discover how "bad" they are inside. As a consumer, the patient legitimately deserves some sort of answer at this early point. In response, some therapists will describe the orientation of

their current supervisor (or analyst), which is not entirely wrong since these individuals have a great deal to do with our therapeutic endeavours. The word *eclectic* was used to satisfy patients in the 1990s, but doesn't hold much water today.

If you are conducting psychodynamically oriented therapy, as discussed in this book, the best way to describe it is probably as a treatment based on understanding the roots of their problems. The following comments may be helpful, but bear in mind that because this question may be a defensive manoeuvre on the part of your patient, it is certainly not necessary to give them a whole paragraph: You might inform them that you will be asking questions about their history and family background, and that it is from this perspective that you will explore their current difficulties together. You can also say that there will be sessions when the two of you will focus entirely on the present, but there will also be times when you will talk about the past, and how it may be affecting them today. You can add that you are not a directive therapist, and therefore will not be telling them what to do.

Remember that your patient may not understand much of what you say, despite appearing to be so knowledgeable, and may just need to hear you talk to be reassured that you seem to know what you're doing. Responding thoughtfully can have a calming effect, regardless of exactly what you say.

The "not-so-bright" patient

This patient presents as seeming not to know anything about therapy, about what is expected here, or even about their own problems. Even though this type of patient may be well-educated, he or she behaves as though you are a genius and every word you utter is far more brilliant than anything they could have ever thought of. There is the feeling of strained idealization because it does not ring true.

This lack of knowing may be a defence against your patient's own need to control the session—the exact opposite of what they seem to be doing—a defence called reaction formation. Or they may be experiencing a fear that you can't help them. It could be anxiety. It could be an attempt to make you feel all-knowing, a habit they had with a parent or sibling.

In any case, it is best to point out gently that your patient appears to be feeling anxious and perhaps would like to talk about that. As the therapy goes along, hopefully you will both understand the motivation for this defence, and how their self-deprecating behaviour is played out in other parts of their life.

The condescending patient

Early in treatment, this patient will refer to your intern status, if you are an intern, or to any minor errors you might make if you are a more experienced

therapist. For less experienced therapists, this type of person is particularly difficult, as they may ask who your supervisor is, and then make comments such as: "I guess you'll have to discuss this with your supervisor," when describing a problem they see as difficult. Or they may ask, "What did your supervisor think about what we talked about last week?"

If you are in training, remember that your patient has probably been informed that they are seeing someone in your position, and that they have agreed to this—maybe hoping for more control over the process and less exposure, or to feel smarter than the therapist, or to feel safe that their "badness" or "sickness" won't be discovered. In some cases, these patients may be having trouble with the fact that a supervisor, or authority type figure lurks in the background, and their transference may at first be manifesting itself towards this imagined person. In this case, because this defence can be undermining to beginning therapists, it is usually best to confront it head on by saying, "Have you noticed you refer to my supervisor quite a lot? Tell me what thoughts you're having about him or her," or, "I wonder if my being an intern has given you some concern. Why don't you tell me more about that."

Patients can behave like this with experienced therapists, too. I had a patient who, every time I thought I had offered him a wonderfully deep and comprehensive interpretation—incorporating his early family experience with his present painful dilemmas and indicating how bound he was to set things up in the destructive way that he did—would say, "I thought that was obvious." And when I summarized what we knew already about a problem, and placed it carefully in a different perspective, he would comment, "I already knew that—maybe you didn't." I could practically hear the eye-rolling from behind the couch. In this case, my patient was terrified of his feelings so that whenever I got too close, he used this condescending defence. This can be particularly eroding of one's self-esteem as a therapist.

Just keep remembering—especially in the beginning of the relationship—that these behaviours are defences; as such, they are protecting the patient against an undesirable feeling, such as intense anxiety. It is best not to take them at face value, as if your patient really thinks you are inadequate, but to be understood together with them as their anxiety hopefully begins to ease off.

The intrusive patient

This patient tries to discover as much about you as possible. He or she may start with the most obvious, "I see by the fact that you're wearing a wedding ring that you're married," and move on from there. Nothing escapes this patient's notice—your hair, your clothing, the pictures in your office—and they will usually ask direct questions that make you uncomfortable.

I once had a patient who, after examining my car keys, which happened to be on my desk, watched to see where I parked. Then she would comment in most sessions about it, "You parked very close to the exit today," and once, "I notice you had such-and-such a theatre program inside your car—did you see that play?"

Sometimes the intrusiveness comes across as critical, as if your patient seems intent on "sizing you up." It is rarely done for purposes of criticism. This is a style some patients learn in their families as a way of being "close." For others, it may be a somewhat desperate way of trying to identify with you. In the above example, it was symptomatic of an erotic transference that became more and more explicit as the therapy progressed.

One of the requirements of psychoanalysts and psychoanalytically oriented psychotherapists is to try to be as anonymous as possible so as to influence the transference projections as little as possible. As Greenson (1967) put it: "There is no doubt that the less the patient really knows about the psychoanalyst, the more easily he can fill in the blank spaces with his own fantasies" (p. 274). The intrusive patient makes this particularly difficult. Therapists may feel that they are depriving a patient, or being cold or impersonal, by not answering their patient's questions about their lives. When a supervisor or colleague suggests that the therapist put the ball back into the patient's court, by asking about the motivation and timing of the question, these therapists may feel they will be perceived as withholding or putting themselves "above" the patient. However, we must remember that the most therapeutic way to deal with this type of defence is to comment, "I notice you are quite concerned about what I wear, etc. Why don't we talk a little more about that."

The entertaining patient

This patient is initially experienced as a delight, someone who brightens your day and whom you look forward to seeing; that is, until you have thought about it or, indeed, discussed it with your supervisor. This person is witty and tells jokes that are actually funny, obviously needing the response of laughter from you. He or she may have learned that they have a talent for this and that it helps them to be more comfortable in anxiety-laden situations, as well as making them more likeable. I once treated a couple who could have been a comedy team. Together they played off each at the beginning of every session to entertain me, as they must have done often in social situations, with very positive results.

However, one of the partners had had an affair, and they had come to treatment to see if their marriage could survive. This was obviously no laughing matter. When I—reluctantly, I must admit—made the observation that perhaps they were using their comedy routine as a resistance against talking about their very painful marital difficulties, they began to catch

themselves in it, and for the most part, were able to spend their therapy time working on their problems. As we talked more about this, it emerged that each of the partners used humour at difficult times in their lives and that, in fact, the other's sense of humour was a large part of their attraction to each other. In a way, then, they were demonstrating to me at the beginning of our therapy what they loved most about each other. Talking more about this nourished their attempts at feeling good about each other again.

The seductive patient

This patient usually operates most effectively in an opposite-sex patient–therapist combo, but same-sex combinations can also be fertile ground for the manifestation of this defence. In this situation, a patient is being deliberately provocative trying to get a sexually aroused response from the therapist. TV series (e.g., "In Treatment," "The Sopranos") often showcase this way of behaving. The patient may dress in a way they think is very revealing and sit in a posture to maximize exposure to sexual parts of their body—watching to see if you are looking. They may also bring in dreams laden with sexual content, or they may describe their sexual exploits in explicit, erotic detail.

Here's an example you might not have thought of: A female therapist I was supervising recently treated a female patient who had been sexually molested and continually described the abuse in a highly erotic manner. After the first several times that the material had been gone over in depth, we began to notice that it was raised at certain points in the therapy—when the patient was feeling bad about herself and when she craved more involvement from her therapist. Being "sexual" was the way she had elicited a response from others in her past and she was repeating this in her therapy. She was also trying to master the trauma, and her guilt about her own sexual excitement, by going over and over it (repetition compulsion) and by being the one to elicit in someone else the response that had been elicited in her (identification with the aggressor).

In this case, it was particularly difficult for the therapist to notice that she was becoming sexually aroused. Once we understood how this patient made use of sexual arousal, the occurrence of those feelings could be observed much more easily by the therapist, in action, as it were, and then gradually interpreted to the patient. In this way, the therapist refrained from falling into the response patterns that had historically been instrumental in producing more difficulties for the patient, and she was able to help the patient understand the functions of her behaviour.

The patient who will not leave

Ending sessions can sometimes be difficult as has been mentioned earlier. There are some patients who make it particularly hard for therapists to end by

looking wistful when the therapist announces that time is up, by starting a new and/or very emotional topic in the last five minutes of the session, or simply by not getting out of their chair when the end of the session has come. These patients may perceive the ending of each session as a loss—or worse, a rejection.

As the therapist, you may then feel guilty about ending a session, especially when your patient has just burst into a flood of tears, and you may want to give "more" to your patient by going into overtime. (I have a clock placed where my patients can see it, in an effort to avoid my patients' "surprise" that the session is over, or their resistance to it. This only works some of the time.)

If the emotions your patient is expressing at this late hour are genuine and unusual then, of course, you may have to go a few minutes overtime. However, if your patient makes a habit of starting emotional topics near the end of the session, or on their way out the door, or if they are reluctant to get up even though you are already standing, then this behaviour is worth analyzing. It is important, in these instances, that you take control and end the session in a firm but gentle manner, "Our time is up for today. I know what you're saying is important, so let's give it more time next week." Then, at the beginning of the next session, you can comment, "Have you noticed that you seem to start talking about important topics just as we are ready to end? Let's talk about that." Or, "Have you noticed that you sometimes feel reluctant to leave here? Tell me what you're feeling as the end of our time together approaches."

Starting with the words "have you noticed" introduces the element of partnership to the patient who becomes an observer, too, thereby reducing the tendency to feel criticized. This exploration may turn into a theme for several sessions, depending on what you both discover. Sometimes a patient will realize they have trouble saying goodbye in most contexts, and that they felt they never had enough time with important people in their lives, as has been mentioned in Chapter 1. This tips you off to valuable transference data, explaining why your patient needs "more" from you as the session draws to a close.

The patient who wants to leave too soon

These patients also anticipate the ending of the session as a rejection, but have the attitude of "I'll get out of here before you have a chance to reject me." Younger patients and adolescents may have more of a tendency to feel this way than older patients—covered over by their having so much "to do" once they get out. These patients often sit on the edge of their chair for the last five minutes of the session, ready to bolt. A patient I heard about in supervision had felt rejected her whole life. This woman had spent so much of her early years trying to avoid being rejected by her mother and sisters that her behaviour seemed like a "reflex" reaction. Approximately seven minutes before the end of each session, she would put on her jacket and

sunglasses while she continued to talk! A highly educated and competent person, she did not notice anything unusual in her behaviour until it was pointed out.

Other patients who fall into this category may be trying to take control of the session by being the one to declare that the session has come to an end. Another supervisee of mine treated a patient who would look at her watch right before the end of the session, yawn, and then say, "Well, I have to go now . . . " implying she had a very busy schedule, and just couldn't stay. She would head towards the door, leaving her therapist to grapple with whatever material she had most recently brought up. Although this therapist's counter-transference reaction (feeling diminished) was different from that of the therapist in the first case (feeling surprised), the underlying motive for the patient—that is, avoiding the rejection of being told it was time to leave—still played a major part, along with the need to take control of a situation in which they were feeling out of control.

The "scary" patient

This patient talks about aggression and aggressive fantasies, and may even behave aggressively in the session by raising their voice—either directly in relation to the therapist, or indirectly under the guise of describing anger felt towards someone else—pounding their fist on the chair to make a point, or by glaring at the therapist. The situation is most difficult when the patient is male and the therapist is female. This type of patient often evokes a counter-transferential response in a supervisor, or colleagues, too, who feel protective of the therapist.

Exploration of your response to this type of patient is particularly important, as these patients can intimidate therapists into not giving interpretations due to fear of aggressive retaliation, thereby making the therapist impotent in their job—which is probably very much how this type of patient feels coming for help. It may be difficult to remember here that the aggression can be used as a defence, and that your patient may really be feeling quite frightened.

The following interventions can be tried: "Have you noticed you are raising your voice to me? Can you tell me how you're feeling right now?" Or, "I'm wondering why you are spending so much of your time in here talking about how you would like to hurt people. Is this something you think about a lot when you are alone?" The first intervention is made to help the patient become more aware of their feelings and of how they express them. The second one probes into whether the aggression is a transferential reaction, or an ongoing preoccupation for your patient. Their answer to this may help you to hear whether they themselves are frightened of their own aggressive urges.

If you continue to feel uncomfortable with your patient—that is, if your interventions don't work and the aggression continues—then it may be that this patient cannot benefit from psychodynamic therapy, or from therapy with

you. A referral to another therapist, and possibly another type of treatment, should be considered.

The overly grateful patient/ungrateful patient

The overly grateful patient seems particularly satisfying initially, especially to the more inexperienced therapist who wants to "help" people. This patient makes statements such as, "I couldn't have gotten through that family visit without our session of last week," or, "I'm so glad to be here, I was counting the days," or, "I thought about everything you said and you were so right—I never would have thought of it that way by myself."

Unfortunately, much as we love to hear this, we must be aware that this kind of behaviour can be manifested due to the defence of reaction formation—where people express the opposite of what they really feel, because the real feeling is too threatening for the situation. As much as we want and need to be the perfect parent for our patient, we have to bear in mind that if we really were the first person to understand them, the patient would be dead! These patients, in fact, may really be feeling that you are not helping them enough. Or, this type of attitude towards the therapist can also be the foreboding of a sticky dependency, from which your patient hopes you will never escape. And for some patients, this is their tried-and-true way of getting others to be close to them, that is, by making them feel important and needed.

It is imperative, of course, to first discover the underlying motivation for the behaviour, to identify it as a relational style, and then, together with your patient, to explore its antecedents and its function.

The ungrateful patient will never give credit to you or to the therapy, even though it may be perfectly clear that it is because of the treatment that they have been able to make certain advances. These patients may say, "I don't know why I'm feeling better lately—maybe it's because I love the spring," or, "Thank goodness I have so-and-so in my life; I don't know what I'd do without them. I can tell them everything, and they give me such good advice." It's as if your presence—not to mention all your hard work—has gone completely unnoticed. Even when you (rather pathetically) ask directly, or maybe especially when you do, for example, "What do you think has helped you to be able to deal with your mother?" these patients may say, "I don't know. I guess she's changing somehow."

This can be extremely frustrating for most therapists who at least, now and then, need some evidence that the treatment is having some effect. For these patients, however, acknowledging that the therapy is working—or what may be more anxiety-provoking, that they have a helpful relationship with you—may be too threatening. It is almost as if they will have given something away, and then that they will feel exquisitely vulnerable to rejection or hurt by you. The patient described earlier, who put on her sunglasses before the end of every session, announced to her therapist after several months of

treatment that there was "no relationship" here. Later, she was able to liken it to going to the dentist, with the same type of relationship she had there.

This kind of "ungrateful" behaviour can also be a defence against becoming dependent. Just as the overly-grateful patient needs to be dependent, the ungrateful one also needs this, but despises this need in themselves. Or, the patient who feels like a really bad person may not be able to cope with the contrast of your apparent "goodness." Therefore, they do not want to give you any more reason to feel good about yourself.

It is usually best not to intervene directly in this behaviour, but rather to measure, as the therapy goes on, your patient's capacity to form a new relationship, in which they have to trust another individual and begin to give them feedback about this. As these patients start to feel better about themselves and about the idea of being in a therapeutic relationship with you, and less fearful of rejection, they will gradually be able to indicate that you and the work are, indeed, important. Patience is the name of the game here.

The caretaking patient

This patient seems very concerned about your state of health or fatigue—more than they are about their own. Sometimes this type of patient will bring you a coffee every session, or they may comment sympathetically that you are looking tired or hassled, and what a difficult job you have listening to everyone's problems.

Tempting as it may be at times to allow your patient to look after you (especially if he or she is the only one in your life who's doing this!), telling them you're having trouble sleeping, or you're worried about a big presentation, should not happen. Instead, after thanking them for their coffee or their concern, you can make the observation that they seem to feel they need to look after you, and you can then explore that. Your task as the therapist is to focus only on your patient's needs and the motivations for their behaviour, as has been stated earlier.

These types of patients often are themselves in great need of caretaking, repeatedly following the "do-unto-others maxim," even though it has never worked for them. This can be explored with them, as can their reasons for being unable to ask directly for this kind of care. Usually the patient has either not gotten their need to be taken care of met by parents or in their early relationships, or they may have been humiliated for having such needs. Since they have to allow themselves to be looked after to some extent in their therapy, this is an ideal place to work on these kinds of issues.

The patient who seems just like you

Although this is not a defence on the part of the patient—at least not a conscious one at first—and pertains to a counter-transference reaction, it seems helpful to include it here.

It may happen that during the first few sessions with a new patient, the therapist may have the feeling that their patient is exactly like them. This may relate to the patient's age, family background, sense of humour, or sometimes to their actual presenting problems. The therapist may then think, "This person has the same problems with their mother as I have—how can I help them if I can't solve my own?" Or, "Maybe I can work through my own problems as I help them."

It rarely happens that patients actually are that much like us as we get to know them, or like any other patient for that matter. The feeling of sameness, which for some therapists may be a defence against their own anxiety in conducting therapy, or even a method for beginning to empathize with the patient, hopefully eases up quickly as the patient is better known and understood, since this perspective never helps the patient. In other words, as your patient becomes a person to you, although you may still see similarities, you will also be very aware of the differences.

Even if your patient presents with a similar problem to one with which you are currently struggling, this does not necessarily mean that you cannot be helpful to them. The main pitfall here is in assuming that your patient feels exactly the same about having this problem as you do. If you can put your version of the problem aside and really listen, then usually you can be of great assistance to them.

I once supervised an intern who himself had a fear of flying, but who managed to successfully treat his patient who had this same presenting problem. Although I hesitate to write this as it can be abused, it is also possible that you will get a better understanding of your own problem by helping a patient with similar issues. The intern described above, however, retained his fear of flying.

The "perfect" patient

This is not to be confused with the above patient who seems to be exactly like you—despite your initial counter-transference reaction to them.

This patient behaves in such a way as to cause absolutely no difficulties, being careful to never incur any bad feeling of any sort. He or she always arrives on time, and leaves easily. They never make additional demands on the therapist—such as changing appointment times or cancelling appointments—and, as if they have read this very book before coming, they never fall into any of the dreaded categories listed above. This patient listens to your comments and interpretations and seems to be giving them the right amount of thought both in the session and in the time between sessions. He or she shows appropriate affect when talking about emotional issues, and never, ever, gives the therapist a hassle about holidays or other breaks. As well, they will readily agree to being the subject of case conferences or academic papers—in general, going along with whatever you might ask of them.

It is particularly difficult to identify this type of patient, especially at the beginning of treatment, other than they seem so pleasant to be with. Therefore, it may take a while to see their behaviour as a defensive style. Only as you are thinking about them, and perhaps talking to a supervisor about them, may it come into your mind that they are being too perfect. As "easy" as this patient seems, we don't want to encourage an old behaviour that they may not be aware of or have never tried to evaluate, and that may not be serving them well. Many of these types of patients have come from families where one or both parents were extremely critical of them, and they have learned to protect themselves by being seamless—that is, never doing anything that might incur criticism. This usually means they have developed a "false self" —which is the perfect self that you are seeing. They know from painful experience that their "real self" is not acceptable, and only brings them hurt and humiliation. Therefore, these patients consciously and unconsciously expect that you will despise or ridicule their true self, just as others have done. Sometimes this type of patient has a "secret" that they think is particularly awful and they are striving to cover it up.

Intervening with patients who manifest this type of defence is often a delicate matter. It is usually best to wait until the working alliance is more clearly established and the patient is starting to trust you. Then, naturally, there will be times when the patient cannot be as perfect as they want to be, and the therapist gets an opportunity to make a comment that demonstrates their acceptance of *any* part of the patient; for example, "I notice you have never sworn before this. Were you feeling I shouldn't be exposed to that part of you that says fuck?" This small "lapse" in the perfect patient's presentation can sometimes change the whole climate of the therapy. Often these patients will consciously or unconsciously arrange for the lapses to occur so that they can show more of their real selves, and see what happens.

For some years I saw a 45-year-old male executive named Kevin, whose job was being threatened. Kevin's father had been a well-known civil servant, but had died at a young age, after which Kevin's mother had declared him the "man of the family." Kevin always arrived at sessions dressed in a suit and tie, even though he was not coming directly from work, and was very careful about how he worded his complaints. After about six months of our work together, Kevin appeared one day in casual clothes with an old and torn, obviously well-loved, cap on his head. He apologized profusely for his clothing, saying that he was going to a baseball game right after our session. During this hour, he behaved in a much more relaxed way than he ever had. He was even able to elaborate on, and become somewhat emotional about, the negative parts of himself that seemed to be costing him his job. I was (happily) surprised at how different he could be. In the next session, Kevin appeared in his regular attire and unfortunately, had returned to his earlier defensive way of talking. I took the opportunity to remark on this change, and I also implied that I had found him more approachable during the session with the

cap. He seemed genuinely grateful, and then said that he was afraid to be that way at work; however, he was willing to consider that others might respond more positively to this side of him than he had previously thought. That session was subsequently referred to by us as the "session with the cap," and this helped as a reminder for him of those good parts of his self that he had thought were unacceptable to others.

Are there any patients—you may be asking yourself—who do not manifest these defences? Fortunately for us, our patients are always challenging us and our own humanness—and defences—in many, many ways. This is part of what makes psychotherapy such a fascinating and insightful experience for the therapist. Patients who seem completely without defences, or who attach themselves too easily, may not have the ego strength and boundaries to be able to benefit from psychoanalytic or psychodynamic psychotherapy. The above descriptions are included to highlight some of the behaviours we might expect—natural enough, and certainly not the worst features a patient may demonstrate.

Chapter 7

Ending

> What I lost . . . it's immeasurable really, a relationship with someone who knew more about me than anyone else in my life, who was completely committed to understanding me.
>
> (quote from a student analyst, Craige, 2002, p. 507)

In "Analysis Terminable and Interminable," Freud (1937) voiced doubts about the possibility of actually completing an analysis, and advised psychoanalysts to return to analysis every five years. He was very skeptical about a cure. We still ask today: Can a psychodynamic/psychoanalytic type of treatment really be completed?

Why is this so difficult to assess? Perhaps it is because the often vague or unstructured goals of the treatment make it hard to know that the end has come; perhaps it is because the patient idealizes the process (this happens frequently with psychoanalysis), imagining they will be "cured" or "fixed," and are reluctant to leave until this has happened. The problem with this is that the goalposts appear to keep shifting as the treatment goes on. And often the patient is reluctant to leave the safe haven of the therapy, fearing they will never have this opportunity again. Sometimes it is the therapist who is reluctant to let go of a patient they have seen grow up before their very eyes. Let's examine these possibilities about whether and when treatment can end.

Many psychoanalysts have written about what might be seen as criteria for ending treatment (e.g., Klein, 1950; Novick, 1982, 1997; Rangell, 1982) including that the patient no longer suffers from his or her symptoms and has overcome inhibitions and anxieties. Berger (1987) stated that there is no single criterion that is in itself sufficient to demonstrate readiness for ending. In addition to symptom improvement, he includes: 1) Freud's thoughts that the patient has an improved capacity to work and to love; and also 2) that they have a more comprehensive appreciation for what underlies their symptoms and conflicts, greater tolerance for anxiety and depression—and for pleasure—an improved sense of autonomy, and the ability to use newfound insights to adaptively alter day-to-day functioning (pp. 259–260). Notice that other than symptom improvement, no one is talking about "cure."

Premature termination

Frayn (1995) investigated premature termination rates in patients who were in analysis with student analysts. He found that the less experience the student therapist had, the more likely it was for their patients to drop out of therapy prematurely. Often students underestimated the degree of psychopathology in their prospective patients. Although this study was conducted some years ago, it still makes sense that beginning therapists may be more optimistic and less aware of potential problematic characteristics, as they are eager to start treating someone.

A patient's premature leaving is often signalled by their sessions being cancelled—sometimes quite far in advance, and sometimes very close to the session time, depending on how conflicted—and how conscious—they are about their plan to stop. If they leave by telephoning to say they are stopping, or if they are simply not showing up for appointments, this can be quite disastrous for the beginning therapist's self-esteem, especially if it is completely unpredicted. Beginning (and even experienced) therapists may take this as an indication that they are not competent, thinking that someone else could surely have held the patient in treatment.

It is important for student therapists to keep in mind that rarely does a patient leave because of one empathic failure. If a working alliance has been established, there is usually room and flexibility in the relationship for you to make a few errors, provided they are well-intentioned errors. Failure to understand your patient's feelings about one certain incident, or the failure to have heard a particular story from their perspective, may be a reason for your patient's temporary withdrawal, flight, or even anger, but rarely termination.

There are some patients, however, who are unable to express their anger in any other way than by leaving the therapy. This may occur in response to your having left for a vacation or other break that has been too painful for the patient to tolerate (e.g., "I'll leave you before you leave me.") Sometimes the early leaving is a transference reaction; this is discussed further in the section on transference issues during termination. Sometimes a patient may initiate the ending early for some of the reasons outlined in the last chapter (the patient who leaves too soon), or with the proclamation of a "flight into health." This latter occurs when your patient suddenly appears better, their symptoms and relationship problems have vanished, and they announce that they are ready to end. Because of the suddenness of the "improvement," it is usually obvious that the patient is trying to avoid getting into the therapy more deeply. It is the therapist's job to try to ascertain, as closely as possible, what is making the patient feel like leaving. Asking questions, sharing your hunches with your patient, and allowing them to express negative feelings that may not be resolvable will usually yield valuable information. If this resistance cannot be budged by careful inquiry and letting the patient know

your thoughts about why they suddenly feel so good (i.e., offering an interpretation), then it may be better to let the patient leave for now; often these patients, if they have felt understood and accepted, will return at a later time when they feel they can handle more work.

Another reason for ending prematurely is that sometimes life can interfere when we are making other plans—for example, if the patient is diagnosed with a serious illness, if he or she gets a job transfer to another city, or if they encounter significant financial difficulty. The therapist's role is to be as supportive and helpful in these circumstances as time and opportunity allow.

Student therapists may encounter specific difficulties that force premature termination, such as an internship or residency coming to an end. These kinds of terminations have to be handled gently to avoid any chance of your patient's feeling rejected. Even if you have warned your patient from the beginning (e.g., "I'm only here till May"), do not expect that your patient will remember this: forewarned is not necessarily forearmed. Your patient will probably have a lot of feelings about the ending—of course, depending on where they are in their treatment—and so it behoves you to warn them again at least a month in advance, raising the upcoming ending as an issue. If you are in the fortunate position of being able to carry on with your patient until the ending would naturally occur, or of being able to take your patient with you to your next placement or residency, then you will have the opportunity to aim for a mutually agreed-upon termination. (Issues of specialness may arise when you take a patient to another setting, e.g., "Why are you asking me to come? Am I the only patient you are taking with you?" and must be discussed and not ignored.)

Transference and counter-transference issues in premature termination

In terms of transferential reasons for early termination (psychoanalysts might say there is usually a transference reason), if your patient is angry at you, they may be acting out against you in the way they dealt with their parents or other important people in their past when they felt frustrated; or, they may have wished that they could have acted out in their early life in the way they are free to do now. Some patients may try to leave impulsively when the therapist is getting to them, if for example, they feel intense erotic or dependent feelings towards the therapist that frighten them and are not acceptable to them. This can happen as a result of finally being deeply understood, when the therapist has managed to get beyond psychological defences that have never been threatened before. The patient may regret having told the therapist "too much" or being "too vulnerable," and may feel they have to leave therapy to protect themselves.

It may happen that your patient is experiencing an intractable negative transference. If the patient is having trouble holding on to the "as if" quality

of the transference, and you remind them too much of an unsympathetic, or even abusive, parent or sibling, they may have the urge to bolt. Since we know that every transference reaction has at least a kernel of reality, it may be that the particular therapist–patient pairing will not work. On the other hand, once recognized and acknowledged by both parties, this can often be worked through (e.g., "What is it about me that is so much like your father? You're right. I am sometimes like that, but my motivation is quite different . . . etc., etc."). By accepting the transference projection instead of fighting it, the therapist can see, from the patient's point of view, how in fact, he or she does resemble the "bad" person from the patient's past. This puts you more on the same page, and makes it much easier to explore the past situation that was so difficult for your patient.

As Novick (1982) has pointed out, there may be counter-transferential reasons for a premature ending, that is, initiated consciously or unconsciously by the therapist. Dealing with a patient who never seems to get better, or facing a patient who is persistently hostile may cause the therapist to think about ending—and, indeed, to start counting the days. It often feels like there is something masochistic about this work, and any sadistic patient can sense that. I saw a patient for some years whose unbounded sadistic nature was frequently directed towards me. She used to say, "I thought I was allowed to do anything in here, or say anything I want." This can evoke unconscious sadism on the part of the therapist, who may act out by terminating the therapy prematurely.

Also, the defences some patients use—described in the previous chapter—may get on the therapist's nerves, or interfere with the therapy to such a great extent, that the therapist may have the urge to bring the treatment to an end. There are times when the therapist is struggling with issues in their own life that preoccupy them to such a degree that it becomes impossible to listen to certain patients. If you are in the throes of divorce, for example, and your patient is describing in glowing, gloating detail a new love they have met, this may provoke you into jettisoning them. If your patient reminds you too much of an abusive parent or sibling, and you can't seem to listen empathically, that may cause you to want to end prematurely. Also, if you are trying to manage your own or a loved one's serious illness, and your patient is talking about how they can't make speeches at work, you may be thinking, "Get over yourself; you should only know what I'm dealing with."

Gabbard (2010) states, "Certain patients may arouse contempt, boredom, hatred, and anger in therapists. There may be a thoroughgoing sense of relief when the patient speaks of terminating, and some therapists may avoid exploring the patient's wish to stop as a way of getting rid of the patient" (p. 181).

In all of these situations, especially if your need to end with this patient is building unconsciously, you have to watch for the signs that you know about in yourself—hopefully from your own personal therapy or analysis. In

order not to act out this urge, it will undoubtedly require consultation with a therapist, supervisor, or trusted colleague.

"Regular" ending

First of all, it has to be stated that there is no "regular" ending. However, let's look at the more-or-less commonly occurring clinical issues that arise when two people are stopping a psychodynamic therapy, and more or less, ending their relationship. The termination of therapy is the opportunity to help your patient find, probably for the first time, a growth-enhancing way of saying goodbye (Novick, 1988).

The decision to end therapy cannot always be clear-cut. However, as the therapist, you should have a sense that some of the goals mentioned above—that you and your patient have understood as important—have been achieved as much as they can be at this time in your patient's life. Is your patient functioning better overall, and has he or she learned as much as possible about how to think on their own psychologically, in other words, have they sufficiently internalized the process? This latter criterion is seen in the contemporary literature as one of the most important, as it allows your patient to continue the psychotherapeutic process without you—to be involved in the ongoing work of understanding their fears and anxieties, and their resistances to doing well, if these still exist. Usually you can tell if they have acquired this skill when you hear about your patient's thoughts between sessions, or when they relate how they analyzed, and behaved differently in, a previously annoying or anxiety-producing situation.

Gabbard (2010) has noted that there is almost a mythology that has developed around the notion of termination that can make beginning therapists feel they are falling short:

> In this mythological version, therapists and patients come to the conclusion that the goals established at the outset have been accomplished, transference feelings towards the therapist have been resolved, the intrapsychic changes have been translated into life changes, and a specific number of weeks or months are mutually agreed on as the "termination phase" of the process.
>
> (Gabbard, 2010, p. 179)

However, he maintains, this perfect picture rarely occurs.

In the best of circumstances, most psychodynamic therapists find it helpful to conceptualize a termination phase, usually initiated by the patient, either directly or indirectly. However, just because this phase begins, it does not have to mean the ending is near—or even in sight; it just means that it is on your patient's mind. Although some therapists use a formula to determine the length of a termination phase, for example, one-two months per year of

treatment, most contemporary therapists get the sense of the time allotment from their patients.

Sometimes, your patient may raise the topic of ending in an *indirect* way, for example, in the form of a dream. Grenell (2002) reports how his patient, a young woman, had a series of dreams going towards the termination of her analysis, one of which follows:

> *I am playing a piano. It was like I was playing for the first time, as I had no concept of what the notes were. To my surprise, no matter what keys I hit everything sounded great . . . Though it was odd, because in the dream there were two pianos: an old piano like the one I grew up playing on, and a newer piano. In contrast, the old piano sounded terrible and the new piano sounded wonderful.*
>
> (Grenell, 2002, p. 791)

Although this dream sounds suspiciously like a gift for the analyst, Grenell maintains that it indicates his patient's readiness to end.

The reason for your patient's indirectness around this topic may be that they are unsure they are ready to end, and they fear that raising the issue may lead to your commenting, "What? You're nowhere near ready to end!" or a more gentle facsimile thereof. This would, of course, be humiliating. Some patients, based on their experience of leaving home, might be concerned about your being lonely without them, and that you might say, "Well, I guess you're ready to leave if you say so. I thought you were still getting a lot out of our time together." If either the patient or the therapist has had severe difficulties in separating from parents, the termination phase can be extremely painful (see both transference and counter-transference issues in "Regular" Ending on p. 90).

Sometimes a patient will spend several sessions reassuring the therapist about how well they feel and how competently they are handling formerly difficult areas. They may say they are thinking of applying for a new job—one that will not allow much time for therapy in the future. (These kinds of inferences can, of course, also be made by patients who are resisting treatment; however, for the purposes of this chapter, let us assume that you have seen that your patient really is better, and is getting ready to leave.)

The signal from the patient may also occur more *directly*; for example, they may ask how long therapy usually lasts, or how termination will take place. Some (brave) patients may come right out and say that they are feeling better and have been thinking that it's time to stop.

Often patients do not know about the mechanics of ending and have been waiting for you to declare that they are "cured." Even when patients have been direct, they may still deny that they have seriously been thinking about ending when you first respond to the signal—as you should—by saying, "I wonder if you've been having some thoughts about ending/cutting back your therapy?" This may be because, as mentioned above, the thought of leaving

the therapy relationship, even when one feels stronger and healthier, can sometimes be quite anxiety-provoking. Some patients are worried about having gotten better, about life without the symptoms that have been with them for so long, and about the expectations that others may have of them now.

Even though beginning therapists may feel anxious when the topic first comes up, once it is realized by both parties that termination is one more phase of the therapy, and that there are no perfect endings, usually things settle down. Fantasies and thoughts about ending can be explored with the same acceptance and care you give to any other important issue in your patient's life. However, since the issue of ending may involve the therapist in a more personal way than other issues the patient is dealing with, listening empathically as the topic ebbs and flows may be more difficult.

As you move towards stopping, all the implications of ending the therapy relationship in terms of everything you now know about your patient's history, personality, and defensive style need to be seen, as it were, through the filter of what ending will mean for them. Both beginning and experienced therapists may collude consciously or unconsciously with their patient in not discussing their feelings about termination. It is helpful to keep in mind that most people—therapists and patients, too—have difficulty saying goodbye. For the patient, the ending will call up painful feelings about other losses. Not dealing with your patient's feelings about stopping treatment cheats them out of a vital part of the psychotherapy. It is important to keep wondering how your patient is reacting to the upcoming ending, their thoughts and fantasies about it, and their plans for the period immediately following termination. In fact, once it has been introduced, the eventuality of termination should be raised at every opportunity (e.g., "I wonder if you're coming late/early to sessions because we started to talk about ending?" Or, "I wonder if you're avoiding that topic/raising this new topic because we have started to talk about ending your therapy?").

No two terminations are alike, of course, and therefore it is difficult to describe exactly what will happen as you and your patient work towards ending. Usually, your patient will be talking about current problems interwoven with the new issue of concluding their psychotherapy with you. In addition, a few surprises may occur: Initial symptoms, complaints, and problem areas that may seem to have been resolved, or at least have received a lot of attention during the therapy, can reappear with a vengeance. This may mean that your patient is challenging the idea that he or she is really better, it may be part of a "regression" that sometimes takes place during termination, or it may constitute a kind of last farewell to these problems that were so much a part of their identity. Sometimes the re-emergence of symptoms occurs because your patient is ready to work on these problems at an even deeper level than they have already, finally resolving the last vestiges of the difficulties. At this point, they may be able to bring forward information about the problem never previously discussed.

For example, I recently treated a 35-year-old woman in psychotherapy who had presented with, among other issues—including a pathological dependency on her parents because of a handicap she suffered—a fear of men and sex. After a few years, during which she had achieved a separation from her parents in a mutually satisfying way, and was feeling more comfortable at work and with friends, she decided to end treatment, and we began cutting back, both of us realizing that the crowning touch for her would be meeting a suitable man. This did not happen during the ending phase, but we were both optimistic as we said goodbye.

Several months later, she contacted me and wanted to talk about a take-over in her company at work, and how diminished she felt by it. As we started meeting weekly again and she talked about this, she spontaneously said, "Oh, I haven't met anyone yet." I said, "Any thoughts about that?" She replied, "Only that I've had this thing in my head, but it's nothing." She then proceeded to describe, in an almost dissociated manner—that is, dissociated from any emotion—that once her father had called her into the bedroom and showed her what a man's penis was like and what can come out of it, and the rug was wet. She could tell from the look on my face that this was a jaw-dropper for me, but wasn't quite sure why. She maintained that he did it to protect her, as they had done other protective things because of her handicap. When I said, "You mean he showed you his penis and masturbated in front of you," she said, "I guess so." It took her a while to come out of the dissociative state and to be outraged and disgusted. After this very painful session—for both of us—there followed two years more of weekly psychotherapy.

Sometimes a totally new issue may emerge as you are terminating. It never ceases to amaze me with my own patients, many of whom are women, how often an episode—or even an ongoing course—of sexual molestation is remembered close to the time of ending. In response to my asking, "Why now?" the answer seems to us to be an urgent sense of "this is my last chance," pushing the material forward into consciousness. Once it is out, patients seem amazed at how such traumatic events could have been so completely repressed. Then the time must be spent in dealing with the new material, and integrating it into the rest of the therapeutic work.

However, a new, or seemingly very important, topic arising close to the time of ending may also be a resistance to stopping, just as patients may bring up highly emotional issues at the very end of a session, hoping that the therapist will go overtime. If this behaviour has occurred before and you suspect this is the case, then another opportunity is presented for both of you to understand its roots and to work it through.

During this period of termination, I often find that there are more positive, good sessions, with the patient looking ahead and making plans. I also find that I like the patient better and better as the therapy has taken effect; especially with very difficult patients, I may have the feeling that, just as I'm really getting to like them, it's time to think about ending.

The same phenomena that occur in more prolonged terminations will often occur in a condensed manner in termination phases that are of shorter duration; for example, the intensifying of symptomatology or the opening up of new material. It is more difficult to handle these factors when the time to end is short, and so they must be handled with even greater sensitivity.

At some point, the patient and therapist should decide on an actual, or rough, date for stopping, with the patient taking the lead. However, keep in mind that your patient may not be aware that ending may trigger additional feelings, and sometimes, new material. Therefore, it is wise to be as generous as possible, if you have the luxury of doing so.

Of course, if new issues emerge after the date has been roughly identified, then the possibility of prolonging the therapy has to be considered. Even if the "new" material is understood as a panic reaction to the idea of terminating, this is an indication that your patient does not feel ready to end and may, quite legitimately, need more time. Therefore you need to be flexible enough to disembark from the termination track for what is hopefully a short detour. It may be your impression, however, that your patient will never feel ready to end and needs some "encouragement." I am reminded here of a *New Yorker* cartoon where a psychoanalyst is pictured pushing an eject button, which causes the couch to tilt forward and the patient to slide off. Here, obviously, the reasons for the resistance to ending are not being fully explored—not to mention the counter-transference.

How the ending actually occurs can certainly be open to negotiation. In the old days when I was in my training analysis, the drill was to go from four or five times per week to nothing. It was thought that this would maximize the patient's work leading up to termination, and get at their feelings about saying goodbye. I can't remember what the rationale was for the patient's emotions after the ending, but there must have been some really important psychoanalytic reasoning. All I remember is feeling eerily bereft.

At any rate, we are all more enlightened today and actually give the patient the leeway to decide whether they prefer a gradual cutting back, even in psychoanalysis—from weekly or several times per week, to every second or third week, or to once a month for a time—as long as feelings about ending are being discussed and not avoided. It is best to effect the decreased frequency of sessions after the greater part of your patient's intense reactions to ending have been explored.

Here is a description of ending with Betty, the 42-year-old woman mentioned in Chapter 1, who became extremely angry when I was late because of her early experience of waiting in the family car, frightened, while her father stormed around inside deciding if and when the family would leave. As was mentioned, Betty's father was suffering from Altzheimer's disease when she entered therapy.

By profession a systems analyst, she had described herself at the beginning of her two years of treatment as not feeling connected to the world of people,

and as being more at home in the world of computers and nature. She felt that with people she always said the wrong things and spoke or laughed too loud, so as to put others off. She was the type of individual who was never included in groups in high school, and even at university, she had felt unlikeable. To summarize a lot of important psychotherapy, as she was able to form a relationship with me, Betty began to nourish and value those parts of herself that were frank, honest, and highly energetic. She saw herself as someone with different ideas and, as such, someone who had a great deal to contribute at work. In other words, she was starting to embrace the "different" parts of herself. Betty became more relaxed and less intense socially, and started to analyze her relationships with men in relation to her relationship with her critical and demanding, but loving and exciting father. She saw how she chose men who were like him—but mostly in the more negative ways that made her feel inadequate, since these were the qualities of her father that stood out as they had been so traumatic in her relationship with him.

It was with extreme pleasure that I watched the growth of this individual from "an unlikeable girl whom people avoided" to a self-confident woman, who managed new and challenging situations with enthusiasm and humour. As a theme throughout the treatment, Betty's father's health deteriorated further and further. Never having allowed herself to cry much before, she began to be able to freely express the real pain and sadness she felt as she watched him move towards this inhumane death. She acknowledged the bond that she had had with him—different from the other family members, as she was his favourite. She was also able to acknowledge her intense anger at him, as well as her deep love for him. In addition, using what she had learned in therapy about listening empathically, she was now able to help her mother, becoming a nonjudgmental listener for her, and her major source of support.

Betty's first mention of ending treatment came while her father was still alive, after she had changed jobs to one requiring more responsibility and had been away on a holiday. She said she felt much better, particularly in that she now expected to be liked, instead of disliked, by others. And so, we began our conversations about termination. After some time, I agreed with Betty's request that meeting every two weeks would be appropriate; we were both concerned about the imminent death of her father.

About two months into this, Betty met a man who, for the first time, made her feel good about herself and whom she felt totally accepted her—criteria adopted from her therapy experience that were now extremely important to her. During our remaining time together, she talked about her fear that she would fall back into old patterns in this new relationship—even though she was usually able to notice and articulate to herself when this seemed to be happening. We had talked about her need to be able to let go of her father in order to really be able to love another man, and she saw the fact that she had been able to meet someone new, before her father died, as a sign that she had done the required work in therapy. At the same time, we acknowledged

that as Betty's father deteriorated, he was not the same powerful influence, so that his permission for her to grow up could now be implied—he was not there to counteract it. Since we could not discount the effect of his illness on her growth, we spent some time discussing how it might have been for her if he had not become ill. At this point, all Betty could see was that she couldn't imagine turning back, and that she was happy to be at the place she was. She even thought that her father would have approved—it was just that getting there would have been so much harder had he remained his usual self.

When Betty's father's death did happen, it was very painful for her, but it did not tear her apart as she had expected. Shortly thereafter, she announced that she was ready to leave treatment, and I concurred. We then set a date for ending. Although we both certainly felt sad saying goodbye, I felt that Betty could, for the most part, handle the problems that would inevitably arise in her life, in a different and better way.

The above is offered as a guide for how the termination of longer-term psychotherapy can be carried out. Note how slowly we approached the actual time of ending; how Betty initiated the changes in frequency; how Betty's fears of backsliding were acknowledged and discussed; and how we were able to see that her father's illness had been a big part of her ability to let go of him—thereby not crediting the therapy undeservedly.

But often endings do not go as smoothly as we would wish, because they represent a difficult time for both patient and therapist. Terminations can be stormy times, even if your patient is ready to leave treatment; or they can be impeded in some other way by unresolved conflicts in the patient and the therapist. Sometimes, because feelings about ending have not been able to be completely worked through, either the patient or the therapist may be left feeling unsatisfied, or (as stated earlier about my own termination) bereft. The next section will discuss this in more detail.

The last session can be a difficult one for both of you. The therapist should be ready to take the lead, if necessary. I usually start by reminding us both that this is our last session.

Some patients bring a gift which, since there won't be time to talk about it, I accept graciously, unless it is inappropriate or too personal. Usually the discussion centres on the patient's immediate plans. They may need reassurance that you feel they will be fine—that you will both be fine. The "what-ifs" can usually be dealt with by discussion, and/or by the reassurance that they can recontact you if they need to—as long as this is really possible. Goodbyes are warm. If the patient says, "I will miss you," I always say, "I will miss you, too." As long as you're not crying when you say that, it will be a boon to your patient to hear this. If the patient wants to shake hands, that is quite appropriate; a hug may be a different matter, depending whether your patient has endured a long spell of an erotic transference. There is nothing wrong with a quick hug goodbye as long as it is clear that's what it is; use your judgment.

Some patients like to be given an appointment about six months after ending. They may imagine that they will then be able to tell you "everything" that has happened since leaving. Setting up this type of meeting has some advantages for patients who seem to need it: your (former) patient can see that you are still alive, and in your office, even though they are no longer with you; they refresh their calming image of you; and they test out that they can contact you again—that the door has not been closed. For the therapist, it usually serves as an opportunity to appease any guilt about letting the patient go into the cold, cruel world. However, if you have done your job well, this six-month check-up should be a huge anticlimax: your patient will be happily into their own life, and may have almost forgotten the appointment.

This is not to say that some patients don't come back for therapy, or even more analysis, several years later. Certainly, I have patients who have returned as long as ten years after termination—usually with different problems, but feeling that I will probably understand how these difficulties are affecting them. In fact, some psychoanalytic writers have referred to termination as an interruption in the treatment, stating that we never really end. Certainly, we hope that the process of thinking in this way never ends for our patients.

Transference issues in "regular" ending

It is even more difficult to sift out the transference from the counter-transference issues in termination than it is in other parts of the therapy, because the ending so clearly involves both people. However, in this section an attempt will be made to highlight the transference first. Remember: This is a relationship like no other—for both parties. It is intimate, without being close; it is revealing of deep truths for both parties—one, silently; it is deeply engaging in a way we don't engage with friends, parents, or even partners. As such, in the anxiety-laden beginning—when the patient does not know what to expect, and in the often intense ending—when again the patient does not know what to expect, the opportunity for transference fantasy and projection is particularly great.

The termination phase is often a fertile time for the crystallization of transference projections, some of them old transferences revisited, as well as an opportunity for new transferences to emerge. As has been mentioned earlier, feelings of loss and abandonment that you may have noticed at other times of separation—for example, vacations—may be prominent as you conclude the therapy. Even though the idea of ending may have been raised by your patient, they may still be feeling abandoned by you. That is why knowing your patient's reaction to early losses and separation is of primary importance.

The patient mentioned in Chapter 4—who found herself humming the Beatles' tune *She's Leaving Home* during one of our last sessions, acknowledged that she thought maybe I was feeling the way the singers/parents in the song

felt: that I had given her so much and now she was leaving me. This concern for me, and for how I would survive without her, came from her experience of having had a sick and needy mother, whose illness worsened after she married, and who actually died within two years of her leaving home. For this patient, the length of the termination phase was particularly important, allowing her to keep checking on me to be sure I was still there. This was a situation where we decided on a six-month follow-up appointment after ending.

When my patient Jeff, described earlier, who had problems committing in relationships, raised the idea of terminating therapy, he was obviously feeling better. He wanted to try out his newfound confidence, particularly in the area of sexuality, which we had been discussing in detail—without having to report his successes, or lack thereof, to me. He began for the first time to become quite flirtatious with me. I pointed this out (gently) and asked him to think about what his relating to me in this way had to do with ending treatment. He thought about if for a while, and then tentatively advanced the theory that he was reverting back to an earlier behaviour where he used to "flirt a lot with a woman before dumping her"(!). This led to further discussion about his sexuality, and to his realizing that making someone feel desired before ending a relationship did not make the break-up easier for either party. If this type of behaviour had occurred at a different time in the therapy, then we undoubtedly would have thought about a different interpretation of it.

Although it has been stated that a symptom may worsen during termination, sometimes when this occurs it is because of a transference reaction. The worsening of a symptom may indicate hostility towards the therapist—especially if the patient is imagining that they are being pushed out of the nest too soon, as parents did, or it may be evidence of a clinging dependency, not yet fully analyzed in the treatment. The meaning of the particular symptom and its relation to—and function for—important others in the patient's life has to be re-explored, so that its significance in the patient's not getting well, or as a cry for help, can be more deeply understood.

Of course patients can act out transferences in a variety of ways during termination, including coming late, missing sessions, bringing in people, and sometimes pets, to meet you: I have met two cats—one of whom was fatally ill, one dog, and one baby during this time. I have met babies at other times, too, and the odd dog, but when they come during termination, they not only function as a distraction from the ending, but they allow your patient to bring in a part of their life that they realize now you will never see. Also, patients may be more reluctant to leave at the end of sessions during this phase, urgently feeling there is much more to say.

Sometimes your patient will refer another patient to you, usually a close friend, either before or just after termination. If it is just before, then there is an opportunity to interpret the behaviour. The referral should not be

accepted until this is done, and possibly not at all. Whether it is before or after, the most common reason for this is to provide you with a substitute for your ending patient—but not any substitute, a well-chosen one. One of my male colleagues told me that a female patient, who had thought she was in love with him, was worried that he would replace her with another, more attractive woman, so she referred her best male friend to him. This referral of a friend also has the benefit of giving your patient the ability to keep an eye on you, to hear about you vicariously, and also, of course, to ensure that you are still there. They may have done this before with a younger sibling, after they left the home. Also, they may hope that this new patient will serve as a place marker, a continuing reminder of them, and thus they can continue their treatment with you by proxy. Your patient may have had the experience of parents who wished for another, younger sibling, but were unable to produce one; in this way, your patient is helping you to have that and to fill their spot in case your practice is waning. It can also be a way of attempting to exercise power over you—and the new patient—by being the one to bring you together.

There are patients who, in striving to hold onto the therapy by identifying with you, will decide at or near termination that they are interested in your profession. They may actually begin taking psychology courses, or in other ways start the process of planning a career choice of, or change to, becoming a therapist. Besides a wish to be you, or to be like you, this behaviour may be an indication of deep feelings of envy that have not surfaced during the treatment, or of sibling rivalry. In this situation, interpreting the underlying motivation may be particularly difficult without seeming to discourage your patient from pursuing this work. As you start to explore it, they may believe you think they are not bright enough, or "together" enough, to be in this field, and that you probably don't want them as a colleague. There could also be times, as well, when your patient has learned so much from the treatment, and has enjoyed thinking psychologically to such an extent, that they legitimately are interested in finding out if they are suited for a profession in this or a related area. In either case, the feelings, wishes, and fantasies about, for example, studying psychology, should be explored. Usually, once patients have had time to discuss this issue thoroughly with you, they will arrive at the best decision for them.

Termination is a time when boundaries can become more permeable in general (Gabbard, 2010). Patients may feel they have the right to ask about the therapist's personal life, and some therapists may feel they have to respond—or they may have been dying to tell the patient all along and they now give themselves permission to do so. It is best to limit the amount of personal information, if any, that you give. Your patient may need to return to therapy with you at some time in the future. (Also—why spoil a nice idealization with the real facts about yourself?)

Another transference reaction that sometimes emerges during the termination phase—and may be particularly difficult for students to manage—is a patient's suggestion that the relationship be carried on in a different form after termination. For example, the more subtle among them may say, "I'd like to bring you a copy of a book I've been reading—I'm sure you'll like it. How about if I drop it by sometime?" Or, getting less subtle, "Since we're both students at the same university, why couldn't we meet for coffee once in a while?" And even less subtle, "I don't see what's wrong with our dating now that we are no longer working in therapy together." The answer to all such overtures must be "no." You might be surprised to learn how many therapists have gotten into trouble in this innocent way.

If this is causing you any difficulty, it is important to discuss the issue of "friendship," or a continuing relationship, in supervision. Some beginning therapists feel obliged to concede to their patient's request so as not to reject them. Some may feel flattered that the patient wants to see them afterwards. Interns may also feel that it is the only "democratic" thing to do; they are relieved that they can finally stop being seen as such a powerful person in the patient's life and can relate to them on a par.

If the motivation for the continued contact seems to be to prolong the therapy relationship under the guise of friendship, as in: "I'll keep talking and you keep listening, and supporting me," then this is obviously a raw deal for the therapist who hopefully has more companionable friends. If it is to prove that they are, and have been all along, your favourite patient—then this may pertain to unresolved issues of sibling rivalry. Sometimes the terminating patient's need to establish a special after-therapy relationship may involve unresolved oedipal wishes that are being acted out, as in: "I've got mommy/daddy all to myself now," and/or of course, an unresolved erotic transference.

In handling this situation, after exploring its roots, you can reiterate that turning the therapy relationship into a friendship—or even romance—would inevitably be very disappointing to your patient, because they would no longer be the central focus and would have to hear about your problems and limitations, too. This may be a good opportunity to further explore transference fantasies with such questions as, "What do you imagine I am like at university? What kind of friendships/relationships/marriage do you think I have?" The displacements from people from your patient's past, and the projections of what your patient wishes for him- or herself can be brought to light in this way.

If it is appropriate, you can reiterate that you do not become friends with your patients because you want to remain a potential therapist for them. They can find many friends—and even lovers—out there, but it may be hard to find a therapist who understands them the way you do now, and therefore it is preferable to leave the door open for future contact with you should they need it.

Transference reactions occur until the very end of therapy, and even long after. If you meet your patient in the street a year later, for example, you will still be a special person to them—and they to you, for that matter. Therefore, these reactions must be flagged and interpreted until the very end. They will continue to provide fascinating material for the understanding of your patient's personality, as long as you can allow yourself to be utilized as a transference object and can work hand-in-hand with your patient at exploring and understanding these reactions together in an accepting manner.

Counter-transference issues in "regular" ending

Novick (1997) states that for almost 75 years after Freud's (1937) seminal paper, psychoanalysts had been unable to conceive the idea of a terminal phase—and wonders whether this is because the word termination connotes death. In the past 20–30 years, however, a vast literature has accumulated on this topic; but Novick still maintains that there is something in the reaction of therapists to the end of treatment that gets in the way. Perhaps it is that with termination we have to get real–to face the realistic capabilities of ourselves, of our patient, and of the therapeutic method. Therapists seem to be experts in the use of denial, especially in denying that an ending is near.

As we have finally begun to examine ourselves and our reactions to this important and intense time, authors (e.g., Viorst, 1982) have written about the therapist's emotional reaction to the loss of the patient. From interviews conducted some years ago, it was found that analysts not only have the same range and intensity of feelings in reaction to ending as patients do, but they also use the same defences as their patients do to minimize the pain or to deny the loss. And like our patients, we may even have fantasies of post-therapeutic contact.

Why is this? Of course we are involved in the treatment to the same degree of intensity as our patients, but from a different perspective. Like parents of young adults, we have to be able to let go of our patients and have them grow further without us, hoping they will use what they have learned from us. As therapists, we are passing along the wisdom of what we have learned in our lives so far from our parents, from our teachers and supervisors, from our personal therapy, and from our own experience. It may be hard to acknowledge that there are some things we have not been able to teach our patients, some things they have not been able to learn, and some things that they will learn better without us.

Novick (1982) describes the ending of an analysis during which the patient expressed the thought that her analyst would miss her more than she would miss him. Quoting his patient, Novick says:

> My patient went on to say that although she knows me, especially from the way I have been with her, from how I have helped her and the

> interpretations I have made, mostly I have been a shadow puppet, a dim reflection on a screen thrown by a flickering candle in her head.
>
> (Novick, 1982, p. 354)

Of course, in analysis where the patient is usually lying on the couch, we are even less visible in almost every way than we are in psychotherapy. Still, the point remains the same.

He goes on:

> But I, on the other hand, have seen her more clearly and know her more intimately than anyone else does. I have watched her grow and change, and I have participated in the growth and change. Probably I will miss her more than she will miss me.
>
> (Novick, 1982, p. 354)

As he says, we know our patients as people, as real objects; they know us only as therapists.

The post-termination six-month check-up, described earlier, is surely as much for the therapist as for the patient, and some therapists even initiate it because of their reluctance to say goodbye. It is a good idea to keep these kinds of possibilities in mind, so that you will hopefully refrain from acting out your own needs with your patient, even as, or maybe especially as, it comes close to ending treatment.

Laura, a mild mannered 34-year-old flute player, came to see me because of extreme performance problems. She had great skill with her instrument, and had received various awards, in spite of being unable to perform without severe anxiety. She was most comfortable in a full orchestra, playing second or third flute, and even then, worried about her stand-mate's potential criticism of her playing. Laura's parents were both musicians, her father being well known as a jazz saxophonist. She had two sisters, neither of whom were musical; therefore, the focus was on her to maintain the family reputation.

Laura was a kind and sensitive soul, telling stories about helping her neighbours, worrying about her parents and other family members, and she behaved in a genuinely sweet manner in our sessions. I liked her almost immediately and respected her as well. She was the kind of person you want to tell your problems to, which, of course, was one of her difficulties. During our work together, Laura was able to understand the roots of her anxiety as related to her oedipal wishes to "play with her father," who only rarely felt she was a good enough musician. This was better, however, than her violinist mother was faring with him—he would never play with her. Of course, the sound of the saxophone could easily drown out the flute when they played, and served as a metaphor for their different personalities.

As Laura began to work through these issues about her idealized father, she remembered two "yucky" incidents where, as a teen-ager, when she was

wearing a bathing suit, he had leered at her in a sexual way. As these memories came to the fore, she became very angry with her father; this was undoubtedly the emotion against which the idealization had served to defend. The anger increased in intensity, and allowed her to question other parts of her father's behaviour, mainly his interest in her only as a narcissistic extension of himself, when he requested that she perform for his friends . As she was able to accept her anger and to allow herself to have negative feelings about her father, she was also able to separate more from him, and to see herself as a musician in her own right. Instead of playing jazz with (loud) saxophone accompaniment, or of being part of a full orchestra where she could hide, Laura began to play chamber music with a small group, which she enjoyed very much.

When Laura told me she was thinking of ending, I felt quite sad. I had enjoyed seeing her, and being a witness to the growth that had come from the way she had made use of my acceptance and support, as well as the insights we had gained together. During our ending, I was able to contain these feelings somewhat, but I know that she had some sense that the ending was hard for me. Still, she carried on and was able to leave without worrying about me so much that it got in the way—or so it seemed—which, in retrospect, would have been an important goal of her therapy. "Maybe you'll come to one of my concerts some time," she said at our last session. "Maybe I will," I agreed. I never did.

If a therapist is involved in treating couples, then the counter-transference feelings evoked at the ending can also be quite intense. The therapist, who is left behind, may feel bereft, or even abandoned (Usher, 2008). Couples have each other with whom to leave the treatment, and with whom to share the future; the therapist, on the other hand, returns to his or her office alone, which evokes a feeling of exclusion that harkens back to oedipal times. Memories of other abandonments are likely to surface in the therapist at this time.

There are times, also, when the therapist may feel a huge sense of relief when a patient terminates. Some of these issues have already been referred to in the section on counter-transference in premature termination, where the therapist actually acts out their negative feelings by ending the therapy too soon. If a patient has been persistently difficult to treat, and therefore makes you feel as though you are an incompetent therapist; if a patient reminds you of someone you don't like, or feel competitive with, or envious of; if a patient is overly intrusive into your personal life, finding ways of knowing more about you than you care to share with them; and/or if a patient is diminishing of your observations—all these factors, and others that have already been mentioned, can lead to the therapist's celebrating with a nice glass of Merlot, when the patient terminates and the file is closed.

Is the ending really the end? In some ways it has to be, when the patient and therapist no longer live in the same city; when the therapist is ill or retired; and when no further contact is desired or needed. Even then we continue to

remember each other—after many years have passed. And always for our patients, we hope termination is a beginning of sorts, where a new appreciation of life and of what one can accomplish has been started, and a new way of thinking about life that stays with them has begun.

Chapter 8

Using supervision

Here is a rather poignant, but unfortunately true, vignette from some time ago, which may seem somewhat exaggerated, but probably not unfamiliar, today.

In a rare early article actually written by a supervisee, Gauthier (1984) describes his experience as a psychiatric resident in supervision. He saw himself in "the role of the messenger," bringing the supervisor's words to the patient. Referring to the impotence student therapists sometimes feel, Gauthier offers this clinical example from a time when he was treating a difficult patient: At one point in the therapy, this patient brought him a gift. He relates:

> I brought the gift, intact, to the supervisor. As I often had the feeling that the real therapeutic relationship was more between him and my patient than between me and her (or at least that it should be, for the patient's sake), wasn't the gift addressed more to him than to me?
>
> (Gauthier, 1984, p. 515)

The use of supervision has been mentioned frequently throughout this book because it is seen as an extremely important and valuable learning opportunity. If made use of correctly and often, supervision can be of enormous benefit to the beginning therapist—and even to the more experienced therapist. Schwartz and Abel (1955) state that, "The heart of the education of the psychoanalytic psychotherapist, apart from personal analysis, is supervised clinical experience" (p. 257). There are several very early articles on dynamics in the supervisory setting that the more eager among you might want to consult, including Knight (1945), Kelly (1951), and Hutt (1953). More recently, Gabbard (2010) has stated, "Long-term psychodynamic psychotherapy occurs in a dyad, but is learned in a triad of patient–therapist–supervisor" (p. 189).

Supervision is a highly personal learning experience for both parties, the skills of which neither party has been taught: students, for the most part, aren't educated in what to expect from supervision, and supervisors rarely get active training in supervisory technique, although an introduction to different

methods of supervision and its structural aspects is offered in an early paper by Wagner (1957). As well, the supervisory dyad is a veritable hotbed of dynamics, given that this twosome contains the anxieties of the supervisee, the patient, and the supervisor, and involves the continuous threat of mutual evaluation, plus the reciprocal fears of exposing one's weaknesses. As Jacobs (2001) commented, "[for supervisors] these can include wishes to be helpful, to be admired, or to be found attractive or intelligent. The student may be seeking a mentor or a parent or an oppressor" (p. 813–814).

Supervision is usually most anxiety-provoking for the supervisee, who is put in the unique and difficult position of being a part of two emotionally charged relationships at the same time—shifting back and forth from the helper to the one being helped—and where every interaction is being scrutinized by the individuals on both sides. In addition to this, unconscious forces are being mobilized in all three people. How then, you ask, can anyone relax enough to learn in this situation?

Let us examine what happens in supervision, step-by-step. Often before meeting your supervisor, you have heard some "information" about them through the grapevine. This information usually revolves around the way the supervisor interacts with the interns—for example, tough or easy; their theoretical orientation to doing psychotherapy; or comments such as, "I learned a lot, or they talked about themselves the whole time." Sometimes you may have the luxury of choosing a supervisor; often they are assigned. Because the supervisory situation is set up not only as a place to get help with your patient, but also as an evaluative situation, it is quite natural to feel that you want to make a good impression on your supervisor and thus to be somewhat defensive, at least initially. As Beckett (1969) has observed, most supervisees need to be "good students." However, when this need is based on the mistaken impression that the "good student," like the "good patient," has no resistances, no reservations about trust or openness, and no crises of confidence, this presents an obstacle to full reporting. Of course, it is easy to say that student therapists should be open and trusting, and should not either fear their supervisors or have irrational expectations of them, but carrying this out is, on some level, impossible, especially in the beginning of the relationship (just as it is for our patients). All of this, of course, will affect the way you present your patient in supervision. This is unfortunate, but certainly to be expected, especially in the beginning.

It may be helpful to realize that the supervisor–supervisee relationship is just that: a relationship; as such, it will have its ups and downs. As Gabbard (2010) has said, we can speak of a supervisory alliance the way we talk about a therapeutic alliance, as they have much in common. In therapy, the patient unloads painful material onto the therapist, expecting the therapist to contain it; in supervision, the supervisee unloads that difficult material onto the supervisor, with the expectation not only of containment, but also of getting help to manage it.

Beginning therapists may have the underlying assumption that the supervisor is above experiencing anxiety or failure, always knows the right thing to say, and is certainly objective. As endearing as this belief may be to those of us who supervise, it encourages a situation that hinders the development of the intern. And we all have to bear in mind that, in the end, it is the patient who knows best.

Before we go any further, it may help to know that most of these dyads run quite smoothly, and a climate usually develops where the student therapist can feel nurtured, taught, and understood in the deepest sense of the word. These relationships often carry on long after the intern has become a colleague, each maintaining a special relationship in the other's professional life.

Most psychoanalytic/psychodynamic supervisors structure supervision in a way that is somewhat analogous to the way the therapy is carried out. Whether you meet with your patient weekly, or more frequently, your supervisor will establish a set time to meet, usually once a week, with the meeting lasting approximately one hour. Both parties commit to this time, which provides you with a protected space in your supervisor's schedule.

The contract of the sessions is, essentially, that the therapist will communicate to the supervisor what has transpired in the therapy hour: an account of the patient, the session, and their own impressions. The discussion will involve the supervisor's offering guidelines, a possible interpretation if it is timely, but mainly a better understanding of why the therapy is progressing—or not—in the way it is. Different supervisors use different methods to hear the data, although most prefer to listen to the therapist present the case, and then make their observations.

As mentioned in the Preface, in the days when I asked students to record sessions, I would listen to their recordings and make notes, my rationale being that this way I heard not only the words, but the music as well. In a rather unique article, Fink (2007) describes finding himself in the unusual position of not only seeing in analysis the same patient on whom he had supervised a student analyst, but also of not recognizing the patient until he had seen him for several months! In this case, both Fink and his supervisee felt they had earlier done an excellent job—both with the patient and in detailed supervision, so much so, in fact, that they had given a presentation of their work together at a professional meeting. So, he asks, why didn't he recognize the patient when he came back for more treatment some years later? He states:

> This patient is not truly known to the supervisor: the supervisor's patient is the one brought by the student to the supervisory session but he changes when he is metabolized by the supervisor, before finally becoming the joint creation of the student and his supervisor.
>
> (Fink, 2007, p. 1265)

The student therapist's experience of the patient was so different from his supervisor's—once the supervisor began treating the patient—because of the

different transference the patient had to the student (mainly negative) compared to his transference to the supervisor (mainly positive), and the resultant counter-transference. Because of his experience of surprise when he discovered that this was the same man his student had treated, Fink suggests, at the end of his article, that recorded sessions would make supervision more accurate; presumably he would have recognized this patient immediately had the sessions been recorded. However, as I mentioned in the Preface, recording has its downside too.

Still, there were times during my own supervisee taping days, that I found listening to the tapes did provide extra insight. In one case, a usually very reserved and quiet intern began to discuss her patient with me in a highly animated fashion. Initially, my thoughts were about how anxious she must be being supervised, and how hard she was trying to please me. In listening carefully to her tapes, however, I noticed that her patient spoke very rapidly and excitedly. Once this was identified, this intern became aware of how overwhelmed she felt with her patient, whose pace was so different from her own. She acknowledged that she was worried that she would not remember the intense flow of words and would not be able to respond appropriately. It felt as if her patient was making a demand on her that she could not meet, and by talking in this way to me, she was turning that demand over to me to help her manage. In this case, the tape probably brought to light much more quickly a phenomenon we may or may not have noticed eventually.

In more recent years, partly because of the cumbersome nature of taping for all involved, I prefer to just listen to my supervisee, which is the most common method supervisors use. In this way, the supervisor can hear the intern's take on the session, with all the accompanying emotion the therapist feels; as time goes on, interns will usually start to notice the data they have distorted or "forgotten." In terms of the supervisee's reading to the supervisor from copious notes, I think something of the same problem holds true as with tape recording—the dyad risks missing the therapist's affect in the service of "completeness." As it turns out, interns learn mostly by how the supervisor behaves with them, than by any theory they are currently espousing.

In a book chapter entitled "The Empathic Vantage Point in Supervision," Sloane (1986) states that supervisors should act in supervision the way we hope our supervisees will act as psychotherapists—basically to shut up and listen. Sloane tried suspending his tendency toward theorizing and interpreting, despite the responsibility he felt to inculcate knowledge into his supervisees, and allowed himself to float with the material presented, reacting emotionally and in fantasy. The dilemma for the supervisor, then, is to teach while providing a role model of how to listen. If you, as a supervisee, do not feel that you are getting enough airtime in your supervisory hour, this needs to be raised with your supervisor.

In an early article, Fleming (1953) outlined three types of learning that may occur during supervisory sessions: 1) Imitative learning, or learning by

identification—where the supervisee completely identifies with the supervisor's approach; 2) corrective learning—where, by discussing the patient's dynamics, the supervisor helps the student clarify their understanding of the patient so as to arrive at a more accurate interpretation; and 3) creative learning—where supervisees are taught to ask questions of themselves (e.g., "Why is the patient telling me this at this time?") and to begin to find their own answers. He suggests that these types of learning often occur sequentially in the relationship as the student begins to gain more confidence as a psychotherapist.

Most of the articles on supervision in the literature have been written by supervisors for supervisors; however, it is important that interns who are about to be supervised, or who are in supervision, be made aware of what is being discussed. In 1955, Searles published a landmark paper identifying an important process in the supervisory dyad, which he termed the process of reflection. This process later came to be referred to as the *parallel process*. (Eckstein and Wallerstein, 1958). Further research on this was carried out by Doehrman (1976).

In essence, the reflection, or parallel process, implies that the therapist may act out, or dramatize, in some way in supervision what is being played out in the therapy. In this way, the therapist communicates to the supervisor what has happened with their patient, causing a parallel process to occur in the supervision hour—that is, parallel to what occurred in the therapy hour. This acting out, or dramatizing, may be subtle as, for example, when the supervisee cancels sessions when their patient cancels appointments. The supervisor, glad to have the free hour, may collude with this type of request. Or, the acting out may be less subtle, for example, acting aggressively with the supervisor, or withholding information from the supervisor—usually unconsciously—in the service of demonstrating what it is like to be treating this patient. As there are direct influences from the patient–therapist relationship on the supervisory dyad so there are influences from the supervisory dyad on the patient–therapist interaction.

A mature, seasoned clinician arrived for her first supervisory session with me carrying a large briefcase, and an even larger purse, and began rifling through them as soon as she was seated. Despite the rather desperate act of dumping out the contents of each on the floor, she discovered that she had not brought with her the exact notes from the session she had wanted to discuss. After we explored this as an indicator of her transference to me—she had expected me to be critical of her work—she began to describe her patient. She was surprised to hear herself talking about how scattered her patient was in their sessions, moving from topic to topic, and also in her life, where she was unable to settle in terms of her job or living arrangements. As it turned out, because of her own counter-transference, this was the most troublesome feature of this patient for her, and the one she needed help understanding.

It is the supervisee's uncharacteristic behaviour, then, that can alert the supervisor to the presence of an unverbalized conflict that has arisen in the therapy, and has not yet been identified or understood.

To reiterate with a quote from Searles (1955), in the parallel process:

> The therapist . . . is unconsciously trying to express something about what is going on in the patient—something which the therapist's own anxiety prevents him from putting his finger upon and consciously describing to the supervisor. It is as if the therapist were unconsciously trying, in this fashion, to tell the supervisor what the therapeutic problem is.
>
> (Searles, 1955, p. 144)

Miller and Twomey (1999), in an article entitled "A parallel without a process," dispute the idea of the parallel process, saying that the supervisory process is not parallel to the therapy because different individuals are involved. From a relational perspective, they state that parallel process is too limiting a concept, as it doesn't take into account the intersubjective field and the larger dynamics of the supervisory relationship. They also state that when a supervisor is interpreting parallel processes, this places them in an authoritative position—as the observer—and does not take into account the part of the supervisor's personality that is affecting the enactment.

Still, most supervisors and supervisees find the understanding of a possible parallel process unfolding very helpful, even if it is not the whole story. One of the aspects of the supervisory relationship that does not parallel the treatment relationship is the fact that there is a clear teacher–pupil component. Because a certain amount of didactic instruction has to be provided, the teacher/supervisor is more sanctioned than the therapist to give advice, offer interpretations, and in general, spread one's knowledge around. Note to supervisors: we know that supervision can be quite gratifying for you since you are permitted, even encouraged, to hold forth with supervisees in a way you cannot with patients. Unfortunately, there are times when we do not behave in supervision in the manner we know to be the best example of empathic listening.

As was mentioned earlier, most of the articles about supervision have been written from the perspective of the supervisor, and much of the supervisee's experience is undoubtedly missed. The article cited at the beginning of this chapter is one exception. Beckett (1969), also writing from the supervisee's perspective, emphasizes the tension in the supervisee–supervisor set-up for the student. He says that if, on top of the therapist's natural anxieties and uncertainties, we add the fear of making mistakes and of being criticized by the supervisor, the difficulty of learning the art of psychotherapy is compounded.

We can certainly see that students feel that the need to present an impressive front to their supervisors, while still being able to report problems with their patients whom they are having trouble managing, requires a fair amount of interpersonal juggling. The student coming to the supervisor has three conscious choices: to disclose the material to the full extent of their awareness;

to severely limit or edit parts of the material, or alter the context of it; or to omit the material entirely from the discussion. There are some students who will solve this dilemma by presenting only "positive" material from the session that shows how well their patient is moving forward, and how they are conducting the therapy consistent with their supervisor's theoretical and therapeutic stance. Of course, the intern in this case learns very little. Other supervisees will present only "negative" data, partly as a cry for help from the supervisor and partly to defend against the possibility of being criticized; therefore, they criticize themselves before the supervisor has a chance. Again, minimal learning is achieved.

Another difficulty that may arise in your first experience as supervisee is that you may sometimes find yourself interacting with your patient in a way that you either do not understand, or do not agree with, simply because this is what your supervisor seems to be advising. This is a very unhelpful situation for all three parties. Certainly, major problems can arise if the student and the supervisor do not have a clear idea that the treatment of the patient is the student therapist's responsibility. "The supervisor's function is to further the growth of the [intern], not to treat his patient by remote control" (Beckett, 1969, p. 173).

Despite the anecdote that opens this chapter, most supervisors do not expect the supervisee to take back to the patient a word-for-word—or even close—interpretation or other observation they have discussed. Because none of us knows what the patient will bring next, the probability is that the very topic you discussed in supervision will not emerge again for quite a while; therefore, even though your supervisor has come up—yet again—with an exquisite interpretation, chances are you will not be able to try it out right away, and it has to be put away in your mental file for possible later use. If you enter your post-supervisory therapy session with your supervisor's comments ready to spill out, your patient will experience you as noticeably unempathic. One of the worst listening "crimes" we as therapists can commit is to go into a session with an agenda. This severely limits your free-floating attention.

Several issues about supervision seem to be forever a challenge for the beginning therapist: How much should you keep your supervisor in your head when you are with your patient? How much do you try to work the way your supervisor advises, even if it does not feel consonant with your own style? How often do you not respond to your patient spontaneously—with what feels right—without first checking with your supervisor? How often do you feel like not sharing something that you are doing with your patient? This latter has been pointed out by Gabbard (2010) as the slippery slope of a possible boundary violation. Managing these sorts of issues can be difficult; however, your supervisor may be able to give you concrete examples of when certain behaviours are appropriate and when they are not.

The timing of your supervisory meeting is also an important factor. From my experience, it is best not to schedule supervision immediately after your

therapy session with your patient, as this tends to encourage ventilation and dumping on your poor supervisor rather than thoughtful consideration of what has just happened. Even worse is scheduling the supervision for the hour before your therapy session, as then you will be tempted to ventilate and dump on your poor patient, having not had the time to digest the discussion you have just had. As has been stated, it will be impossible to listen to your patient if you are still preoccupied with what your supervisor has said in the session before.

Transference issues in supervision

Melanie, a clinical psychology graduate student, came to the hospital where I worked because she wanted to learn about a psychodynamic approach to therapy. She had been in other placements where shorter-term therapies had been taught and had found them unsatisfying. I happily agreed to be her supervisor, and she managed to locate herself in an office across the hallway from mine. As the supervision progressed on a very difficult case, she began to reveal more and more about her personal life to me. Wallace and Alonso (in Greben and Ruskin, 1994) have noted:

> As the supervisory relationship unfolds, there evolves a dynamic tension and interplay between the dual pulls toward privacy on the one hand and disclosure on the other . . . The pull toward disclosure on the part of the trainee is fueled not only by the wish for connection with an admired teacher, who may come to serve as an object for identification, but also by the necessity of exposing psychotherapeutic work in order to learn. Supervision is based on the premise that the supervisee will disclose (as fully as possible) what has occurred [with the patient] . . . and, in addition, will discuss feelings that are pertinent to the interaction.
>
> (Greben and Ruskin, 1994, p. 211)

Doehrman (1976) studied the intense transference reactions that therapists have to their supervisors and tried to assess the effects of these transferences on the way they conducted psychotherapy. She concluded that if the conflicts in the supervisory relationship are not resolved, they will be acted out with patients.

In Melanie's case, the conflicts centred around her controlling mother (what else?), implying that I was so different from her—in a positive way, of course. She began to suggest shops that her mother frequented, stating that I would buy more exciting clothes in these shops than her mother had. And as she told of trips home, she covertly asked for advice in dealing with her parents. Things became even clearer when another graduate student joined our department and also requested supervision from me. Predictably, perhaps,

these two students did not get along very well from the beginning, and often fought over the office space they were supposed to be sharing. I finally suggested to Melanie that she could benefit from her own psychotherapy, and she readily agreed. About one month later, she came into my office quite sheepishly, and said, "I don't know if this is appropriate, but I was wondering if you would see me in analysis or psychotherapy." As tempting as this was in some ways, I did not acquiesce and referred her to a colleague. She felt rejected at first, and it took some time for us to work this through. Now I enjoy meeting her at conferences and hearing about her life.

Actually carrying out psychotherapy under the guise of supervision has been referred to in the literature as the *teach-or-treat* dilemma. Supervisees are often tempted to use their supervisors as therapists, even when they are in their own therapy, and supervisors are often tempted to collude. Because transference and, particularly, counter-transference issues in terms of work with the patient are being discussed, interns will probably be involved in at least some self-disclosure, as in: "Why does this patient get to you so much? What is it about this patient that you find exciting, annoying, scary?" This naturally involves the supervisee's reflecting on their own issues, and is referred to as counter-transference focused supervision. Most authors agree with Sarnat (1992) and Zaslavsky, Nunes, and Eizirik (2005) that the supervisees' counter-transference problems that are actively impinging on their professional functioning should be dealt with in the supervision where the actual case is being discussed. It is important, however, for supervisors to be able to draw the line appropriately here, and to understand the part of the material from the supervisee that reflects directly on their treatment of their patient. Other issues troubling the supervisee will have to be referred to a therapist outside of the supervisory relationship.

A recent expression of transference in a supervisee really took me by surprise. I was supervising an experienced intern when I suddenly had a speeded up heart rate and some dizziness. I thought it was just a minor thing and continued with the supervision until the end of the hour. The supervisee, whose husband was a physician, kept asking me if I was ok, and looked very worried. I told her I would go to the ER to have it checked out right after we finished, and said, repeatedly to her, "Thank goodness this didn't happen when I was with a patient!" When I saw her next, I had received medication and reassured her that I was fine. She had spoken to her husband about it, and he had said that such things could be dangerous. Again I said that I was relieved I wasn't with a patient when it happened. At the end of our supervision contract, I heard very little from this intern—which is unusual—and decided that she had found other sources of support. Just recently—about one year after we ended—she wrote to me asking for a referral for one of her friends. It was only when I noticed that she began her email with, "How are you? How is your heart?" that I realized how spooked she had been by

that episode. I again reassured her that things were fine, and now newly enlightened, wished I could ask her about her past experience with illness and death. However, the circumstances were no longer right for this kind of exploration, and so I had to rely on her knowing that I am still around to be helpful to her—and to be grateful to her for teaching me another lesson about transference in supervision, that is, that it occurs!

One of the important parallel processes that we can observe in supervision and in therapy is that the ending of the intern's psychotherapy with their patient may also signal the termination of the supervisory relationship. Here again, the beleaguered therapist is in the middle of two emotionally charged situations. Often the termination of the supervisory relationship is dealt with vicariously by using the patient's feelings about stopping treatment, and the therapist's feelings about ending work with the patient. This can serve as a displacement of the supervisory couple's feelings about ending their relationship. If this happens, the ending of supervision may not be talked about in detail—or at all. However, since the possible intensity of this relationship with its many transference opportunities has been described, the ending of the supervisory relationship should be viewed as significant. The issues that arise in the termination of psychotherapy—issues of separation and loss, and of growing up—are an integral part of the ending of supervision.

For some students, of course, the ending of the supervisory relationship may come as a relief, as they feel they no longer have to account for their every word and they are no longer being evaluated. Particularly if the relationship has been intense and negative and transference feelings have not been able to be worked through, or in reality there has been a bad match, the intern may feel they have been let out of school and are now free to go their own way. If the relationship is one that has been characterized by dependency, the student therapist may feel uneasy, or even frightened, about going out alone into the professional world.

Very often both students and their supervisors feel sad to say goodbye. They see the relationship as having been a mutually rewarding one and one in which each has learned from the other. They usually have developed a bond of mutual respect and a comfortable way of relating to each other. In the best of situations, each has enhanced the other's self-esteem and sense of professionalism. It is important and helpful to both the student and the supervisor to allow time for the discussion of at least some of these feelings before ending the supervisory relationship.

And, as Gabbard (2010) has said, the effective use of supervision in our training years sets the stage for ongoing consultation throughout our professional lives. Even if you have been in your own therapy, you will still have blind spots—we all do—and you will find that talking to a colleague or supervisor who is not embroiled in the transference–counter-transference mix is extremely valuable.

Counter-transference issues in supervision

As we have said about the parallel process, the supervisor may be pulled into an involvement with the supervisee in the way that the supervisee is pulled into an involvement with the patient. One of the methods that helps decide whether this phenomenon is occurring is the supervisor's ability to tap into what they are feeling during the supervision, and evaluate it. This is counter-transference in the sense of having a partly unconscious response to the student therapist and their interaction with the patient, and can be an extremely useful source of information:

> The emotions experienced by a supervisor—including even his private, "subjective" fantasy experiences and his personal feelings about the supervisee—often provide valuable clarification of processes currently characterizing the relationship between the supervisee and the patient. In addition, these processes are often the very ones causing difficulty in the therapeutic relationship.
>
> (Searles, 1955, p. 135)

Gorkin (1987) has written an excellent chapter on counter-transference in supervision, acknowledging the emotional phenomena that arise within supervisors as they engage in the supervisory process. These parallel processes can flow in both directions: from the patient "upward" through the therapist to the supervisor, and from the supervisor "downward," so that the patient is affected.

Supervisors have their own vulnerabilities as well as narcissistic needs to help, to teach, to be admired, to be emulated, and to know all the answers. They may enjoy being seen as a guardian angel—giving much-needed help and guidance to the struggling therapist and patient. Or they may dread being seen as the chaperone on a honeymoon—intruding into the private therapy relationship:

> Supervisors, furthermore, are not immune to desire for, or envy of, their students. Because of aging, or out of some other perceived loss of powers, a supervisor may [use the supervision to] . . . recapture a lost youth, vitality, or power . . ..
>
> (Jacobs, 2001, p. 817)

These feelings will affect how they supervise.

Just as the patient who knows their therapist is being supervised may have a fantasized relationship/transference to the supervisor, a supervisor may have a counter-transference reaction to the patient, as they are hearing about them. The supervisor may feel sorry for the patient, may feel attracted to the patient, may feel angry at the patient, may identify with the patient, or may wish

they were the therapist. All of these supervisory counter-transference reactions —especially the latter where the supervisor has the fantasy of rescuing the patient from the intern and treating them himself, as Fink (2007) cited above inadvertently did—of course will affect how the supervisor listens to/evaluates the therapist.

Supervisors know that they, too, are being evaluated and judged. How they treat the supervisee will be talked about among the supervisee's peers, so that depending on how much they need to be liked, they may limit their observations accordingly. Hint for supervisors: If you are spontaneous and natural, humble and empathic, able to listen patiently, and have a sense of humour, your students will notice this. They will also appreciate if you share with them your own views, doubts, concerns, guiding principles—and ignorance—not necessarily your own accomplishments, during the process. A good supervisor knows that learning in supervision goes both ways.

Epilogue

And so we have come to the ending of this book; hopefully it will have provided an interesting beginning to your career as a psychodynamic psychotherapist. Of all the professions, this one—at once scientific and enigmatic —demands the most of its practitioners as human beings: it will challenge your intellect, your emotions, and your personal philosophy of life as no other profession will.

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